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The evolution and experience of stomal therapy nurses in Australia 1959-2000

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**The Evolution and Experience of Stomal Therapy Nurses in Australia
1959 - 2000**

Keryln Carville RN, B.Hlth.Sc.(Nsg), PhD(Candidate)

A thesis submitted in fulfilment of the requirement for the award
of
Doctor of Philosophy (Nursing)

Faculty of Computing, Health and Science
Edith Cowan University
Churchlands, Western Australia

December, 2003

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ABSTRACT

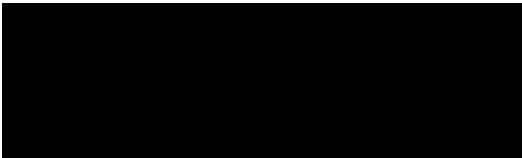
The Evolution and Experience of Stomal Therapy Nurses In Australia 1959 - 2000

In Australia, stomal therapy nurses are registered nurses who have undertaken an educational programme in the care, counselling and rehabilitation of persons who have, or who could potentially have, a wound, an ostomy (that is an artificial opening into a body cavity) or incontinence of bodily waste. The genesis of stomal therapy nurses in Australia as a specialty group within the broader nursing profession was in 1971, when 11 founding members established an association for registered nurses with an interest in the care of patients with stomas. However, the serendipitous event that pre-empted the formation of this special interest group, can be traced to an individual nurse's first clinical experience of caring for a patient with a stoma in 1959. The purpose of this study was to uncover the historical events that led to the development and evolution of stomal therapy nurses in Australia, and to describe the lived experiences of stomal therapy nurses within that historical context. The study employed two different qualitative methodological approaches. Separate historical and phenomenological studies were conducted and the uniqueness and philosophical foundations of both methodologies were preserved. The two independent studies stand alone in their sample population, data collection, data analysis and findings. The historical study findings opened a window to the past and revealed the persons, events and forces, that were instrumental in the development and evolution of stomal therapy nurses and nursing in Australia. The phenomenological study findings revealed the essence of what it is to be a stomal therapy nurse in Australia and a member of the Australian Association of Stomal Therapy Nurses. Comparative and contextual analysis of the historical and phenomenological findings was then conducted in order to enhance the understanding of the phenomena. This comparative and contextual analysis of historical and phenomenological findings has been termed *historio-phenomenology* and this approach has revealed the key findings of this study. These key findings revealed an exciting insight into the professional characteristics that define a *Good* nurse and the behaviours and attitudes that reflect the essence of *Good* nursing.

DECLARATION

I certify that this thesis does not, to the best of my knowledge and belief:

- (i) incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education;
- (ii) contain any material previously published or written by another person except where due reference is made in the text; or
- (iii) contain any defamatory material.



Keryln Carville

December, 2003

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‘When an old person dies a library burns to the ground.’

(African proverb)

During the years I have taken to complete this thesis, four great and influential ‘libraries’ burned to the ground. They were Sir Edward Stuart Reginald Hughes, Norma Gill-Thompson, Gwen Anderson and Professor Bryan Brooke. The significant contributions of these extraordinary people impacted on the establishment and evolution of stomal therapy nurses and ostomy associations in Australia. I dedicate this thesis in part to their memories. Furthermore, I extend this dedication to Elinor Kyte, who I acknowledge to be the ‘Mother of Stomal Therapy Nursing’ in Australia.

To all the stomal therapy nurses, surgeons and people who so generously gave of their time and shared their memories and experiences with me I offer my sincerest appreciation, and pay due professional homage to their contributions to the development and evolution of stomal therapy nursing within Australia.

To my supervisors Dr Kathy Ahern, Prof Geoffrey Bolton and more recently, Dr Kate White, I express my sincere appreciation and gratefully acknowledge their most valuable supervision and encouragement. In particular, I would like to acknowledge Dr Kathy Ahern’s enduring professional support. This odyssey has been enriched and the burden of the research journey lightened because of her belief in the value of this study.

Words remain inadequate however, to acknowledge the support, love and encouragement I have received from those I hold most dear.

Frank – my beloved and the wind beneath my wings.

Deborah – wise beyond her years and endlessly generous in her encouragement.

Andrew – gifted with patience and ability to impart his expertise in computing.

Above all, to God who truly has held me in the palm of His hand and shown me something I had not known. Isaiah 49:16 and 52:15b.

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Preamble

The traveller views a two dimensional object that projects onto the horizon. A shimmering haze obstructs his vision, but the object is perceived to be a solid structure sandwiched between the valley floor and the sky canopy. It appears as a dominant dark stain blotted against the softer hues on the landscape canvas. The traveller's past experience allows him to assume that it is a mountain but he feels compelled to confirm its existence and identity. A road map confirms a named mountain exists, but the distance prevents him from knowing the true nature of that mountain.

As the traveller approaches, the mountain grows in size and he realises that it is not a flat vertical shape but a series of undulations that cascade from a central peak. It is still viewed as a two-dimensional object, but now the single-coloured landmass offers variations in shade and light that reflect the passing of the sun. As the road draws him closer he comes to a fork in the road and he has to decide which route to take. The more direct route bypasses the mountain and affords a view from one aspect only. The other road winds around the mountain and although this route will extend his trip, the traveller anticipates the route will afford comprehensive views that will enhance his understanding of the terrain. He selects the latter route.

As he drives around the mountain the traveller observes its three dimensional construction, which projects an image of stability and strength. The lateral and rear slopes reflect different characteristics of shape, colour, shadow and light. The traveller notices a narrow track winding up the slopes. He stops at the base of the mountain and decides to walk upon the track.

He notices that nature's palette has decorated the closely viewed landscape in a kaleidoscope of hues. It is now not the single dark coloured mass that he noted from the distance. As he advances on foot he has the opportunity for close contact with trees, grasses, shrubs, flowers, boulders, pebbles and earth. The traveller gains a more intimate understanding of the mountain as he walks and his eyes focus on the uniqueness of individual botanical specimens. He breathes in the fragrances that radiate from the earth and the surrounding vegetation. His ears capture the sounds of his footsteps upon the loose gravel, of the wind whispering in the trees and the songs of

birds. The path winds upwards and an occasional signpost points to a site of geographical or historical interest. He takes the time to investigate each phenomena and his perception of the mountain alters as he gains an understanding of the past effects of time and events on the mountain.

On reaching the crest the traveller pauses to take in the view that lies before him. The mountain is now contained under his feet and what appears vast is the flattened landscape that reaches towards the shimmering horizon. He views a line snaking far into the distance. It is the road he travelled and although time and distance tend to reclaim familiarity, he recalls the journey and his past experience of the mountain from the now distant horizon. On reflection he decided it had been a *good* decision to change course en-route, for not only had he gained from the experience of the journey, but his understanding had been expanded as a result of experiencing the essence of the mountain.

Chapter 1

The Introduction

The narrative of the traveller is an allegory. The tale describes a traveller's journey and his experience of that journey as a phenomenon in itself. The journey and his experiences en-route are both independent and interdependent experiences. The traveller began his journey with a destination and anticipated route in mind. Had the traveller continued on his planned journey he would have passed the mountain and although he would have been able to define it for what it was, his understanding of the mountain would have been limited to a single view. His journey toward the mountain was an evolutionary experience, whilst his decision to explore the mountain afforded him an opportunity to experience the essence of the phenomenon. Both experiences expanded his understanding.

To the traveller, the journey and the exploration of the mountain represented a quest for the fullness of experience. So it was with me, who in search of my proverbial 'mountain' realised in the midst of data collection that there was an opportunity to gain a greater understanding of the life and world of stomal therapy nurses in Australia. Like Odysseus' fabled journey to Ithaca, this odyssey has been subject to the winds of change. The study began as an historical study, but in recording and reviewing the oral histories of the stomal therapy nurses, it became obvious to me that the nature of some of the data lent itself to historical analysis and some of the data to phenomenological analysis. The reasons for this decision will be explained fully in chapter 2. However, the predominant reason to combine these two qualitative methodologies in the one study was made when I realised that they afforded greater insight and understanding of the experiences of stomal therapy nurses in Australia. This approach presented an opportunity to compare the applicability of the two methodologies for answering the research questions.

Moreover, it became increasingly apparent that present experience is influenced by both past and anticipated experiences. Therefore, I sought a more profound understanding of how the historical experiences of stomal therapy nurses, as they evolved into a specialty

of nursing in Australia, influenced the experience of being a stomal therapy nurse. A combined historio-phenomenological approach offered me an opportunity to view both sides of my proverbial 'mountain' and more importantly, provided an opportunity to compare the views.

In Australia, stomal therapy nurses are registered nurses who have undertaken an educational programme in the care, counselling and rehabilitation of persons who potentially will have, or do have, a wound, an ostomy (which is an artificial opening into a body cavity) or incontinence of bodily waste. The genesis of stomal therapy nurses in Australia as a specialty group within the broader nursing profession was in 1971, when 11 founding members established an association for registered nurses with an interest in the care of patients with stomas. However, the serendipitous event that pre-empted the formation of this special interest group, can be traced to an individual nurse's first clinical experience of caring for a patient with a stoma in 1959. This study focuses primarily on the evolutionary events that have impacted on stomal therapy nursing in Australia from 1959 until 2000. However, the historical events that long preceded, and ultimately influenced, the need for stomal therapy nurses and their evolution as a nursing specialty in Australia will also be discussed. Insight into these events will expand the reader's understanding, and therefore will be referred to as the historical background to the study.

An historical study allowed me to define the developmental and evolutionary processes of Australian stomal therapy nurses and stomal therapy nursing. It also allowed me an opportunity to include the experiences of certain surgeons who performed ostomy surgery and individuals who underwent surgery for the formation of a stoma. It contextualised these past experiences of stomal therapy nurses, surgeons and individuals in regard to events, societal forces and contemporary societal values of the day. This not only led to an understanding of how and why stomal therapy nursing evolved in Australia, but how these evolutionary forces impacted on the experience of being a stomal therapy nurse. In addition, the historical study provided insight into how the evolution of stomal therapy nursing has influenced nursing practice generally in Australia. It also highlights comparative trends in stomal therapy as a nursing specialty and the surgical specialty of colo-rectal surgeons.

In recording the interviews of the stomal therapy nurses, it became obvious to me that many of the experiences discussed by some of the nurses were very intrinsic in nature. Although these experiences were initiated by extrinsic events or forces, they had a personal and internalised consequence, which caused the stomal therapy nurses to question their attitudes and behaviours and compare them to those of other nurses. I perceived that the stomal therapy nurses considered themselves to be different to their non-stomal therapy nurse colleagues. Whilst their narratives revealed a personal willingness and interest in caring for persons with a stoma, they frequently talked of the reluctance to care and stigmatising behaviours of other nurses they had seen directed towards persons with a stoma. This stimulated a desire within me to know the nature of any difference that may have existed amongst stomal therapy nurses and their generalist nurse colleagues. Phenomenological analysis afforded the method for interpreting the essence of these intrinsic experiences. It provided insight into being a stomal therapy nurse.

Much like the traveller in the allegory mentioned previously, I was faced with a dilemma. To have continued on my initial methodological route would have allowed me to define the historical experiences of stomal therapy nurses and stomal therapy nursing in Australia. On reflection, there is no doubt that this would have been the shortest route to have taken. However, an increasing desire to know how these nurses perceived what it was to be a stomal therapy nurse pulled strongly at my professional heartstrings. I was also very mindful that the shared experiences of the nurses were all contextual to time and situation.

Both history and phenomenology are interested in interpreting experience, albeit in different ways. In this study the experiences of stomal therapy nurses were seen to be influenced by time and situation. Therefore, I was interested to know if historical and phenomenological methods offered different interpretations of the same experience, or if a combination of these methods would expand the opportunity for interpretation of the essence of that experience. Like the traveller in the allegory, I extended my research journey in order to comprehensively define the genesis and evolutionary history of stomal therapy nurses and the experience of being a stomal therapy nurse in Australia.

Background to the Study

There are 24,000 Australians with stomas that are the result of surgery of the gastrointestinal or urinary systems (Australian Council of Stoma Associations, 2000). A further 960,000 Australians have urinary incontinence (Millard, 1998). How these figures compare to the numbers of Australians with acute or chronic wounds is difficult to determine in the absence of comprehensive national data. However, the known number of people with stomas and associated wounds as well as those with incontinence is high, and they warrant specialised nursing expertise in ostomy, wound and continence care.

The title 'stomal therapy nurse' does not actually reflect the diversity of skills and activities which are embraced by these practitioners. In reality, stomal therapy nurses are generally expected to possess a range of skills and expertise necessary to care for people with wounds, ostomies and incontinence. The literature does not explain why such a selective title has been adopted by this nursing specialty, nor does it provide an historical explanation for the evolution and refining of stomal therapy nursing practice in Australia. Likewise, a phenomenological study has not previously interpreted what it is to be a stomal therapy nurse in Australia.

The formation of the Australian Association of Stomal Therapists (AAST), which was the initial name of the professional body, began with 11 founding members on 27 March 1971 in Sydney. In 2002 the Australian Association of Stomal Therapy Nurses Incorporated (AASN) as it is now known, had a membership of approximately 450 registered nurses. To qualify for full membership, registered nurses must have completed a recognised stomal therapy education programme. Stomal therapy nurses are usually to be found in limited numbers in acute, chronic and community health care settings.

I am a stomal therapy nurse and this thesis represents a personal and professional odyssey. In effect, the odyssey began in 1966 when, as a neophyte nurse in preliminary training school, I experienced my first encounter with a patient. On a tour of a surgical ward two days after donning a nurse's uniform for the first time, I was seconded to assist with the repositioning of a post-operative patient. The patient was acutely ill. Blood was being transfused at a rapid rate to replace the blood that seeped from a huge

perineal¹ wound and that stained the white bed linen at an alarming rate. Swathes of bandages covered the patient's abdomen and a sense of fear permeated that small world that was screened off from the surrounding ward routines. Such was the experience, that it was to leave an indelible imprint on my memory.

As fate would have it, this was the first ward that I as a novice nurse was sent on completion of my preliminary training 6 weeks later. The first patient allocated to me was *the* patient who had since haunted my imagination and memory. Although I was delighted to find him alive, I was horrified to find he had something called a 'colostomy'. I was directed to care for him and his colostomy. The experience was an overwhelming one, for how could one care for such a patient without the knowledge or skill necessary to provide appropriate care. It was an initiation of the worst kind into stomal therapy care for both the carer and the recipient. On reflection, care was equally shared by myself and the patient, as I endeavoured to combat his problems and he endeavoured to support me.

I will always remember the immense sense of relief and regret with which I farewelled him from the hospital many weeks later. His discharge afforded me relief from having to confront the continual care challenges associated with effluent leakage, malodour and pain that resulted from his severely denuded skin. The nursing interventions of the day were totally inadequate to combat the complexity of problems that arose and I experienced an immense sense of regret and frustration in regard to the poverty of care options. For me, there has long remained a need to know whether, and how, this patient did manage to care for himself after he left the hospital.

On frequent reflection throughout the intervening years, I have contemplated whether this profound experience had consciously or subconsciously impacted on my professional journey through nursing and the subsequent decision to specialise in the domain of stomal therapy nursing. Aligned with this was an increasing desire to research my nursing roots and pay professional homage to the individuals whose efforts

¹ Pertaining to the perineum or pelvic floor and associated pelvic outlet structures. This anatomical area is bounded anteriorly by the symphysis pubis, laterally by the ischial tuberosities and posteriorly by the coccyx (Miller & Keane, 1978, p. 766).

contributed to the founding and evolution of stomal therapy nursing in Australia. The purpose of this study was in part an obligation to fulfil that desire.

Significance of the Study

The significance of this study lies firstly, in the exploration and analysis of the historical events that led to the development and evolution of stomal therapy nurses as a specialty nursing group in Australia. To date there has been no research into the role individuals have played in this development. Nor has there been any research into the role nurses as a collective group, under the umbrella of the AASTN have played in this development and evolutionary process.

This study examines historical events that impacted on the development of current stomal therapy nursing knowledge. It also highlights the origins of clinical practices and specialised 'tricks of the trade' that are used widely by stomal therapy nurses in the care of people with ostomies, wounds and incontinence. It examines these practices in the light of current scientific knowledge.

Secondly, the significance of this study lies in revealing what it is to be a stomal therapy nurse in Australia from an individual and collective perspective. Nurses in search of a career path within the profession cannot afford to be lured by 'sirens' of false expectations and misunderstanding. Whilst all learning experience is useful in a nurse's overall development, it comes at a cost. Nurses at all levels are confronted with the explicit and implicit costs associated with professional development and they readily appreciate the need to maximise cost efficiencies in education and in the selection of a career pathway. Therefore, it is anticipated that the insight to be gained from this study into the experience of being a stomal therapy nurse will be welcomed by nurses who are considering undertaking a stomal therapy education programme and deciding on a career in stomal therapy nursing. It is also anticipated that the study results will be equally welcomed by hospital or agency managers who find it necessary to appoint suitable nurses to these positions.

Another significant outcome of this study is the collection of oral history records from the stomal therapy nurses, surgeons and patients. These oral histories provide a rich insight into the experiences and contributions of these people in the evolution of stomal

therapy nursing in Australia. It is anticipated that the collection of oral histories will be a resource of immense interest for future stomal therapy nurses who desire to hear their collective history from those people who blazed the professional trail. This oral history collection will also provide a valuable resource for other nurse researchers, especially in light of the fact that four of the people interviewed for this study have since died.

Purpose of the Study

The purpose of this study is to describe the historical events that led to the development and evolution of stomal therapy nurses in Australia, and to describe the lived experiences of stomal therapy nurses within that historical context.

Research Questions

The thesis will study five key questions and they are as follows:

1. What was the professional genesis of stomal therapy nurses in Australia?
2. What events and forces influenced the evolution of stomal therapy nurses as a specialty group in Australia?
3. What are the origins of the practices that define stomal therapy practice?
4. What is it to be a stomal therapy nurse in Australia?
5. What is it to be a member of the Australian Association of Stomal Therapy Nurses Incorporated (AASTN)?

Definitions of Key Terms in the Study

The following list of definitions are offered to the reader who may not be familiar with the medical or nursing terminology that relates to stomal therapy practice.

Stomal therapy is the biopsychosocial nursing management and rehabilitation of the person who has the potential for, or has a stoma, wound, urinary or faecal incontinence (AASTN, 1994, Constitution Regulation 3.2).

Stomal therapy nurse is any registered nurse who has completed a stomal therapy nursing education programme and is recognised by the AASTN to practice stomal therapy (AASTN, 1994).

Colostomy is the surgical creation of an opening between the colon (large intestine) and the abdominal wall for the purpose of faecal diversion when disease, trauma or surgery inhibits the normal physiological process of defaecation via the anus.

Ileostomy is the surgical creation of an opening between the ileum (terminal segment of the small intestine) and the abdominal wall for the purpose of faecal diversion when disease, trauma or surgery inhibits the normal physiological process of defaecation via the anus.

Urostomy is the surgical creation of an opening between any part of the urinary system and the abdominal wall for the purpose of urinary diversion when disease, trauma or surgery inhibits the normal physiological process of voiding via the urethra.

Ileal conduit is a urostomy where a segment of ileum or small bowel has been used as a conduit between the ureters and the abdominal wall and for the formation of a stoma.

Stoma is a Greek word that means mouth and a stoma is a surgically created opening that exteriorises a segment of the gastrointestinal or urinary system to the abdominal wall or the trachea to the base of the neck.

Ostomy is a medical term for a surgically created opening between a body cavity and the body surface.

Fistula is a surgically created or spontaneous abnormal connection between two internal organs or an internal organ and the skin or two cutaneous surfaces.

Anastomosis is a surgical connection between two normally distinct anatomical structures.

Evisceration is the abnormal extrusion of the viscera or internal organs through the abdominal wall and it may occur as a result of trauma or complications following surgery.

Emesis is vomiting.

Ostomate is a term used to refer to a person who has had surgery resulting in stoma formation. This is the accepted term used by the Australian Council of Stoma Associations (ACSA).

Peritonitis is acute inflammation of the peritoneum, it can be fatal without appropriate antibiotic therapy.

Evaginated stoma is the eversion of an end segment of bowel with the intent of making a spouted stoma.

Mucocutaneous junction is the junction of skin and mucosa when a stoma is evaginated and sutured to the skin.

Intussusception is the prolapse of one part of the intestine into the lumen of an immediate adjacent part.

Good is italicised and awarded an upper case introduction when used to refer to the attitudes and behaviours of the nurses found in this study in regard to caring, competence, cognisance, comradeship and commitment.

History is both a discipline and an activity, in a similar way that nursing is both a discipline and an activity.

Historical is used as an adjective to define the nature of historical research.

Historiography is the writing of history. Historiography can be descriptive, historical and analytical in style (Stanford, 1994).

Organisation of the Thesis

This chapter introduces the thesis and discusses the background and significance of the study. The purpose of the study is defined and the research questions identified. An operational list of definitions related to this study is provided.

Chapter 2 outlines the methodology employed and discusses the selection of sample population, the research design, the data collection methods, data analysis employed, ethical implications considered and the limitations to the study. It serves as a companion to the historical and phenomenological literature reviews of chapters 3 and 6 and outlines the key features of both historical and interpretative phenomenological methodologies in table form. This allows a succinct comparison to be made of both methodologies and demonstrates how they can be combined into a experimental methodological approach, which is referred to as historio-phenomenology.

A literature review will be featured in chapter 3 and 6 and these chapters are respectively titled 'Defining the Historical Context' and 'Phenomenology – A Science of Phenomena'. The literature reviews will introduce the respective historical and phenomenological sections of the study. This will set the scene for the reader and illuminate the findings presented in chapters 5 and 7.

Chapter 4 provides an understanding of the historical background to the study phenomenon. This chapter discusses the relevant historical events prior to 1959. Although this chapter does not comprise a formal component of the study time frame it has been included in order to expand the reader's understanding of the historical need for stomal therapy nurses and the international events that impacted on the evolution of stomal therapy nurses in Australia. This background information will enrich the reader's insight into the experiences of pioneer Australian ostomates, stomal therapy nurses and surgeons that have been outlined in this thesis.

Chapter 5 discusses the origins of stomal therapy nurses and nursing in Australia and examines the historical events that influenced the development and evolution of stomal therapy nursing as a specialty. This chapter encompasses the events from 1959 until 2000.

Chapter 7 records the experiences of 19 stomal therapy nurses and thematic interpretative phenomenological analysis revealed the essence of what it is to be a stomal therapy nurse in Australia.

Chapter 8 outlines the key finding of this study, which is *Good* nurses practice *Good* nursing. This finding has been revealed as a result of historio-phenomenological analysis of the data, which involves comparative and contextual analysis of the findings of both the historical and phenomenological studies. Furthermore, this chapter discusses the relevance of this finding to nurses and nursing in Australia.

Chapter 9 provides a summary that succinctly answers the research questions. Implications for clinical practice that arose from this study are discussed and suggestions for further research are made. References and appendices follow the conclusion and provide additional information to support the research process and outcomes.

Chapter 2

The Methodological Journey

Introduction

Prior to 1996, my original purpose in a Master's Degree study at Edith Cowan University was to determine the historical events and experiences that led to the development and evolution of stomal therapy nurses in Australia. In recording and listening to the oral interviews of the stomal therapy nurses that had been collected during the years 1994 to 1995, it was evident that some of these stomal therapy nurses recalled profound personal experiences – some joyous and some tragic (the nature of these experiences is revealed in chapter 7). When they were talking of their personal experiences in relation to the events that led to them becoming a stomal therapy nurse or those that influenced their practice, I sensed a cathartic need in some of the nurses to discuss these intrinsic or very personal experiences. It appeared to me that these stomal therapy nurses saw themselves as being different to other nurses in general. This caused me to begin to question the nature of being a stomal therapy nurse within the evolving historical context of stomal therapy nursing in Australia.

In 1996 the Master's Degree was converted to a Doctoral Degree with the intent of continuing and expanding the study that had begun in 1994. Following intensive discussion with the university, a decision was made to expand the research questions in order to study the history of stomal therapy nursing in Australia *and* the experience of being a stomal therapy nurse. Two methodological approaches seemed well suited for this venture: history and phenomenology. It was appreciated that the combination of both of these two qualitative methodologies was experimental, but it was also appreciated that a dual approach offered not only an opportunity to enhance the understanding to be gained, but it offered an opportunity to compare both methodologies and their suitability for answering the research questions. It is my belief that these two points summarise the two distinct strengths of this study. An algorithm of the methodological journey I undertook is presented on page 40 as an aid to comprehension.

History as a discipline and a research approach is committed to recovering the human experience as it was in the past, as well as interpreting past experience in relation to contemporary values and anticipated future situations. History is concerned with the commonality and diversity of experience. It explores the singular and multiple experiences of individuals as well as the collective experiences of populations. For example, historical research allowed me to define how the individual and collective experiences of ostomates impacted on the stomal therapy nurses, and what the experiences were of ostomates and surgeons in regard to stomal therapy nurses.

Phenomenology however, is concerned with the commonality within the diversity of experience. It explores thematically the singular and multiple experiences of individuals in an attempt to understand the essence of the common experience of being. For example, what is it to be a stomal therapy nurse in Australia. The philosophies underpinning these two approaches will be discussed fully in chapters 3 and 6.

In truth, it would have been more expedient to focus on one aspect of experience: either the evolution of stomal therapy nurses or what it was to be a stomal therapy nurse in Australia. However, I identified within myself a need for professional knowing, that is a need to know the historical truth as to why and how stomal therapy nurses did become a specialty group within nursing. I also identified a need for self knowing, that is a need to know what it is to be an Australian stomal therapy nurse. Although I am a stomal therapy nurse, phenomenological analysis of the experiences of other stomal therapy nurses would afford me the opportunity to determine how their experiences mirrored and differed from mine.

Like the traveller in the allegory, I decided to view the phenomena from two viewpoints and chose to employ both approaches in order to better understand the phenomena. I name this partnership of research methodologies an 'historio-phenomenological' approach. I have also coined the term 'contextual triangulation' (which shall be explained in full later in this chapter) to define the process for partnering these methods in order to answer the research questions.

Rationale for the Study Design

The chosen study design is an historio-phenomenological design, which is a partnership of historical and phenomenological methodologies that employs within method analysis of the individual findings and across method comparative and contextual analysis of the findings of both studies. Throughout this study I have endeavoured to preserve the uniqueness and philosophical foundations of both historical and phenomenological methodologies. The two independent studies stand alone in their sample population, data collection, data analysis and findings. Comparative and contextual analysis of the historical and phenomenological findings was then conducted in order to enhance the understanding of the phenomena. It is this comparative and contextual analysis of historical and phenomenological findings that distinguishes historio-phenomenology.

History and phenomenology share a commitment to understanding the phenomena of experience, and both utilise an interpretative approach to develop that understanding. Interpretative phenomenology focuses on the ontological-existential aspects of experience and endeavours to describe and interpret meanings attached to that experience (Spiegelberg, 1982). History on the other hand, endeavours to interpret the effects of past known experience. It also allows one an opportunity to interpret that experience with contemporary values, and provides insight into future implications (Carr, 1961).

My view is that all experience occurs within an historical context and that the lived experience is influenced by the moral, social, political and economic values of a given time and situation. Furthermore, past experiences impact on present and future experiences. Therefore, if one is to have a comprehensive understanding of any lived experience then it is necessary to interpret that lived experience within the historical context.

History as a discipline is derived from the histories of the ancient Greeks, Herodotus and Thucydides and as a discipline and a research approach, it has been honed over the intervening centuries. Phenomenology on the other hand, was derived largely from the phenomenologies of the nineteenth century philosophers, Husserl and Heidegger in particular, and adopted in the mid-twentieth century by the social sciences and more recently by nursing. To clarify the philosophical foundations and concepts of both

historical and phenomenological methodologies, I have adapted a comparative outline as presented by Wilson and Hutchinson (1991). Table 2.1 offers a comparison of the philosophical and methodological features of historical and interpretative phenomenological research. Table 2.2 outlines the philosophical and methodological features of a marriage of these two methodologies, while Figure 2.1 provides a graphic representation of historio-phenomenology.

Table 2.1: A comparison of independent philosophical and methodological features of history and phenomenology.

Feature	History	Interpretative Phenomenology
Origin	Derived from the histories of Herodotus and Thucydides	Derived from the philosophies of Husserl and Heidegger
Context	Considers the historical context	Considers context called relational situatedness
Emphasis	Emphasis on the fullness of past experience (individual or collective) and its relationship to the present and future	Emphasis on meaning and practices in lived experience
Purpose	Discovery orientated	Discovery orientated
Focus	Focus on knowing <i>what, when, how and why</i> .	Focus on knowing <i>how</i>
Interest	Interest in past and present time and space	Interest in perceived time and space
Data source	Importance of language, textual and artefactual data	Importance of language and textual data
Data collection	Oral interviews, documents and artefacts are the source of data	Oral interviews are the source of data
Analysis	Focus on constitutive meaning of practices and situations	Focus on constitutive meaning of practices and situations
Outcome	Analysis generates facts, experiences and events and reveals their relationship to past, contemporary and future practice and situations.	Analysis generates exemplars, paradigm cases and themes for revealing the lived experience.

(adapted from Wilson & Hutchinson, 1991, p. 263).

Table 2.2: The philosophical and methodological features of historio-phenomenology

Feature	Historio-phenomenology
Origin	Derived from history and phenomenology
Context	Considers the lived experience within the historical context
Emphasis	Emphasis on the fullness of lived experience and its relationship to the past, present and future
Content	Considers average everydayness and interprets it within the historical context
Purpose	Discovery orientated
Focus	Focus on knowing <i>what, when, how and why</i>
Interest	Interest in experience and its relationship to past, present and perceived future time and space
Analysis	Focus on constitutive meaning of practices and situations as influenced by the historical context
Data collection	Interviews are sufficient for phenomenological analysis but interviews, documents and artefacts (primary and secondary sources) are used for historical analysis
Parallel outcomes	Phenomenological analysis of exemplars, paradigm cases and themes provides an understanding of the lived experience, whilst historical analysis provides an understanding of the historical context of that lived experience
Triangulated outcome	Reflects the contextual relationships of a phenomenon via <i>contextual</i> triangulation of the two qualitative methodologies.

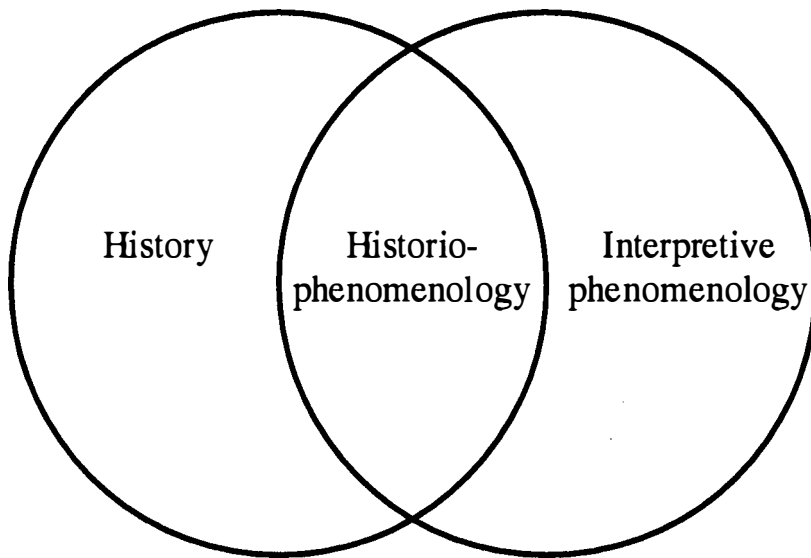


Figure 2.1

The Concept of Triangulation

I have named the process I used for comparative and contextual analysis of the findings of the two separate but concurrent studies *contextual triangulation*. Triangulation is a technical term familiar to navigators and surveyors. It refers to the technique used to identify an unknown position on a map by using more than one point of reference. Campbell is acknowledged as being “the first person to apply the term ‘triangulation’ to research methodology” and he first used the term in this context in naval research in 1956 (Breitmayer, Ayres & Knafl, 1993, p. 237). During the years that followed, the term grew in popularity within the social sciences and was used metaphorically to converge discrete variables or constructs for the purpose of focusing on the phenomenon under investigation. Triangulation was also perceived to be a means for increasing reliability and validity in a study as well as a means for increasing investigator confidence in interpretation of the phenomena (Hunt, 1991; Sohler, 1988; Streubert & Carpenter, 1999).

Denzin’s definition of triangulation is broadly referenced in the nursing literature and declares that triangulation is a combination of methodologies, data, investigators and theories in the study of the same phenomenon (Cormack, 1991; Kimchi, Polivka & Stevenson, 1991; Mitchell, 1986; Streubert & Carpenter, 1999). The combination of

more than two of these concepts produces an offspring called ‘multiple triangulation’ (Denzin, 1970). Denzin proposes that because no one method is able to reveal all the relevant characteristics of empirical reality for investigation or theory development, triangulation enhances that possibility. Denzin (1989) favours the use of triangulation to confirm research findings and ‘confirmatory’ triangulation can be conceptualised as a navigator’s drawn lines on map that converge towards the apex of a triangle. Others consider that between method triangulation, (such as quantitative and qualitative), offers an approach that bridges the methodological divide between quantitative and qualitative research (Dreher & Hayes, 1993; Sohler, 1988). However, concerns have been voiced that between method triangulation runs the risk of compromising the integrity of paradigmatically diverse methods (Sandelowski, 1995).

Sandelowski (1995) argues that the increasing practice of researchers to mix, blend, merge, complement and integrate research techniques runs the risk of producing confusion rather than a new approach. The literature reveals that between method triangulation has been used for two distinct purposes and they are to achieve confirmation or completeness of data (Breitmayer et al. 1993; Knaft & Breitmayer, 1989). In debating the use of triangulation to obtain either confirmation or completeness of data, Sandelowski (1995, p. 573) argues that the term should be “reserved for designating a technique for confirmation employed within paradigms in which convergent and consensual validity are valued”. However, she acknowledges that when triangulation is employed to achieve completeness “in the service of holism” then the “multiple realities” obtained from different techniques combine to form a holistic view and this then “becomes comparable to triangulation for confirmation” purposes (Sandelowski, 1995, p. 573). It was my intent to obtain such an holistic view of the evolution and experiences of stomal therapy nurses in this study.

When triangulation is used to achieve completeness of data there is an “expectation that each source will contribute an additional piece to the puzzle” (Knaft & Breitmayer, 1989, p. 229). As has been discussed previously in this chapter, researchers who expound this concept of triangulation appear to favour it as a method for comparing qualitative and quantitative data (Breitmayer et al. 1993). Some appear to consider the application has little relevance for comparing data from multiple qualitative studies (Fielding & Fielding, 1986). However, others who do triangulate qualitative studies

offer little explanation as to their interpretation and application of the process and this has the potential to lead to ambiguity (Wilson & Hutchinson, 1991).

I appreciate that comprehensive understanding can be augmented by triangulating multiple methods within the same methodology (qualitative historical and phenomenology methodologies). I also appreciate that researchers need to define their use and interpretation of the type of triangulation employed so that a consensus in understanding can be achieved. In this study I have chosen to triangulate two qualitative methods – history and phenomenology – because of their respective and complementary commitments to the interpretation of experience. I have applied the term *contextual triangulation* to this across method analysis of the independent findings of both studies. Contextual triangulation contributes to and contextualises understanding of the phenomenon. It seeks an holistic understanding of the phenomenon. The outcome in this study is a more complete understanding of the lived experience of stomal therapy nurses within the historical context of that lived experience.

If confirmatory triangulation is to be conceptualised as a navigator's drawn lines that converge towards the apex of a triangle, then contextual triangulation can be best conceptualised as viewing the navigator's drawn lines as they diverge away from the apex and towards the base of the triangle. An analogy can be drawn between confirmatory and contextual triangulation and the allegory of the traveller and the mountain. As the traveller converges on the apex of the mountain, he is able to confirm the existence and the nature of the mountain - this is analogous with the concept of confirmatory triangulation. Contrary to this, is the expansive understanding he obtained when he stood on the apex of the mountain and considered the mountain within the context of the divergent vista. This latter view is analogous with contextual triangulation.

It was exciting to find similarities existed between the concept of contextual triangulation as outlined above and what has been defined as 'conceptual' triangulation (Mitchell, 1986; Foster, 1997). According to Mitchell (1986) conceptual triangulation:

involves a search for logical patterns of relationship and meanings between the variables measured by either or both qualitative and quantitative methods. The

integration of both types of data could lead to a more in-depth conceptual understanding of a particular phenomenon. Hypotheses could then be generated from this conceptual analysis for testing in a subsequent study (Mitchell, 1986, p. 25).

Foster (1997) explains that conceptual triangulation is a method for preserving the scientific rigour of two distinctly different but parallel studies, for across method triangulation does not occur until the qualitative and quantitative results have been determined and analysed. She indicates this avoids the inherent problems of blending studies with different assumptions and criteria. This was also my intent in this study. Mitchell (1986) and Foster (1997) regard conceptual triangulation as a systematic method for analysis and comparison of quantitative and qualitative studies in order to “achieve a more complete and contextual portrayal of the phenomenon” (Foster, 1997, p. 4). Both authors rely on conceptual model development as a common denominator for weighting and explaining qualitative and quantitative findings.

Similarly, I propose that contextual triangulation offers a systematic method for analysis and comparison of two distinctly different but parallel qualitative studies. However, model development is reserved for explaining the relationships and key findings that result from comparative and contextual analysis of the findings of both parallel studies. In order to ensure a framework for methodological rigour within this study I have adapted a five-step procedure as discussed by Foster (1997, p. 4) for conceptual triangulation, and have used it as a six-step procedure for within method and across method analysis (contextual triangulation) of the two qualitative studies. The framework used is as follows and bracketed comments inform the reader of relevant chapters where these steps have been implemented or outlined.

1. Conduct two qualitative research studies true to the paradigmatic assumptions of each qualitative method (as outlined in chapter 2),
2. Distinguish pertinent results within each method and display a summary of results in table form (this is presented in chapter 9),
3. Adhere to the philosophical and methodological frameworks of each parallel study (as outlined in chapters 3 and 6) and examine confidence in the results of parallel studies (as presented in chapters 5 and 7),

4. Compare and contextualise relationships of the parallel studies (as presented in chapter 8),
5. Compare and contextualise study findings to the literature (also discussed in chapter 8),
6. Construct one or more conceptual models to explain the key findings that result (the model is presented in chapter 8) (Adapted from Foster, 1997, p. 4 & 6).

Rigour in Qualitative Studies

The terms reliability and validity were previously used to define the concept of rigour and these three terms are seen by some to persist “as a hegemonic legacy of empirical-analytical research” (Koch, 1996, p. 178). The challenge is for researchers who embrace non-empirical-analytical paradigms to demonstrate rigorous principles within a framework and language not designed for evolving qualitative studies. Such attempts to do so have frequently resulted in inconsistent definitions of concepts and researcher ambiguity. Examples of this are seen in the literature, which fails to provide a consensus of opinion on criteria for ensuring rigour, credibility and validity in qualitative studies (Beck, 1994; Foster, 1997; Oiler, 1982; Sandelowski, 1986). Rigour is generally defined as a concept “associated with discipline, scrupulous adherence and strict accuracy” (Burns & Grove, 1987, p. 80).

Qualitative nurse researchers commonly cite the criteria for rigour in qualitative studies devised by Lincoln and Guba (1985). These authors list four criteria for ensuring rigour in qualitative studies and they are: truth value, applicability, consistency and neutrality. Other qualitative researchers favour the terms: credibility, auditability and fittingness for determining rigour in qualitative studies (Streubert & Carpenter, 1999). Streubert and Carpenter’s interpretation of these terms as follow are adopted for this study.

Credibility:

Do the study participants recognise the experience as their own?

Auditability:

Can the reader follow the researcher’s thinking?

Does the researcher document the research process?

Fittingness:

Can the findings be applicable outside of the study situation?

Are the results meaningful to individuals not involved in the research?
(Streubert & Carpenter, 1999, p. 67).

In addition to the six-step procedure adapted from Foster (1997) and discussed earlier, I have used Streubert and Carpenter's criteria to ensure rigour in this study. The phenomenological findings were given to a sample of the participants to test for credibility and received an overwhelming positive response. To ascertain fittingness I asked for validation of the phenomenological findings from independent persons: stomal therapy nurses, a surgeon and a lay person. Appendices have been included to demonstrate the study's auditability (see Appendices A and B). External and internal criticism were employed in the analysis of the data in the historical study in order to verify authenticity and accuracy of those findings. This is expanded later in this chapter.

Collection of Oral Data

During the years 1994 to 1995 I had invited 20 Australian stomal therapy nurses to participate in a study to determine the historical events and experiences that led to the development and evolution of stomal therapy nurses in Australia. The nurses were selected for interview on the basis of their respective contributions to the development of stomal therapy nursing in Australia. The identities of these nurses were sourced from the archival documents of the AASTN, other historical records, the relevant literature and from recommendations received from their colleagues.

In 1996 the study was expanded in the manner that has been previously explained on page 14. A decision was then made to categorise the 20 interviews, which were collected during the years 1994 to 1995, according to the nature and content of the interview (this process is outlined below) for historical or phenomenological analysis. A further seven Australian stomal therapy nurses, six international enterostomal therapists, five Australian surgeons and five Australian ostomates were also invited to participate in the expanded Doctoral study. These interviews were collected during the years 1996 to 1999.

In total 27 Australian nurses were invited to participate in the study. They were contacted via telephone and/or mail and an invitation to participate was extended. Eleven of the nurses were not known to me personally prior to the study. The remaining

16 nurses were known to me in a professional context, that is, we had met at conferences or meetings. However, I had not worked with any on a day to day basis. The interviews were all conducted in places unfamiliar to me, such as conference venues, hotel rooms or their private abodes.

Seven of the 20 original interviews were used for historical analysis. These interviews were selected because of the historical relevance of the content of the interviews. These nurses had either extremely good recall of significant happenings within the domain, were pioneer stomal therapy nurses or the first or most significant person to contribute in a major way to the practice or professional developments within the group. During 1996 to 1997 two other stomal therapy nurses who were identified to be relevant for historical data collection were invited to participate in the study and their data was used for historical analysis. One of these participants was the first male Australian stomal therapy nurse. One of the original interviews was used for historical and phenomenological analysis as the interview was very applicable to both historical and phenomenological analysis.

Fourteen of the original 20 interviews were used for phenomenological analysis. These interviews were selected for phenomenological analysis because of the personal and experiential nature of their interviews, the nurses' ability to engage freely with myself as an interviewer and their enthusiasm and willingness to share their lived experiences. Five additional stomal therapy nurses were invited to participated in the study during 1996 to 1997 and the data obtained from these interviews were used specifically for phenomenological analysis, which made a total of 19 nurses.

Each of the nurses who participated in the study were fully briefed on the purpose of the interviews (see Appendix C). That is, that the purpose of the study was to research the history and experiences of stomal therapy nurses in Australia. They were informed of their right to withdraw from the study at any time and written consent was obtained prior to the recording of the oral interviews (see Appendix D). Consent was also sought from each participant to deposit a copy of their interview in the archives of the AASTN and either the Battye Library of Western Australia or the National Library in Canberra for the use of other researchers (see Appendix E).

All the interviews were conducted in accordance with the guidelines outlined by Thompson (1992). Because the collection of oral data is dependent on the interaction of the interviewer and the interviewee, I endeavoured to employ good interpersonal skills in order to facilitate a good interviewee-interviewer rapport prior to, and during the recordings. I had undergone a course in oral history at the Battye Library of Western Australia prior to the study. The interviews were semi-structured and conducted in a relaxed and quiet environment conducive to optimal memory recall and quality recording. Interviewees were informed that they could stop the interview at any time, and occasionally did so if they wished to review their thoughts or conversation. The questions were open and used to begin and guide the interview process, whilst at the same time allow for spontaneous discussion. The interview instrument used for nurses is shown in Appendix F.

The questions were abandoned soon after commencing the interview if the participant was spontaneous in their recollections and involvement. The interviews were approximately 1 to 2 hours in length as determined by the response and enthusiasm of the interviewee. Kyte was interviewed on two separate occasions when additional information was recalled and the interviewee and interviewer desired to include this data. Field notes were recorded during the interviews and these were used to ensure correct spelling of unusual names, exact dates and particular points that required further clarification. Transcripts or copies of the tapes were sent to the interviewees for approval.

Historical Study Population

The interviews selected for historical analysis were collected from nine Australian stomal therapy nurses; eight of whom were female and the other a male nurse. The nurses who feature in the historical analysis of this study (see Table 2.3) completed their general nurse education in five Australian states and territories. All of the stomal therapy nurses initially completed hospital based diplomas in general nursing. Five of the nurses had completed their general nurse training in the 1950s and the others during the 1960s. All but two of the nurses had completed a formalised stomal therapy education programme (STNEP). The remaining two nurses had either been accepted into the association as founding members or because of their stomal therapy experience prior to the development of education programmes. At the time of their interviews, six

of the nurses were still actively employed as stomal therapy nurses (STNs), two nurses were employed as registered nurses (RN) in other domains of nursing practice and the remaining nurse had retired.

Although the real names of participants are used in historical research, it is the research custom to use pseudonyms for participants in phenomenological research when the nature of the data is sensitive or confidential. Because this was found to be the situation with the data obtained from a large number of the interviews used for phenomenological analysis, a decision was made to use pseudonyms for all participants in the phenomenology study. The confidentiality of the one participant who's interview was used for both historical and phenomenological analysis has been preserved and no cross reference is made to this participant's name or pseudonym.

In addition to the oral data collected from nurses, data was also collected from five Australian ostomates (see Table 2.4) who had received a faecal or urinary stoma, and from five eminent Australian surgeons (see Table 2.5). One of these surgeons also had a stoma and was able to discuss his experiences as both a surgeon and as an ostomate. The five Australian ostomates were selected for interview because of their involvement in the establishment or running of Australian ostomy associations or their contributions to ostomy appliance developments. The five surgeons were selected for interview because of their recognised contributions to ostomy surgery and the advancement of the AASTN. Four of these surgeons had been awarded an Honorary Membership of the AASTN in recognition of their contributions.

I have also recorded the oral histories of six other nurses or enterostomal therapists who practiced in the United Kingdom (UK), South Africa (SA) and the United States of America (USA). In these countries stomal therapy nurses are respectively called stoma care nurses (SCNs), stomaltherapists (STs) and enterostomal therapists (ETs) (see Table 2.6). Each of these persons had at some time, been an Executive Committee Member of the World Council of Enterostomal Therapists (WCET) or were recognised by their peers for their significant international contribution to stomal therapy nursing. The oral histories collected from these participants allowed a comparison to be made between the development of stomal therapy nursing in Australia and overseas. Norma Gill-Thompson and Paula Erwin-Toth were both ostomates and enterostomal therapists and

were able to discuss their experiences as both an ostomate and an enterostomal therapist. The oral data collection period for the surgeons, ostomates and enterostomal therapists was from 1994 to 1999.

Table 2.3: Australian STNs Interviewed for Historical Data

Name	Year began Nursing	Year of STNEP	Employed as a STN
Elinor Kyte	1957	No STNEP	Retired
Meryl Barrett	1959	No STNEP	No, but an RN
Rae Bourke	1959	1973	Yes
Tricia Woods	1952	1986	Yes
Helen Simcock	1952	1981	Yes
Fay McMeniman	1954	1975	Yes
Julia Thompson	1969	1979	Yes
Rhonda Walsh	1966	1992	Yes
Anthony Hutapea	1962	1973	No, but an RN

Table 2.4 Australian Ostomates Interviewed for Historical Data

Name	Year of surgery	Place of surgery
Mabel Cook	1956	Melbourne
Ken Phelps	1960	Sydney
Gwen Anderson	1968	Sydney
Peter McDonald	1969	Perth
Gwelda Dawson	1981	Perth

Table 2.5 Australian Surgeons Interviewed for Historical Data

Name	Employed as a surgeon	Honorary Member
Sir Edward Hughes	Victoria (retired)	Yes
Mr Mark Killingbach	New South Wales	Yes
Mr David Failes	New South Wales	Yes
Mr Neville Davis	Queensland	Yes
Mr Desmond Hoffman	South Australia	No

Table 2.6 International SCNs, STs and ETs

Name	Country of practice
Norma Gill-Thompson	USA
Pricilla d'Eresby Stevens	SA
Nancy Faller	USA
Paula Erwin-Toth	USA
Barbara Borwell	UK
Mavis Watson	UK

Historical Data Collection

Collecting data for an historical analysis is rather like playing detective. Data for the historical study were collected from both primary and secondary sources, and were both oral and documentary in nature. Primary sources include the recorded oral histories and official documents of the AASTN, some of which preceded the inaugural meeting of this organisation in 1971. The minutes of meetings held by the Executive of the AASTN proved to be a valuable source of both primary and secondary data as were those of the Australian Council of Stoma Associations (ACSA) since its inaugural meeting in April, 1970. Personal correspondence, photographs and mementoes made available by some of the interviewees were gratefully reviewed. I was especially grateful to be invited by Mrs Norma Gill-Thompson of Akron, Ohio, to review her vast collection of records, which included letters, published and unpublished papers, minutes of international meetings and personal artefacts.

An extensive review of related stomal therapy or ostomy newsletters, journals, official magazines, textbooks and educational literature were examined for primary and secondary data sources. This included a review of all past copies of the: *AASTN Newsletter* (this preceded the *Journal of Stomal Therapy Australia*), *Journal of Stomal Therapy Australia*, *World Council of Enterostomal Therapists Journal* (WCET), *Ostomy Australia* (journal of the Australian Council of Stoma Associations) and the *Western Australian Ostomy Association Newsletter*.

Numerous editions of the following publications were also reviewed for historical data: *ia Journal* (journal of the Ileostomy Association of Great Britain and Ireland), *ET Journal* (the publication of the International Association for Enterostomal Therapy in the United States), and its successor the *Journal of Wound, Ostomy, Continence Nursing*, and *Ostomy International Magazine*.

All available proceedings of AASTN and WCET Conferences were examined. Booklets and correspondence received from the Ileostomy Association of Great Britain and Ireland and the Colostomy Association of Great Britain were most helpful and provided additional sources. Archived copies of relevant product literature held by individuals and the Western Australian Branch of the AASTN were also examined. Personal correspondence with the

manufacturers of ostomy equipment and devices provided additional information in regard to products when clarification was required.

Collected data obtained from primary and secondary sources were categorised and cross-referenced according to person, place, subject, events and chronology. The review of these sources also assisted in identifying potential participants for the study. The data were collected during the years 1994 to 2000.

Oral histories

As was the case with each of the Australian nurses in this study, the international enterostomal therapists, the surgeons and the ostomates were contacted by phone and/or mail and invited to participate in the historical study. They were fully briefed on the purpose of the interviews (see Appendix C) and the same consent form was used for all participants. All were informed of their right to withdraw from the study at any time. Written consent was obtained prior to each interview and the recording of the oral histories (see Appendix D). Mrs Mabel Cook, an ostomate, declined to have her interview recorded but gave consent to a non-recorded interview. Permission was given to record field notes during this interview. All these interviews took place in a venue nominated by each interviewee and this was usually their workplace, their private abode or at a national conference venue.

The interviews with the six international stoma therapists, stomal therapists or enterostomal therapists were recorded at international venues that corresponded with conferences attended by myself and the interviewee. Norma Gill-Thompson was interviewed at her business in Akron, Ohio. Consent was also sought from the international nurses, the surgeons and the ostomates to deposit a copy of the interview in the archives of the AASTN and either the Battye Library of Western Australia or the National Library in Canberra for the use of other researchers (see Appendix E).

As was the case with the Australian stomal therapy nurse interviews, all the interviews were conducted in accordance with the guidelines outlined by Thompson (1992). The interviews were conducted in a relaxed and quiet environment conducive to optimal memory recall and quality recording. Interviewees were informed that they could stop the interview at any time, and occasionally did if they wished to review their thoughts or

conversation. The questions were open and used to begin and guide the interview process, whilst at the same time allow for spontaneous discussion. The interviews were semi-structured and the instrument used to begin and guide the surgeons' interviews is found in Appendix G and the instrument used to interview ostomates is found in Appendix H.

The questions were abandoned soon after commencing the interview if the participant was spontaneous in their recollections and involvement. The interviews were approximately 1 to 2 hours in length as determined by the response and enthusiasm of the interviewee. Field notes were recorded during the interviews and these were used to ensure correct spelling of unusual names, exact dates and particular points that required further clarification. Transcripts or copies of the tapes were sent to the interviewees for approval. The interviews from international enterostomal therapists, Australian surgeons and ostomates were collected during the years 1994 to 1999.

Historical Data Analysis

The tapes of the interviews selected for historical analysis were listened to and transcribed verbatim by either an experienced typist or myself. Analysis of tape recordings took into account the inherent values of the human voice in the interpretation of recorded data. Vocal pauses, vocal emphasis, laughter, and questioning tones were noted and recorded using gaps, bracketed explanations or punctuation marks. The interviewer and interviewee's comments were separated and identified in the transcripts. The date and place of each interview was recorded on each tape and transcript. Tapes transcribed by the typist were reviewed closely in order to ensure accuracy of transcription of unusual or medical terms used by the interviewees. I reviewed the audio tapes and written transcripts numerous times in order to obtain an understanding of the participants' comments. Historical data was categorised according to person, place, subject, events and chronology, and when appropriate was verified against data obtained from written primary sources. Field notes were reviewed and used for clarification purposes. The interviewee was also contacted if further clarification was required.

External and internal criticism were employed in the analysis of the oral and written data in order to verify authenticity and accuracy. External criticism seeks to ensure the authenticity of the data and endeavours to confirm that documents were written by those who were reported to have written them. This was an important consideration with

many of the early documents, especially letters. Internal criticism is concerned with establishing the truth of oral or documentary statements. Historians generally seek to have at least two primary sources, or multiple different secondary sources, agree before determining the possibility of a fact. Probability is said to exist if only one source is able to provide information (Woods & Catanzaro, 1988). This discussion is expanded in chapter 3. Critical historical analysis was employed to determine the relationship of past events on the past and contemporary experiences of the stomal therapy nurses.

Phenomenology Study Population

The interviews selected for phenomenological analysis were collected from 19 Australian stomal therapy nurses; all of whom were female. Saturation of data was achieved after 17 interviews however, data collection was continued with the two remaining stomal therapy nurses to confirm the researcher's analysis and to acknowledge the nurses' desire to participate in the study. No new themes emerged from the additional interviews.

The nurses who feature in the phenomenological analysis of this study (see Table 2.7) had initially completed hospital based diplomas in general nursing, while six of the nurses later added university qualifications to their professional standing. Eight of the nurses began their general nurse training during the 1950s, eight in the 1960s and the remaining three nurses began their training in the 1970s. Six of the participants had not undertaken a formalised stomal therapy education programme. They had been accepted as a member of the AASTN under the 'grandmother clause' for they had began their practice prior to the establishment of formalised programmes. The remaining 13 nurses had undertaken a stomal therapy education programme between 1974 to 1996.

At the time of interview 12 of the nurses were still actively employed as stomal therapy nurses. The employment periods of these nurses in the role were found to lengthy. One participant in fact, stated that it was a "dead man's shoes position". (Meg) This comment is indicative of the finding that once a dedicated stomal therapy position was secured it was noted that they remained in the position for very long periods. Six of the early stomal therapy nurses were at the time of interview working in other areas of nursing or healthcare. Their move away from stomal therapy practice occurred prior to the introduction of nursing career structures in the various Australian states during the

early 1990s. Prior to this time nurses who sought promotional advancement generally had to move into management positions.

The 19 nurses whose interviews are used in this study are not identified by their real names or initials as has been previously outlined. The use of pseudonyms was considered important in the phenomenology study considering the sensitive nature of some of the data. Each of these stomal therapy nurses has been given a pseudonym and a list of these pseudonyms is provided in Table 2.7. The table also lists the stomal therapy nurses (STNs) and the year they began general nursing training, the year they completed a stomal therapy nursing education programme (STNEP) and their status of employment at time of interview.

Phenomenological Data Collection

In the recording of interviews in this study I was very mindful of the need to record the participant's individual experiences and not be perceived as having, as a stomal therapy nurse, any insider information or knowledge or experience which would influence the participants' responses. This was explained to each participant and was reinforced with open body language and non-verbal communication during the interviews. I avoided all opinions or criticisms and employed the technique of bracketing (see below) whilst being open to the body language and information being shared by the interviewee.

Bracketing is a method of phenomenological reduction, which was first used in this context by the philosopher Husserl (1982). Bracketing allows the natural attitude to be converted into the phenomenological attitude where presuppositions about phenomenon or objects of consciousness are suspended and the phenomena are seen in a new way (Husserl, 1982). Heidegger, Husserl's perceived successor, did not agree with the concept of phenomenological reduction as described by Husserl, but he referred to the need to eliminate the presuppositions or preconceptions that arise as a result of traditional or metaphysical influences (Speigelberg, 1982). The philosophical development and differences that defined the phenomenologies of Husserl and Heidegger are outlined in detail in chapter 6.

Table 2.7 Australian STNs Interviewed for Phenomenological Data

Pseudonym	Year began nursing	Year of STNEP	Employed as an STN
Kate	1957	No STNEP	Retired
Barbara	1956	1977	Yes
Anne	1953	1977	Yes
Judith	1950	No	Yes
Linda	1956	1976	Yes
Maxine	1955	1974	Yes
Danni	1957	No STNEP	No, but nursing
Meg	1954	No STNEP	Yes
Tessa	1960	1975	Yes
Christine	1961	No STNEP	No, but nursing
Esme	1961	1981	No, but nursing
Susie	1963	1971	No, but related health field
Nancy	1965	1983	Yes
Colleen	1964	1996	Yes
Sabrina	1968	1974	No, but nursing
Sharon	1968	No STNEP	Yes
Alicia	1970	1979	Yes
Joanne	1973	1982	Yes
Kylie	1972	1979	No, but related health field

In reality, both Husserl and Heidegger placed clear emphasis on the importance of eliminating any presuppositions or barriers that would prevent unhindered access to the phenomena. This, too, was my intent in conducting the interviews and in the analysis of their contents. Further discussion in regard to various, and at times contentious interpretations of bracketing are included in chapter 6.

Phenomenological Data Analysis

Phenomenological analysis is a method for making subjective experience objective experience. Phenomenological data collection and analysis occur simultaneously and rely on the researcher's ability to bracket and intuit data (Burns & Grove, 1987). This statement highlights the dynamic and interactive processes that are involved in developing phenomenological understanding. Furthermore, it requires of the researcher good interpersonal skills, concentration and insight (Streubert & Carpenter, 1999).

Thematic analysis of the data obtained from the 19 transcribed interviews was conducted. Analysis involved the use of bracketing, phenomenological reduction, intuiting and phenomenological interpretation of the data in order to identify the common themes and sub-themes. There are numerous methodological procedures for conducting phenomenological research documented in the literature (Colaizzi, 1978; Giorgi, 1985; van Manen, 1984; Streubert, 1991). However, I have chosen to follow the steps outlined by Streubert (1991), a nurse phenomenologist. Streubert's method is aligned with the methods recommended by phenomenologists from other disciplines and has the added advantage of being devised by a nurse for nursing research. Streubert's methodological procedure is as follows and the comments in brackets summarise the way I implemented this procedure. Further explanation follows the outlined steps.

1. Explicate a personal description of the phenomenon of interest (my personal experience of the phenomenon was presented in the Introduction to this thesis);
2. Bracket the researcher's presuppositions (following reflection I documented a list of my presuppositions in regard to the phenomenon under research);
3. Interview participants in unfamiliar settings to the interviewer (the sites where the interviews were conducted have been previously explained);

4. Carefully read the interview transcripts to obtain a general sense of the experience (this was done on multiple occasions as has been previously explained);
5. Review the transcripts to uncover the essences of the data (the transcripts were read and reviewed on an ongoing basis until the essences of the data were made clear – see Appendix A for an example of an interview extract);
6. Apprehend essential relationships (as codes, sub-themes and themes emerged they were recorded and reviewed – see Appendix B for an example of this process);
7. Develop formalised descriptions of the phenomenon (five themes emerged from the data that described the ‘experience of being a stomal therapy nurse’ and one independent theme emerged that described ‘the specialty of stomal therapy nursing’);
8. Return to participants to validate descriptions (validation and clarification was sought when necessary from the participants);
9. Review the relevant literature (the literature was reviewed in regard to the findings found following analysis of the phenomenological data, and the overall key finding as discussed in chapter 8); and
10. Distribute the findings to the nursing community (the findings of this study have been presented at local professional meetings and at two national conferences in 2002 and 2003. However, this commitment will continue to be honoured in professional forums) (Streubert, 1991, p. 121).

Streubert’s methodological steps were followed in the manner outlined in this chapter. In particular, I would like to highlight the fact that a personal description of my experience of stomal therapy nursing as a novice nurse was provided in chapter 1. Also reflection into my personal lived experience of being a stomal therapy nurse, enabled me to examine those personal experiences and purposefully lay any presuppositions aside by employing the technique of bracketing and phenomenological reduction.

I returned to four of the participants to validate an emerging theme “professing thoroughness”. Four participants were deemed sufficient as a consensus of opinion among them was very strong. However, I also sought validation of their descriptions from four

non-participant persons. One of these latter people was a colo-rectal surgeon and the other two were stomal therapy nurses and a lay person.

Historical and phenomenological data were analysed independently, but interdependent relationships between both methodologies were also identified. This is in keeping with the philosophical approach proposed by Dreher and Hayes (1993) in regard to triangulation. These authors suggest that “triangulation is not just a combination of methods but a back and forth movement” (Dreher & Hayes, 1993, p. 217). ‘Back and forth’ analysis between the historical and phenomenological studies identified kindred relationships, causes and effects. The literature was reviewed in regard to the dependent and interdependent findings of this study and relationships found to exist are discussed in chapters 8 and 9. It is my intention to distribute the findings to the nursing community in general and thus, fulfil the final procedural step recommended by Streubert (1991). An algorithm is used to summarise for the reader the research methodological journey that I undertook.

Algorithm of the Methodological Journey

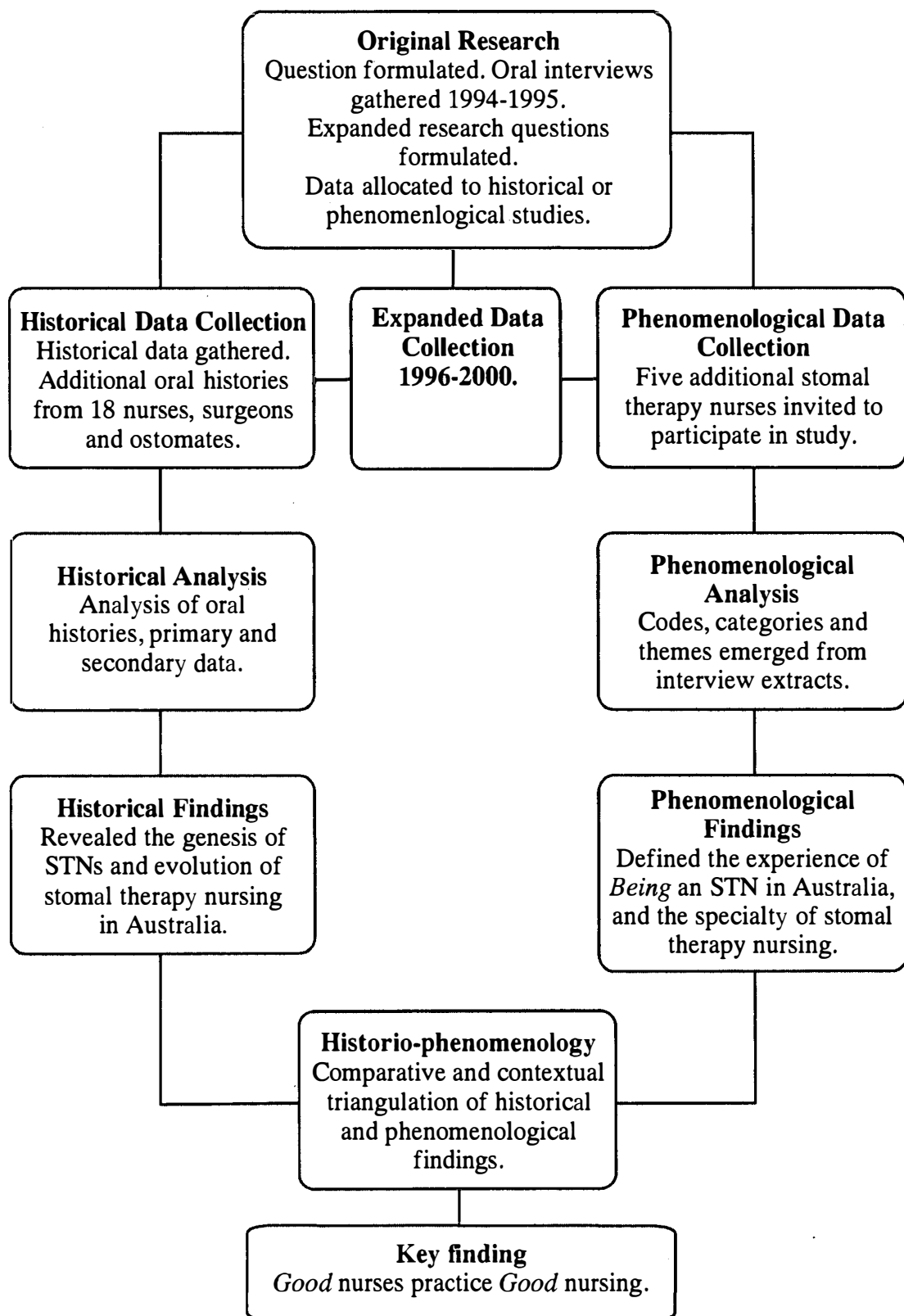


Figure 2.2

Study Limitations

There was little demographic variation in the phenomenological sample. All of the stomal therapy nurses in the phenomenology study were Caucasian females of Anglo-Australian heritage and of ages, which ranged from 40 to 62 years at the time of interview. The stomal therapy nurses who participated in the historical study were of similar ages but included one male of non-Anglo-Australian heritage. The surgeons were all male and aged over 60 years of age. The ostomates were aged over 65 years and there was only one male amongst the four females. Therefore, the perceptions and experiences of the study population may differ from those of other Australian stomal therapy nurses, surgeons and ostomates.

A perceived limitation of this study involved the ability and willingness of interviewees to recall accurately their experiences. It is recognised that memory is influenced by elapsed time, subsequent experiences of the interviewee, cognitive changes and societal, cultural and political changes (Douglas, Roberts, & Thompson, 1988). Memory recall, which is discussed more fully in chapter 3, is also considered to relate to “the degree of interest or significance of the event” (Douglas et al. 1988, p. 23). It was my assumption that a degree of interest would be best safeguarded in selecting subjects who by the nature of their stomal therapy nursing practice or related endeavours, would have had a perceived interest in stomal therapy nurses and nursing. However, there was no definitive way to determine the exact degree of interest or significance of each participant.

Ethical Considerations of the Study

Permission to conduct this study was obtained from the Committee for Conduct of Ethical Research at Edith Cowan University. Each potential participant was invited to participate in the study and informed of the purpose and objectives of the study (see Appendix C). The one consent form was deemed relevant to the collection of data for both methodologies employed for it stated that the purpose of the study was to research the history and experiences of stomal therapy nurses. All participants were informed of their right to withdraw from the study at any time. Written consent was obtained prior to each interview (see Appendix D). The interviewer also abided by the Guidelines of Ethical Practice as stated by the Oral History Association of Australia.

I also abided by the Copyright Act and informed the participant of their rights related to that Act (Douglas et al. 1988). The consent form sought permission from the participant to permit the interviewer to use the information for the purposes of research and related publication. Permission was also sought to allow the researcher to preserve a copy of the oral interviews for the purpose of possible future interest and research. The participant was asked for permission to place a copy of the interviews with the Australian Association of Stomal Therapy Nurses and in an acknowledged archival library, such as the Battye or National Library (see Appendix E).

Conclusion

An historical methodology was used to research and define the genesis and evolution of stomal therapy nurses in this study and to determine the significance of that historical context. This methodology could be conceptualised as a prism that reflects a past phenomenon for present and future interpretation. Phenomenology was used to understand the lived everyday experience of the stomal therapy nurses, and in so doing provided an insight into what it was to be a stomal therapy nurse in Australia during the years 1959 to 2000. This methodology could be conceptualised as a window, which gives a clear view of the essence of the phenomenon. In partnering these two qualitative methods a new research approach – historio-phenomenology has evolved. Historio-phenomenology has provided a means for describing the historical events that led to the development and evolution of stomal therapy nurses in Australia during the years 1959 to 2000 and to describe the lived experiences of stomal therapy nurses within that historical context. This approach could be conceptualised as a two-way mirror that both reflects and provides a clear view of the phenomenon.

Chapter 3

Defining the Historical Context

Introduction

What *is* history? This is a frequently asked question in the literature of historians and although there is a common assumption that ‘history’ relates to all things past, historians debate the qualities and value of historiography - the study and writing of history (Carr, 1961; Commager, 1965; Kitson Clark, 1970; Windschuttle, 1994).

History is both a discipline and an activity in much the same way that nursing is both a discipline and an activity. However, there appears to be as many literary efforts expended in defining what history is and what it is not, as there are in recording and interpreting past events and the activities of past societies and individuals. In part, debate hinges largely on whether history is a science or an art and this debate has claimed an inordinate amount of attention over the past 200 years.

It is not surprising then, that the dearth of contemporary nurse historians are called to defend both the scientific relevance and the methodological approach of this research method (Lusk, 1997; Sarnecky, 1990; Streubert & Carpenter, 1999). Perhaps of even more importance, is that nurses until relatively recently have also been called upon to justify why they should want to study the history of their profession (Chinn, 1990; Kruman, 1985; Rafferty, 1991). The answer to this call is to be found in the profound words of Theresa Christy, a nurse historian, who asked: “How can we in nursing today possibly plan where we are going if we don’t know where we have been nor how we got here?” (Christy, 1978, p. 9).

I was very aware of the need to understand where stomal therapy nurses ‘had been’ in the historical context, and how they evolved into a specialty within nursing in order to fully understand the phenomenon of being a stomal therapy nurse. The purpose of this chapter is therefore, to discuss the merit of defining the historical context associated with stomal therapy nursing experience - both past, present and future.

The Art Versus Science Debate

Nurses and historians appear to have one thing in common – they have been frequently called upon to define their practice and align their practice with either the humanities or physical sciences. In the fifth century Herodotus, who is acknowledged as the ‘father of history’, is considered to have treated history as both an art and a science. In describing the war between the ancient Ionians and Persians in 499 B.C. Herodotus’ literary style is said to be reflective of the artistic or “poetic spirit of Homer”, whilst his efforts in the search for the truth are said to be reflective of the “scientific temper of his age” (Bowra, 1972, p. 103). The significant difference however, was that Homer wrote of myths and legends and Herodotus wrote of his interpretations of known human endeavours (Collingwood, 1956; Picard, 1960).

The trend towards a scientific approach to history was further progressed by Herodotus’ successor Thucydides in his fifth century B.C. treatise *The Peloponnesian War*.

Thucydides’ approach to history is considered to have been influenced by the developing science of medicine that sprung from the teachings of Hippocrates of Cos. Thucydides adopted an almost “clinical” approach to the researching and writing of history. His awareness of the cause and effect of events on future generations and his analysis and interpretation of these events and their potential future effects, established what was broadly considered to be a scientific approach for future historians to emulate (Bowra, 1972, p. 104). However, some historians have challenged this stance and have continued to demonstrate protracted confusion in regard to whether history could be considered a science (Carr, 1961; Commager. 1965).

Confusion of this genre is most familiar to nurses for in attempting to define nursing, the ‘art versus science’ debate holds court regularly. Like Herodotus, Florence Nightingale, the founder of modern nursing, wrote as if she considered nursing to be both an art *and* a science. “Nursing is an art... it is one of the fine arts; I had almost said, the finest of the fine arts” (Nightingale, 1997, p. 79). Equally, Nightingale alluded to the science of nursing for she wrote of certain aspects of nursing as “the first real experiment of the kind” (Nightingale, 1997, p. 81). Furthermore, Nightingale established nursing practice on ‘laws’ or principles of health and wellness and made great use of statistics to support her theses. These latter concepts are now entrenched in

nursing science and hallmark Nightingale as the first nurse theorist (Marriner-Tomey, 1989).

It is evident however, in the literary titles and body of texts of some nurses and historians that they diverge from the concepts portrayed by Nightingale and Herodotus for they continue to align their respective disciplines to the humanities alone (Commager, 1965; Donahue, 1996). Some historians were found to be most adamant in their opinion that the study of “history is not a science and the historian is not a scientist” (Commager, 1965, pp. 64-65). Commager was of the opinion that the study of history was instead an art and a philosophy. He argued that it was this approach that gave the historical narrative moral value. Although Commager appreciated the desire to use a scientific method to “test all things” in the search for truth – he just disputed that all things historical could be tested scientifically and preferred instead to refer to the term “critical method” for historical analysis (1965, p.13). As has been outlined in chapter 2, rigour in this historical study is promoted by applying internal and external criticism to data analysis.

Collingwood wrote that history “is a science, but a science of a special kind... whose business is to study events not accessible to our observation, and to study these events inferentially” (Collingwood, 1956, p. 251). Collingwood’s concept of ‘inferential’ equated to an organised body of knowledge that could be supported with evidence. Such a principle is fundamental to the physical sciences. Carr however, was found to be more benevolent and referred to ‘science’ as an umbrella term for a diversity of fields of knowledge and their respective methodologies – historical research amongst them. Carr argued instead that the science verses art dispute was a reflection on the prejudices that exist between the humanities and the physical sciences (Carr, 1961).

Shafer (1960, p. 159; 1985, pp. 149, 157) simply stated that the entire debate was “futile” for history was “the essential preliminary, the accompanying study of both” art and science. He claimed that history is the foundation for all understanding and action. There is an analogy to be made with this historian’s claims and of those of the early phenomenologist, Edmund Husserl (1982) who claimed phenomenology was the science of beginnings (this will be discussed in chapter 6).

The relevance of this debate to nurses however, is to be found in the reminder it extends to the profession. A reminder of the need to look back as well as forward and in doing so, to analyse the significance of past on present and future practice. The constant advances in knowledge and technology that confronts nurses today, causes them to lose sight of the significance of past discoveries, events, practices and behaviours (Vaughan, 1985). Even products and technology of the past decade seem old-fashioned and irrelevant in modern practice. This was found to be the case in this study when the ostomy appliances and wound dressings used by stomal therapy nurses in current times were compared with those they used 10 years ago. Knowledge of the origins of current practice assists nurses to examine them in the light of current scientific knowledge and facilitates the elimination of those practices or rituals that serve no scientific purpose, whilst preserving those that do.

It has also been proposed that in examining the history of nursing, there is to be gained an understanding of social history. As the related effects of diseases, the development of hospitals, medical advances and issues related to gender, class, ethnicity, politics and professionalism of nurses impacted on society generally (D'Antonio, undated; Brush & Lynaugh, 1999). Alternatively, in exploration of the history of diseases, hospitals, medical advances, gender and class et cetera, the history of nurses and the evolution of nursing as a discipline will be reflected (Haeger, 1988; Rafferty, 1996; Goldin, 1994; Nelson, 1998). D'Antonio (undated) refers to this as the "cross-disciplinary reciprocity between nursing and social history". This cross-reciprocity is very evident in the historical nursing literature and provides critical insight into the conditions and expectations that have been imposed upon succeeding generations of nurses (Baly, 1986; Russell, 1990; Nelson, 2001).

The influence of society and politics on nursing as a profession is far reaching and has been since the founding of modern nursing (Baly, 1986; Donahue, 1996). Brush and Lynaugh (1999, p. xiii) in recording the history of the International Council of Nurses, had considerable cause to comment on the impact of world calamities, prejudices of class and gender and exploitation of races on international nursing activities over the last century. They wrote that "nursing, so intimate in its work, faithfully mirrors both the unattractive and the uplifting aspects of the human experience". That diversity in human experience is clearly mirrored in the literature that records the joys and

sufferings that Australian military nurses witnessed and endured during the course of military conflicts (Bassett, 1992; Biedermann, 2002; Nelson & Rabach, 2002).

According to Nye (1975, Forward) “history is a way of looking at human experience” and offers a method for interpreting the effects and diversity of that experience. Carr debated that an unassailable tenet of historians, like physical scientists, is to collect the facts and then interpret them (Carr, 1961, p. 57). Although the methods employed by physical scientists and historians may differ, as the former searches for facts in experimentation and the latter searches for facts amongst documents and oral records. The significant point is however, that the methodology employed be disciplined, be reproducible and build on the body of knowledge about the past as suggested by Windschuttle (1994).

Similarly, it should allow for interpretation from a contemporary view as suggested by Carr (1961). It has been argued however, that contemporary history is not “real” history and that one can not achieve maximum objectivity when writing of current times and events (Hughes, 1965, p. 65). I would like to suggest that historians making these claims have lost sight of the origins of their discipline for Herodotus and Thucydides were contemporary historians and were acknowledged for being “remarkably fair” and “clinical” in their writings (Bowra, 1972, p. 103). Stomal therapy nurses in this study demonstrated exceptional traits of fairness and clinical ability and there is little reason to suspect that these characteristics would not be employed by contemporary nurse historians. However, Nelson (1999) warns that nurse historians need to be mindful of the risk of celebrating their achievements, rather than affording them due scholarly analysis.

Historical Objectivity

Leopold von Ranke (1795-1886) was a German historian whose concept of history was ‘to show it how it actually was’ (*Wie es Eigentlich Gewesen*). Ranke considered it to be the historian’s purpose to find evidence and the evidence was to be found in documents, and the more documents the better. Ranke’s focus was on the need to describe, rather than interpret, history and this has been referred to as an hermeneutical approach to history (Black & Macrailld, 1997). The Rankean era has been referred to as the ‘scientific school’, for the philosophy of the day was to avoid moral judgement and

ensure accuracy in data and quotations, with the support of copious footnotes (Gawronski, 1975). However, even a vast number of documents and footnotes does not guarantee objectivity in research and even Ranke was criticised for being judgemental (Black & Macrailld, 1997).

Moral judgement and bias should concern historians for both can either consciously or unconsciously impact on the selection and interpretation of facts. It must also be appreciated that the very nature of the records written are subject to the values of the writer of the record. In addition, those records that are kept at the expense of those that are not, are also subject to the values of the archivist. I found this selectivity to be the situation when I reviewed the documentary archives of the AASTN. It was obvious that the various archivists over the years had alternative views in regard to the type of documents worthy of archiving. Commager proposed that not only did “caprice and fortuity” influence the availability of documentary evidence but “modern-mindedness and subjectivity” influenced its interpretation (1965, p. 49).

Modern-mindedness was a term he penned to refer to the interpretation of past events and the actions of past persons with the values, assumptions and standards common to present day historians. In other words, modern-mindedness equates to contemporary interpretation. It has been said that “no human being is capable of complete objectivity ... whatever, they write is the product of their own environment, education, and value structure” (Gawronski, 1975, p. 15).

It is my opinion that the value of history lies in the ability of succeeding generations of historians to interpret past events and deeds with contemporary values. Such activities illuminate for modern society the relevance of lessons to be learned from the past. If the study of history is not to simply provide narratives of interest akin to bed-time stories, but an understanding of past human experience then interpretation must not only be mindful of past societal values, but must be aligned with contemporary values and understanding. It would appear that the relevance of history to nursing is not to be found solely in objectively describing past events or practices, but in defining the contemporary relevance of those events and practices to present practice and perceivable future practice.

According to Carr (1961) there can be no ‘ultimate’ history but progressive and ever-changing interpretations that will ensure that each historian’s interpretation of events and deeds will be superseded. Kruman (1985, p. 111) compares the resultant differences in historical interpretation - as a result of the facts being “filtered through human intelligence” - to the changes that evolve in other forms of scientific knowledge. If one is to appreciate and value the evolving knowledge that will result from multifarious filtering processes, one must fully appreciate the need to filter accurate facts if history is to warrant scientific merit in nursing studies. This reasoning suggests that historical truth and objectivity are fundamentally reliant on the type, nature and extent of data collected and the methods employed to collect it and preserve it for future contemporary re-interpretation.

The Merit of Historical Research

Instead of denigrating historians for a perceived lack of objectivity, Carr suggested that the best measure of a historian’s objectivity was primarily his or her ability to recognise the impossibility of total objectivity. In addition, he surmised that objectivity in a historian could best be measured against the historian’s ability to:

project his vision into the future in such a way as to give him a more profound and more lasting insight into the past than can be attained by those historians whose outlook is entirely bounded by their own immediate situation (Carr, 1961, p. 123).

In other words, the lessons to be learned from the study of history have a relevance to the present as well as to the future. The need for the historian to connect the past with the present and potential future is considered a tenet of historians. Sir Winston Churchill was attributed to have said ‘that the further you look back, the further you can look forward’ (Shafer, 1960; 1985). Christy’s comment referred to in the introduction of this chapter is also reflective of this philosophy.

Although Nightingale laid no claim to being an historian she frequently demonstrated the ability to move outside her immediate situation and project her vision for nursing well into the future, as evidenced in the following quotation, which she penned in 1867.

My view you know is that the ultimate destination of all nursing is the nursing of the sick in their own homes... I look to the abolition of all hospitals and workhouse infirmaries. But no use to talk about the year 2000 (Nightingale, 1997, p. 56).

One could rationalise that Nightingale's ability to move outside her immediate situation was because she was fully cognitive of her immediate situation or the 'history of the present', and she was certainly mindful of the impact of past events (Baly, 1997). Nightingale's legacy of letters and writings provides ample evidence of this ability and set a precedent for succeeding generations of nurses to emulate and debate (Baly, 1986). The modern trend however, is for nurses to debate the broader implications of Nightingale's legacy and the legacy of other early nursing leaders and religious orders, for the evolving profession (Kalisch & Kalisch, 1983; Godden & Forsyth, 2000; Nelson, 2001a; Nelson, 2001b). Although early nursing texts such as Woodham Smith's *Florence Nightingale* (1950) and Abel-Smith's *A History of the Nursing Profession* (1960) celebrated the founding and early history of modern nursing, it was left to the nurse historians of more recent decades to interpret the far-reaching effects of that founding on modern day nurses and those that shall succeed them (Baly, 1986; Nelson, 1997; Godden & Forsyth, 2000).

Fortunately, the number of nurses who do seek to research and write the history of the profession are gradually increasing and they are becoming more scholarly in their approach (Nelson, 2002). D'Antonio (1999) and Nelson (2002) claim that the explosion of interest in nursing history by historians from other disciplines during the 1980s is largely responsible for this scholarly maturity. The outcome of this maturity however, has been an appreciation that nursing history is an independent entity to medical history, although it possesses some commonalities (Kalisch & Kalisch, 1986; Donahue, 1996). Nelson (1998) argues strongly that nursing history is not an off-shoot of the history of medical science, but rather the histories of religion, charity and women.

The fact that nurses are interested in their profession's past is in itself is an interesting phenomena when nursing as a discipline is perceived to be predominately preoccupied with current practice and advancing technology. But nurses are also constantly reminded of the need for evidence-based practice and many of the practices so familiar to nurses are heirlooms of the past. In addition, nursing practice is frequently found to

be endowed with rituals and many of these rituals can not be justified when examined in the light of current scientific knowledge. Examples of these type of rituals were found in this study and are revealed in chapters 5 and 7.

In order to understand the clinical experiences of stomal therapy nurses in this study, it was deemed necessary to define the nature of their rituals and practices, and to determine their historical origins and current relevance. It has been claimed that this is the very reason nurses should undertake historical studies (Wood & Paul, 1993). In this study there was also a need to determine the historical origins and evolutionary path of stomal therapy nurses in order to obtain an understanding of the experiences associated with their professional identity and development. Lynaugh defines this as a search for nurses' "cultural DNA" (1996, p. 1).

In uncovering that 'cultural DNA', I had also expected to gain insight into the culture of the people who required the care of stomal therapy nurses. For Church advocated that "care givers of the past belonged to the same culture and society from which those identified as needing their care emerged" (1987, p. 275). Oral history was deemed an appropriate method for revealing insight into the culture and society of the nurses, enterostomal therapists, surgeons and ostomates in this study.

Oral History

Historians, like nurses, have specialty sub-groups within their respective wider discipline (Fletcher 1995; Roper 1994; Scott 1988). In fact, it has been stated that there are as many kinds of history as there are historians (Commager, 1965). Regardless, there are two primary sources from which all historians extract evidence, and they are written and oral sources. It has been stated that during the Rankean era the written record came to be viewed as the supreme source for historical evidence. However, this was not always the situation for ancient historians and indeed modern historians, who search for data amongst predominately illiterate populations, have had to rely heavily on oral sources.

Ironically the lack of credibility afforded oral historians during the Rankean era was awarded at a time when illiteracy amongst European populations was common. This academic and social disparity ensured that much of the populace was historically

disenfranchised (Dunaway & Baum, 1984). There is also a notion that history has been “written by the victors, not the vanquished”, and in virtually all instances those victors were male (Commager, 1965, p. 5). The histories of the female rank and file or the conquered appear to have little historical merit. This type of historical disenfranchisement is common to the nursing profession, especially in Australia. It has been noted that whilst the histories of major health agencies and the occasional nurse leader have made their mark on Australia’s historical page, the histories of rank and file nurses and nursing specialties have been sorely overlooked (Gare, 2001; Hobbs, 1980; Oppewal, 1997).

The literature reveals that there are two forms of oral historiography – oral tradition and oral history. Oral traditions “are those recollections of the past that are commonly or universally known in a given culture” (Henige, 1988, p. 2). They represent the oral traditions passed from generation to generation. An example of oral tradition is to be found in the account of Arthur Haley’s ancestry in his book *Roots: The Saga of an American Family* (1976). Likewise, the many narratives passed to succeeding generations of nurses could be considered examples of oral tradition.

Oral history on the other hand refers to the “study of the recent past by means of life histories or personal recollections, where informants speak about their own experiences” (Henige, 1988, p.2). Many of these personal recollections and experiences, which would “rarely be committed to paper just because most people do not think them of much importance to others” provide the historian with a rich insight (Thompson, 1988, p. 27). It has been said that oral history “allows the voice of ordinary people to be heard alongside the careful marshalling of social facts in the written record” (Tosh, 1984). Biedermann (2001) argues that a particular strength of oral history for nursing is that it preserves the experiences of non-elite nurses and patients who would otherwise leave no record of their experiences. This was certainly found to be the situation in this study as it was the oral histories that provided background and substance to minuted records and the few documented clinical practices of stomal therapy nurses. Moreover, the oral histories of international enterostomal therapists, Australian surgeons and ostomates provided testimonies which provided alternative views of the phenomenon.

In Australia, reliance on oral evidence for the writing of historical texts, manuscripts and reports has been common place since early colonisation. This practice continues as transcripts from courts, government inquiries and parliamentary activities make their way into the official records of the land. The earliest sound recording however, was made in Tasmania in 1899 when the voice Mrs Cochrane Smith, who claimed to be the last remaining Tasmanian Aboriginal, was recorded. Since then oral histories have been used to supplement written primary sources by many an emergent Australian historian. This activity led to the establishment of oral history departments in the National Library in Canberra and the Battye Library in Western Australia in 1970 and 1975 respectively (Douglas, Roberts & Thompson, 1988). It is my desire that the oral history collection that results from this study will be placed in safe keeping in either of these libraries.

The value of oral history is to be found in the recording and interpretation of the personal experiences of those interviewed (Silins, 1993). It is also to be found in the recording and preservation of the language that is: the accents, colloquialisms, nuances and pauses that are unique to the spoken word of each generation. Australian nurse historians have in the past relied on oral histories to fill the gaps in documentary evidence of every day nursing experience, as evidenced in the Wiles and Daffurn's (2002) history of Australian critical care nursing and Bassett's (1992) history of Australian military nursing. In this study the 'tricks of the trade' or rituals that were practiced by the stomal therapy nurses were not found in the documentary evidence, but were described in detail by several participants. For example, participants gave graphic details of the rituals that abounded in the making of 'long bags' prior to the availability of commercial alternatives (Appendix I) and of the unorthodox treatments they used on ulcerated skin, when they found no orthodox pharmaceutical remedies were available.

Oral history offers the researcher a privileged view of the participant's very personal lifeworld and demands of the researcher the ability to deal with the memories of others in an honest, sympathetic and imaginative manner (Hoopes, 1979). The collection of an oral history is a two-way process, which requires of the both the participant and the interviewer the ability to 'give and take' (Counce, 1994). Summerfield (1998) however, declares that feminist scholars dispute that equality between the participant and interviewer can be achieved because the interviewer represents a section of society that has as its purpose the intent to collect data for the public domain. She claims that

feminist oral historians endeavour to overcome this imbalance by “seeing the interview as a sharing experience; second, by placing themselves in a subjective position within the interview; and third, by giving interviewees some responsibility for the project (Summerfield, 1998, p. 24).

In this study I was very appreciative of the participants’ willingness to share their experiences. I was also very aware that my personal experience as a stomal therapy nurse could have caused some participants to assume that I either needed, or did not need, to hear certain facts. Therefore, I endeavoured to make it clear to the participants that they were to adopt the stance that I had no previous personal experience or knowledge of the field and that I was interested in their personal experiences and memories. My role was largely to offer encouragement and memory prompts as required.

In regards to memory, criticism directed towards oral history is normally directed towards testing the validity of memory. Human experiences and reactions to those experiences impact on the memories people choose to keep, and those they choose to share. Elapsed time between the event and the sharing of the recollection is also known to contribute to inaccuracies in the oral record. Summerfield (1998) argues gender will also influence assumptions of what is considered public and private domain. She alludes to the fact that in recounting one’s testimony one is confronted with the need to maintain one’s sense of self-worth and public image as well as deal with memories that are perhaps less favourable.

Hamilton (1994) challenges the common view that history and memory are potential combatants. She reminds her readers of ancient times when memory was regarded as the “source” and “life” of history (1994, p. 11). In illiterate populations in the world today memory continues to be the guardian of history. Hamilton infers that memory also presents a credible challenge to popular recorded history and uses as her example the recent role that memory played in acknowledging the previously unappreciated history of the ‘lost generations’ of indigenous Australians. One can also see similarities in the role memory played in preserving the history of past prisoners’ of war when documentary evidence of war atrocities had been destroyed. Hamilton (1994) proposes that it is of greater importance to consider why and how memory is maintained rather

than how it is distorted or lost. She argues that the public airing of memories at venues such as reunions and anniversaries reinforces the emphasis and slant on collective memories as does the need to justify the behaviours of the past-self in contemporary times. These attitudes of course, present challenges to the oral historian and give insight into why historians seek collaborative evidence from more than one person or use a combination of oral and documentary evidence. It was my intent to seek and compare both the oral and written evidence.

It has been argued that the integration of oral and written data requires the same skill as the integration of different written sources and that the enhancement of the written word with oral sources is the “principal purpose of oral historiography” (Henige, 1988, p. 71). Biedermann (2001) suggests that an oral history interview may also be an opportunity for revealing unknown documents, artefacts and photographs. I found this to be the case on several occasions during this study when personal ‘treasures’ were presented in response to oral testimony. One study participant’s memory in fact was responsible for saving the first stomal therapy film that had been made over 30 years ago by an eminent and now deceased surgeon. The film demonstrated the technique for applying the first skin barrier to an ileostomy stoma. A pioneer stomal therapy nurse’s memory of the making of this film prompted me to investigate further and the search proved fortunate when the film was found abandoned on a hospital rubbish pile. It is now archived safely in the hospital. The juxtaposition of oral and written primary sources in the search for truth proved to be the key that expanded my historical understanding of the origins and evolutionary experiences of Australian stomal therapy nurses in this study.

Conclusion

The intent of this chapter was to discuss the purpose and value of history in defining the historical context of this study. In the minds of many individuals history is synonymous with the past - a record of bygone times, events and experiences. But this chapter has outlined the tenable hold history has on the present and the future, and asserts with confidence that historical research is the means for investigating and proclaiming that relationship.

I would like to suggest that all experience occurs within a moral, social, economic and political context of a given time, and in order to understand fully that experience one

needs to examine it in context with the established values of that time. Only then is one able to make comparable interpretations with contemporary values, and forecast future relationships. This is the purpose and value of defining the historical context of the experiences of the stomal therapy nurses in this study.

Chapter 4

Historical Background to the Study

Introduction

The phenomenon to be discussed in this dissertation is the evolution and experience of stomal therapy nurses in Australia. Strictly speaking this focuses on the period 1959 to 2000. However, it was assumed that the history that preceded the study period would have had an evolutionary and possibly a significant effect on the phenomenon in question. I found it necessary therefore, to obtain an understanding of the historical background to the study period in order to ascertain the relevance of past historical events on the development and evolution of stomal therapy nurses in Australia. The purpose of this chapter therefore, is to provide the reader with an overview of the history of ostomy surgery and the care of people with stomas, both nationally and internationally, before 1959. This chapter will also highlight the historical development of products and appliances used in the management of stomas prior to 1959. In this, and subsequent chapters it will become evident to the reader that the limited availability of such equipment greatly impacted on surgical endeavours, the development of stomal therapy nursing and the experiences of stomal therapy nurses as revealed in chapter 7.

In the Beginning

Ehud put forth his left hand, and took the dagger from his right thigh and thrust it into his belly. And the haft also went in after the blade; and the fat closed upon the blade, so that he could not draw the dagger out of his belly; and the dirt came out (Judges 3:21-22, King James Version).

Ehud's mortal attack on King Eglon of Moab, as documented the book of Judges, relates to an event that occurred approximately 1000 B.C. This appears to be the first written record of a traumatic opening into the gastrointestinal tract. Although King Eglon did not survive this assault, history records other ancients did survive spontaneous rupture or traumatic perforation of the gastrointestinal tract, although against considerable odds at times. Similarly, mortality rates for people undergoing surgery that resulted in the formation of an ileostomy or ileal conduit were equally as high until relatively recent times.

Ancient literary works record the results of humanity's tendency to war and violence down through the ages and the injuries that resulted. Homer's *Iliad*, written approximately 700 BC, graphically documented a high mortality rate from the sword, spear and arrow wounds (Picard, 1960). A reader can only wonder however, how many of these victims survived or died from wounds that perforated their gastrointestinal or urinary tracts. Fortunately, some eminent ancient medical authorities were more specific in their observations. Hippocrates (460-377 BC), referred to as the 'father of medicine', implied in writings accredited to him, that wounds of the large intestine were not deadly, whereas wounds of the small intestine, stomach and bladder were. Celsius (53 BC - 7 AD) supported this belief and provides us with an graphic picture of surgical art during the time of Christ in his work *De Medica Libri Octo* in which he discussed the assessment and management of eviscerated wounds (Richardson, 1973). Galen (130-200 AD), who was surgeon to the Emperor Marcus Aurelius and the Roman gladiators, also discussed the surgical management of wounds of the large intestine and abdominal wall following penetrating injuries (Haeger, 1988). Galen's experiences however, led him to believe little could be done to save the person with a rupture of the small intestine (Haeger, 1988).

The challenges presented to military surgeons were exacerbated from the 14th century onwards, for it was in 1346 at Crecy that artillery was first used in battle (Leavesley, 1995). Apparently many who survived gunshot injuries to the abdomen, often did so as a result of human endurance rather than on account of surgical skill (Dunphy, 1970). George Deppe, a soldier, was wounded at Ramillies in 1706 and he surprised many when he lived for 14 years with what appeared to be a severely prolapsed double-barrelled colostomy. Some of those who did survive perforations of their gastrointestinal system afforded the surgeons of the day an opportunity to observe over time, the physiological and psychosocial adaptation of individuals. The most well recorded observations of this nature were those made by the North American military surgeon, William Beaumont, on 18 year old Alexis St. Martin who was wounded in the stomach in 1822. Beaumont enthusiastically observed and experimented with St. Martin's gastric fistula over a period of 10 years and this resulted in the publication in 1883 of a major thesis titled *Experiments and Observations on the Gastric Juice and the Physiology of Digestion* (Leavesley, 1995; Moore, 1976).

Historical records also provide insight into the management and mortality rate following spontaneous bowel obstruction and rupture in eras past. King Stephen of England died in 1154 with what was termed “iliac passion”, a Saxon term used in 923 AD in relation to: “a disorder in which a desire cometh upon a sick man for discharging his bowels, and he is not able, when he is shut in the outhouse” (Brooke, 1980, p. 1). In ancient times, survival from such a malady was dependent upon the ability of the affected person to spontaneously clear the obstruction or survive rupture of the gut. Affluence or prestige did not appear to be influencing factors for Queen Caroline, wife of George II died in 1736 from a ruptured strangulated umbilical hernia that was preceded by 7 days of suffering due to ineffectual medical treatment (Leavesley, 1996).

However, Mrs White a patient of British surgeon, William Cheselden (1688-1752), was more fortunate. According to Cheselden, 73 year old Mrs White survived a rupture of an umbilical hernia, which left her with a lengthy segment of prolapsed gut. It is difficult to decipher from Cheselden’s account as to whether Mrs White was left with an ileostomy or a transverse colostomy. Regardless, she would have had to contend with difficulties associated with uncontrolled effluent. However, Cheselden’s medical records do not mention difficulties of this nature, but focus instead on his surgical prowess rather than any ramifications of the event on Mrs White’s quality of life. This literary neglect appears to have been emulated by virtually all the surgeons who pioneered ostomy surgery and published their accounts (Richardson, 1973).

Surgeons of the eighteenth and nineteenth centuries were well aware of the risk of peritonitis and subsequent death following gut surgery (Hastings, 1856). As a result, alternative methods for clearing bowel obstructions were routinely employed. They involved purging with laxatives and enemas, attempted dilatation via the anus, blood-letting and the ingestion of large amounts of mercury in the hope that the weight of the mercury would push an obstructing bolus through the gut. Death due to mercury poisoning was a common side-effect of this latter treatment (Leach, 1986).

Thomas Sydenham, a noted London physician during the mid-1800’s, prescribed horseback riding as a means to promote peristalsis and assist the passage of stool through obstructed gut. His treatment for paralytic ileus also required the assistance of

the animal kingdom for he recommended placing a kitten on the distended abdomen (Leavesley, 1995). Although this advice would no doubt be disdainfully disregarded by today's clinicians, there is a comparison to be made between the application of a warm kitten and a heat pack. The latter therapy is occasionally recommended by stomal therapy nurses today in cases of sub-acute bowel obstruction.

Origins of Colostomy Surgery

It was Monsieur Littre who in 1710, first suggested that a surgically created colostomy may preserve life in infants born with an imperforate anus. Littre performed an autopsy on a baby who had died from complications of imperforate anus. His observations caused him to suggest the following:

It would be necessary to make an incision in the belly, open the two ends of the closed bowel, and stitch them together, or at least bring the upper part of the bowel to the surface of the belly wall, where it would never close, but perform the function of an anus. Upon this slight suggestion a clever surgeon could imagine for himself details which we suppress. It often suffices to know in general that a thing may be possible and not to despair of it at first sight (Fontanelle in Dinnick, 1935, p. 142).

The first planned colostomy procedure was not performed however, until 1776 when another French surgeon, M. Pillore operated on a M. Morel. Surgery was seen as a last resort when other aggressive non-surgical interventions such as purgatives, dilatation and the consumption of two pounds of mercury had failed to clear his malignant bowel obstruction. An opening was made into the caecum and the bowel was sutured to the skin. A sponge held in situ with an elastic bandage was used to control the effluent between regular enemas. All went well for 2 weeks until the patient showed signs and symptoms of acute bowel obstruction from which he died 2 weeks later. An autopsy attributed the cause of death not to the surgical procedure, but to a gangrenous jejunum, from which was retrieved the two pounds of mercury (Cromar, 1968).

The first successful left inguinal colostomy recorded was performed by Duret, a French naval surgeon, in 1793 on an infant who was born without a rectum and with congenital abnormalities of the perineum. Although the infant was close to death prior to surgery, he recovered to live for 45 years. During the late 1700s to early 1800s French surgeons such as Desault in 1794, Daguesceau in 1795 and 1811, Dumas in 1797, Dupuytren in

1818 and Miriel during 1816-1823 pioneered colostomy surgery with limited but increasing success (Dinnick, 1935). Surgery was generally performed on patients however, only when death was inevitable. This demonstrated the ancient principle extolled by Celsus when he stated “it is better to employ a doubtful remedy than to condemn the patient in certain death” (Celsus in Moore, 1976, p. 283). There is an analogy to be made here between the principles embraced by these early surgical pioneers and the Australian pioneer stomal therapy nurses in this study. Their willingness to employ doubtful remedies rather than condemn their patients to certain distress will become evident in chapter 7.

Other European surgeons who added their names to the list of pioneers were Professor Fine from Geneva, who in 1797 performed the first transverse colostomy, albeit by mistake. Fine had endeavoured to perform an ileostomy on a female patient with an acute malignant obstruction and it was not until an autopsy was performed following her death 3 months later that he realised his mistake (Cromar, 1968). Danish surgeon, Hendrik Callisen (1740-1824) described a surgical lumbar approach for performing a colostomy, this he claimed would reduce the risk of damage to the peritoneum and therefore reduce the risk of peritonitis. However, his colleagues of the day disagreed with his technique stating that the increased benefits did not outweigh the surgical difficulties it created (Richardson, 1973). Callisen was later to be vindicated when his successors resurrected the technique.

The first British surgeon to perform a colostomy was George Freer who in 1815 operated on an infant with imperforate anus and in 1818 on a 47 year old farmer with a rectal obstruction (Cromer, 1968). Both patients lived only weeks, although the cause of death in both incidences was not related directly to the surgery. The infant died from marasmus (protein-calorie malnutrition) and the farmer’s demise was no doubt assisted by an excess of purgatives and numerous enemas via the stoma, which resulted in a ruptured caecum (Dinnick, 1935). The second British surgeon to perform colostomy surgery was Daniel Pring, from Bath, who operated on 7th July, 1820 on a 64 year old patient named Mrs White. Pring outlined in detail the formation of a left inguinal sigmoid colostomy and Mrs White’s complicated recovery. It is perhaps the first record of post-operative stoma complications such as skin ulceration, prolapse and sloughing of the stoma. Pring also described how Mrs White found what appeared to be an

elaborate truss-like appliance not as effective as a pad and binder in containing her two stools per day (Richardson, 1973).

Pring commented that Mrs White's colostomy "has afforded her a moral, as well as a physical advantage; for she is now at no loss for an interest, and is provided with something to think of for the rest of her life" (Pring in Richardson, 1973, p. 18). In a review of Pring's published report, which was titled 'Artificial Anus', Moore contends that Pring's satirical comments were a reflection of social and literary fashion of the times (Moore, 1976, p. 284). On reflection however, I question whether Pring's remarks in relation to Mrs White were meant to be derisory. It could be assumed that what Pring noted, were his patient's many concerted efforts to maintain comfort, hygiene and quality of life. Later in this chapter the reader will gain insight into similar efforts found to be common practice among more recent ostomates.

Although Mrs White's surgery was deemed a successful outcome in the medical literature of the day, surgeons continued to be reluctant to emulate Pring's endeavours because of the risk of causing mortal sepsis. At that time, knowledge of bacteria, antiseptics and the importance of asepsis was unknown. Jean Amussat (AD1796-1856), a French surgeon, believed that the reluctance of his colleagues was compounded by the fear of compromising their reputation if the patient should die. When Amussat carried out a retrospective review of all published surgical colostomy procedures between 1716 and 1839 he found that there were 27 cases listed; 21 for imperforate anus and the remaining six cases for obstruction. Of these, only four infants and two adults had survived to a reasonable lifespan (Richardson, 1973).

Amussat was concerned with developing a surgical technique that would reduce the mortality risk. In order to avoid entering the peritoneum, he resurrected the lumbar retroperitoneal approach recommended by Callisen (AD1740-1824) and Dupuytren (AD1818). Amussat's modified lumbar approach was introduced to British surgeons via the writings of his pupil, John Ericson, in 1872 and it remained the favoured site for incision on the rare occasion that colostomy surgery was performed during the nineteenth century (Girdlestone, 1874). The lumbar, or loin approach as it was often referred, was the surgical approach first used in Australia in 1874 when eminent surgeon, T. M. Girdlestone from the Alfred Hospital in Melbourne, performed a

‘colotomy’ on a female patient with a total rectal obstruction (Girdlestone, 1874). The woman had failed to respond to attempts to dilate the obstruction and was in a moribund condition when the surgery was performed under chloroform anaesthesia.

Apparently this woman relied on pads and binders to contain her stools and this causes one to wonder how a person with a posteriorly positioned stoma could have managed independently. Regardless, the lumbar approach was employed until the late 1800s when Cripps and Reeves, both British surgeons, again reintroduced the inguinal approach. It was not until 1920 that surgeons began positioning the end stoma in the left iliac fossa (Brooke, 1980). Even so, colostomy surgery was performed most reluctantly up until the end of World War I and it was not until the availability of sulphonamides and penicillin during the 1930-40s that surgical confidence was boosted (Haegar, 1988).

Origins of Ileostomy Surgery

The first recorded operative ileostomy was performed in 1879 by Baum, a German surgeon from Danzig. The procedure was performed on a patient with a malignant obstruction in the ascending colon. The patient died 9 weeks later from peritonitis as a result of a leaking anastomosis, which occurred following an attempt to close the stoma and re-anastomose the ileum to the transverse colon. A successful recovery in a patient following an ileostomy procedure however, was reported by Maydl from Vienna in 1883. In 1889 Finney from Johns Hopkins Hospital performed a procedure that secured a loop ileostomy stoma flush to the skin. However, the post-operative complications that were reported, especially those involving severe ulceration of the peristomal skin, were particularly discouraging (Cattell, 1939). The creation of a flush stoma resulted in contraction and stenosis and a sub-acute bowel obstruction resulted. The patient would present with increased peristalsis, which in turn led to an increase in watery ileal output, dehydration and electrolyte disturbance. This condition was later to be termed ileal dysfunction. In addition, a flush or retracted stoma made it almost impossible to contain the prolific ileal output and painful skin ulceration resulted.

In 1912 John Young Brown, a surgeon from St Louis, published a study of 10 patients that outlined an alternative surgical approach. His procedure involved the deliberate prolapse of a 5-7.5 cm section of ileum through the laparotomy wound and the insertion of a catheter through the lumen of the gut. The catheter was kept in place until gradual

retraction and scarring caused anastomosis of the intestine to the abdominal wall (McGarity, 1992). Although this technique did little to overcome eventual complications of stenosis, intestinal obstruction and skin ulceration, it continued to be used for 40 years. However, ileostomy surgery was rarely performed and then only on the most moribund patients with inflammatory bowel disease, because it was feared that body weight and electrolyte balance could not be maintained (Cattell, 1939).

Idiopathic inflammatory bowel disease is a broad term used to define chronic inflammatory and ulcerative conditions of the intestines - ulcerative colitis and Crohn's disease being the two most virulent entities. Traditionally, these conditions were generally named 'bloody flux' because of the frequent bloody loose stools that characterised the conditions. Although both conditions are thought to have existed for centuries they attracted little specific medical investigation until the twentieth century (Mendeloff, 1975).

Ulcerative colitis was named by Sir Samuel Wilks of Guy's Hospital in 1859 as a specific disorder but the symptoms of this disease had beset people through the ages (Richardson, 1973). The Roman Emperor, Claudius, was thought to be a sufferer and in 117 A.D. a physician named Soranus, from Ephesus documented an insightful clinical case (de Dombal, 1971). In 1932, Dr Burrill Crohn and his colleagues, Gingberg and Openheimer from the Mount Sinai Hospital in New York, isolated an inflammatory disorder with different pathology to ulcerative colitis, and this disease was named Crohn's disease (Hawley, 1970). Whilst ulcerative colitis is limited to the colon, Crohn's disease can be widespread throughout the gastrointestinal tract with potential extralesional manifestations, such as painful skin ulceration and fistulae formation (Morson, 1975). Ulcerative colitis and Crohn's disease remain the most common conditions that result in the creation of a permanent ileostomy.

Prior to the World War II, morbidity and mortality rates amongst people with severe inflammatory and septic bowel disease were excessively high. The Lahey Clinic in Boston reported a mortality rate of 22.2% in patients undergoing ileostomy surgery during the years 1928 to 1946 (Cattell, 1953). A Californian study reported a mortality rate of 90% following ileostomy in patients who had advanced ulcerative colitis and were in a poor condition prior to surgery (Grimes, Boudoures, Crane & Goldman,

1955). The advances made by medical science following World War II and which led to the therapeutic use of intravenous blood transfusions, antibiotics and steroids, had an obvious effect on reducing the mortality rate. The Lahey Clinic's mortality rate as reported above, was reduced to 5% during the post-war years 1947 to 1952 (Cattell, 1953). However, ileal dysfunction remained a major complication following ileostomy surgery and carried with it an independent high risk of mortality.

The term, ileal dysfunction, was coined by Doctors Warren and McKittrick from the Lehey Clinic in Boston in 1951 to describe the post-operative complications following an ileostomy. The condition was characterised by stoma oedema, profuse watery ileostomy output and associated dehydration and biochemical disturbance (Hawley, 1971). Ileal dysfunction was later attributed to serositis due to the exposure of the serosa, or outer layer of the ileum, to the extra corporeal environment. This serosal exposure caused thickening, fibrosis and subsequent partial obstruction at the stoma. This led to increased peristalsis and profuse ileal output, which resulted in dehydration, electrolyte imbalance and death.

Attempts to overcome the problems of ileal dysfunction led Dragstedt in 1940 to propose that the outside surface of the stoma be covered by a split skin graft (Brooke, 1982). Initially this appeared to solve the problem although, within a few weeks the resultant scarring and stricture resulted in the same dilemma (Weakley, 1994). It was Dr Bryan Brooke, a surgeon from Birmingham, who came up with a relatively simple surgical technique for eversion of the stoma and suture of the everted stomal mucosa to the peristomal skin. This created a spouted stoma which covered the serosa of the prolapsed section of ileum and resolved the problems associated with strictures and related ileal dysfunction (Brooke, 1952).

During the early 1950s, surgeons Turnbull and Crile from the Cleveland Clinic Foundation in Ohio, also recognised the cause of ileal dysfunction. Turnbull's initial suggestion was to surgically trim the stoma "in such a way as to leave the mucosa long enough to evert part of the way down the sides of the ileostomy" (Turnbull, 1953, p. 622). Crile and Turnbull eventually adapted this procedure and everted the mucosa to the level of the abdominal skin and sutured it to the subcuticular portion of the skin (Crile & Turnbull, 1954). Although this procedure solved the problem it was more

complicated to perform and on reading of Brooke's work Turnbull wrote to him to acknowledge the superiority of Brooke's procedure (Brooke, 1982). The Brooke ileostomy procedure continues to be the standard surgical procedure performed today and it is occasionally referred to as the Brooke-Turnbull procedure in the United States (Turnbull & Turnbull, 1991).

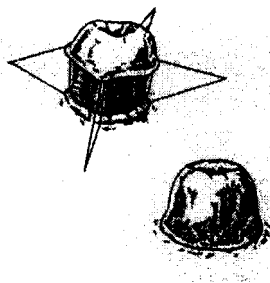


Figure : 4.1

Brooke's surgical technique for eversion of the stoma (Weakley, 1994, p. 73).

In an effort to eliminate the need for stoma construction, Swedish surgeon, Nils Kock, developed a 'continent' ileostomy in the 1960s. An internal pouch or reservoir was made from lengths of ileum and positioned under the abdominal wall and patients were taught to empty the internal pouch regularly with catheters. Leakage was a problem however, and in 1972 Kock overcame this problem by surgically creating an intussuscepted valve in the ileal outlet (Kock, 1976). The Kock's pouch offered a more aesthetic choice for some people, but it was still a far cry from the normal means of defaecation. In fact, some surgeons of that time felt the procedure was ill-advised because a reasonable amount of ileum was defunctioned in the making of the pouch and there was a risk of obstruction in the pouch (Castro, 1976).

In 1933, Rudolph Nissen from Berlin had performed a procedure for an ileo-anal anastomosis however, this procedure resulted in diarrhoea because of rapid transit rates through the gut (McGarity, 1992). A review of the 56 cases of ileo-anal anastomoses that had been published world-wide and reviewed by Ravitch in 1956, demonstrated that less than a third of these patients were satisfied with the outcome (McGarity, 1992). In an effort to reduce the degree of diarrhoea experienced by a patient with an ileo-anal anastomosis, Parks and his colleagues surgically created an S-shaped ileal reservoir or

artificial rectum in 1976 (Parks & Nicholls, 1978). This anal sphincter-saving procedure followed experimental work conducted by Valiente and Bacon in 1955 on animal models (Valiente & Bacon, 1955). This procedure became known as restorative proctocolectomy and individual surgical techniques are identified by an ileal pouch alphabet. The “S” shaped pouch was described by Parks and Nicholls (1978), the “J” pouch was created by Utsunomyia and his colleagues (Utsunomiya et al. 1980) and the “W” and “H” pouches followed (Tjandra & Fazio, 1993). These internal ileal reservoirs or pouches eliminated the need for an abdominal wall stoma and provided a ‘normal’ means of defaecation for the person who had to undergo a total colectomy.

Origins of Urostomy Surgery

The first record of a surgical attempt to divert the urinary system was in 1851. Urine from the ureters of a child with a congenital displacement of the bladder, was drained into the child’s rectum however, the procedure was not successful and the child died (Richardson, 1973). Verhoogen and de Graeuwe fashioned a pseudo-bladder from caecum and created an appendicostomy in 1909 but this too, proved unsuccessful at that time. In 1911, Coffey devised a procedure where he implanted the ureters into the sigmoid colon and urine and faeces were evacuated from the anus. This method also proved less than ideal because of the biochemical disturbance, which resulted from reabsorption of salts and potassium (Brooke, 1980).

During the second half of the 1880s and early 1900s experimental urinary diversion surgery resulted in high morbidity and mortality rates. Successful results were not achieved until 1950 when American surgeon, Eugene Bricker, published an account of a procedure that used a small section of terminal ileum to construct a conduit and a stoma in order to deliver urine from the ureters to the abdominal wall (Bricker, 1950). Bricker adapted the work of Heinz Emile Haffner who in 1908 had used ileum instead of the customary sigmoid colon for diversion.

Since the 1950s, Bricker’s ileal conduit procedure has remained the most commonly used technique for fashioning an urostomy. However, research during the 1970s demonstrated that this procedure led to an increasing degree of renal deterioration over time (Shapiro, Leboweitz & Colodny, 1975). In light of this research, surgical ‘undiversion’ of previously diverted ureters became increasingly popular. This was

especially the case in children with urostomies due to impaired neurological function of the bladder, and where the bladder had been preserved. Although bladder augmentation was occasionally required to produce a bladder of reasonable capacity, patients were taught intermittent self-catheterisation as a procedure to empty the reconnected bladder. The invention of the artificial urinary sphincter implant greatly assisted in achieving continence in people with reconnected neurogenic bladders (Bellinger, 1989).

Over more recent years, surgical creativity has led to the construction of continent urinary reservoirs. Internal reservoirs or pseudo-bladders have been created from small or large intestine and exteriorised to the abdominal skin via a conduit of intestine, appendix or in the case of the Indiana pouch - a fallopian tube. The Kock urinary pouch, the Mainz, Indiana and the Mitrofanoff pouches are some of these procedures. Although regular intermittent catheterisation is still required to empty these pouches (Bellinger, 1989).

The Development of Ostomy Appliances Prior to 1959

In 1776 before Pillore performed the first planned colostomy he realised the need to devise some method to contain body effluent following the surgery.

Before operation my patient and I had discussed the matter and together we had devised a small plate with, attached to it, a sponge in the shape of a large button. Held in place with an elastic bandage, this served instead of a sphincter and allowed the patient to remove it whenever he felt the need. Also, by means of a small enema, he could from time to time cleanse the reservoir (Pillore in Richardson, 1973, p. 12).

Pillore's report appears to be the earliest record of a post-operative device for the containment of stool from a stoma. The first 'ostomy bag' appears to have been a small leather sac, which was worn by an 81 year old French farmer with a colostomy in 1795. However, sponges, pads and bandages tended to be the accepted method of colostomy management until the end of the nineteenth century (Cromer, 1968). Pring in 1820 and Martland in 1824, experimented with truss appliances however, their patients found these to be unreliable and uncomfortable (Richardson, 1973). In addition, purgatives were frequently relied upon to regulate the gut and were often used with such enthusiasm that they led to rupture of the gut and death (Dinnick, 1935).

Colostomy irrigations were also used to regulate the passage of stool and was a method employed by Freer in 1815 to regulate his patient's colostomy (Cromar, 1968). The popularity of colostomy irrigation waxed and waned in Europe, but it became an almost mandatory method of social management of a colostomy in the United States until the development of modern appliances in the later 1990s (Orowan, 1967). It was therefore, not surprising to find that the first purpose devised colostomy irrigation set was the invention of Smith and Greer who were employed by a Californian surgical supply company in the early 1930's (see Appendix I: Figure 1). This device was termed a 'colostogator' and was similar in design to the modern colostomy irrigation devices, except a catheter rather than a cone-shaped tip was used to instil the water into the colon. Greer went on to establish his own surgical supply company, which also produced a reusable belted canvas hat-like device that was lined with various thicknesses of toilet paper and one piece of oiled paper (Turnbull & Turnbull, 1991).

Other reusable appliances evolved during the 1930s and 1940s and these were generally constructed of a belt and flange. Flanges tended to be made of rigid materials such as wire, plastic, vinyl or rubber. Cup-shape flanges were designed to hold absorbent materials, which were discarded when contaminated. Ring-flanges were used to stabilise plastic bags. The plastic bag was usually everted over the flange and anchored by belt clips, a rigid ring or a rubber band. These devices were not odour or leak proof and tended to rustle on movement. Meticulous skin and appliance hygiene was crucial for maintaining skin and social integrity.

The first disposable, self-adhesive plastic appliance was thought to be the idea of a 50 year old Danish domiciliary nurse, Elise Sorensen, in 1954 (see Appendix I: Figure 2). When her sister, Thora, had to have colostomy surgery she conceived the idea of such an appliance which would be hygienic and more reliable. The following year she finally found a plastics engineer who was willing to experiment with her idea. He was Aage Louis-Hansen and he owned a small plastic bag company called Dansk Plastic Emballage. Louis-Hansen's initial reluctance to produce an adhesive plastic bag specifically for people with a colostomy, was overcome by the encouragement of his wife, Johanne, who had been a student nurse and could appreciate the concept. The company hand-made a thousand bags which Sorensen distributed to hospitals around

Denmark. When she launched the concept in a professional journal in 1955, orders increased and two years later the company evolved into a major ostomy appliance company known as Coloplast A/S (Coloplast, 1997).

Although some of these early appliances were acceptable for the person with a less active colostomy, they proved to be totally unreliable for a person with an ileostomy or ileal conduit because of the more frequent flow of fluid effluent. The dearth of reliable ostomy appliances was a major deterrent to surgeons performing ileostomy and urostomy surgery prior to the mid-1940s. When there was no option but to operate, ingenuity and perseverance was required. A perfect example of the ingenuity exerted by individuals for containing ileal effluent was evidenced in the efforts of Australian prisoners of war during the Second World War. In the prison camps of South-East Asia, ileostomies were frequently performed on Australian soldiers with severe dysentery. Rounded aluminium water bottles used by Dutch soldiers were converted into 'ileostomy bottles' and these were held in position with pack straps (Dunlop, 1986).

It was not until 1944 that an ileostomy appliance was devised that offered a relatively reliable method of ileostomy management. This appliance was the idea of a Mr Koenig, a chemistry student, and his Chicago surgeons Alfred and Siegfried Strauss. Koenig had ulcerative colitis and although he had previous surgery elsewhere for an ileostomy he had turned to the Strauss team for revision of his stoma and a colectomy. Koenig developed the appliance under guidance from Alfred Strauss (Strauss & Strauss, 1944) but he was later to go into partnership with Rutzen when the appliance became known as the Koenig-Rutzen appliance (Brooke, 1980). Following Koenig's death it was known simply as the Rutzen bag (Turnbull, 1953). It was manufactured in Chicago by H. R. Rutzen Company and comprised of a rubber bag attached to a rubber covered metal flange, which was adhered to the peristomal skin with latex cement. A belt was used for added security and the outlet of the bag was secured with an elastic band (Strauss & Strauss, 1944) (see Appendix I: Figure 3).

The Koenig-Rutzen appliance was the prototype for other brands and adaptations in appliances for urostomies (see Appendix I: Figures 4,5,6) (Bricker, 1950; Hardy, Brooke & Hawkins, 1949). Although these appliances did much to increase the confidence of the person with an ileostomy or ileal conduit, they were not infallible.

Meticulous skin care regimes and daily or more frequent changes of appliances were still required. Skin cements were used to adhere flanges to the skin and it was not uncommon for people to develop allergies to these agents (Orowan, 1967). Others relied on double-sided adhesive discs to adhere flanges to skin (see Appendix I: Figure 4) (Seidel, 1972). Even so, leakage was a common and expected event as can be appreciated by the following comments.

A bag seldom sticks firmly from the outset, and there is often a tendency to leak on the outer side during the first month or two. This naturally disappoints the patient who should be reassured, for, if the stoma has been placed correctly, the leak will cease as the patient puts on weight and the gutter between stoma and anterior superior iliac spine fills up. There is a further tendency to leak at night, for recumbency causes the ileal contents to form a pool over the stoma instead of draining into the bag (Brooke, 1952, p. 102).

Waterproof adhesive tape such as Sleek™, tight belts and elastic corsets were used to provide added security and increase the wear time (Brooke, 1952). A variety of pharmaceutical and non-pharmaceutical agents were employed to preserve peristomal skin integrity and promote adhesive of appliances. These included: tincture of benzoin, kaolin, aluminium or bronze paint or powder, Fuller's earth (Cattell, 1939), cod liver oil compounds (Brooke, 1956), zinc paste, castor oil (Harris, 1996), talcum powder, corn flour and aluminium paste (Turnbull & Turnbull, 1991). However, it was karaya powder that proved to be a most therapeutic agent and improved the quality of life for many. Karaya is derived from gum drained from the trunk of an Indian species of tree known as *stericulia urens* and had traditionally been used in the cosmetic, confectionary, ice cream, pharmaceutical and the textile industries. Karaya powder was also used as a denture fixative and it was in this form that it was first applied to peristomal skin in the hope that it would promote adherence and healing (Ileostomy Association of New South Wales, 1972).

The credit for this discovery goes to Dr Rupert Turnbull from the Cleveland Clinic and like many great discoveries it began with a simple observation. In 1952, when Turnbull was cleaning out the desk of his colleague, Tom Jones, who had died of a ruptured aneurysm, he knocked over a small container of karaya dental powder into spilled coffee on the desk. Turnbull noticed that the karaya powder absorbed the coffee and stuck to his wet hand. He extrapolated the value of these properties in the application of

an ostomy appliance and protection of peristomal skin and consequently experimented with the karaya powder on his patients (Turnbull & Turnbull, 1991).

Karaya powder was dusted onto ulcerated skin and it formed a thin gum that provided a base for the cementing of appliances (Turnbull, 1953). It was also applied liberally to protect surrounding skin from effluent. In addition, the powder was mixed with water or glycerine and made into ring shapes for the same purpose (Gill-Thompson, undated). Eventually Turnbull went on to collaborate with an engineer who would manufacture solid karaya washers, which were used with rubber bags (see Appendix I: Figure 7). These karaya rings were later incorporated into disposable adhesive polyethylene appliances during the 1960's (Turnbull & Turnbull, 1991). Ultimately, it was the development of disposable ostomy appliances and the evolution of self-help groups that improved the lot of a people with a stoma during the 1950-60s.

Evolution of Lay Support Groups

Most lay persons, as well as all too many physicians and surgeons, have a horror image of the constantly discharging intestinal stoma and frequently think, out of ignorance, that death is preferable to ileostomy (Lyons, 1952, p. 812).

Such was the understanding of many health professionals when faced with the prospect of performing or caring for a person with a stoma during the 1950s. At that time, people undergoing ostomy surgery were given little direction in their management and rehabilitation. They were left largely to their own devices once discharged from hospital and social ostracism and suicide were common occurrences (Harris, 1970).

The surgical advances of Bricker (1950) and Brooke (1952) described previously resulted in larger numbers of people undergoing and surviving ostomy surgery during the latter part of the 1950s. People with inflammatory bowel disorders who underwent ileostomy surgery tended to be in the younger age brackets and once they had recovered from their surgery were more inclined to seek better management options and support services (Turnbull & Turnbull, 1991). When these services were not to be found they sought advice and solace in the experiences and support of other persons with ostomies.

The ostomy support movement originated in the USA. The first meetings were informal social gatherings that took place in the late 1940s and early 1950s amongst people with ileostomies. The concept of group support meetings began with a group of eight women with ileostomies, who had established friendships during their long periods of hospitalisation at the Mt Sinai Hospital in New York. Following discharge from hospital, they would meet socially and discuss problems and ideas in regard to the management of their stomas. Lucy Neary, because of her work as a nurse and social worker at Mt Sinai, became aware of these informal meetings and informed the surgeon, Albert Lyons (Lyons, 1952).

Lyons was impressed with the idea and could see the potential in developing the concept and opening the meetings for all people with stomas. However, it was persons with an ileostomy who initially embraced the concept of such meetings and who formed the first group, which became known as the QT Alumni. It took its name from the Q (male) and T (female) wards at Mt Sinai where patients undergoing ostomy surgery were hospitalised. Lyons was instrumental in obtaining space for regular meetings at the hospital and he encouraged involvement from other patients and doctors. The meetings were held monthly and people travelled considerable distances to attend. The object of these meetings was to provide an opportunity for social interaction as well as provide information on stoma management. It was not long before the group substantially grew in numbers and meetings became more structured. An 'ileostomy newspaper' was distributed and a visiting programme was established for hospitalised persons preparing to undergo ileostomy surgery (Lyons, 1952).

The 'club', as it was commonly referred to, raised awareness of the rehabilitative needs of the person with an ileostomy. Furthermore, it played a role in educating the hospital personnel in ileostomy and appliance management. It was not long before Lyons opened the first 'intestinal rehabilitation clinic' at the Mt Sinai Hospital. In an attempt to expand the concept of ostomy rehabilitation he wrote an article for the American Medical Journal (Lyons, 1952) and with the help of Dr George Schrieber, a surgical registrar, set up an exhibit at an American Medical Association conference. Their purpose was to educate doctors in the special needs of ostomy patients and the advantages of self-help groups. However, despite his interest and encouragement, Lyons

was adamant that the group should continue to be managed by the members, and the doctors should fulfil a consultancy role only.

Eventually similar groups were formed across the country (Turnbull & Turnbull, 1991). In 1956 the QT New York invited representatives from all the groups across the country to a meeting with the intention of investigating the potential unification of all groups under one banner. Although the United Ostomy Association did not become an official reality until a meeting in Cleveland in 1962, the 1956 meeting gave birth to the *Colostomy Quarterly* and the *Ileostomy Quarterly*. The latter publication was edited by a young woman from the QT Boston group, who had previously published a *Manual for Ileostomy Patients* (Lenneberg, 1954). Lenneberg, who was not a nurse, was later to be voted the first president of the North American Association of Enterostomal Therapists (Gill-Thompson, 1984a), an association for persons practicing stomal therapy.

Although the medical literature of the day described a person with a colostomy as a “colostomite” (Cromer, 1968, p. 446) it was the term ‘ostomate’ that appeared more appealing to those persons with a stoma in North America. Ergon Orawan, an engineer from Massachusetts, is accredited with devising the term ‘ostomate’ (Turnbull & Turnbull, 1991). People with an ostomy in Britain however, were to adopt the title ‘ostomist’ (Fox, 1969; Harris, 1970) and like their North American counterparts, Australians, were found to prefer the term ‘ostomate’ (Australian Council of Stoma Associations, 1982).

The Birth of the British Associations

In the United Kingdom eminent Birmingham surgeons, Lionel Hardy, Clifford Hawkins and Bryan Brooke, were performing considerable numbers of ileostomies during the first half of the 1950s. Although, the problem of ileal dysfunction had been largely overcome and the rudimentary improvements in ostomy appliances had occurred, the recovery of patients was still fraught with challenges. Like their counterparts in the United States, British ‘ostomists’ were left to cope with their problems as best they could once discharged from hospital. Although the removal of the diseased bowel improved the physical health of an individual, the existence of a leaking ileostomy compromised their mental health.

I felt really fit...but my state began to get me down. I thought, what is the point of living if I cannot live as I want to? I began to think of painless ways of ending it all, I was quite sane. Should I jump out of a window at Lewis's, drink a bottle of gin and jump in the canal, run in front of a train? (Too painful, please no more pain). Yes I really was serious (Harris, 1996, p. 7).

Doreen Harris had her ileostomy performed in Britain in 1947 for ulcerative colitis and she was very much aware of the lack of support services. The idea to form a self-help group originated from a conversation with a shop assistant at Messrs Salt and Son in Birmingham (a distributor of medical aids and equipment). When she was questioned by the shop assistant in regard to whether there was an association for people who had ileostomies she thought this would be a good idea. Harris wrote to Professor Lionel Hardy, her surgeon from Birmingham University, asking if such a group existed. Hardy could not provide any information and recommended that she contact Dr Bryan Brooke, which she did in September 1955.

Brooke replied that some of the doctors had previously discussed the need to establish a QT styled club in the United Kingdom, but they thought it "wise to wait for demand from the ileostomists themselves" (Brooke, 1970, p. 3). When Brooke and Harris met in November 1955 he informed her of the existence of the QT group in Boston. He showed her some of their newsletters and it was in them that she first read of karaya powder, which had been promoted in the United States as the most effective skin protection agent. Neither Harris nor Brooke knew what karaya was, but later experimentation caused them to agree with this claim (Harris, 1970).

Following this meeting, Brooke wrote to his patients asking for expressions of interest in forming a support group and he received an enthusiastic response from 80 patients. According to Harris (1970) "from then began a camaraderie between doctors and patients such as had never before been experienced, nor yet equalled since". The first meeting in England of ileostomists, was in April 1956 at Birmingham General Hospital. The meeting was also attended by other eminent surgeons of the day: Mr Cuthbert Dukes, Mr Ian Todd, Mr Peters and Mr Lloyd-Lucus. Such was the medical men's interest that they travelled from London to attend the meeting and a month later they were instrumental in establishing a similar group in London (Harris, 1970).

The Ileostomy Association of Great Britain and Ireland as it became known had rapid growth and established other divisions across the country under the leadership of a National Council. Some of the most eminent surgeons of the day supported the movement and appeared to have played a greater role in the development of the movement than their North American colleagues had done. They were seen to offer their services on committees or as medical advisors. Brooke acted as the first President and Dukes even opened his home for some of those early meetings in London (Harris, 1970).

A newsletter unified the groups and this quickly grew into a journal. The association's support activities expanded rapidly and Leslie Kingston, a fellow ileostomist, was instrumental in raising sufficient funds to buy and run a home for recuperating ostomists. The first home, known as Kingston House was purchased in the Leigh-on-Sea, Essex in 1966 and this concept grew to three other premises (Powell, 1971). They had a Welfare Officer on the Committee who fulfilled a 'social worker' role. The group lobbied manufacturers for improvements in equipment and the government for their listing on the National Health Scheme. They supported and encouraged medical and appliance research, established a national register of ostomists and began a hospital visitor programme in 1956. They even started courses for ostomists and nurses in stomal therapy (Kingston, 1971). All significant achievements for a group of lay activists.

The Ileostomy Association in Britain became a strong and organised group that did much to promote the welfare of their members, which included members who had colostomies until the formalisation of a separate body. The British Colostomy Association was founded as the Colostomy Welfare Group in 1963 largely as a result of the efforts of Nurse Francis Goodall who at that time was connected with the Royal Marsden Hospital. Goodall realised that patients with colorectal cancer benefited significantly from meeting rehabilitated persons. The activities of the group spread across Britain and in 1967 they were awarded charity status, and Francis Goodall a civil award (Jones, personal communication 10 October, 1996).

The goal of the British ostomy associations was to improve the lot of a person with an ostomy. Their experiences had taught them that the health profession's sympathy was a hollow offering when informed assistance was not available. As a body they were not prepared to wait until the nursing and medical fraternities were able to meet their support needs. As Kingston so aptly proclaimed:

We in the Association plod on waiting for the lead which must one day come from those in authority in the medical world. Until then it is our duty to accept the responsibilities demanded of us and to carry them out to the best of our ability (Kingston, 1971, p. 9).

The Genesis of Stomal Therapy Nursing

During the 1950s some ostomates embraced the challenge to improve the lot of their fellow ostomates with a fervour that required zeal and much self-sacrifice. It is to one such North American ostomate that the credit must go for laying the foundations of stomal therapy nursing world-wide. This lady was Norma Ann Gill-Thompson and she was born on 26 June 1920. Norma married Edward (Ted) Gill when she 18 years of age. She was widowed in 1974 and married Herbert G. Thompson Senior in 1983 and from then on was known as Norma Gill-Thompson (Thompson, 1996).

Gill was not a nurse, but a wife and a mother and she lived in Akron, Ohio. In 1948, when aged 28 years, she experienced the first symptoms of ulcerative colitis. She spent the following 5 years trying to find a medical panacea, which included the new drug cortisone, which had become available in the early 1950s (Thompson, 1996). In 1952, when she was pregnant with her third child, her disease exacerbated to a state where she had 15-20 bowel movements a day, enlargement of the spleen and liver and exquisitely painful pyoderma gangrenosum ulcers spread over her body (Gill-Thompson, 1989). Conventional medical treatment of the day was ineffectual and surgery was the only option. On 1 October 1954 she was admitted to the Cleveland Clinic Foundation in Cleveland, Ohio under the care of Doctor Rupert Beach Turnbull Junior.

Turnbull was born in Pasadena, California on 3 October 1913. He has been referred to as "a modern Renaissance Man" (Anderson, 1977, p. 5) because of his ability to excel in many realms of life. His competitive nature influenced all his life's activities.

Turnbull graduated from McGill University Medical School in Canada in 1940 and he took up a general surgical residency under Dr Tom Jones at the Cleveland Clinic Foundation in Ohio (Weakley, 1994).

On the death of Jones in 1949, he took over his practice and by early 1952 he was virtually specialising in colorectal surgery. Although it was not until 1968 that he finally formalised his specialisation credentials and he took his Board examination in colorectal surgery. Turnbull remained at the Cleveland Clinic until 1978 and during that time he established an international reputation for surgical excellence and research. Amongst his peers and patients there was a consensus of opinion that Turnbull was a very gracious and likable man who left a lasting impression on all those who met him whether they be; sick or well, professional or lay people (Weakly, 1994, 1996; Anderson, 1977).

Gill considered herself to be fortunate that she was referred to the Cleveland Clinic under Turnbull, for she was acutely ill (Gill-Thompson, 1995, interview). She spent 4 weeks in hospital prior to undergoing a sub-total colectomy and ileostomy. Surgery was followed by a 5 week complicated recovery in hospital. When discharged home in time for Christmas she lasted only a day before being readmitted with severely ulcerated peristomal skin due to appliance failure. Weeks were spent in hospital trying to heal the skin before being discharged again with a different appliance. A further admission for removal of her diseased rectum was required in the following January in an attempt to heal her pyoderma ulcers (Gill-Thompson, 1995, interview).

Gill's rehabilitation was slow and appeared to have relied heavily on her own ability to cope. She was perhaps a little more aware than most put in her position, for she had helped look after her grandmother who had colostomy surgery in 1950 for cancer of the rectum. She remembered well the frustration and lack of dignity involved in trying to manage a stoma with no appliances (Gill-Thompson, 1984b, p. 1). Gill had experienced the physiological and psychological barriers to rehabilitation following stoma surgery and this highlighted her concerns for others.

So I thought I could be of help to patients if they let me. Well one thing about being ignorant - is not being afraid. So what I did, I went around to something like 29 or 32 doctors - here in Akron - and I visited them and asked them if I could help them. And this one doctor here in Akron was

very progressive and helped me meet some of the surgeons...and I eventually was doing a lot of bedside care, even home care and helping them out with the patients (Gill-Thompson, 1995, interview).

Her experience caused her to believe she could offer some assistance to other ostomates and she undertook voluntary work in hospitals and the community in Akron. In May 1958 Gill went to the Cleveland Clinic for a check up and had an unscheduled meeting with Turnbull (Gill-Thompson, 1995, interview).

When I talked with him, why he asked me what I was doing and I said why, I was trying to get into his line of work? So I explained what I was doing (Gill-Thompson, 1995, interview).

The seeds of an idea were sown and they were to germinate on 1 October 1958 when Turnbull invited Gill to work at the Clinic as an 'ostomy technician'. This name was changed to '*enterostomal therapist*' in 1959, when Turnbull coined what he thought a more descriptive title from '*entero*' relating to the intestine, '*stomal*' derived from the Greek meaning of mouth and '*therapist*' to indicate the carer (Gill-Thompson, 1984). The genesis of enterostomal therapy was in the gut and confined to the gut in those pioneering days (Jeter, 1996).

The concept of increasing the scope of practice to urinary and other types of stomas was not an early consideration. Initially the role was conceived with little more in mind than as a service devised to offer support and advice to persons with an ileostomy or colostomy who had their surgery at the Cleveland Clinic. However, the role soon expanded and the title 'ET' as it tended to be abbreviated, appeared to evolve into a licence to practice nursing. Many nursing tasks were allocated to, or adopted by, Gill during her 10 years at the clinic.

I removed sutures (wires and clips), gave pre-enemas for O.R., removed and changed dressings on non-ostomates. We also had three clinic afternoons a week. Often on rounds, we wheeled someone to surgery, and since that was really the only time I could discuss cases with him (Turnbull), I spent 2 to 3 hours two times a week watching him operate, sometimes applying the pouch after sterile surgery was completed (Gill-Thompson, undated).

It was not long before word spread across the country and for that matter, other countries, of the specialised care that ostomy patients were receiving in Cleveland. This attracted much interest and there were many requests to train other enterostomal therapists. The prerequisite for those early students was that they had to have a stoma. The fact that some of them were nurses, either registered or licensed practitioner nurses (the equivalent to enrolled nurses in Australia), was quite coincidental (Turnbull & Turnbull, 1991). The rationale for this criteria was founded on the judgement that a person with an ostomy would have more of an affinity with the needs of the ostomate. This view can be appreciated when one remembers the past shortcomings of health professionals and the success the lay person had achieved in assisting the rehabilitation of their peers and ostomy neophytes. However, this was not to be the case in Australia, as chapter 5 shall reveal.

Conclusion

Winston Churchill (1874-1965) is acknowledged to have stated that: 'the further backward you look, the farther forward you are likely to see' (Shafer, 1960; 1985). It was with these words in mind that I perceived a need to explore the historical background, prior to the study period. I was mindful of the fact that to fully appreciate the phenomenon under study and the reasons for the evolution of stomal therapy nursing in Australia one had to have an understanding of the events that preceded this development. This chapter has uncovered that historical background and has revealed that long before 1959 there was a need for lay ostomy groups, ostomy appliances that ensured a quality of life for those who required them and a specialty in stomal therapy nursing.

The Evolution of Stomal Therapy Nurses in Australia: The Historical Context

Introduction

The purpose of this historical study was to examine the specific events that influenced the development and evolution of stomal therapy nurses in Australia during 1959 to 2000. The history of nursing is reflected in current day practices and traditions, yet the origins and development of these practices and traditions are poorly appreciated and rarely questioned. Most of the current literature on nursing history focuses on the profession as a whole, institutions or occasionally, prominent nurse leaders. There is a scarcity of research into specialty nursing groups or individuals who have contributed to the development of these groups. The intent of this chapter was to detail the individual and corporate contributions of nurses to the development of stomal therapy nursing, as well as the contributions stomal therapy nurses have made to the broader nursing profession.

This chapter reveals the genesis of stomal therapy *care* and stomal therapy *nursing* in Australia. It identifies the persons of vision who were prepared to search for a better way to care for patients with stomas. Data analysis revealed that the nurses in this study had the insight to appreciate that it would require the dedication and commitment of nurses with an interest and specialty knowledge in stomal therapy care to bring about this type of change. Prior to the 1970s there was a general dearth of knowledge to be found amongst Australian nurses in regard to the care and rehabilitation of persons with a stoma. This lack of experience sorely challenged some nurses who went on to demonstrate an interest and commitment to advancing specialised knowledge in stomal therapy care. These nurses became known as *stomal therapy nurses*. As this chapter details the evolution of this group of nurses it becomes apparent that in order to establish their identity they had to step outside the traditional boundaries familiar to nurses of the day and align themselves with lay groups and professionals from other disciplines. In the beginning, their professional journey is shown to be intertwined with the development of mutual self-help groups established by lay ostomates during the 1950s and 1960s. Their continuing journey is found to be supported by, and supporting of, the professional recognition afforded the specialisation of colo-rectal surgeons. But

as should be the case when individuals or groups progress professionally, they learned to stand alone.

I have used the oral histories of nine Australian stomal therapy nurses. The oral histories of only one of these nurses was also used in understanding the experience of *Being* a stomal therapy nurse, as described in chapter 7. The decision to use this one interview in both arms of the study was because of the relevance of data to both historical and phenomenological analysis. In addition, I have used the data from the oral histories of five Australians who have had a faecal or urinary stoma constructed and the oral histories of six eminent Australian colo-rectal surgeons. One of these surgeons did himself have a stoma and was able to discuss his experiences as both a surgeon and an ostomate.

Data from other extensive primary and secondary sources, as indicated in chapter 2 were also used. I was concerned that the extent and nature of data sources (interviews, personal communication, official records, documents and published materials) would require lengthy in-text referencing if the preferred university reference format was to be employed. Therefore, in order to maximise clarity and comprehension for the reader, I have used detailed footnotes referencing for this chapter.

The Australian Awakening

The 1950s was a decade of recovery and stability in Australia. The war weary forties had ended and there was a sense of national pride and identity as society began to rebuild. Generally, there was a national spirit of mateship and the freedom to '*hav-a-go!*'. This philosophy and the spread of consumerism, activism and altruism that heralded the 1960s¹ supported the concept and development of mutual self-help groups. The ostomy support groups appear to have been the first of such groups established in Australia. It has been outlined in chapter 4 that ostomy groups evolved in the United States during the early 1950s. However, Australia quickly followed suit and established its first ostomy self-help group in 1957, a year after the inaugural British group was

¹ Alterescu, V. (1991). Reflections upon the history and future of the IAET. Journal of Enterostomal Therapy, 18(4), 126-131.

founded. The impetus to establish an Australian group came from a noted medical authority rather than the lay initiative that instigated the development overseas. Although once the concept had been explored the reins of control were readily passed on to, and eagerly accepted by, a group of persons who called themselves 'ostomates'.

As has been pointed out in chapter 4, ostomy surgery, and ileostomy surgery in particular, was performed with greater confidence and increased survival rates during the 1950s and 1960s.² This was largely due to the advances in antimicrobial pharmaceutical agents and surgical techniques. However, the quality of life experienced by persons with a stoma remained unacceptable and frequently intolerable. There was a dearth of ostomy appliances and those that were available were expensive, difficult to obtain and minimally effective.³ The effectiveness of equipment was frequently compromised by the inexperience of nursing and medical staff.

My physician came on a Sunday morning and I was in a big mess. He himself said to the sister, come on get all the things I'm going to have a go at this. He knew a bit about it and the sister knew a bit about it and they put a double-sided plaster on a rubber flange and it went well, except they forgot one thing, they forgot to take the paper off one side of the plaster. It lasted about 2 or 3 hours and by that time they had gone. So I had to try to do it myself then and I learned very quickly how to do it.⁴

Stoma care tended to be regarded as a 'dirty' dressing procedure rather than an alternative method of toileting. This obviously broached some aesthetic barriers to health professionals providing care and no doubt impacted on the degree of experience they gained. Moreover, these attitudes led to feelings of shame and isolation amongst patients with a stoma.

The main thing that I remember (*about the post-operative ostomy care*) was that it was practically nil. The nurses weren't too keen on it at all. It was always done at the end of the day when everyone had their dressings done. I think they called it the dirty dressing.⁵

² Dunphy, J. (1970). The cut gut. The American Journal of Surgery, 119, 1-8.

³ Ms D. Harris, personal communication, 24 May 1996.

⁴ Mr Ken Philps, interview, 7 February 1997.

⁵ *ibid.*

Delays in changing these ‘dirty’ dressings aggravated existing skin problems and added to the patients’ sense of shame caused by malodour and the loss of dignity. Skin ulceration was a common problem and treatments were limited to a few simple topical pharmaceuticals and frequent changing of dry dressings. In recalling his experiences as a resident medical officer at Sydney Hospital during the 1950s, Dr Mark Killingbach, a colo-rectal surgeon, stated:

Aluminium paste™ was liberally spread over the patient’s peristomal skin and towels were wrapped around the abdomen in an effort to contain the faecal output. The patient was given a bell to ring and instructed to ring it for attention when the towel was soaked.⁶

Needless to say, this method offered little skin or odour protection and as the denuded skin increased in size, Killingbach recalled the nurses applied “loads” of mercurochrome and zinc cream in an effort to heal the skin. Treatments such as these were not aesthetic or therapeutic and patients were left to cope as best they could with the pain, malodour and embarrassment.⁷

Not only did patients frequently recognise the inexperience of health professionals but they also sensed a reluctance amongst them to provide the care at all. In the face of such adversity, patients were left with little option than to take responsibility for their own management.

I didn’t get a lot of help from the nursing staff. The one think that stuck in my mind was that I was classed as a dirty dressing ... and I was always holding visitors up because my dressing had to be done last before the visitors could come in ... Of course I always had the odour problem, they just couldn’t do it. So the moment I could get out of bed, I insisted on a mirror so that I could do my own dressing.⁸

People with an ileostomy were particularly disadvantaged because fluid effluent was extremely difficult to contain and skin breakdown, malodour and loss of quality of life problems were abundant and made life a misery for many. These problems gave them cause to seek assistance and their frustration was compounded when they found little, if

⁶ Mr M. Killingbach, interview, 20 February 1996.

⁷ *ibid.*

⁸ Mrs G. Anderson, interview, 7 March 1997.

any, assistance available. Such difficulties provide an insight into why the first ostomy 'clubs' established in Australia were actually clubs for people with ileostomies. A colectomy and the creation of an ileostomy was usually performed for inflammatory bowel disorders such as Crohn's disease and ulcerative colitis. These diseases tend to become evident at a younger age than malignant bowel disease, which more frequently results in the formation of a colostomy. This was particularly the situation during the 1950-60s before the sophisticated diagnostic technology of the following decades. Generally the health of younger ileostomates improved dramatically following removal of the diseased colon and it could be perceived that they had more energy and advantages to be gained in actively and assertively seeking support services.

The 'Father of Stomal Therapy'

The credit for instigating the first meeting of an ileostomy group in Australia must go to an eminent Australian surgeon, Dr Edward Stuart Reginald Hughes. Hughes was born in Bruthen, Victoria on 4 July 1919 and he died on 16 October 1998. He was known as Bill to his friends, 'E.S.R.' to his associates and in 1977, Sir Edward, on receipt of a knighthood in recognition for his services to surgery.

According to his colleagues, Hughes proved himself to be a most gifted surgeon, brilliant teacher and conscientious medical and social reformer prior to his retirement in 1990⁹. He was a noted clinical researcher and prolific writer with 306 scientific papers and 12 books to his credit. Amongst these books were the first books written in Australia on ileostomy and colostomy care. In addition, he was awarded a multitude of honours and honorary fellowships from prestigious international medical colleges. Hughes was appointed the Professor of Surgery at Monash University and the Head of Surgery at the Alfred Hospital in Melbourne in 1974 and during this time he was President of the Royal Australasian College of Surgeons for a period of 3 years. It was during this appointment that he lobbied the government of Victoria to introduce a parliamentary Act for the compulsory wearing of seat belts in motor vehicles. Victoria became the first state in the nation to implement such a policy.

⁹ Royal Australasian College of Surgeons. (1998). Biodata on Sir Edward Hughes. Melbourne: RAC Archive.

Many of his patients, and informed stomal therapy nurses, would concede that Hughes' greatest contribution to medical and social reform was the role he played as the Australian 'Father of Stomal Therapy'. The father's offspring were to be the founding of the first ileostomy association and the founding of stomal therapy nursing in Australia. Hughes' relentless political lobbying was also largely responsible for the inclusion of ostomy appliances on the national Stoma Appliance Scheme in 1975. It was Hughes' steadfast commitment to improving quality of life outcomes for persons with a stoma that led to these happenings.

Hughes' commitment was fuelled by his observations on his return from England in 1950 to the Royal Melbourne Hospital. It was then that he noted that:

"no one person was able to understand the care of ileostomies ... there was no nursing group, there was no trained group who were interested in apparatus ... and skin problems were routine".¹⁰

Dr John Turner, a colleague of Hughes from the Royal Melbourne Hospital, had previously taken an interest in patients with colostomies. Turner was a surgeon who completed his postgraduate training at Gordon Hospital in London. He had returned to Melbourne in the early 1930s and began teaching his colostomy patients irrigation as a method of management¹¹.

The Gordon Hospital was one of the very few centres in Britain at that time that taught and encouraged colostomy irrigations as a means of bowel management.¹² However, irrigation is not an applicable method of management for regulating the frequent fluid stools that flow from an ileostomy and these people are required to wear an appliance at all times. The early rubber appliances were limited and often difficult to obtain as they had to be imported from Britain or the United States. For example, Mrs Mabel Cook, a Melbourne ileostomate recalled having to wait many weeks following her surgery for a rubber Down's ileostomy bag and flange that had to be ordered from Britain. The delay in fitting an adhesive appliance led to severe skin ulceration and her suffering was

¹⁰ Sir E. Hughes, interview, 1 March 1994.

¹¹ *ibid.*

¹² Proceedings of the Royal Society of Medicine. (1970). International Conference on Proctology. 63. Supp. London: The Royal Society of Medicine.

compounded when topical orthodox treatments failed to improve the situation. Nurses in their desperation, applied unorthodox treatments to her skin, such as the sandwich spread Vegemite™ and she remembered well the pain this salty product caused.¹³

An Adelaide surgeon, Desmond Hoffman, remembered that the ubiquitous Australian icon, Vegemite™, was adopted for stoma management in other ways.

I was horrified to find people speaking in glowing terms of using tops of Vegemite jars as an appliance for a colostomy ... a plastic bag could be punched through the top of the Vegemite lid and you could attach this in various ways.¹⁴

After working with eminent surgeons such as Professor Bryan Brooke and Professor Goligher in Britain, it was approaches to stomal therapy such as this that caused Hoffman, to think he had returned to the “middle ages” instead of a major teaching hospital in Australia. The dearth of stomal therapy knowledge and the shortage of appliances caused many ostomates to rely on their own ingenuity for problem solving.

In 1951 when I had my ileostomy, the nursing staff on the ward seemed to know very little about it ... so after 4 months when it was time for me to be discharged, the Maimed and Limbless Association were asked to come and fit me with some equipment. This consisted of a heavy metal ring about four inches across with four studs to which a two inch elastic belt was fitted and inside a latex rubber bag was attached; it was not drainable so it had to be tipped up to empty ... At one time when I was unable to buy bags I had to go to Coles and buy the largest balloons they had and make use of them; they proved quite successful.¹⁵

In the absence of professional knowledge, information flow to ostomates was stymied. Those who searched for better management options had to be persistent in their search and then be prepared to pay rather exorbitant prices.

The only appliance I can recall was an old brown rubber bag (a very smelly item) made by a firm called Down's. This was not for me. One day I saw an advert for an appliance and sent to America for it. When I received it, it contained a plastic flange and plastic bags. They were

¹³ Mrs M. Cook, interview, 21 April 1996.

¹⁴ Mr D. Hoffman, interview, 25 February 1994.

¹⁵ Eyles, M. (1994). A balloon party! *Ostomy Australia*, 3(2), p. 6.

shaped like a babies bootie, but fitted nicely into the groin. It cost 20 pounds a kit, a very expensive item in those days.¹⁶

This event occurred in 1957 when the average weekly earnings for males in Australia equated to \$36.70.¹⁷ Hughes, was aware of the problems associated with obtaining appliances. He was also aware of the development of the QT clubs in the United States and the formation of the Ileostomy Association of Great Britain and Ireland in 1956.¹⁸ This awareness arose as a result of his overseas travels and his friendships with Dr Rupert Turnbull from Cleveland and Professor Bryan Brooke from Birmingham. Chapter 4 revealed how the surgical prowess of these two doctors had overcome the problem of ileal dysfunction and the role they had both played in advancing stomal therapy care in their respective countries. Although the dedication of Turnbull, Brooke and Hughes appeared to be of sincere altruistic and professional accord, it could be said that they all possessed an element of fierce competitiveness.^{19 20 21} It could also be said that it was this element of competitiveness that led to the advances to be reported in this chapter. It was certainly Hughes' intention to be the best in his field of practice.

You see the thing that motivated me was that I was determined to become the top surgeon in the country.²²

It was this altruistic-professional-competitive streak that appeared to fuel the 'fire in the belly' of these pioneers in colo-rectal surgery. They displayed a remarkable willingness to break away from the traditional surgeon's image of professional exclusiveness. This was rather extraordinary behaviour for medical professionals of that rather conservative era. Individually they demonstrated that collaborative relationships between surgeons and lay ostomates were possible, and in fact desirable, if progress was to be made. Chapter 4 related how Turnbull had employed Norma Gill, a lay ileostomate, as an 'enterostomal therapist' at the Cleveland Clinic and how this partnership led to the first

¹⁶ Mrs B. Reid, personal communication, 17 May 1997.

¹⁷ Australian Bureau of Statistics (1992). Table 2: All males: Average weekly total earnings not seasonally adjusted. Average weekly earnings Australia: September 1941 – November 1990. Catalogue 6350.0, p. 5.

¹⁸ Sir E. Hughes, interview, 1 March 1994.

¹⁹ Weakley, F. (1994). A historical perspective of stomal construction. Journal of Wound, Ostomy and Continence Nursing, 21(2), 59-75.

²⁰ Masterson, J. (1998). Obituary Sir Edward Hughes, surgeon and road safety pioneer. The Age, Friday 30 October.

²¹ Obituary Bryan, Nicholas Brooke. (1998). ia Journal, 162, 4-6.

training programmes in enterostomal therapy.²³ Similarly, Brooke's collaboration with Doreen Harris, a lay stoma therapist (the title adopted in Britain) from Birmingham had been fundamental in establishing the Ileostomy Association of Great Britain and Northern Ireland.²⁴

The Origin of Ostomy Associations

Hughes demonstrated that he too, was a particular exponent of this collaborative philosophy and it led to him being instrumental in establishing the first ostomy support group in Australia. The group was initially known as QT Australia, although it became known as the Ileostomy Association of Victoria in 1972. The first meeting was held at the Federal Hotel in Melbourne on 18 May 1957. Hughes organised the meeting, and he placed notices in Victorian newspapers to inform ostomates of the event.²⁵ ²⁶ Following a talk on ileostomies he proposed and gained approval for the formation of an association and then he asked two lay ileostomates, Mrs Beryl Reid and Mrs Hazel Johnson, if they would be prepared to run the group with his support.²⁷

Most of the founding members were Hughes' patients but at least one attendee, Mrs Mabel (May) Cook, had been a patient of Dr Edward 'Weary' Dunlop.²⁸ This lady became an active member of the Association and she later established an ostomy appliance business. Cook was awarded a Churchill Fellowship in 1969 to travel to the Cleveland Clinic and Britain.²⁹ Whilst in Cleveland she undertook an enterostomal therapy training programme run by Gill and Turnbull. This actually made her the second officially 'trained' Australian stomal therapist, albeit a stomal therapist with no formalised nursing qualifications.³⁰

²² Sir E. Hughes, interview, 1 March 1994.

²³ N. Gill-Thompson, interview, 29 July 1995.

²⁴ Harris, D. (1996). The rising of the phoenix: The origins of ia, Halesowen, UK: Midlans News Bulletin.

²⁵ Plan to form Ileostomy Association. (1957). The Melbourne Herald, Undated newspaper clipping obtained from archives of the Victorian Ileostomy Association, 30 November 1999.

²⁶ 'QT'. Group formed to aid sufferers. The Melbourne Sun, Undated newspaper clipping obtained from archives of the Victorian Ileostomy Association, 30 November 1999.

²⁷ Mrs B. Reid, personal communication, 17 May 1997.

²⁸ Mrs M. Cook, interview, 21 April 1996.

²⁹ The Winston Churchill Memorial Trust. (1969). Churchill Fellowship Summary. Canberra: The Winston Churchill Memorial Trust.

³⁰ Mrs N. Gill-Thompson, personal records, Undated.

At that time, the Cleveland Clinic ran the only training school for 'enterostomal therapists' and the selection criteria required trainees to be an ostomate.³¹ The programme tended to attract lay persons who had been endeavouring to provide services for ostomates.

When enterostomal therapy became a field for which one could be trained, some of the ladies decided to add the legitimate training to their personal experience and to become the very best possible Stoma Technician that one could be.³²

This same regard was not afforded Cook in Australia as her training at the Cleveland Clinic was not recognised as a licence to practice stomal therapy by Hughes and the early nurses involved in stomal therapy in Melbourne.³³ ³⁴ This attitude was to cause contention between the Australian and American contenders to the title of stomal therapist and shall be discussed in more detail later in this chapter.

Word of the Victorian QT Club soon spread interstate and a QT Club, which was later renamed the Ileostomy Association, was begun in Sydney in 1958 under the guidance of Dr Edward (Ted) Wilson and Betty Hughes, a Senior Tutor Sister from Balmain and District Hospital. Betty Hughes had a vested interest in improving outcomes for ostomates for she herself had undergone ileostomy surgery under Dr Wilson in 1957. It appears that even as an experienced nurse educator she had little knowledge, nor prior nursing experience, to equip her for managing her own ileostomy. Nor did she appear to gain sufficient advice from her professional peers, for she had need to write to the newly formed Melbourne group asking for advice on appliances and skin care.^{35, 36}

The role Betty Hughes played in advancing stomal therapy in Australia was not insignificant, but is recorded more liberally in the early records of the ostomy associations rather than those of the Australian Association of Stomal Therapy Nurses

³¹ Turnbull, R., & Turnbull, G. (1991). The history and current status of paramedical support for the ostomy patient. Seminars in Colon & Rectal Surgery, 2(2), 131-140.

³² Letter from Edith Lenneberg, Boston, Massachusetts, to E.S.R. Hughes, dated 27 February 1970.

³³ Letter from Mr E.S.R. Hughes, Melbourne, to Mrs Edith. Lenneberg, dated 29 January 1970.

³⁴ Ms E. Kyte, interview, 28 February 1994.

³⁵ Mr R. Murray, History of the Ileostomy Association, Unpublished paper forwarded as personal communication, dated 15 October 1995.

³⁶ Dean, F. (Undated). How ostomy rehabilitation associations came into being in Australia. Handout obtained from the Ileostomy Association of N.S.W. Lewisham.

(AASTN). She is recognised as a founding member of the Ileostomy and Colostomy Association of New South Wales and also a founding member of the AASTN in 1971. In 1967 in conjunction with Wilson, she wrote the first Australian book specifically on colostomy care.³⁷ This book provided a comprehensive resource for both ostomates and nurses alike.

Dr Edward Wilson was born in Melbourne on 25 January 1913. Wilson had a most prestigious medical career and like his previously mentioned colleague, Dr E.S.R. Hughes, he was a high achiever. His academic pursuits in clinical pathology, clinical research and surgery left him with a string of qualifications after his name – MB.BS.(Hons), B.Sc., MRACP., MD., MSc., MS., FRACS., FACS., FRCS., FRCS (Edinburgh), BA. This caused some people to refer to him as ‘Alphabet Wilson’.³⁸ His contribution to surgery was acknowledged by his peers and superiors and a knighthood was later awarded for exceptional service.

It was his appointment as a resident surgical officer to St Mark’s Hospital in London in 1947 “which undoubtedly reshaped his surgical horizon”.³⁹ ESR Hughes was also working as a resident surgical officer at St Mark’s Hospital at that time and this contact led to the development of a strong friendship and professional regard between the two Australian surgeons.

In 1948 Wilson returned from London to take up an honorary relieving position at Sydney Hospital where he established an outpatient rectal clinic that year. This was the first clinic of this type in Australia. In 1971 he was appointed senior surgeon in charge of the newly formed Colon and Rectum Unit at Sydney Hospital. This unit was later to bear his name following his death on 30 October 1972.

In 1958 Wilson asked Betty Hughes to explore the possibilities of starting a rehabilitation group for ileostomates in Sydney.⁴⁰ Hughes placed advertisements in some Sydney newspapers in an attempt to attract the attention of interested persons with

³⁷ Hughes, B., & Wilson, E. (1967). Colostomy care. Glebe: Australasian Medical Publishing Company Limited.

³⁸ Mr M. Killingbach, interview, 20 February 1996.

³⁹ Killingbach, M. (1972). Thomas Edward Wilson: Obituary. Unpublished.

⁴⁰ Mrs J. Murray, personal communication, 15 October 1995.

an ileostomy. The Inaugural Meeting was held on Saturday 15 March 1958 at the Plaza Hotel, Sydney.⁴¹ Hughes was appointed the Honorary Secretary and Wilson the Honorary Medical Advisor of the Association.

The Colostomy Association of New South Wales began in a similar manner 6 years later. Mrs Rose Houghton, a colostomate, was discharged from a Sydney hospital with little information and wished to establish contact with other colostomates. She also advertised in some Sydney newspapers notifying her intent to form a Colostomy Association. The meeting was held at the Balmain Council Chambers on 3 February 1964. There were seven people who came to this meeting and included Peter Franks from the Barrere Surgical Company, Sister Sue Ryan, three members of the Ileostomy Association, Sister Betty Hughes and Mrs Houghton.⁴²

From these humble beginnings an association evolved. The second meeting held on 2 March 1964 at the same premises, attracted 16 people and Dr Mark Killingbach, a surgical colleague of Wilson, offered his services as an Honorary Medical Advisor. Killingbach was responsible for organising the regular meetings, which were held at the Maitland Lecture Theatre at Sydney Hospital. These meetings were advertised through radio, newspapers and letters to doctors and at the end of the first 6 months the membership totalled 60 persons.⁴³

The ostomy associations that were formed during the late 1950s and 1960s made up for many of the short-comings of health professionals. Like their North American and British counterparts, they fulfilled an active role in the rehabilitation of persons with a stoma, both in the hospital and community setting.

Mrs Johnson and I used to get calls from Mr Hughes to visit people in hospital who felt they couldn't cope with having an ileostomy. We did our best to assure them they would be okay. Also we showed the nursing staff how to put on the appliances and care for the skin. This was a rewarding thing to be able to do. There were also private homes we visited.⁴⁴

⁴¹ *ibid.*

⁴² Mrs J. Murray, personal communication, 15 October 1995.

⁴³ *ibid.*

⁴⁴ Mrs B. Reid, personal correspondence, 17 May 1997.

Some ostomates were afforded a semi-professional status. The previously mentioned Mabel Cook stated that she attended the spina bifida clinic at the Royal Children's Hospital in Melbourne on a fortnightly basis at the invitation of the paediatric specialist. On these visits she provided advice on equipment and stoma management.⁴⁵ Lay ostomates were frequently called upon to be educators of nurses as well as patients. Most of the pioneer stomal therapy nurses in this study freely acknowledged that as junior nurses, this was the only source of their stoma care education (these experiences will be discussed in chapter 7).

We went around as a group with the Colostomy Association and we spoke to nurses when they started to do their training for there wasn't anybody else to help them. So we went along as a person who had a stoma... and we suggested they wear an appliance around with water in so that they would get the same feeling as how we felt.⁴⁶

The need for health professionals to depend on lay ostomates to fulfil the roles of counsellor, clinician, educator and appliance officer was indicative of a marked deficit in the general nursing and medical knowledge required for the care and rehabilitation of a person with a stoma. Although the need for this knowledge was fully appreciated by persons having to undergo ostomy surgery.⁴⁷ It was also acknowledged by the nurses in this study who were confronted by patient problems and had no experience to call upon (these experiences are detailed in chapter 7.)

Surgeons who found themselves performing surgery, which resulted in increasing numbers of stomas were also aware of the lack of knowledge in regard to management of the stoma once they had created it.^{48, 49, 50} The experiences of these nurses and doctors, provide insight into why the rehabilitated ostomate was accredited with semi-professional status in regards to stomal therapy practice and why the doctors and nurses relied on past patients' life world experiences for educating new ostomates. It appears that during the late 1950s and 1960s rehabilitated ostomates were commonly called to

⁴⁵ Mrs M. Cook, interview, 21 April 1996.

⁴⁶ Mrs G. Anderson, interview, 7 April 1996.

⁴⁷ *ibid.*

⁴⁸ Mr D. Failes, interview, 7 April 1996.

⁴⁹ Mr M. Killingbach, interview, 20 February 1996.

⁵⁰ Mr D. Hoffman, interview, 25 February 1994.

support the nurses and surgeons, whilst they in turn were supported by their fledgling associations.

The concept of ostomy support groups gradually spread to the other states and territories. Although some states ultimately formed more than one association, the first ostomy association began in: South Australia in 1959⁵¹, Queensland in 1960⁵², Tasmania in 1963⁵³, Western Australia in 1969⁵⁴, Australian Capital Territory in 1971⁵⁵ and in the Northern Territory the Royal Darwin Hospital distributed appliances until the Cancer Council took over the responsibility in 1984.⁵⁶ In the year 2001 there were 22 individual ostomy associations in Australia.⁵⁷

Today, Australian ostomy associations are united under the umbrella of the Australian Council of Stoma Associations. This body was established following an initial proposal in 1962 to form a national group, which would be an united voice for all the associations. On 28 September 1963 representatives from the earliest ostomy associations - New South Wales, Victoria and Queensland - met at Balmain Hospital in New South Wales, to discuss the formation of a Federal Council.⁵⁸ The members of this body appeared to have met very infrequently and did not establish a high profile or active brief. A second attempt to establish a unified body was productive and at a meeting in Canberra of 5 April 1970 the Australian and New Zealand Council of Stoma Associations (ANZCSA) was formed.⁵⁹ The convenors of this meeting were Sisters Betty Hughes and Elinor Kyte and Doctors ESR Hughes, Edward Wilson, Mark Killingbach. The following persons were elected to the executive committee: Dr Hughes (Patron), Dr Wilson (President), Mr Cyril Seidel (Vice President), Betty Hughes (Secretary) and Reverend Pagdin (Treasurer). The affiliation of the Australian Ostomy Associations and the Ostomy Association of Auckland and Canterbury in New Zealand

⁵¹ Ileostomy Association of South Australia, personal communication, 30 November 1999.

⁵² Queensland Stoma Association, personal communication, 29 November, 1999.

⁵³ Ileostomy & Colostomy Association of Tasmania, personal communication, 29 November 1999.

⁵⁴ Mr P. McDonnell, interview, 24 November 1998.

⁵⁵ ACT & Districts Stoma Association, personal communication, 30 November 1999.

⁵⁶ Anti-Cancer Foundation of NT, personal communication, 30 November 1999.

⁵⁷ Australian Council of Stoma Associations. (2001). *Ostomy Australia*, 10(1), 31.

⁵⁸ Allen, L. (1994). The early years. *Ostomy Australia*, 3(2), 4-5.

⁵⁹ Minutes of the Inaugural Meeting of the Australian and New Zealand Council of Stoma Associations, 4 April 1970, Canberra.

continued until 1979 when a Constitutional change was made in favour of adopting a totally Australian identity.⁶⁰

The Stoma Appliance Scheme

As a united body of ostomy associations, under the banner of the ANZCSA, the members perceived they would be a stronger force to lobby the government during the early 1970s for the inclusion of ostomy appliances on a national free appliance scheme. Failing that, they planned to request the government remove the excise and sales taxes on all ostomy appliances.⁶¹ Individual associations had been lobbying the government for some years and a petition was sent to the Minister of Health from the Ileostomy Association of New South Wales requesting free ostomy appliances in 1960.⁶² This aided the cause, but was only successful in having a limited number of pharmaceutical agents listed under the Pharmaceuticals Benefits Act in January 1962. Amongst these agents was karaya powder, surgical cement, deodorant agents, benzol, acrylic resin (Nobecutane™) and some silicon cream preparations.⁶³

Originally these pharmaceutical agents were dispensed on presentation of a prescription to an approved chemist. However, in June 1962 amendments by the Federal Minister of Health made in accord with Section 100 of the National Health Act (1953) allowed the various ostomy associations to supply the pharmaceutical agents directly to persons with a stoma. This established a precedent for distribution of pharmaceuticals and appliances to ostomates via the associations.⁶⁴

The success of this endeavour encouraged them further in their attempts to lobby the government for provision of free appliances. Politicians amongst the Federal Opposition ranks appeared to recognise the potential political advantage in supporting the cause. A letter was received from Mr Caldwell, the Federal Labour leader in 1966 stating he

⁶⁰ Minutes of 10th Annual General Meeting of the Australian Council of Stoma Associations, 7 April 1979, Adelaide.

⁶¹ Letter from E. Wilson, Chairman ACSA, to Sir W. Refshauge, Commonwealth Director General Department of Health, Canberra, dated 27 June 1972.

⁶² Mr K. Philips, personal communication (a written summary of historical data obtained from a review of a collection of newsletters and journals of the Ileostomy Association of NSW), 2 May 1996.

⁶³ QT Australia SA Division. (1993). The Ileostomy Association Newsletter, Special Edition 1963/64. Reprint. Ostomy Australia, 2(4), 22.

⁶⁴ Ms T. Woods, interview, 18 May 1994.

Kyte was born 12 March 1930 and began her training as a nurse at the Royal Melbourne Hospital in Victoria in 1953. She has no memory of ever having cared for a patient with a stoma during her general nurse training and her memory of receiving formal education on stoma care was miniscule. So when she had to care for her first ostomy patient in 1959, whilst working at St Andrew's Private Hospital in Melbourne, the experience proved to be profound. The patient had a history of ulcerative colitis and his surgeon, Mr E.S.R. Hughes, performed surgery that resulted in a temporary colostomy. The patient was in a poor state of health following his surgery and Kyte was confronted by her knowledge deficit, which prevented her from providing the standard of care she realised was required.⁷¹

Well here was I trying to work out what to do with a colostomy, I'd never seen one. I knew such things existed but I didn't know what they looked like. A few days post-operative Mr Hughes arrived, handed me a packet of double-sided stickers, a bundle of bags and a couple of Wallace flanges and a couple of belts and some rubber bands...he said use these.⁷²

It was by trial and error that she learned to use these devices. The patient's recovery in hospital spanned 10 weeks and this became a learning time for both patient and nurse. Kyte quickly learned that caring for patients with a stoma meant caring for the 'whole' not just the 'hole'.

It was very much a learning thing for both of us. And, of course, trying to teach a man who just wanted to lie down and die and I was just as determined he was going to live.⁷³

The experience resulted in an exceptional commitment to care. It also gave Kyte an opportunity to obtain new knowledge and skills and these were further broadened when the same patient was readmitted 6 weeks after his first discharge. He was readmitted with a recurrence of his colitis and this complication led to him having to have a total colectomy and the construction of a permanent ileostomy.

So he'd gone to theatre and he came back with an ileostomy. I thought heavens above, what do I do with this?⁷⁴

⁷¹ Ms E. Kyte, interview, 28 February 1994.

⁷² *ibid.*

⁷³ *ibid.*

⁷⁴ Ms E. Kyte, interview, 28 February 1994.

Kyte's experiences in caring for this gentleman appear to have directed her sense of purpose and activities toward the good of her patient to an extraordinary degree. The early nurse theorist, Ernestine Weidenbach,⁷⁵ stated it should be a fundamental goal of all nurses to direct one's purpose toward the 'good' of one's patient. However, it is the degree to which one strives to achieve the good that illuminates the exceptional from the expected care. It could be hypothesised that when nurses realise that they have provided exceptional nursing care, as evidenced by good patient outcomes, that they are rewarded with a sense of 'feeling good'. In Kyte's case, this in turn appears to have inspired greater commitment.

Kyte's commitment must have been obvious to Hughes for on interview in 1994, at a time when he was affected by advanced Parkinson's disease, he recalled quite readily her "interest" in caring for this patient and the impact it had on the patient's recovery. This commitment was also pivotal to the development of stomal therapy, for it caused Hughes to offer Kyte a job as a nurse in his professional rooms, a position she took up in 1960. Thus began a professional journey for Kyte, which saw her evolve from a novice to an expert in stomal therapy nursing.

During the 1960s Kyte gained knowledge and practical experience in the care, counselling and rehabilitation of ostomy patients. Interestingly, her abilities and knowledge appeared to have been more readily acknowledged at the time by Hughes' medical colleagues rather than her nursing contemporaries. Not only did she visit Hughes' ostomy patients in various private hospitals in Melbourne, but occasionally she would receive requests to review patients under the care of other doctors.⁷⁶ Although access to these patients was often hindered by the possessive attitudes of some ward charge nurses who were reluctant to allow Kyte entry to 'their' wards. In comparison some of Hughes' medical colleagues were anxious to have 'their' nurses cross state boundaries to learn from Kyte.^{77, 78, 79} Medical recognition of her ability resulted in an invitation in 1969 for Kyte to present a paper at an international medical conference on

⁷⁵ Wiedenbach, E. (1964). Clinical nursing: A helping art. New York: Springer Publishing Company Inc.

⁷⁶ Ms E. Kyte, interview, 28 February 1994.

⁷⁷ Ms L. Whittingham, interview, 23 January 1996.

⁷⁸ Letter from Dr G. Bedbrook, Royal Perth Rehabilitation Hospital to E.S.R. Hughes, dated 19 June 1967.

proctology in London. The relevant events surrounding this meeting will be discussed later in this chapter.

In 1967, Kyte co-authored with Hughes a book titled *All About an Ileostomy*⁸⁰. The precursor of this book was a type written bound volume, which was written and illustrated entirely by Hughes in 1959. Subsequent typeset editions however, were published in 1961, 1967 and in 1971 Dr Alan Cuthbertson added his name to the credits. The later editions were illustrated by Mr W. Owen, a past patient of Hughes. In 1969 Hughes, Kyte and Cuthbertson wrote *All About a Colostomy*. Both books were to be important resources for ostomates and texts for early stomal therapy nurse training.

In addition, Kyte was to co-author in 1969⁸¹ and 1970⁸² articles on stoma management that were published in the prestigious Medical Journal of Australia. (The latter article will be used as evidence later in this chapter, to correct an historical misrepresentation.) During the 1960s, these achievements were well ahead of what was expected or demonstrated by Kyte's Australian nurse contemporaries. As this chapter progresses it will become obvious that Kyte's achievements were largely supported and encouraged by Hughes.

Such support and mentoring helped prepare and position Kyte as a nurse leader. She in turn was able to encourage succeeding nurses into a new nursing specialty. It is my belief that the title 'Mother of Stomal Therapy' in Australia belongs to Elinor Kyte and I draw support for this belief by Hughes' following comments, which he recorded in 1970.

Miss Kyte has made an outstanding contribution to stomal therapy in this country. She was the first in the field, has done considerable research and probably has had more experience than anyone in the world on stomas.⁸³

⁷⁹ Letter from Mr E. Fleming, Canberra, to E.S.R. Hughes, dated 10 May 1971.

⁸⁰ Hughes, E.S.R., & Kyte, E.M. (1967). *All about an ileostomy* (2nd ed.). Melbourne: Angus and Robertson.

⁸¹ Kyte, E.M., Moynihan, B.M. & Hughes, E.S.R. (1969). A postoperative colostomy and ileostomy appliance. *Medical Journal of Australia*, 2, 1215-1216.

⁸² Kyte, E.M., & Hughes, E.S.R. (1970). Peristomal skin protection with "Orahesive". *Medical Journal of Australia*, 25 July.

⁸³ Letter from E.S.R. Hughes to Berth Okun, North American Association of Enterostomal Therapists, Montreal, Canada, dated 14 December 1970.

However, even Kyte had to rely on the 'tools of the trade' and during the 1960s they were sadly inadequate to cope with the diversity of problems encountered by Australian nurses and ostomates alike.

Australian Advances in Ostomy Appliances

In Australia during the 1950s and 1960s, the greatest encumbrance to caring for a person with a stoma or fistula was the lack of efficient appliances and skin protective agents. It has been reported that appliances were generally difficult to obtain and the few appliances that were available were all imported and expensive to purchase.

It was so antiquated. Mostly I think we had the rubber bags and the flanges to go with them, but I think what I can remember most of all was all the cotton wool we used and I think at times we only had one bag and there never seemed to be adequate materials.⁸⁴

Ileostomates and urostomates, would endeavour to access drainable rubber bags and rubber flanges. The Koenig-Strauss-Rutzen rubber bag and flange invented in 1944 and discussed in chapter 4, was the first of these appliances (see Appendix I: Figure 3). A rubber flange was secured to the skin with a double-sided adhesive disc, skin cement or a karaya gum disc and tight belts were worn for added security in most cases. Colostomates on the other hand, relied upon dry dressings or a belted flange, which was used to anchor a plastic bag. These appliances were not odour or noise proof and were subject to frequent leakage.^{85, 86}

Most of the early manufacturing companies of ostomy appliances, which had evolved in the United States, Britain or Denmark had founders who were ostomates, or who were related to people who were ostomates.⁸⁷ This also reflected the situation in Australia at that time. A number of innovative Australian ostomates were responsible for some credible appliances such as the Wallace flange, the Philp flanges, disposable cryovac bags and the Cook ostomy belt.

⁸⁴ Sr F. McMeniman, interview, 24 March 1994.

⁸⁵ Ms G. Anderson, interview, 7 April 1997.

⁸⁶ Mr K. Philp, interview, 7 April 1997.

⁸⁷ Davidson, W., & Fischer, J. (1996). In P. Erwin-Tooth & D. Krasner (Eds.). Enterostomal therapy nursing growth & evolution of a nursing specialty worldwide: A festschrift for Norma N. Gill-Thompson. ET. Baltimore: Halgo, Inc.

I took this flange to Mr Hughes and he was very impressed with it and was anxious to get it made here. Mrs Johnson's husband, Gordon, took it along to the place where he worked and asked them if they would be interested in making it for us. A Mr Wallace who worked for the firm said "yes", so that was how the Wallace plastic flange originated.⁸⁸

The Philp polyurethane flange was made in the backyard shed of Sydney ileostomate, Ken Philp. Prior to his ileostomy surgery in 1960, Philp had been in the "engineering business". He created a range of flat and convex low profile, polythene flanges to fit every size and shaped stoma⁸⁹ (see Appendix I: Figure 8).

I was looking at these rubber flanges one day and I thought to myself, there has got to be something better so I went out and purchased a big piece of plastic. I had a lathe at home ... and I turned up out of plastic something very similar to the rubber flange but out of low density polythene. I used those for a while but they were still too high, so I had several goes at it and I finally came up with the right one that was a reasonable height, it didn't deteriorate like the rubber ones. They discoloured a bit, but a soak in bleach would get that out and they were definitely an improvement... I got making that many that... a tool maker friend made me up a plastic mould ... and with a little bit of machining on a lathe I could get two or three types out of the one mould. I must have made up to 10,000 of these and when the Appliance Scheme first started they were on the free list.⁹⁰

Philp's cry "there has got to be something better" were words found to be echoed by several pioneer stomal therapy nurses whose experiences are detailed in chapter 7. Similar feelings of desperation were to cause them to seek or create alternative care options. In Philp's case however, it caused him to experiment with plastic mediums and design a range of low-profile flanges. These flanges could be considered to be the precursor to the low-profile flanges, which incorporated skin barriers that were produced by corporate enterprises in the 1980s. His convex flanges preceded the availability of other commercially available convex flanges in Australia by 30 years. In 2001, Australian ostomates were still waiting for one of the major ostomy appliance companies to introduce a flange that offered an oval shaped aperture. Philp produced such a flange in his backyard shed during the 1960s.

⁸⁸ Mrs B. Reid, personal communication, 17 May 1997.

⁸⁹ Mr K. Philp, interview, 7 April 1997.

Simple plastic bags were used in conjunction with the flanges. The Wallace flange, which was made in Melbourne, had a plastic bag folded through and over the flange and the belt anchored the system securely to the abdomen. A plastic bag was attached to the Philp or rubber flange by a rubber band. Plastic bags normally purchased from the supermarket for a multitude of household tasks were used as stoma bags. However, these bags tended to draw attention to the wearer as they crackled under clothing and were not odour proof. These problems were appreciated by an ileostomate's husband who worked as an electrician with a plastics firm called Nylex in Mentone, Victoria. Reid had noticed rolls of four or five inch wide soft and virtually noiseless plastic and decided to experiment (see Appendix I: Figure 9).

We wondered if we made a straight bag about nine inches in length if it would serve the purpose. So he made some up for me and sealed them off with a pair of asbestos scissors and hey presto it worked, so it was off to see Mr Hughes again.⁹¹

Mabel Cook and her husband, also produced disposable bags in a similar manner and these they sold through their Melbourne business. In addition they made wide elasticised belts, which are still listed on the Stoma Appliance Scheme.⁹² Prior to the listing of products on this scheme Hughes would order plastic bags by the thousands, along with Wallace and Philp flanges and these he would resell at cost to his patients in smaller lots. This ensured a regular supply of available equipment for his patients.^{93 94}

Hughes obviously favoured the use of stoma appliances instead of traditional dressings and was even known to use the former on wound drainage sites. During the 1950s he devised the first Australian post-operative drainable bag, which became known as the 'long bag'. His staff would make these appliances out of metre lengths of cryovac (soft plastic) tubing. There would be an opening at either end of the tubing and an adhesive double-sided disc would be applied approximately 30 centimetres from the top opening. This would be then applied to the surrounding skin of a stoma or drainage site. A sheet of karaya gum was added as a skin barrier when it became available in the late 1960s. The lower opening would be drained into a receptacle under the bed. The top opening

⁹⁰ *ibid.*

⁹¹ Mrs B. Reid, personal communication, 17 May 1997.

⁹² Ms M. Cook, interview, 21 April 1996.

⁹³ Sir E. Hughes, interview, 1 March 1995.

would be closed with a rubber band or a stationery clip. Hughes would apply the long bags in the operating theatre and they would be flushed through with water on a regular basis by the ward nursing staff. Although this procedure frequently proved to be messy and the cause of significant malodour, the long bag was almost revered by nursing staff for it significantly reduced the number of stoma dressing changes^{95, 96} (see Appendix I: Figures 10 and 11).

The long bag would be removed on approximately the tenth post-operative day and a 'permanent' appliance - such as the rubber flange and bag or the Wallace system - would be applied. Even with these appliances malodour was a considerable force to be reckoned with, which explains why some equally offensive deodorant agents were listed early on the Pharmaceutical Benefits Scheme for ostomates.⁹⁷ Skin ulceration and malodour were significant problems and virtually accepted as the norm by all the nurses in this study. The discovery by Turnbull of the advantages of karaya powder for stoma care (as discussed in chapter 4) was a major bonus, but allergies to this product plagued a considerable number of ostomates. The karaya products also had limited durability in the hot and humid regions of Australia.⁹⁸ In addition, karaya was known to cause a stinging sensation when it came into contact with denuded skin, due to a release of acetone.⁹⁹ Therefore, the discovery in 1969 of a superior skin-friendly product became the single most important discovery in ostomy care at that time.

The Great Discovery

The product discovery that was to revolutionise stoma care, and which was to ultimately herald great advances in wound management for many patients was Orahesive™ bandage. It was not in fact intended for use in stoma or general wound care at all. The story concerning the course of events and persons involved in discovering the therapeutic value of Orahesive™ bandage has been disputed since the beginning. Thirty years after the event, I have unearthed what I believe to be the factual story of this

⁹⁴ Mr K. Philp, interview, 7 April 1997.

⁹⁵ Sir E. Hughes, interview, 1 March 1995.

⁹⁶ Kyte, E.M., Moynihan, B.M., & Hughes, E.S.R. (1969). A postoperative colostomy and ileostomy appliance. Medical Journal of Australia, 2, 1215-1216.

⁹⁷ QT Australia SA Division. (1993). Pharmaceutical benefits. Ostomy Australia, 2(4), p. 22.

⁹⁸ Ms R. Walsh, interview, 24 March 1994.

⁹⁹ Irrgang, S., & Bryant, R. (1984). Management of enterocutaneous fistula. Journal of Enterostomal Therapy, 11(6), 211-225.

discovery and I feel compelled to report it in detail in order to remedy what I consider to be a failure to acknowledge the significant contribution of an Australian stomal therapy nurse.

In the mid 1960s a pharmaceutical chemist, Dr James Ling Chen, employed at E. R. Squibb and Sons Pty Ltd. in New Jersey, created a 'bandage' that would adhere to moist oral mucosa.

I took some commercial gum base, the kind used to make chewing gum then I added gelatine, and pectin, which is used to make jam, and some other sticky things. I mixed them into a dough and then rolled it flat between two sheets of wax paper using a Sears Roebuck laundry wringer. Finally, I covered one side with polyethylene, so you could hold on to it.¹⁰⁰

Two sheets of the Orahesive™ bandage and some of its sister products – Orahesive™ emollient and Orahesive™ powder - were given to Kyte and Hughes early in 1969 by Mr R. Maine a Melbourne representative of E.R. Squibb and Sons Pty Ltd. Dr Alan C. Jenkins, who was also employed by the company and a medical acquaintance of Hughes, had asked them to review the product as the company were considering selling the patent on the product.^{101, 102} Norma Gill-Thompson (nee Gill) was to write in 1984 that it was also her understanding of that time that the company had already sold the patent to Orahesive™ powder and had intended to do the same with the Orahesive™ bandage.¹⁰³

Kyte experimented with the Orahesive™ emollient, which had been marketed as a dental fixative agent, in the expectation that it would be an useful agent for securing flanges. As such it failed, and it was not until 18 April 1969 that Kyte found a need to experiment with the Orahesive™ bandage. The need arose when Mrs Jean Burgess, a 29 year old patient of Hughes, presented in his rooms with severe skin ulceration around an abdominal sinus. Burgess had Crohn's disease and had undergone previous surgery and had an ileostomy constructed. Kyte found the area of painful ulceration to be consistent

¹⁰⁰ McKean, K. (1993). The story of Orahesive, Stomahesive, and DuoDERM. Unpublished manuscript written following an interview with E. Kyte in 1992.

¹⁰¹ Sir E. Hughes, interview, 1 March 1994.

¹⁰² Ms E. Kyte, interview, 28 February 1994.

¹⁰³ Gill-Thompson, N. (1984). Update. Stomahesive history. Unpublished manuscript.

with the shape of the karaya gum sheet, which had been used as a skin barrier under an appliance. This patient had a past history of allergies to adhesive agents and Kyte surmised that she had developed an allergy to karaya gum products as well.^{104 105}

What was needed urgently was a non-allergenic product that would protect and heal the skin, but one which would not prevent the adherence of an appliance. With no other remedies in her armoury, Kyte was prepared to try the Orahesive™ bandage. However, only one side of the product was adhesive and it was necessary to find another double-sided adhesive to adhere the polyethylene layer to an appliance. Kyte found three Stomaseal™ (a product of 3M™ Company) discs amongst her stores. These she had previously trailed and discarded as a double-sided adhesive disc suitable for securing an appliance directly to the skin. The Stomaseal™ was applied to the polyethylene (outer) side of the Orahesive™ bandage and the drainage bag was applied to the other adhesive side. The device was then applied to the ulcerated skin with the Orahesive™ bandage in contact with the denuded area. Kyte observed that Mrs Burgess obtained initial relief from the discomfort and with some trepidation she was sent home with the device in situ.^{106, 107}

The night of Friday 18 April was interminable. At 7.30 a.m. on Saturday the 19th Mrs Burgess as instructed made her all important phone call. She was able to give an encouraging report. The bag had remained intact. The burning and irritable sensation had ceased and the skin was less painful. The relief on behalf of both the patient and the recipient of the call (Kyte), was immense especially for the latter. A report was later given to Mr Hughes who was equally excited.¹⁰⁸

The Orahesive™ bandage and appliance were removed 3 days later and the skin was noted to be dramatically improved. A second appliance was applied in the same fashion and Mr Maine was contacted to let him know of the “exciting development”. He was invited to witness the next appliance change which took place on 25 April when they found that “the skin was pinkish in colour with no sign of irritation or excoriation”. The

¹⁰⁴ Ms E. Kyte, interview, 28 February 1994.

¹⁰⁵ Kyte, E. (1992). Necessity is the mother of invention. Unpublished manuscript.

¹⁰⁶ Ms E. Kyte, interview, 28 March 1994.

¹⁰⁷ Kyte, E. (1992). Necessity is the mother of invention. Unpublished manuscript.

¹⁰⁸ *ibid*, p. 3.

skin was found to be completely healed when the appliance was removed 5 days later.¹⁰⁹

Further experimentation occurred on this lady when she presented on 9 May 1969 with peristomal skin excoriation secondary to another allergic reaction to karaya gum. Orahesive™ bandage was applied to her ileostomy appliance in a similar manner to that used around her abdominal sinus. The results were found to be equally as good when the appliance was changed 5 days later. However, 2 days following the second application of the device Mrs Burgess observed blood on her stoma. When Kyte removed the appliance she found that there was a laceration on the stoma which had been caused by the sharp edges of the polyethylene film on the Orahesive™ bandage and the Stomaseal™ disc. From then on Kyte cut radial slits in the combined products around the aperture she cut to fit the stoma and this eliminated the problem. This became a ritual in practice that was handed down to succeeding generations of Australian stomal therapy nurses and surgeons.^{110, 111}

The importance placed on this ritual and other rituals that evolved in the preparation and application of the skin barrier and flange increased in significance over time. When Brisbane surgeon, Daniel Lane made a film on ileostomy care at the Brisbane Mater Hospital in 1972 he neglected to demonstrate the need to cut slits and smooth any wrinkles in the skin barrier and adhesive disc, prior to applying it. Hughes was quick to point this deficit out to his colleagues and some animated correspondence flowed between him and McCaffrey, another Brisbane surgeon. McCaffrey succeeded Lane following Lane's death in December 1972.¹¹² The stomal therapy nurses in this study whose experiences are detailed in chapter 7, also made comment in regard to the rituals practiced in the care and application of appliances.

A third opportunity to experiment on Mrs Burgess arose on 12 May when a Crohn's ulcer erupted on her left thigh. Extraintestinal manifestations, which can include

¹⁰⁹ *ibid*, p. 3.

¹¹⁰ Ms E. Kyte, interview, 28 March 1994.

¹¹¹ Kyte, E.M., Moynihan, B.M., & Hughes, E.S.R. (1969). A postoperative colostomy and ileostomy appliance. *Medical Journal of Australia*, 2, 1215-1216.

¹¹² Letter from Mr J. McCaffrey, Department of Surgery University of Queensland, to E.S.R. Hughes, dated 17 September 1973.

dermatological lesions, can occur in cases of Crohn's disease.¹¹³ The thigh lesion was incised and another device applied to contain the purulent discharge.¹¹⁴ Kyte and Hughes continued to experiment with the product on subsequent patients and used it in lieu of karaya gum sheets under the long bag or with the Philp or rubber flanges (see Appendix I: Figures 12 and 13). They published the first report of the discovery in the *Medical Journal of Australia* in December 1970. I would like to highlight the fact that Kyte was listed as the first author of that report.¹¹⁵

As the adage goes - the rest is history. E. R. Squibb and Sons Pty Ltd adapted the size of Orahesive™ bandage from a three inch square to a four inch square, so that it would fit under flanges, and changed the prefix in the name to *Stomahesive*™ in 1970.¹¹⁶

Although the revamped product was listed on the Pharmaceutical Benefits Scheme in Australia before March 1971¹¹⁷ it was not launched onto the market in the United States officially until 1972.¹¹⁸ This first hydrocolloid skin barrier not only revolutionised ostomy care but eventually wound management when it was adapted for use on wounds in the late 1970s. This product was then known as Varihesive™¹¹⁹. Further adaptations were made to the concept in 1983 and the product was renamed DuoDerm™. In 2001, this product was but one of 18 hydrocolloid dressings available for use in wound management on the Australian market.¹²⁰

It is intriguing, to find that in the 30 years following Kyte's discovery that she had received no public acknowledgement from the manufacturer of the product in regard to her original clinical application of Orahesive™ bandage. This is particularly pertinent in light of the fact that Orahesive™ bandage not only revolutionised stoma management

¹¹³ Bresln, N., & O'Morain, C. (1999). Extraintestinal manifestations. In G. Bianchi Porro (Ed.), *Gastroenterology and hepatology* (pp. 417-423). London: McGraw-Hill International (UK) Ltd.

¹¹⁴ Kyte, E. (1992). Necessity is the mother of invention. Unpublished manuscript.

¹¹⁵ Kyte, E.M., & Hughes, E.S.R. (1970). Peristomal skin protection with "Orahesive". *Medical Journal of Australia*, 25, 186-187.

¹¹⁶ Squibblin. (1975). Stomahesive – Evolution of an important product. 10(4), 14-15.

¹¹⁷ Australian and New Zealand Council of Stoma Associations. (1971). Minutes of Annual General Meeting, 27 March, Sydney Hospital.

¹¹⁸ McClees, N. (2000). The history of Stomahesive: Skin barriers the state of the art. Stomahesive: The gold standard, Nobel Park, Victoria: ConvaTec A Bristol-Myers Squibb Company.

¹¹⁹ Tracy, G., Lord, R., Kibel, C., Martin, M., & Binnie, M. (1977). Varihesive sealed dressing for indolent leg ulcers. *The Medical Journal of Australia*, 1, 777-780.

¹²⁰ Carville, K. (2001). Wound care manual (4th ed.). Osborne Park, Western Australia: Silver Chain Foundation.

but could be said to have launched a new sub-division of an international corporate enterprise.

The resounding corporate reluctance to acknowledge Kyte's 'discovery' continued after company communication with Kyte in 1987¹²¹ and an interview with her and company representatives in the spring of 1992¹²². At this time it was proposed to document the history of Stomahesive™. The interview was documented and forwarded in draft back to Kyte and Hughes in January 1993 for comment.¹²³ Kyte responded to the document on 3 February 1993. Even as late as 2000, Kyte informed me that she had received no other correspondence on the matter.¹²⁴

It is equally intriguing to note that a company monograph published in 2000¹²⁵ gives credit to the discovery of the product to Hughes alone, yet references the article referred to above by Kyte and Hughes, which was published in the *Medical Journal of Australia*.¹²⁶ This oversight to acknowledge Kyte's involvement in the discovery was found to be in keeping with a published history, which appeared in 1975 in a company newsletter named *Squibblin*¹²⁷. In this article equal credit for the discovery was given to Hughes and an Australian dentist. The latter claimant was not substantiated by Hughes or Kyte in written or oral communications with myself.

To compound this confusion Clarke, an Associate Medical Director, from Squibb Pharmaceuticals Ltd published an article in July 1974¹²⁸ giving credit to an unnamed stomal therapist from Essex for using the product on severe skin excoriation. It was interesting to note that Clarke made mention that an equally unnamed surgeon from Melbourne had carried out the first full length trial on the product and referenced the article by Kyte and Hughes in the *Medical Journal of Australia*.¹²⁶

¹²¹ Letter from Ms E. Kyte, to Mr Peter Hurran, Marketing Director, Squibb Surgicare Ltd, dated 9 November 1987.

¹²² Letter from K.S. McKean, New York, to Ms E. Kyte, dated 10 January 1993.

¹²³ Draft of article written by K.S. McKean and following an interview with Elinor Kyte recorded in the Australian 'spring' of 1992, titled The Story of Orahesive, Stomahesive and DuoDerm.

¹²⁴ Ms E. Kyte, personal communication, 5 September, 2000.

¹²⁵ E.R. Squibb & Sons. (2000). Stomahesive™ the gold standard. ConvaTec A Bristol-Myers Squibb Company.

¹²⁶ Kyte, E.M., & Hughes, E.S.R. (1970). Peristomal skin protection with "Orahesive". Medical Journal of Australia, 25, 186-187.

¹²⁷ Squibblin. (1975). Stomahesive – Evolution of an important product. 10(4), 14-15.

This could imply that the kudos associated with such a discovery would be diluted if it was afforded to an Australian nurse, rather than a more eminent professional. The fact that people who were in the employ of the manufacturer of Orahesive™ bandage at that time, seemed to have disagreed over who first used the product as a skin barrier added to the confusion and clouded historical accuracy. It appears that claimants to the honour of discovery were perceived to exist in Australia, Britain and the United States of America.

A North American interest in the product was ignited at a lunch in Boston in 1969 when Kyte and Hughes were in the city to attend a medical meeting. Kyte teased Turnbull with the fact that she had “something wonderful and great” for peristomal skin problems but she would not divulge the details. Her reasons for such reticence for providing further information was that the product was in the experimental stages. The ‘something wonderful and great’ was Orahesive™ bandage and its application as an ostomy skin barrier.¹²⁹ Turnbull’s curiosity was stimulated and he instructed Gill to “find out about this”.¹³⁰

Further discussion between Kyte and Turnbull in regard to the Orahesive™ trials occurred when they met again in London at an International Conference of the Royal Society of Medicine. In the personal records of Gill-Thompson, it stated that when she and Turnbull returned to the United States following that meeting they contacted the local representative from E. R. Squibb and Sons Pty Ltd and obtained samples of the Orahesive™ for trial. They too, were impressed with their findings and when they contacted the company some months later, they were invited to conduct a formal study.¹³¹

However, in a letter Kyte wrote to Daniel Lane in March 1971 she tells of a visit to Melbourne by Turnbull in November 1970, and stated that during this visit Hughes, Kyte and Turnbull spent “much time discussing the merits of Stomahesive™” and one is

¹²⁸ Clarke, T. K. (1974). Advance in stoma care. British Clinical Journal, July, In house publication Squibb Company, UK.

¹²⁹ Ms E. Kyte, interview 28 March 1994.

¹³⁰ Ms N. Gill-Thompson, interview, 29 June 1995.

led to believe that it was following Turnbull's return to the United States after this visit that they trialled the product. Kyte quoted to Lane a paragraph from a letter from Turnbull to her dated 25 January 1971, which said:

We are delighted with Orahesive™, but not delighted with the price, which is prohibitive in this country. Everything you said about it has proven to be quite correct. We have put it on selected patients who could wear nothing else, and found that the skin has returned to normal, just as you said.¹³²

The strongest evidence in support of Kyte's claim of being the first to use Orahesive™ bandage in this manner however, comes from Gill-Thompson who claimed credit for coining the phrase "skin barrier", but gave credit to Kyte for her discovery of the advantages of using Orahesive™ as an ostomy skin barrier.^{133, 134}

The following statement of Gill-Thompson as recorded in 1995 gives insight into the how the task of ensuring historical accuracy can be particularly onerous and potentially misconstrued.

So Elinor Kyte was the one that discovered it and I'll give Dr Turnbull (because he was my senior person) the credit for making it known because he was not a bit afraid to get up and say what he thought was good at meetings.¹³⁵

The above statement by Gill-Thompson emphasises the degree of respect afforded Turnbull and could be perceived to allude to a joint claim to the initial use of Orahesive™ bandage as a skin barrier. There is an analogy to be drawn with this claim and the enthusiasm employed in North America for hyphenating the 'Brooke-Turnbull' ileostomy procedure, which was discussed in chapter 4.

In 1954, Crile and Turnbull surgically solved the problem of ileostomy dysfunction in the US at about the same time Brooke published his solution in England.¹³⁶

¹³¹ Gill-Thompson, N. (1984). Update. Stomahesive history. Unpublished manuscript.

¹³² Letter from E. Kyte to D. Lane dated 19 March 1971.

¹³³ Gill-Thompson, N. (1984). Update. Stomahesive history. Unpublished manuscript.

¹³⁴ Ms N. Gill-Thompson, interview, 29 June 1995.

¹³⁵ *ibid.*

¹³⁶ Turnbull, R., & Turnbull, G. (1991). The history and current status of paramedical support for the ostomy patient. Seminars in Colon & Rectal Surgery, 2(2), 131-140.

Although one can readily appreciate the regard and loyalty Turnbull engendered in those who knew him, history records that the Crile-Turnbull procedure although effective, was more complex to perform and did in fact differ to the Brooke procedure.^{137, 138} Turnbull acknowledged this and gave credit to Brooke for the technique he devised.¹³⁹ In addition, Brooke published his findings first in 1952 and the procedure is internationally referred to as the Brooke ileostomy procedure.

In regard to the use of Orahesive™ bandage as a skin barrier, it is to be expected that the manufacturers of Orahesive™ bandage at that time (E.R. Squibb and Sons Pty Ltd) would focus on the experience of their well-respected compatriots, Turnbull and Gill. Both of whom had been involved in North American trials using the new skin barrier. In addition, Gill had been awarded a certificate of appreciation for an exhibit on “A Revolutionary New Skin Barrier” at a meeting of the American College of Surgeons in Chicago in October 1973.¹⁴⁰ The reader is reminded that Kyte and Hughes did report the use of Orahesive™ bandage as a peristomal skin barrier in 1970.¹⁴¹

It would be interesting to contemplate what would have been the sequence of events had Kyte’s story been widely acknowledged at the outset. It is likely that the healing advantages noted in the care of peristomal skin would have been appreciated for other domains of wound management much earlier. The first clinical use of Orahesive™ bandage (other than for mouth ulcers) by Kyte had after all, been to manage a wound rather than an ostomy problem. Although the actual use of the skin barrier for wound management was reported by some of the Australian pioneer stomal therapy nurses in this study, this was long before such use was sanctioned by the manufacturer (see chapter 7). This however, did not appear to overly disadvantage the manufacturer of the product.¹⁴²

¹³⁷ Brooke, B. (1952). The management of an ileostomy including its complications. The Lancet, 2. 102-104.

¹³⁸ Crile, G., & Turnbull, R. (1954). The mechanism and prevention of ileostomy dysfunction. Annals of Surgery, 140(4), 459-466.

¹³⁹ *ibid.*

¹⁴⁰ Copy of a certificate obtained from Ms N. Gill-Thompson.

¹⁴¹ Kyte, E.M., & Hughes, E.S.R. (1970). Peristomal skin protection with “Orahesive”. Medical Journal of Australia, 25, 186-187.

Many of the early sales of Stomahesive™ originated in Australia as nurses and ostomates became increasingly aware of the advantages of the skin barrier. Nurses found this treatment a superior alternative to the many unsubstantiated practices they had at time employed, such as the topical application of food stuffs to ulcerated skin. As the product use widened, the use of other traditional topical agents such as aluminium paste, tinc benz solution, zinc cream, aluminium hydroxide mixture and mercurochrome grew out of favour. However, as the experiences of nurses reveal in chapter 7, there was a reluctance to forego the use of these agents entirely when skin problems were encountered.

Effecting Change Through Partnerships in Practice

Skin ulceration frequently occurred as a result of a poorly sited stoma.¹⁴³ In an attempt to correct this problem, Kyte in 1966 began to routinely site and mark patients pre-operatively for ileostomies. Previous to this, few surgeons sited the stoma¹⁴⁴ and although Hughes tended to, he marked the site for the stoma when the patient was supine in the pre-anaesthetic room or when they were positioned on the operating table. However, anatomical contours and creases are not always obvious when a person is relaxed or unconscious in the supine position and when the patient stands or sits, these creases and folds interfere with adhesion of appliances and leakage results.¹⁴⁵

Kyte's practice of siting patients pre-operatively often met with resistance from senior nursing staff in hospitals. It appears, this practice was deemed outside of the traditional nursing role. Kyte found it took some years for the practice to be accepted, as were her visits to wards to see Hughes' patients or those of other surgeons if requested. It seems charge nurses frequently felt affronted by an outsider nurse being asked to advise on care.^{146, 147, 148} These attitudes were not isolated to the 1960s according to succeeding generations of stomal therapy nurses interviewed in this study. Helen Simcock who completed a stomal therapy course in 1981 prior to taking up a full-time position at a major tertiary hospital, stated that she learned very quickly of the importance of "paying

¹⁴² In 1975 the sales of Stomahesive™ had been projected to exceed \$US2,000,000 that year.

¹⁴³ Letter from Ms E. Kyte, to Mr R. Hollings, dated 20 February 1974.

¹⁴⁴ Mr N. Davis, interview, 24 March 1999.

¹⁴⁵ Ms E. Kyte, interview, 28 March 1994.

¹⁴⁶ Mr D. Failes, interview, 7 April 1997.

¹⁴⁷ Ms E. Kyte, interview, 28 March 1994.

¹⁴⁸ Ms H. Simcock, interview, 17 January 1996.

respect to the charge sister” if one was to be “accepted on the ward”.¹⁴⁹ However, it seems that lay ostomates were not perceived to be a professional threat to charge sisters when they visited hospital wards.¹⁵⁰

Nor was it the case for visiting nurses under the protection of visiting surgeons. Hughes, like his colleague Rupert Turnbull, also saw the advantages in employing his own theatre nurse.¹⁵¹ Bridget Moynihan accompanied Hughes into private and public operating rooms around Melbourne and when interviewed in 1994 Hughes could not remember any animosity being expressed towards Moynihan. In fact, he recalled a sense of disappointment amongst theatre nursing staff if she did not accompany him, for it meant he had to employ one of them.

The fact that Hughes employed his own nurse ‘specialists’ in the operating suite and for stomal therapy practice demonstrated not only his desire for optimal outcomes but his understanding that both roles were in reality specialised roles. In July 1971 he was to draw an analogy between surgical specialisation and nurses specialising in stomal therapy.¹⁵² He argued that the evolution of nurses specialising in stomal therapy and the evolution of colo-rectal surgeons had many common elements. In 1963 Australian surgeons with a dedicated interest in surgery of the gut had established a Section of Proctology under the auspices of the Royal Australasian College of Surgeons, the name of this group was changed to the Section of Colo-rectal Surgery in 1968.¹⁵³ However, the Colo-rectal Surgical Society of Australia which attracts its membership from surgeons with specialised training in colo-rectal surgery, was not formed until 1988.¹⁵⁴

Sydney surgeon, David Failes, also discussed the similarities that existed in the development of stomal therapy nursing and colo-rectal surgery as domains of specialised practice. Failes considered these factors were related to a trend in specialisation generally.¹⁵⁵ But according to Hoffman a colo-rectal surgeon from

¹⁴⁹ *ibid.*

¹⁵⁰ Gwen Anderson, interview, 7 April 1997.

¹⁵¹ Mr D Failes, interview, 7 April 1997.

¹⁵² Letter from E.S.R. Hughes to Dr B. Nicholson, Royal Adelaide Hospital, dated 16 July 1971.

¹⁵³ C. Green, Records and Archives Unit Royal Australasian College of Surgeons, Melbourne, personal communication, 3 July 2001.

¹⁵⁴ Mr G. Newstead, Colo-rectal Surgical Society of Australia Inc., personal communication, 3 July 2001.

¹⁵⁵ Mr D. Failes, interview, 7 April 1997.

Adelaide, that the specialisation of nurses in stomal therapy actually facilitated the recognition of colo-rectal surgeons as a medical specialty.

I suppose that with the introduction of stomal therapy and as it became more professional ... I think it did facilitate the recognition that surgery needed to be specialised as well... I think the understanding of the needs for stomal therapy led people to understand that there were needs for specialist surgeons as well.¹⁵⁶

Hoffman's view suggests a serendipitous sequel to the evolution of stomal therapy care in Australia. Hoffman was instrumental in establishing a dedicated colo-rectal unit at the Royal Adelaide Hospital, and such units highlighted the expertise of specialists within both nursing and medical practice.

During the 1960s, Hughes also employed Elisabeth (Robbie) Debney, a registered nurse, who's prime role was to correlate his extensive records.¹⁵⁷ Hughes left a legacy of one of the largest study series on carcinoma of the bowel and impeccable records were needed to maintain this legacy.¹⁵⁸ The working partnership between Hughes and the nurses he employed acknowledged the expertise of both disciplines and was ahead of its time in medical and nursing circles of the day.

The partnership extended to overseas travel on occasion. Kyte first accompanied Hughes and Moynihan to the USA in 1967 and it was on this trip that she visited the Cleveland Clinic. In June and July 1969, she travelled with Debney and Hughes on a world trip to the United States, Britain, Stockholm, New Delhi and Hong Kong. Kyte and Hughes were to attend two prestigious medical conferences and Debney was to review record-keeping facilities. This trip also afforded them opportunities to visit hospitals and stoma clinics and to meet with leading surgeons, ostomy associations and manufacturers of ostomy and surgical equipment.

In Los Angeles on 11 June 1969 they attended a dinner meeting with five members from the Ileostomy Association of Los Angeles. This "Stoma to Stoma Meeting" as

¹⁵⁶ Mr D. Hoffmann, interview, 25 February 1994.

¹⁵⁷ Sir E. Hughes, interview, 1 March 1994.

¹⁵⁸ Hughes, E. (1980). Results of surgery for cancer of the large bowel. Proceedings of the World Enterostomal Therapists Congress, 11-14 August, Cleveland, pp. 28-31.

mentioned by Hughes in a diary of the trip was most informative and seeded many useful ideas in his mind.

It is hard to believe that a dinner would be improved by discussions on stomas, bags and philosophies but whether that is so or not, it proved one of the most exciting dinners we have had.¹⁵⁹

They were shown samples of new stoma appliances and some new ostomy teaching models produced by United Surgical Corporation. A plastic model, the Miniature Visual Ostomy Demonstrator, was designed to demonstrate intestinal anatomy and changes made with a colostomy or ileostomy stoma was constructed. Another model was designed to wear over clothing so that the instructor could demonstrate appliance changes.

Discussion took place regarding the establishment of a “stoma service station”. This concept had been proposed in Los Angeles in 1965 and there were to be a series of these stations set up by the Ileostomy Association of Los Angeles in the city and surrounding counties. They avoided the word ‘clinic’ in what was probably an attempt to normalise the setting and inversely, the condition. The stations were to be staffed by “stoma technicians”.¹⁶⁰

It was following this meeting that Hughes appears to have settled on the words *stomal therapy* and *stomal therapist*. He used this terminology from that point onwards in the diary when referring to persons or facilities dealing with stoma care. He never appeared to approve of, or use the term *enterostomal therapy* which had been adopted by his American colleagues or *stoma therapy* which was favoured by his British contemporaries.

The meeting in Los Angeles in 1969 was obviously very stimulating and Hughes documented several ideas in his travel diary that he and Kyte were later to act upon. I take the liberty to reproduce three of the five recommendations for they give insight into Hughes’ ideas for advancing stomal therapy in Australia. They were listed as:

¹⁵⁹ Hughes, E.S.R. (1969). Diary travel, Unpublished manuscript, p. 6.

¹⁶⁰ *ibid*, p. 7.

1. Improved services will be obtained with Hospital Stomal Therapy Departments. We have got this by E.M.K. (*Elinor Margaret Kyte*) visiting the private hospitals. But this is purely a private concern. This could be extended and the Royal Melbourne Hospital encouraged to develop its own department.
2. Stomal "Service Stations" is an idea that could be developed and moulded into a community. As stomas become more and more an accepted way of life such a service will develop.
3. We should consider running a course for stomal therapists, or "would-be" interested persons.¹⁶¹

His latter suggestion was made with the knowledge that persons who were trained in stomal therapy in Cleveland were not necessarily nurses. However, by the end of the trip Hughes and Kyte were to develop some very firm ideas about who should be allowed to train as a stomal therapist.

The group left Los Angeles and flew to Minneapolis to visit the 3M™ factory. Here they previewed some products under testing; a new visceral steri-drape designed to minimise contamination risks when performing an anastomosis of the bowel, adhesive washers and double-sided foam washers for adhering ostomy appliances to the skin. The next stop on their agenda was the Mayo Clinic in Rochester, which appeared to leave them relatively unimpressed, and then they travelled to New York and Boston.¹⁶²

The prime reason for going to Boston was to attend the American Proctology Meeting, which Hughes in his diary noted as "a mixture of good and bad". With the exception of a few, he found the scientific papers "uninspiring" however, he was once again impressed with the contacts he made from the colostomy and ileostomy associations. This meeting fertilised the ideas planted in Los Angeles concerning the establishment of a stomal therapy department at the Royal Melbourne Hospital, with the added vision that it would be a source for the supply of ostomy equipment.¹⁶³

It was over lunch in Boston with Hughes, Kyte and Debney that Turnbull informed the group of the establishment of the North American Association of Enterostomal

¹⁶¹ *ibid*, p. 11.

¹⁶² *ibid*, pp. 14-15.

¹⁶³ *ibid*,

Therapists and suggested Kyte became a member. Although interested, the group from Melbourne had begun to have reservations about the mixing of lay and professional persons in forming such a group.

And most of the people who belonged to this did have ileostomies which isn't altogether the idea, one really needs to be completely unbiased when it comes to managing stomas.¹⁶⁴

They perceived bias would develop in regard to an ostomate's personal preference and the selling of products. Kyte was of the impression that it was at this point that Hughes believed they could do "something better" in Australia. The 'something better' was to restrict the training of stomal therapists to registered nurses. It was also at this lunch that Kyte first alluded to the Orahesive™ discovery as discussed previously.

On leaving the United States Hughes documented in his diary his summary recommendations for stomal services in Australia. Again there is understanding to be gained in reproducing this summary for the recommendations give further insight into Hughes' vision for nurses in stomal therapy in Australia. This vision was to expand the traditional boundaries of nursing practice significantly. Hughes' recommendations were as follows:

1. That a stomal therapist be recognised as a special rehabilitation officer. The stomal therapist need not have a stoma but is required to possess a special interest in the problems of stomas, and contact with other stomal therapists for exchange of knowledge. Ideally the stomal therapist should be a fully trained nurse.
2. That steps be taken to ensure supplies at low cost and immediate availability. Suppliers should have special interest in and knowledge of stomas. Such individuals would be kept informed by stomal therapists of requirements, trends etc. Stoma people would be advised to secure apparatus from this supplier.
3. Stoma Associations should continue their activities. They would receive regular reports from the stomal therapists and stomal suppliers which could be passed on to members.¹⁶⁵

On leaving the United States the troupe went via Paris to London where they met with Professor Bryan Brooke, Doreen Harris from the Ileostomy Association and medical emissaries from around the world who were there to attend a meeting of the Royal

¹⁶⁴ Ms E. Kyte, interview, 28 February 1994.

Society of Medicine's International Conference on Proctology that was held 23-26 June 1969.

Kyte had received an invitation from the Honorary Secretary of the Section of Proctology, Mr John Griffiths, on 18 March 1969 to attend this meeting and present a paper on stoma management. The paper Kyte presented was titled 'Colostomy Management - Washout or Appliance?' She was the fifth speaker on a panel that was to discuss stoma management. There was an audience of 300 eminent medical persons, but only senior nursing officials were invited. Lesser recognised nurses were only able to listen to the session, from an adjoining hall into which the sessions were broadcasted.. Panel members also included Dr Turnbull and Norma Gill from Cleveland, Sister Barbara Saunders from St Bartholomew's, Sister June Apps from St Mark's Hospital in London and Mr Tom Sturgeon, Chairman of the National Executive Ileostomy Association.

The panel discussion stimulated some interesting debate on the advantages and disadvantages of colostomy irrigation and the wearing of disposable or permanent appliances. Colostomy irrigation attracted the most comment. The practice was the favoured method of managing a colostomy in the United States, but it was only taught to a limited extent in Australia and Britain at that time. Reasons for this latter reluctance ranged from time constraints for teaching, possible patient dexterity or cognitive deficits, fear of perforating the gut, or a lack of private bathroom facilities (which was a particular problem in parts of Britain). Turnbull and Gill on the other hand listed the advantages as the cost savings on equipment and the independence to be gained by regulating stool evacuations.¹⁶⁶

The major significance of this meeting was the opportunity it gave for international and interdisciplinary debate. It was rather extraordinary for nurses and patients at that time to be invited to participate at an international medical meeting. However, whilst the surgeons demonstrated a willingness to foster collaboration, the nurses appeared to distance themselves from the non-nurse stomal therapists. Gill who qualified for the

¹⁶⁵ Hughes, E.S.R. (1969). Diary travel. Unpublished manuscript, p. 46.

¹⁶⁶ Royal Society of Medicine. (1970). Proceedings of the International Conference of Proctology. 63. London: The Royal Society of Medicine.

latter title, recalled being ostracised by the British nurses at that forum when they discovered she was in not in fact a nurse.¹⁶⁷

Establishing a Common Philosophy

On return to Australia, Hughes and Kyte continued to be confronted with problems that hindered the rehabilitation of a person with a stoma. The lack of suitable appliances was a particular hindrance and for the convenience of his patients, Hughes purchased equipment and resold it to patients through his rooms at no added cost. This practice was beneficial to patients and according to Hughes, facilitated research into appliances and pharmaceuticals. It also had its drawbacks and Hughes recalls that he estimated that he had “1 million bags in his rooms at one time and he had little space to move”.¹⁶⁸ Hughes encountered some opposition to this appliance distribution process from Melbourne ostomates who were trading in stoma equipment. They argued that he was taking business away from them.^{169, 170}

Trading in appliances and ostomy pharmaceuticals had become quite common practice amongst enterostomal therapists in the United States. Hughes was firmly of the opinion that a stomal therapist ought not to have any pecuniary interests in equipment.

We have wondered and discussed the advisability or otherwise of a stomal therapist having the job of selling equipment. Personally, I do not think this is a good combination. There well may be a tendency to advise patients according to stocks on hand and this impedes progress...it is certainly recognised in the medical profession here and is unethical.¹⁷¹

This was a cause of conflict between Hughes and Mabel Cook. Although she was better prepared than most to give advice because of the training she had received in Cleveland. Hughes felt very strongly that individuals or associations with a vested interest in profit would have a conflict of interest and should not be advising patients on equipment or stoma care.^{172, 173} He also saw this as detrimental to research in ostomy care and equipment, for he felt that new products would not be recommended or trialled if one

¹⁶⁷ Ms N. Gill-Thompson, interview, 29 June 1995.

¹⁶⁸ Sir E. Hughes, interview, 1 March 1994.

¹⁶⁹ Letter from ESR Hughes to Mrs E. Lenneberg, Boston, dated 29 January 1970.

¹⁷⁰ Letter from ESR Hughes to Mrs E. Lenneberg, Boston, dated 17 March 1970.

¹⁷¹ Letter from E.S.R. Hughes to Edith Lenneberg, Boston, dated 29 January 1970.

¹⁷² *ibid.*

had a stock of 'old' appliances or a vested interest in specific brands. This viewpoint was a major stimulus in the development of a Code of Ethics at the formation of the Australian Association of Stomal Therapists and it led to further conflict situations between nurse and non-nurse stomal therapists.

When Kyte applied to join the North American Association of Enterostomal Therapy (NAAET) in 1969-71 she found her nomination blocked. Correspondence between Hughes, Turnbull, Lenneberg (President NAAET) and Okun (Membership Chairman NAAET) over a period of time from 1 August 1969 to 12 March 1971 indicated there had been opposition to Kyte's application on the grounds of a perceived lack of training in stoma care and that it would interfere with Mrs Cook's livelihood.^{174, 175, 176, 177, 178} Neither Okun nor Lenneberg were registered nurses, but ostomates, who had both been 'grandmothered' into the NAAET on its inauguration, as had most of the pioneer enterostomal therapists in the United States.¹⁷⁹

It took some forceful correspondence from Hughes to the NAAET committee members in order to vouch for Kyte's work and professional experience and to ascertain that there would be no competition between the services offered by Cook and Kyte. Needless to say, this exercise strengthened Hughes' belief that stomal therapy should be practiced by registered nurses not lay people, and particularly not lay people with stomas. Although he acknowledged the contribution of lay people in "filling a gap, pending professional nurses becoming interested"¹⁸⁰ he believed it was time lay bodies withdrew from a care advisory role.

Hughes found allies in two North American medical colleagues, Ferguson and Muldoon, from Grand Rapids. This was a site of the second enterostomal training programme in the United States. Ferguson replied to a letter from Hughes stating that they believed stomal therapists should be highly qualified, fully trained, professional

¹⁷³ Letter from E.S.R. Hughes to E. Lenneberg, Boston, dated 17 March 1971.

¹⁷⁴ Letter from R. Turnbull to E.S.R. Hughes, dated 1 August 1969.

¹⁷⁵ Letter from R. Turnbull to E.S.R. Hughes, dated 7 August 1969.

¹⁷⁶ Letter from B. Okun, Montreal, to E.S.R. Hughes, dated 26 October 1970.

¹⁷⁷ Letter from E.S.R. Hughes to B. Okun, Montreal, dated 14 December 1970.

¹⁷⁸ Letter from E. Lenneberg, Boston, to E.S.R. Hughes, dated 30 March 1970.

¹⁷⁹ Jeter, K. (1996). In P. Erwin-Toth & D. Krasner Enterostomal therapy nursing growth & evolution of a nursing specialty worldwide: A festschrift for Norma N. Gill-Thompson, ET. Baltimore: Halgo, Inc.

¹⁸⁰ Letter from E.S.R. Hughes to J. Ferguson, Grand Rapids, dated 21 June 1971.

nurses.¹⁸¹ However, it was not until 1976 that a licence to practice nursing was a prerequisite for enrolment in all enterostomal therapy programmes in the United States.¹⁸²

A Formal Beginning

During the late 1960s some surgeons across the country became aware of the work Hughes and Kyte were doing with ostomy patients in Melbourne and they negotiated with Hughes to send nurses to work with Kyte to learn about the care of ostomy patients. One such surgeon was George Bedbrook, from Royal Perth Rehabilitation Hospital in Perth, who arranged for his Charge Sister, Lynette Cox, to visit Melbourne in 1966.¹⁸³ Edward Wilson from Sydney Hospital arranged for Bunty Oldmeadow from the Sydney Home Nursing Service to visit in 1969.¹⁸⁴ Both of these nurses were to become founding members of the Australian Association of Stomal Therapists (AAST) in 1971.

Early in 1970 Kyte travelled to Sydney and met with nurses Bunty Oldmeadow and Betty Hughes. They discussed the possibility of forming a nurses special interest group similar to the NAAET. The idea appealed and as a result of those discussions Kyte, Oldmeadow and Betty Hughes drew up the first draft of a proposed Constitution. On return to Melbourne discussions were had with other interested nurses and further consultation held on the proposed constitution. It was determined that a Code of Ethics would be necessary as well and this they modelled on the Code of Ethics of Physiotherapists.¹⁸⁵

Kyte then travelled to Perth to discuss the proposed venture with Lynette Cox and two other recruits she had recommended. They were Mary Josephine Kroeber from Princess Margaret Hospital for Children and Dorothy Murphy from Sir Charles Gairdner Hospital. In 1969, Cox and Kroeber had been involved in the founding of the Western Australian Ostomy Association.¹⁸⁶ Murphy, who was known as 'Murph' to her friends

¹⁸¹ Letter from J. Ferguson, to E.S.R. Hughes, dated 25 June 1971.

¹⁸² Alterescu, V. (1991). Reflections upon the history and future of the IAET. Journal of Enterostomal Therapy, 18(4), 126-131.

¹⁸³ Letter from G. Bedbrook, Shenton Park, Western Australia, to ESR Hughes, dated 19 June 1967.

¹⁸⁴ Ms E. Kyte, interview, 28 February 1994.

¹⁸⁵ *ibid.*

¹⁸⁶ Mr P. McDonnell, interview, 24 November 1998.

and colleagues had been sent to the Cleveland Clinic in 1968 by the hospital and in response to the urging of the Western Australian surgeon, Mr Solomon Levitt, to undertake the enterostomal therapy programme that had been established in 1963.¹⁸⁷ This made Murphy the first 'formally' trained stomal therapist in Australia and in a paper she presented at the first scientific meeting in Melbourne in 1972 she discussed this experience.¹⁸⁸ Murphy established the first stomal therapy education programme in Western Australia in 1974.

On Kyte's return to Melbourne, arrangements were made for a meeting to be held in Sydney with the purpose of establishing an association for nurses interested in the care of people with stomas. The Inaugural Meeting of what was known as the Australian Association of Stomal Therapists (AAST) took place on 27 March 1971 at the Maitland Lecture Theatre in Sydney Hospital. Sydney was chosen for the venue in order to encourage participation from other States not only Victoria.¹⁸⁹ It was also the date and venue for the second Annual General Meeting of the Australian and New Zealand Council of Stoma Associations and some doctors and nurses were expected to attend both meetings.¹⁹⁰

The meeting was initially chaired by E.S.R. Hughes until a committee was elected. The nurses present were: Joy Considine (Sydney Home Nursing Service), Betty Hughes (Balmain and District Hospital and Honorary Secretary NSW Ileostomy Association), Elinor Kyte (Mr Hughes and Mr Cuthbertsons's Private Clinic Melbourne), Helen Tucker (Appliance Sister from Royal Children's Hospital Melbourne), Elizabeth Arnold (Charge Sister from Royal Melbourne Hospital) and Meryl Barrett (Charge Sister from Royal Melbourne Hospital).¹⁹¹

The concept of such a group was largely encouraged by E.S.R. Hughes and his surgical colleagues who attended the meeting.^{192, 193, 194} The other surgeons present included:

¹⁸⁷ Gill-Thompson, N. (1986). The badge becomes of age. Unpublished manuscript.

¹⁸⁸ Murphy, D. (1972). My training as an enterostomal therapist. The Medical Journal of Australia, 2, 221.

¹⁸⁹ *ibid.*

¹⁹⁰ Australian and New Zealand Council of Stoma Associations. (1971). Minutes of Annual General Meeting, 27 March, Sydney Hospital.

¹⁹¹ Australian Association of Stomal Therapists. (1971). Minutes of Annual General Meeting, 27 March, Maitland Lecture Theatre, Sydney Hospital.

¹⁹² Ms M. Barrett, interview, 1 March 1994.

¹⁹³ Mr D. Failes, interview, 7 April 1997.

Edward Wilson (Chief Colo-rectal surgeon, from Sydney Hospital), Mark Killingbach (Honorary Surgeon, Sydney Hospital), David Failes (Honorary Surgeon from Sydney Hospital) and Graham Groves FRACS. Apologies for the meeting were received from the three Western Australian nurses: Lynette Cox, Mary Josephine Kroeber and Dorothy Murphy.¹⁹⁵

The meeting resulted in an unanimous decision to formalise the Australian Association of Stomal Therapists. 'Stomal therapist' was chosen as a title because according to Kyte the name was a "little different from the name adopted in the States and less of a mouthful".¹⁹⁶ Though in reality the name had been comfortably used by Hughes and Kyte for at least 2 years.¹⁹⁷

Those present at the Inaugural Meeting voted that membership would be limited to registered nurses with a "special interest in stomas and their management".¹⁹⁸ The choice of title was to emphasise the fact that this was to be a professional group and not open to lay people. The decision to limit membership to registered nurses was heavily influenced by the experiences of Hughes and Kyte and their exposure to the lay memberships of similar bodies that existed in the United States and Britain. Such arrangements they perceived would hinder their progress. However, the nurses in the group also perceived some limitations as nurses.

There was much discussion as to what we could call ourselves. And unfortunately, well at that stage if we'd just called ourselves nurses probably we wouldn't have had any clout at all. So seeing that occupational therapists and speech therapists et cetera used the word therapists, and in America they used the word therapists. We decided it should be stomal therapists.¹⁹⁹

This trade off in settling for a non-nursing title reflected the disempowerment that nurses generally felt in the early 1970s. It was a time when nursing, predominately a female occupation, genuflected to the priesthood of medicine, which was predominately

¹⁹⁴ Mr M. Killingbach, interview, 20 February 1996.

¹⁹⁵ Australian Association of Stomal Therapists. (1971). Minutes of Annual General Meeting, 27 March, Maitland Lecture Theatre, Sydney Hospital.

¹⁹⁶ Ms E. Kyte, interview, 28 February 1994.

¹⁹⁷ Hughes, E.S.R. (1969). Diary travel, Unpublished manuscript.

¹⁹⁸ Australian Association of Stomal Therapists. (1971). Minutes of Annual General Meeting, 27 March, Maitland Lecture Theatre, Sydney Hospital.

¹⁹⁹ Ms E. Kyte, interview, 28 February 1994.

male. The traditions practiced by nurses within their own pecking order, also reinforced this sense of inferiority. Although the rising feminist movement of the 1960s pushed for improvements in the status of women across society it made little impact in the ghettoised female nursing world.²⁰⁰ So it is easily understood why the founding nurses adopted the title therapists in their search for a title that would afford them power and prestige. It was not until 1984 that they changed their name to the Australian Association of Stomal Therapy Nurses and reclaimed their birthright.

The title 'stomal therapist' was not universally liked amongst the nursing hierarchy of the day. When the surgeons at Royal Melbourne Hospital, as a result of urging from Hughes²⁰¹, lobbied the hospital to appoint a full-time stomal therapist, they met with resistance from nurses in regard to the name, rather than the concept. The Lady Superintendent of Nursing, Miss L. Aitken, found the term 'stomal therapist' decidedly unsuitable²⁰² but documentary evidence suggests that no one amongst the Royal Melbourne Hospital hierarchy could come up with a more appropriate title.^{203, 204} Negotiations took place over several months before the title was finally deemed acceptable and the first full-time stomal therapist was appointed. The appointee to the first full-time stomal therapist position in an Australian hospital was Elizabeth Arnold, one of the founding members, who was also later to be the first stomal therapist appointed in South Australia at the Royal Adelaide Hospital.

The discontent expressed over the title 'stomal therapist' and later 'stomal therapy nurse', was found to be reflected in the comments of many nurses who were interviewed for this study some 20 to 30 years later. Their concerns at the time of interview were generally related to the perceived limitations of such a title when compared to the diversity of the role (their experiences are discussed in chapter 7).

At the Inaugural Meeting a previously circulated Constitution and Code of Ethics was accepted and a design for an emblem and badge was to be organised. An Executive Committee was elected and members were: Elinor Kyte (President), Meryl Barrett

²⁰⁰ Bullough, V., & Bullough, B. (1984). History, trends and politics of nursing, London: Prentice-Hall International, Inc.

²⁰¹ Letter from E.S.R. Hughes to D. Leslie, Royal Melbourne Hospital, dated 31 May 1971.

²⁰² Letter from R. Lewis, Royal Melbourne Hospital, to E.S.R. Hughes, dated 2 August 1971.

²⁰³ Letter from E.S.R. Hughes to L. Aitken, Royal Melbourne Hospital, dated 9 August 1971.

(Vice-President) and Elizabeth Arnold (Secretary and Treasurer). It was thought that it would facilitate business and communication if the committee members resided in the same state.²⁰⁵ In 2002, this was still the situation, even though modern communication technology would have largely eliminated long-distance communication problems.

A proposed list of the Founder Members was drawn up and the decision was finalised at the first Executive Meeting. There were 11 Founder Members, coincidentally the same number as the NAAET and they were: Elinor Kyte, Elizabeth Arnold, Meryl Barrett, Helen Tucker and Jill Jardine from Victoria. Betty Hughes, Buntly Oldmeadow and Joy Considine from Sydney, Lynette Cox, Mary Josephine Kroeber and Dorothy Murphy from Western Australia.²⁰⁶

Stomal Therapy Nursing 1971 to 1980

Following the establishment of the AAST there began an intensive campaign to inform the Health Departments and the various nursing, medical and ostomy organisations of the new association and their objectives.^{207, 208, 209} Their overall aim was to increase nursing knowledge and understanding of the physical, psychological and rehabilitative needs of the person with a stoma and to develop the role of stomal therapists (as they were then called).²¹⁰ In order to achieve this aim it was necessary to establish a formal foundation for the building of a body of specialised nursing knowledge and skill.

The first committee made education a priority and they coordinated a training programme and seconded the assistance of Melbourne surgeons and nurses who were experienced in ostomy care. The first interim training programme was held in at Royal Melbourne Hospital on 18 October 1971 with one full-time and three part-time students. The second programme was held in May 1972 and seven students participated. Between 1973 and 1975 they ran three programmes a year, each of 3 weeks duration but these

²⁰⁴ Letter from E.S.R. Hughes to T. Jamieson, Royal Melbourne Hospital, dated 9 August 1971.

²⁰⁵ Ms M. Barrett, interview, 1 March 1994.

²⁰⁶ Australian Association of Stomal Therapists. (1971). Minutes of First Executive Committee Meeting, 29 April, Melbourne.

²⁰⁷ Ms M. Barrett, interview, 1 March 1994.

²⁰⁸ Letter from Australian Association of Stomal Therapists to Professor Bryan Brooke, Chairman Ileostomy Association of Great Britain and Ireland, dated 23rd March 1972.

²⁰⁹ Australian Association of Stomal Therapists (1975). Minutes of Executive Committee Meeting, 11 February, Royal Melbourne Hospital.

were soon expanded to 4 weeks duration.²¹¹ In addition to formalised lectures, the students accompanied experienced stomal therapists and surgeons on their rounds and attended their clinic sessions. Learning was very focused on care of the skin, selection and practical application of appliances and tips that would assist with rehabilitation of the ostomate.

The gender of the nurses who undertook the early stomal therapy programmes held between 1971 and 1975 was almost exclusively female. As alluded to previously, nursing in general was predominately a female occupation during that era. The first male stomal therapy nurse was Antony Hutapa from the Sydney Adventist Hospital, who completed a programme in November 1973.²¹² Since then only a relatively small number of male nurses have enrolled in stomal therapy nursing programmes and in 2000 there were no male stomal therapy nurses employed in full-time stomal therapy positions.

The AAST held their first annual Scientific Meeting which corresponded with the second Annual General Meeting (the Inaugural Meeting was declared the first AGM) at the Royal Children's Hospital in Melbourne on 25 March 1972. The Opening Address was delivered by E.S.R. Hughes and there were 80 nurses in attendance. Barrett, Kyte, Martin, Kroeber, Jardine, Arnold and Murphy presented papers and a summary of each paper was actually published in the *Medical Journal of Australia* in July that year.²¹³ This prestige encouraged the fledgling group of nurses, albeit nurses known as 'therapists'.

In 1972 the Executive of the AAST met with representatives of the Royal Victorian College of Nursing (RVCN) in an endeavour to obtain professional recognition of stomal therapy courses. However, the College "believed it undesirable to establish such courses beyond the level of in-service courses because of the risk of isolating this type

²¹⁰ Australian Association of Stomal Therapists. (1971). Report to Australian Council of Stoma Associations, March.

²¹¹ Notes on the first stomal therapy training courses held at the Royal Melbourne Hospital, between October 1971 and November 1975. Obtained from the records of the Australian Association of Stomal Therapy Nurses.

²¹² Mr A. Hutapa, interview, 8 April 1997.

²¹³ Australian Association of Stomal Therapists. (1972). Second annual meeting. Medical Journal of Australia, 2(4), 220-222.

of nursing care from the basic general nursing in all aspects of which the general nurse should be proficient".²¹⁴ The AAST committee argued strongly that stomal therapy courses were not intended to fragment generalist nursing care but rather to ensure more skilled nurse involvement in the care of these particular patients. They reminded the College that prior to the establishment of the AAST, lay persons had been educating nurses within this field and that nurses in general had abrogated their responsibility. Furthermore, they argued this demonstrated that generalist nurse educators did not have the necessary clinical expertise to be teaching stomal therapy to nurses. It was of interest to note that 25 years after this event, stomal therapy nurses in this study continued to voice similar concerns even though by that time nurses in the tertiary setting were taught the fundamentals of stomal therapy (these concerns will be discussed in chapter 7).

The early courses did not receive the official blessing of the RVCN, but they continued to be held at the Royal Melbourne Hospital biannually. Demand for training far-outweighed the offered places in the Royal Melbourne Hospital programme. In August 1973, there was a waiting list of hopeful nurse applicants from 30 hospitals and 18 of these requests were from interstate.²¹⁵ It is interesting to note that with such a high demand for places in these early programmes, that three of the students enrolled in the first seven courses were nurses in the employ of appliance manufacturers.²¹⁶ It appears that the organisers of the early programmes perceived that these representatives would infiltrate hospitals, which did not have a stomal therapy nurse on staff.²¹⁷ Regardless, their enrolment appears to be a contradiction to the Code of Ethics drawn up by the founding members and which included in its charter the following statement.

No member shall be employed or self-employed for financial gain in the manufacture or sale of appliances or drugs used in connection with prosthetic appliances for the care of a stoma.²¹⁸

²¹⁴ Australian Association of Stomal Therapists. (1972). Minutes of Meeting held with the Royal Victorian College of Nursing, 23rd October, Melbourne.

²¹⁵ Working Party on Medical and Surgical Aids and Appliances. (1974). Obtained from the Commonwealth Department of Health and Aged Care, Canberra.

²¹⁶ Notes on the first stomal therapy training courses held at the Royal Melbourne Hospital, between October 1971 and November 1975. Obtained from the records of the Australian Association of Stomal Therapy Nurses.

²¹⁷ Ms M. McKenzie, personal communication, 3 July 2001.

²¹⁸ Australian Association of Stomal Therapists. (1971). Code of ethics.

The high demand for stomal therapy training placed a considerable burden on the AAST and the Royal Melbourne Hospital and in 1976 the course was transferred to Mayfield Education Centre, which was the training centre for the Victorian Health Commission²¹⁹. By 1978 all the states except Tasmania and the Territories had established Stomal Therapy Education Programmes. The numbers of Australian stomal therapists in acute or community facilities grew steadily and as 1 April 1974 there were 52 nurses who had undertaken a course in stomal therapy.²²⁰ How this equated to the number of ostomates in Australia at that time is unknown, for even in the year 2001 there was not a comprehensive national register of persons with a stoma. However, according to information stated to have been available to the Commonwealth Department of Health in 1974 it was estimated that there were 8,500 ostomates in the country.²²¹ If these figures are accurate, that would equate to approximately 164 ostomates to each stomal therapist. The accuracy of this ratio however, is likely to be suspect considering the lack of a national register. It was also known that not all ostomates belonged to the fledgling associations, and not all the associations belonged to the Australian and New Zealand Council of Stoma Associations.²²²

The significance of these figures however, lies in the fact that they were used by the National Working Party on Medical and Surgical Aids and Appliances. This working party had been set up in 1973 at the recommendation of Hughes²²³ and it was sanctioned by the Federal Minister of Health. It was this working party that recommended that “the Australian Government provide stoma appliances to all who need them and assistance in the provision of counselling, and facilities for the distribution of appliances”.²²⁴ They also made recommendations that “financial assistance be given for the provision of, and attendance at, training courses in stomal management and care”.²²⁵ The first recommendation was adopted by the Treasurer, but the second recommendation was

²¹⁹ Ms R. Bourke, interview, 3 March 1994.

²²⁰ Working Party on Medical and Surgical Aids and Appliances. (1974). Obtained from the Commonwealth Department of Health and Aged Care, Canberra.

²²¹ *ibid.*

²²² Australian and New Zealand Council of Stoma Associations. (1974). Minutes Annual General Meeting, 30 March, Canberra.

²²³ Letter from E.S.R. Hughes to Sir W. Refshauge, Commonwealth Director General of Health, Canberra, dated 13 December 1972.

²²⁴ Working Party on Medical and Surgical Aids and Appliances. (1974). Obtained from the Commonwealth Department of Health and Aged Care, Canberra, p. 6.

²²⁵ *ibid*, p. 11.

disregarded. It remained the responsibility of stomal therapy nurses to agitate for opportunities to promote stomal therapy nursing.

In July 1975, the National Health Act (1953) was amended and this allowed the government of the day to establish the Stoma Appliance Scheme, which was activated on 1 October 1975. The Scheme, which was to provide all ostomates with free ostomy appliances and associated pharmaceuticals, was to be administered by the Department of Health, Housing and Community Services. This department has changed its name five or six times over the intervening years and in 2002 was known as the Department for Health and Aged Care. The ostomy associations agreed to distribute the products on a volunteer basis and for this service they would receive a 2.5% handling fee. Such a venture demanded a certain level of business acumen and a great deal of product knowledge from the lay groups.

Many of the associations had to arrange for larger premises in order to store anticipated supplies and distribution processes had to be established quickly. Although the working party had estimated that the Scheme would cost the Australian taxpayer \$450,000 per annum,²²⁶ only \$56,309 worth of appliances were distributed through the ostomy associations during that first year of operation (1974 to 1975).²²⁷ However, this sum quickly exceeded the budget during the following year when \$687,010 was spent and regular cost increases have been accrued annually since.²²⁸ Increased expenditure on stoma appliances and pharmaceuticals reflects both increased numbers of ostomates and advances in technology.

Following the introduction of the Scheme, a greater variety of appliances and accessories soon became available as enterprising ostomates sourced new and improved devices. The first appliances that were listed were the rubber bags, flanges, adhesive discs, simple plastic bags and belts. These were supplemented with the first one-piece adhesive disposable appliances. Manufacturers of ostomy appliances were able, and continue to, submit a request for listing of products to the government biannually. List

²²⁶ *ibid*, p. 18.

²²⁷ Mr M. Holgate, Department of Health and Aged Care, personal correspondence with author, 20 June 2001

²²⁸ *ibid*.

prices were negotiated and submissions for listing, or support statements for submissions, were also sought from members of ACSA and the ASST.²²⁹

Not only did this scheme impact positively on the care and rehabilitation of Australian ostomates, but it also impacted on the clinical and professional development of the stomal therapists. The nurses had a wider choice of products from which to choose as new products were frequently added to the scheme. This demanded a greater product knowledge and the ability to discern the advantages and disadvantages of products in the clinical setting. The stomal therapy nurses were expected to be financially astute and accountable not only to their employers, but to taxpayers as a whole. They were aware that their submissions, or support of submissions, could influence the listing of products on the Scheme.²³⁰ Personal preferences could also influence patient preference and this afforded the stomal therapists a position of economic control not usually afforded clinical practitioners. This was readily appreciated by the commercial sector, if not initially appreciated by the stomal therapists.

In the year 1979-80 the Scheme had cost \$1,772,385²³¹ and there were 400 trained stomal therapists amongst a population of 14 million, which equated to one stomal therapist to every 35,000 people.²³² However, not all of the trained stomal therapists were employed within the specialty. Identification of the exact number of ostomates remained exceedingly unreliable and estimates made in the early 1980s suggest a diverse range of figures. The Commonwealth Health Department estimated 9,000, but Hughes and his colleagues calculated a total of 20,000²³³. Averaging the cost of the Scheme for 1979-80 for both given estimates, equates to an annual amount spent per ostomate of somewhere between \$89.00 and \$197 respectively.

²²⁹ Ms T. Woods, interview, 18 May 1994.

²³⁰ Ms T. Woods, interview, 18 May 1994.

²³¹ Mr M. Holgate, Department of Health and Aged Care, personal correspondence with author, 20 June 2001.

²³² Collins, N. (1980). Australian report to the World Council of Enterostomal Therapists. Cleveland Congress Proceedings, 11-14 August, Abbott International Ltd.

²³³ Hughes, E., McDermott, F., & Jackson, J. (1982). Stomonics. Association of Stomal Therapists Conference Proceedings, held 25-27 March, Sydney, p.21.

The advantages of the Scheme were appreciated by the ostomy associations²³⁴ and the stomal therapists²³⁵ and both groups frequently reminded their members of the need for conservative use of products. On one hand, they were mindful that any abuse of the Scheme could jeopardise its viability. On the other hand, they were anxious to ensure their patients had access to the latest technology. Appliance manufacturers adopted competitive behaviours and courted the stomal therapists with samples, education literature and teaching resources. They readily sponsored education opportunities for ostomates and nurses. In comparison to other medical manufacturers, the ostomy companies employed a relatively high number of representatives to service a relatively low number of stomal therapists in full-time employment. The 'Reps' as they soon became known, were taken into the fold and whilst the stomal therapists were supporting the ostomates, the 'Reps' were seen to be supporting the stomal therapists. These enabling relationships continued throughout the intervening decades and the degree to which the nurses valued them will become evident in chapter 7.

Throughout the 1970s and in fact, until his retirement in 1990, Hughes continued to champion the cause of the AAST. In 1971 he encouraged the fledgling group of stomal therapists to apply to the Australian Medical Association (AMA) for recognition as either an Affiliated or Associated Member.²³⁶ This they did, to find that the ASST did not meet the criteria for either membership. However, they were awarded Ancillary Membership in August 1971²³⁷ and this affiliation was formally announced in the *Medical Journal of Australia* on 22 July 1972.²³⁸ Although nursing services generally were acknowledged by the AMA as an Ancillary Medical Service, no other nursing group had been awarded individual recognition and in their view, it set them apart from their nursing peers. This affiliation with the AMA was seen as a source of professional advantage over the next 15 years.

²³⁴ Australian Council of Stoma Associations. (1979). Minutes Annual General Meeting, 7 April, Adelaide.

²³⁵ Letter from M. McKenzie, Secretary AAST, to Mr Scanlon, Minister of Health, Melbourne, dated 24 October 1975.

²³⁶ Letter from E.S.R. Hughes to E. Arnold, Secretary AAST, dated 4 June 1971.

²³⁷ Letter from D. Spark, Secretary General AMA, to E. Arnold Secretary AAST, dated 4 November 1971.

²³⁸ Stomal therapy. (1972). Medical Journal of Australia, 2(4), p. 174.

It was a cause of great disappointment therefore, when in 1985 the Association notified the AMA of their name change, and they were informed that the formal concept of Ancillary Medical Services was no longer applicable²³⁹. A policy change by the AMA in 1978 rescinded the previous arrangement and substituted three resolutions that gave blanket coverage to the contribution of all health professionals. Hughes again lobbied the AMA suggesting to them “that it would be a fine gesture if the AMA continued with the ancillary named groups”.²⁴⁰ But even Hughes was not able to bring this to pass and the Australian Association of Stomal Therapy Nurses, as it was then known, had to be content with the same recognition awarded all health professionals, including nurses generally.²⁴¹ However, the commitment and support of Hughes for stomal therapists and the development of stomal therapy care was truly appreciated and was the reason in 1977 that the AAST awarded him the first Honorary Membership of the Association.

Stomal Therapy Nursing 1981 to 1990

The 1980s was a period of professional consolidation for the stomal therapists and their Association. This was in keeping with the change in attitudes and behaviours of nurses in general. The women’s movement which was so active during the 1970s had radically introduced the concept that women should be considered equals in all aspects of society. Although the movement initially denigrated female dominated occupations such as nursing, it “gave permission to women to challenge some of the age-long discrimination”.²⁴² It encouraged nurses to challenge the discrimination in salaries and education that existed between their apprentice system of training and the tertiary education received by other health professionals. During this decade tertiary education for nurses gradually became an expectation rather than an exception. It also became the key to equalising the status amongst nurses and their allied health colleagues who tended to bare the title ‘therapist’.

Nurses began to overhaul their professional image and it was a decade for marketing that professional image. Amongst the members of the AAST the title ‘therapist’ became obsolete. It had outworn its usefulness. Stomal therapists, like other nurses, began to

²³⁹ Letter from Dr G. Repin, Secretary General AMA, to E. Lewis, Secretary AASTN, dated 22 August 1985.

²⁴⁰ Letter from Sir E. Hughes to Dr G. Repin, Secretary General AMA, dated 29 May 1986.

²⁴¹ Letter from Dr G. Repin, Secretary General AMA, to Sir E. Hughes, dated 15 May 1986.

freely use words such as autonomy, accountability, competence and professionalism. Nurses generally began to exert their own control over nursing²⁴³ and nurses in stomal therapy desired to do the same. Therefore, at the Annual General Meeting in Launceston in 1984 members voted to change the name of the Association to the Australian Association of Stomal Therapy Nurses.

That same year they also decided to acknowledge the contributions of nurses within the organisation and awarded Elinor Kyte, their first President, and Meryl Barrett, their second President, Life Memberships.²⁴⁴ The nurses sought ways to advance themselves and the Association professionally. The Newsletter that was begun in 1973 was converted to a journal format²⁴⁵ and they formed an Education Sub-committee in 1985²⁴⁶. The charter of this committee was to review stomal therapy education and to determine whether a national programme could be developed and aligned with other postgraduate nursing programmes.

Negotiations with recognised centres of postgraduate education took place. Initially the College of Nursing was approached to develop a distance education programme with the intent that it could be accessed by would-be stomal therapy nurses from across the country. However, after 18 months of negotiations the Association was disappointed to find the College was only prepared to offer a certificated programme instead of a graduate diploma. Renewed discussions took place between the Association and the New England University in New South Wales. After a rocky start the group were once again disappointed to find that the programme would only be offered at a certificated level and agreed to this, presuming that it would be a beginning step. The programme did not commence until 1994 and was abolished in 1997, because it failed to attract the number of students necessary to maintain the programme's viability.²⁴⁷ Once again the Association was confronted with a philosophical divide that separated academic and

²⁴² Bullough, V., & Bullough, B. (1984). History, trends, and politics, Norwalk, Connecticut: Appleton-Century-Crofts.

²⁴³ Jenkins, E. (1989). In Gray, G., & Pratt, R. (Eds.). Issues in Australian Nursing 2, Melbourne: Churchill Livingstone.

²⁴⁴ Ms M. Barrett, interview, 1 March 1994.

²⁴⁵ Australian Association of Stomal Therapy Nurses. (1985). The Journal of Stomal Therapy Australia, 7(3).

²⁴⁶ Australian Association of Stomal Therapy Nurses. (1985). Minutes Annual General Meeting, held Adelaide, 18 April.

²⁴⁷ Ms J. Thompson, interview, 28 March 1994.

clinical endeavour. As a group they had lost faith in academic institutions for they sensed the institutions failed to appreciate the need to have academics with stomal therapy clinical experience coordinate the programmes.²⁴⁸

Other avenues for advancing stomal therapy practice were explored and embraced. During the 1980s the annual conferences were expanded to 2 or 3 day events. Papers presented at these meetings reflected significant changes in the stomal therapy nurse's role. By then the role had evolved to accommodate the surgical and technological advances of the era. Stomal therapy practice was seen to include the care of increasing numbers of *other* types of stomas such as gastrostomies, tracheostomies, nephrostomies and continent urinary reservoirs.

Amongst the stomal therapy nurses there was also a greater awareness that their practice had expanded generally into other clinical domains such as: wound management, continence promotion and in some hospitals in Victoria, breast care.^{249, 250, 251} Professionally, they were recognised to be clinical nurse specialists or consultants and their duties incorporated aspects of specialised practice, management, education, counselling, mentorship and networking with other professionals or agencies.^{252, 253}

The standard of their conferences held them in good stead and in 1986 they hosted the Congress of the World Council of Enterostomal Therapists (WCET) in Perth. The Congress attracted over 400 delegates from 24 countries.²⁵⁴ Although some Australian stomal therapy nurses had demonstrated a strong commitment to the WCET since its inception in 1980,^{255 256} this congress on home soil broadened the international network significantly. The professional culmination of this world meeting for Australian nurses however, was the announcement of a registered National Stomal Therapy Week by the

²⁴⁸ *ibid.*

²⁴⁹ Ms R. Bourke, interview, 3 March 1994.

²⁵⁰ Sr F. McMeniman, interview, 24 March 1999.

²⁵¹ Ms R. Walsh, interview, 24 March 1994.

²⁵² Ms R. Bourke, interview, 3 March 1994.

²⁵³ Bull, D. (1987). What does the stomal therapy nurse do? *Journal of Stomal Therapy Australia*, 7(4), p. 6.

²⁵⁴ Truscott, J. (1987). Report on Sixth Biennial Congress of the World Council of Enterostomal Therapists – April 1986 – Perth Australia. *Australian Association of Stoma Therapy Nurses Newsletter*, Autumn.

²⁵⁵ Ms R. Bourke, interview, 3 March 1994.

²⁵⁶ Ms H. Simcock, interview, 17 January 1996.

Minister of Health, Neal Blewett.²⁵⁷ This week continues to be celebrated as an annual event in June and stomal therapy nurses use the opportunity to promote the services they offer.

It has been previously stated that advances in surgery and technology had impacted significantly on the tasks performed by stomal therapy nurses during the 1980s. Some of these technological advances such as the stapling gun, were also expected to reduce the number of permanent stomas and inversely the need for stomal therapy nurses.²⁵⁸ Because of the lack of a reputable national record, it has proved impossible to determine the exact number of ostomates at that time, let alone the number of permanent or temporary ostomates. Figures obtained from ACSA during the late 1990s and which are considered generally reliable, will be used later in this chapter, to show an overall increase in number of Australian ostomates rather than a declining trend.

There were several surgical and technological advances of this era that were perceived to have influenced the numbers and types of ostomates. Amongst these developments was the availability in 1978 of the surgical stapling device that facilitated the creation of an ultra-low rectal anastomosis. Although this procedure often eliminates the need for a permanent stoma, it frequently requires a temporary stoma to protect the anastomosis during healing.²⁵⁹ This is also the situation with the surgical procedure referred to as a restorative proctocolectomy and ileoanal reservoir. This procedure was performed in increasing numbers during this decade.^{260, 261} Advances in diagnostic technology facilitated the identification of bowel and bladder problems at an earlier stage and earlier diagnosis also tended to reduce the potential need for a permanent stoma. However, advances in adjuvant therapies such as chemotherapy and radiotherapy had the potential to prolong the life of ostomates and thus, statistics stabilised.

²⁵⁷ Letter from Mr N. Blewett, Federal Minister of Health, published in the World Council of Enterostomal Therapists Congress Programme, 11-18 April, 1986, p. 2.

²⁵⁸ Bell, A. (1993, April). Advances in colo-rectal surgery. Paper presented at the Annual General Meeting Australian Council of Stoma Association, Gold Coast, Queensland.

²⁵⁹ Lavery, I. (1979). Low rectal anastomosis. Proceedings of World Council of Enterostomal Therapists Conference, held Dusseldorf, 13-16 August.

²⁶⁰ Todd, D., & Dozois, R. (1993). Ileoanal reservoirs: Construction and management. Journal of Enterostomal Therapy, 20(1), pp. 26-35.

²⁶¹ Mr M. Killingbach, interview, 20 February 1996.

The 1980s also saw a plethora of new ostomy appliances and care accessories (skin barriers and protective pastes and skin films) launched onto the Australian market. During the 1970s the one-piece appliance was heralded as the panacea for simplifying stoma care. However, during the following decade there was a return to the concept of two-piece appliances in the belief that they reduced the need for frequent removal of adhesive agents from the skin. Two-piece appliances were also promoted as being more cost-effective and this was in keeping with the perceived need to curtail spending on the Stoma Appliance Scheme. The first of these appliances was the ConvaTec Sur-Fit Flexible System™ which resembled a Philp's polythene flange, attached to a Stomahesive™ skin barrier. A closed or drainable bag was clipped onto the flange and the bag could be changed independently of the flange (see Appendix I: Figure 14). Each of the major ostomy manufacturing companies produced a two-piece system and competition ensured a variety of special features such as a 'floating', 'accordion' or 'low-profile' flange.²⁶² Paediatric sized appliances were also added to a stomal therapy nurse's box of tricks.

Manufacturers became more ingenious as they sought to eradicate the need for wearing appliances. In 1990 Coloplast A/S from Denmark launched a device called the Conseal Plug™, which was an expandable tampon that when inserted into the stoma expanded to control passage of stool and was removed for defaecation purposes (see Appendix I: Figure 15). Devices such as this, not only demanded a greater degree of product knowledge but more time was required for patient education. With each new device however, there were concerns raised by ostomates²⁶³ and by stomal therapy nurses²⁶⁴ many of which were related to the need for responsible product use. The cost of the Stoma Appliance Scheme for the year 1990-1991 was \$12,630,581 which exceeded the projected budget by \$1,230,581.

Stomal Therapy Nursing 1991 to 2000

The advances in surgical skill and technology of the later part of the twentieth century led to an increase number of ostomates, although many of the stomas created were

²⁶² Davidson, W., & Fischer, J. (1996). In Erwin-Toth, P., & Krasner, D. Enterostomal therapy nursing growth & evolution of a nursing specialty worldwide: A festschrift for Norma N. Gill-Thompson, ET. Baltimore: Halgo, Inc.

²⁶³ Ms G. Dawson, interview, 7 October 1998.

²⁶⁴ Deakin, E. (1989). President's report. The Journal of Stomal Therapy Australia, 9(2), p. 4.

temporary rather than permanent. The increase in patients with stomas resulted in an increase in nurses' knowledge and ability to care generally. Unlike many Australian nurses prior to 1970, nurses of the following decades were taught the fundamentals of caring for a person with a stoma in the tertiary and clinical setting. Although the impact of this expansion in general nurses' knowledge could have resulted in a decline in the need for specialised nurses in stomal therapy, this does not appear to have been the case. On the contrary, the advances in appliance technology, which may have improved the lot of ostomates during the 1980s continued to the point that during the 1990s the variety of choices became more complex for both ostomates and nurses generally. Combined with this trend was the increasing use of stomal therapy skills and products in the domains of wound management, continence promotion and in some states, breast care.

During the 1990s appliances became more discrete, flexible and lightweight (see Appendix I: Figure 16). Odour filters were incorporated into drainable appliances and skin barriers were lauded in degrees of 'skin-friendliness'. The major innovation of this decade however, that reduced the need for time consuming stoma care and potential skin problems, was the concept of convexity. Convex shaped base plates were incorporated into one-piece and two-piece appliances and this concept largely eliminated the need for additional skin defect filling agents. Pastes and skin barriers, had previously been required to fill and level skin folds or creases under appliances. It seems rather puzzling that although convex flanges had been produced in Australia by Ken Philp in the 1960s, they had all but been overlooked by the major distributors in Australia until this time.²⁶⁵

New technology comes at a cost, and spending on the Stoma Appliance Scheme escalated rapidly in the year 1998 to 1999 to an astounding \$28,862,519.²⁶⁶ This equates to \$5,603,008 in '1975 dollars' or minus inflation, which is a cost of 100 times greater than the overall cost of appliances in 1975, which was the first year of the Scheme.²⁶⁷

²⁶⁵ Charles-Banks, C. (1999). The escalating cost of the Stomal Appliance Scheme. Journal of Stomal Therapy Australia, 19(4), p. 4.

²⁶⁶ *ibid.*

²⁶⁷ Australian Bureau of Statistics. (2003). www.abs.gov.au Also personal communication with on duty officer ABS National Office.

According to the ACSA that year, there were 24,493²⁶⁸ ostomates nation wide. Therefore, the cost of the Scheme equates to approximately \$1,178 per ostomate. Escalating costs paralleled escalating concerns from stomal therapy nurses who were fearful that the Stoma Appliance Scheme would be dismantled. These concerns came at the end of a decade when phrases such as cost-containment, cost-effectiveness and economic rationalisation became buzz-words. These terms complemented a vocabulary of new-age terms that evolved in response to directing care and preventing budget blow-outs. Critical paths, clinical pathways, care-maps, clinical algorithms, case-mix and diagnosis related groups were but some of the terms used to direct and track quality and cost-effective care. Hospital stays were reduced to the minimum and patients generally were discharged from acute care facilities faster.

Like all nurses, stomal therapy nurses had to adjust to radical changes in patient care systems. Pre-operative education and counselling for scheduled patients generally took place in pre-admission clinics. Day surgery, day of surgery admission and shorter stays meant less time in hospital for post-operative recovery, education, counselling and rehabilitation. Stomal therapy nurses were required to prepare patients for later admission and earlier discharge at a time when they were frequently not physically or psychologically prepared to learn. The onus for rehabilitation shifted to the community setting. A setting that was frequently under-resourced to accommodate this shift.

This decade of economic rationalisation also impacted on stomal therapy nurses professionally. During the 1980s, nursing career structures in the various states went under review and stomal therapy nurses in many instances had to justify their positions. In 1985 Victorian stomal therapy nurses, along with their colleagues, went on strike and were involved in industrial arbitration over pay and conditions. Stomal therapy nurses in full-time employment in major agencies were able to demonstrate their worthiness for recognition and pay increments at nurse consultant level at that time. However, it placed an onus on them to continually demonstrate their cost-effectiveness within the health care system.²⁶⁹

²⁶⁸ Australian Council of Stoma Associations. (1999). Minutes Annual General Meeting, held Hobart, 18-21 March.

²⁶⁹ Ms R. Bourke, interview with author, 3 March 1994.

During the 1990s there was a need for stomal therapy nurses to exert a great deal of business acumen, professional status and the ability to diversify their clinical skills. In support of these ventures the Association developed standards for stomal therapy²⁷⁰ and a process for credentialling stomal therapy practice which was initiated in 2000.²⁷¹ In addition, the Association renewed their vision, values and philosophies. The corporate goal was to promote quality, respect, accountability, commitment, leadership and excellence in stomal therapy at a national and international level.²⁷² The individual onus was on each stomal therapy nurse to demonstrate accountability for their practice and professional development as they journeyed into the new millennium.

Conclusion

This chapter has detailed the historical evolution of stomal therapy *care* and stomal therapy *nurses* in Australia. Informal stomal therapy care began with the formation of the first ostomy support group in 1957. Unlike the similar developments in the United States, the first two Australian groups began as a result of the vision and practical commitment of two eminent surgeons from Melbourne and Sydney, Sir Edward Hughes and Sir Edward Wilson respectively. Once these groups were established, both surgeons had the foresight to relinquish the reins of control into lay hands. However, they continued to offer their support as political lobbyists and were instrumental in convincing the government of the day of the need to implement the Stoma Appliance Scheme.

Hughes in particular, had the added foresight to appreciate the limitations to advancing stomal therapy care if it were not supported by nurses with expertise in stomal therapy nursing. His investment in the professional development of Elinor Kyte, as the first ‘stomal therapist’ in Australia and his commitment to the formalisation of a specialty group of nurses under the banner of the Australian Association of Stomal Therapists, earned him the title of ‘Father of Stomal Therapy’.

²⁷⁰ Australian Association of Stomal Therapy Nurses. (1997). Standards of stomal therapy nursing practice. Journal of Stomal Therapy Australia, 18(1), 6-11.

²⁷¹ Charles-Banks, C. (2000). Credentialling stomal therapy practice. Journal of Stomal Therapy Australia, 20(1), 23-27.

²⁷² Australian Association of Stomal Therapy Nurses National Executive Committee. (1999). Vision, values and purpose for the AASTN. Journal of Stomal Therapy Australia, 19(4), 22.

Australian Association of Stomal Therapy Nurses National Executive Committee. (1999). Vision, values and purpose for the AASTN. Journal of Stomal Therapy Australia, 19(4), 22.

However, stomal therapy nursing would not have evolved into a nursing specialty within the broader context of nursing without the commitment of Kyte and her pioneer contemporaries. They sought to find a better way to care for patients with a stoma. In the beginning they saw the need to take on the guise of ‘therapists’ if they were to confront the challenges extended by territorial nurses who perceived them to be a threat. As a fledgling group of nurses they were audacious enough to take shelter under the professional protection extended by their avuncular medical colleagues. Bonds of professional allegiance were established between surgeons and nurses who chose to specialise in stomal therapy. These bonds were maintained when the social and political forces of the 1980s encouraged stomal therapy nurses to reclaim their birthright and realign themselves with nursing nomenclature.

The historical origins of stomal therapy nursing are founded in the care of people with intestinal stomas. Stomal therapy practice however, has evolved to incorporate the management of other types of stomas, wound management, continence promotion and in some instances, breast care. However, in Australia this professional evolution has not been without confrontation and challenge.

Phenomenology: A Science of Phenomena

Introduction

What is phenomenology? A simple question one would think, but there is no simple answer. Merleau-Ponty, a French philosopher who is acknowledged as an important contributor to the French Phase of the Phenomenological Movement, thought it strange that the question continued to be asked during the early 1960s - a half a century after the earliest publications of the proclaimed founder of the phenomenological movement, Edmund Husserl (Merleau-Ponty, 1962). Forty years later, controversy still surrounds the topic in question and students of phenomenology continue to be bewildered by the apparent lack of a consensus on definition and approach. In fact, there is strong evidence to suggest that there is more than one methodology that can be labelled phenomenology. Historically, it appears that phenomenology is a philosophical chameleon – illusively altering its philosophy and methodology, in accordance with the interpretation of the philosopher or researcher of the time.

Spiegelberg, the phenomenological historian wrote that because phenomenology has “kept reinterpreting its own meaning to an extent that makes it impossible to rely on a standard definition for the purpose of historical inclusion or exclusion” (1982, p. 1). Spiegelberg’s argument is that the underlying assumption of a unified philosophy of phenomenology is an illusion because so-called phenomenologists have been too individualistic in their philosophy to agree to a common approach or body of knowledge. Although this creates a dilemma for the researcher who seeks the best phenomenological methodology, it has established precedents for individual and creative approaches.

However, if understanding and scientific rigour in phenomenological research are to be promoted, common characteristics that justify the use of a common label need to be identified. Therefore, the intent of this chapter is to determine if there are common core elements amongst the variety of phenomenological approaches and to determine whether these elements offer sufficient basis for unification of approaches under the title

of phenomenology. Furthermore, this chapter will evaluate the relevance of phenomenology to the development of nursing knowledge.

The Evolution of the Phenomenological Movement

It is not the purpose of this discussion to recount an in-depth account of the history of the development of the Phenomenological Movement or to review the phenomenologies of all its disciples. However, there can be no discussion of the relevance of phenomenology to the development of nursing theory without some reference to the historical developments of the Movement and its significant interpretations and re-interpretations. In order to review the history of the Phenomenological Movement comprehensively, I have had to refer intermittently and perhaps more often than is usual, to a specific text which is Herbert Spiegelberg's (1982) historical account of the development of the Movement. The value of Spiegelberg's review is reflected in the fact that he was a member of what is referred to as the original Phenomenological Movement and he recorded a most exhaustive and insightful historical account of the development of the various phases of the Movement. The literature is fairly expansive in recognising the historical and phenomenological development of the better known philosophers of the Movement, such as Husserl and Heidegger. Unfortunately, it has not been so generous in recording the history and contributions of many of the lesser known philosophers such as Stumpf, Brentano and to some extent, the philosophers of the French Phase.

Phenomenology had its genesis within the discipline of philosophy during the latter part of the nineteenth century. During the succeeding years it has been adopted by other disciplines such as psychology, sociology, anthropology and more recently nursing. However, as is usually the case with adoption, the offspring tends to establish its own identity within a new social environment. Such is the case with phenomenological theory. It has been adopted and interpreted, or misinterpreted according to some scholars, since its inception as an independent philosophic entity (Kersten, 1989).

Some nurse scholars would have one believe that any theoretical shift from the purported 'pure' theory proposed by the original philosophers is phenomenological heresy (Crotty 1996; Paley 1997). However, an increasing number of nurse researchers appear to support an evolutionary trend away from this purist view in favour of a

phenomenological approach more sympathetic to the nursing profession's needs (Benner, 1994; Daly & Jackson, 1999; Sveinsdottir, Lundman, Norberg, 1999; van der Merwe, 1999). Many of these latter day phenomenology evolutionalists claim that their approaches are grounded in, and faithful to the phenomenology of philosophers from the German or French Phase of the Phenomenological Movement (Benner, 1994; Cody, 1999; von Post & Eriksson, 1999). Some of the phenomenological purists view this as incorrect (Crotty, 1996; Paley, 1997) and their view is probably influenced by the increasing number of nurses who appear to rely on the work of preceding nurse phenomenologists instead of returning to the work of the founding philosophers (Daly, 1999; Gates, 2000; Parse, 1997).

Ambiguity of course, is not isolated to defining themes or concepts related to individual phenomenologies. Throughout history, the word 'phenomenology' itself appears to have been used by a variety of philosophers, for an equal variety of purposes, long before Husserl claimed it as a descriptive title for his philosophical theory (Spiegelberg, 1982). Although the phenomenological movement was born during the last decades of the nineteenth century, the word phenomenology appears to have had a relatively long history. The term appears to have been used first in a scientific context by Immanuel Kant in 1764 in relation to a physics problem of relativity or absoluteness of motion (Streubert & Carpenter, 1999). During the eighteenth and nineteenth centuries it was adopted as a term for describing phenomena in the natural sciences and other non-philosophical studies such as religion (Spiegelberg, 1982).

The first documented use of the word phenomenology within the realms of philosophy, although admittedly not connected to ideals of the phenomenology movement, was also in 1764 in a text by Johann Heinrich Lambert who used the term to describe the theory of illusion. Hegel, a German philosopher, was for a brief time considered a contender to the title of founder of the Phenomenological Movement, because he used the term phenomenology in two publications in 1807 and 1817 to refer to consciousness or subjectivity (Heidegger, 1970). However, Hegel's philosophy did not embrace the concepts of phenomenology as a method, or mention the need for 'eidetic reduction' or 'eidetic seeing'. These latter terms were to become pivotal phenomenological concepts in later phenomenological development and shall be explained in more detail later in this chapter.

There was no distinct birth date of the Phenomenological Movement, nor a point in the development of Husserl's theories where one could clearly point to and proclaim a 'founding'. The Phenomenological Movement evolved out of an informal association of philosophy students from the German cities of Munich and Gottingen. Around 1905 they began to meet in groups or circles, as they were known, for the purpose of philosophical debate (Spiegelberg, 1982). The choice of the word 'movement' suggests that from the onset it was to be a dynamic and evolving movement, which welcomed fluidity in philosophical debate and anticipated change in theory development.

The development of the Phenomenological Movement is seen to have evolved over three periods: the Preparatory Phase, the German Phase and the French Phase. These periods relate not so much to time *per se* but to the life's work of certain eminent philosophers who are recognised as contributing to the development of phenomenological philosophy. It is interesting to note, and to speculate why, the nursing research literature commonly cites philosophers from the German Phase (Benner, 1994; Benner & Wrubel, 1989; Moloney, 1995; Omery, 1983; Ray, 1985; Streubert & Carpenter, 1999), alludes less frequently to the French Phase (Beitz, 1999; Moyle & Oiler, 1982) and virtually ignores the Preparatory Phase of the Phenomenological Movement. This trend could possibly be interpreted as a clear endorsement by nurse scholars of the philosophy of Husserl and Heidegger, whose work dominated the German Phase.

It may also be more indicative of either a general reluctance of nurses to explore the history behind phenomenological theory or the degree of reliance on limited secondary literature sources, as suggested by Paley (1997). However, neither explanation will adequately determine the relevance of the philosophy of the early Phenomenological Movement to modern nursing, nor assist in determining the existence of common characteristics amid the different phenomenological theories that nurses have inherited. Nurse scholars cannot afford to overlook this early developmental period of the Movement for it potentially offers insight into the thinking of the time and the influence that thinking projected onto later developmental periods with which the nursing profession appears more willing to align itself.

With this view in mind, it is therefore an intent of this chapter to review the three individual phases of Phenomenological Movement. The purpose of such a review is not only to determine the major phenomenological concepts of each individual Phase but to determine the hereditary effects of these concepts on phenomenological research in nursing generally, and this study in particular.

The Preparatory Phase

The Preparatory Phase focuses on the work of German philosophers, Franz Brentano (1838-1917) and Carl Stumpf (1848-1936) during the later half of the nineteenth and the first years of the twentieth centuries. During his early years Franz Brentano was both an eminent teacher of philosophy and a Catholic theologian. This combination of theology and philosophy appears to have been common amongst academics in Germany from the Middle Ages and until the rise of the Nationalist Movement. During this period, the church strongly influenced appointments in philosophy at many universities. Brentano's appointment was no exception and as a result of his conflict with the doctrine of the Catholic Church in regard to papal infallibility and ecclesiastical authoritarianism, he separated himself from the church. Although this separation was not officially recognised, it ultimately cost him his teaching position at the University of Wurzburg in 1873. The following year he accepted a professorial position at the University of Vienna but was forced to resign 6 years later, in 1880, when as a final act of divorce from the priesthood he chose to wed. Following this, he continued as an unpaid lecturer or *Privatdozent* at the university for 15 years, and it was during this period that he counted amongst his most prominent students, Edmund Husserl (Hudson, 1981).

Brentano could be described as a Renaissance Man of his time for he saw it as his mission to enlighten traditional thinkers and bring about a fundamental reform in philosophy. It was curiosity in regard to Brentano's radical philosophy that ultimately caused Husserl to enrol in his lectures in Vienna. In a book edited by Oskar Kraus to commemorate Brentano's death, Husserl remembered his tutor in his *Recollections of Franz Brentano* as an impressive figure and a most articulate orator (Husserl, 1981). Both characteristics Brentano employed to the fullest in order to influence the thinking of his contemporaries and aspiring students. Amongst the latter were listed Stumpf, Meinong, Husserl and Freud (Grossmann, 1984).

Brentano's major philosophical interest lay with physical and psychical (mental) phenomena. He never claimed to be a phenomenologist, rather he referred to himself as an empirical psychologist and metaphysician (Bell, 1991). Needless to say, Brentano used the word phenomenology as an alternative title for a course on descriptive psychology during 1888-1898. Brentano's main contribution to what is now referred to as phenomenology is his doctrine of intentional reference or concept of 'intentionality'. This was drawn from Scholastic philosophy, which originated within Aristotelian philosophy, and which in turn was adopted during the Middle Ages by scholars such as Thomas Aquinas. The concept of intentionality provided the means by which Brentano could separate psychological (mental) phenomena from non-psychological (physical) phenomena (Grossmann, 1984).

According to Brentano:

Every mental phenomenon is characterised by what the Scholastics of the Middle Ages called the intentional (or mental) in-existence of an object, and what we might call ... or immanent objectivity. Every mental phenomenon includes something as object within itself, although they do not all do so in the same way. In presentation something is presented, in judgment something is affirmed or denied, in love loved, in hate hated, in desire desired and so on (as cited in Crotty, 1996, p. 37).

Stated more simply, all mental acts are intentional or directed towards an object. That is, we think of someone or something and we desire someone or something.

However, one of the criticisms of Brentano's concept of intentionality is that not all-mental phenomena are intentional or have an object. Therefore, it is important to distinguish between mental phenomena, which are intentional mental 'acts' and mental phenomena which are not intentional. To emphasise this point Grossmann (1984) uses the analogy of a red apple, which is not capable of thinking of, or desiring an object or individual. On the other hand, an individual's mental act can think of or desire the apple. Stumpf, a student of Brentano, was to expand on this theory.

As previously mentioned, Brentano's influence on his students was of both an academic and personal nature. The former influenced philosophical theory development in his students and the latter is said to have influenced more than one student in their decision

to enter the priesthood. One such student was Carl Stumpf who viewed Brentano's thinking on phenomena as too rigid a distinction between physical and psychical phenomena. He perceived that there were some entities that did not fall into either group and these he called '*Sachverhalte*' (states of affairs). Furthermore, he came to the belief that there were in fact, two types of physical phenomena – "those dealt with traditionally by the psychologists in studies on sensation, and those investigated by the physical sciences proper, such as atoms, molecules, waves and similar items" (Spiegelberg, 1982, p. 54).

Stumpf, also reasoned that philosophical renewal would depend on the discipline of philosophy adopting empirical research principles. He termed phenomenology a 'pre-science' or neutral science and as such he considered it to be a fundamental foundation for rigorous scientific research into the natural sciences, social sciences and the humanities. He reasoned that phenomenology would allow researchers a means for "investigating the dependence of these phenomena on factors other than the phenomena" (Spiegelberg, 1982, p. 57). Stumpf expounded the idea of experimental phenomenology and its significant implications for scientific research within the emerging field of psychology. During the second half of the nineteenth century psychology was struggling to be recognised as a credible 'science of the mind' and was endeavouring to declare its independence as a discipline separate from that of philosophy (Bell, 1991, p. 4).

Stumpf considered phenomenology a suitable lever for declaring psychology's independence from philosophy and because of this, he is generally recognised as being a pioneer of experimental psychology rather than phenomenology. Overall, the significant developments during the Preparatory Phase were the defining of the concept of intentionality and the vision that phenomenological philosophy could be a rigorous and 'first' science, or beginning, for *all* disciplines. Furthermore, the work of Brentano and Stumpf during this period led to the emancipation of psychology as an independent science of the mind.

The German Phase

The German Phase of the Phenomenological Movement originated with meetings and membership of what were initially termed the Gottingen and Munich Circles. Many of

those who participated in these meetings were students of established German philosophers such as Edmund Husserl (1859-1938) or his contemporaries. Some of these early members such as Alexander Pfander (1870-1941), Adopf Reinach (1883-1917), Moritz Geieger (1880-1937) and Eugen Fink (1905-1975) are best known for their collaborative works with Husserl. Whilst others who include: Hedwig Conrad-Martius (1888-1966), Edith Stein (1891-1942), Roman Ingarden (1893-1970), Max Scheler (1874-1928), Nicolai Hartmann (1882-1950), Martin Heidegger (1889-1976) and Hans-Georg Gadamer established themselves independently as lauded philosophers of the German Phase.

The nursing literature strongly indicates that it is the philosophies of Husserl and Heidegger which have had the most influence on the increasing use of phenomenological approaches in nursing research (Benner, 1994; Moloney, 1995; Streubert & Carpenter, 1999) and for this reason it is their phenomenologies and contributions to the Movement, which will reviewed in this chapter.

Edmund Husserl gained his PhD in mathematics in 1882 from the University of Vienna. During 1883 whilst he was teaching in Berlin he felt himself to be increasingly drawn towards the discipline of philosophy, which he had previously studied as a minor towards his doctorate in mathematics. Indecision about his choice of career pathway caused him to return to Vienna where he enrolled in Brentano's lectures during the winters of 1884-85 and 1885-86. It was during these lectures that he decided that his future lay with philosophy and he obtained from Brentano the foresight that if he should choose philosophy, his commitment to scientific rigor need not be compromised (Husserl, 1981).

Amongst scholars there is considerable debate about the extent of Brentano's influence on Husserlian phenomenology and most commentators agree that Husserl's work was heavily influenced by Brentano's thinking during his formative years. Although discord between the two philosophers and their thinking became evident as the years progressed, Husserl gratefully acknowledged Brentano's earlier influence on the development of his phenomenological philosophy, especially the concept of intentionality (McCormick & Elliston, 1981).

The dividing line between the Preparatory Phase and the German Phase of the Phenomenology Movement is drawn between the philosophical border that separated Brentano and Husserl's theories. *Prima facie* the line between these theories is indistinct because Husserlian vocabulary reflects frequently the terminology and principles of Brentano and Stump. Husserl is said to have inherited from Brentano principles concerning "phenomena, intuitions, presentations, judgements, consciousness, intentionality, meaning, language, logic, science, truth, certainty, evidence, and analysis" (Bell, 1991, p. 4). But he expanded and developed these themes so differently that his themes ultimately had little in common with those of Brentano (Gurwitsch, 1966).

In everyday language, consciousness is a characteristic of neurological alertness but Husserl's interpretation of consciousness was that individuals are conscious of something whether that be animate or inanimate objects or the literature (Husserl, 1982). Thus, consciousness is the source and matrix of all phenomena and that it is in the structure of consciousness "that we can locate its essential character as the bearer of perceptual reality" (Natanson, 1973, p. 12). Natanson went on to describe phenomena as "objects of intentional acts... they are whatever present themselves by way of the acts of perception" and are synonymous with essences which are "simply aspects or qualities of objects-as-intended" (1973, p. 13). To be more specific, *every act of thinking implies the thought of*¹ *some object, something remembered, imagined, willed* (Husserl, 1982). Furthermore, consciousness is "by its very nature always *consciousness-of*, and that is the kernel of the axial principle of phenomenology: the intentionality of consciousness" (Natanson, 1973, p. 13).

Husserl gave full credit to Brentano for the concept of intentionality but Husserl developed the concept radically and named it intentionality of consciousness, in his *Logical Investigations* which was published in 1900. Husserl's intentionality offered a means to consider the *intentional* nature of an individual's thinking. In other words, in thinking, one thinks of an object. Cognitive functions such as thinking, remembering and fearing cannot occur without being related to a thought of, a remembrance of, or a

¹ Or as Husserl put it, *intend* (Husserl, 1982).

fear of something, and there is a distinction between cognitive action and object of focus (Shultz, 1966).

For example, a patient who has undergone surgery for a bowel resection and the formation of a colostomy focuses on their newly formed stoma. The stoma is the intended object but within the individual's subjective consciousness many thoughts, remembrances and fears are stimulated in relation to the stoma and the perceived changes in body function, life style or body image. The stomal therapy nurse 'intends' or observes the stoma from a clinical perspective and while the nurse's thinking might involve clinical observations, it is still a cognitive act of consciousness directed towards the object (stoma). This in turn stimulates thoughts and remembrances within the nurse which are unique to them and which will influence the nurse's actions. It is this relationship between the object and the subject that reflects intentionality.

The development of Husserl's phenomenological philosophy evolved over time and accordingly it could be classified into three distinct periods of development, which related to his three major university appointments. His first appointment was at the University of Halle during the years 1887 to 1901. Heidegger (1993) refers to this time at Halle which extended until 1889, as Husserl's pre-phenomenological period and this period reflects his philosophical thinking as published in his *Logical Investigations* (*Logische Untersuchungen*).

Husserl's second period spans his early years at Gottingen where he held an appointment during 1901 to 1916. During this period he analysed the objective and subjective aspects of experience (Cohen, 1987). The third period began in 1906 and continued throughout his years as Professor at Freiburg until his retirement in 1928 and extended to his death in 1938. It was during this period that he assimilated his later and mature reflections with his earlier insights. Husserl's third period refined his theory of a 'pure' or transcendental phenomenology (Biemel, 1977).

Pure or transcendental phenomenology was meant to be a universal foundation for all philosophy and science. It was a "philosophy from the ground up" (Husserl, 1981, p. 185). As a mathematician and physicist Husserl was grounded in the principles of rigorous science and he was obviously frustrated with the lack of deductive scientific

rigor he had observed in philosophy. He declared that philosophy could never claim to be a rigorous science because it lacked a doctrinal system that could stand the test of generations of criticism and not be controverted according to the interpretation of a given school of thought or point of view (Husserl, 1981). Ironically, this chapter will show that even phenomenology has proven not to have been exempt from criticism and controversy in the hands of succeeding generations.

Husserl was not intent on building a 'system' as the word implied to the classical German philosophers of his time (McCormick, 1981). Rather, he was seeking a systematic order for the finding of knowledge, and the foundation he sought was to identify the beginnings or the 'roots' of knowledge. Husserl was convinced that these beginnings or roots of knowledge were to be found in the 'things' (*Sachen*) or the phenomena, and how they appeared to the consciousness of the subject to whom they appeared. This concept he referred to as 'transcendental subjectivity' (Spiegelberg, 1982). Simply, transcendental subjectivity refers to the subject's internal perception of the phenomena before any phenomenological reduction has occurred.

Husserl referred to himself on many occasions as a "perpetual beginner" (Crotty, 1996, p. 30; McCormick, 1981, p. 2) because he continually sought to return 'back to the things themselves'. Natanson (1973, p. 9) so aptly described him as a "philosophical Columbus" because of his continual explorations into the unexplored philosophical wilderness in search of a fundamental 'science of beginnings' or 'first' science. Such a science was to emphasise knowledge in the generic sense and would be applicable to both the physical and social sciences (Natanson, 1973). This was a philosophy Husserl had in common with Brentano and Stumpf and one that was to be embraced by Heidegger in his earlier years. Like Brentano and Stumpf before him, Husserl proclaimed that philosophy must be a rigorous science, and that phenomenology was to provide philosophers with the method to ensure this occurred (Husserl, 1981).

One can understand this passionate stance in the light of his background in mathematics, but for phenomenology to be called a rigorous science in the objective physical sense appears, at least superficially, to be an antithesis to his equally passionate call to return 'to the things themselves'. The very nature of 'returning to things' implies a subject-related act. Historically, it is the very risk of subjectivism which has always

been the focus of those individuals who favour a rigorous quantitative approach to research and prevents them from conferring equal scientific merit on phenomenology. However, Husserl's argument was that only through profound investigation of the subject could one explore and define the object. He was convinced that the origin of all object knowledge was to be found in subjective consciousness (Anderson, Hughes & Sharrock, 1986).

The extent of regard for the importance of the subject in Husserl's phenomenological philosophy is mirrored in the art and philosophy of nursing (Benner, 1984; Leininger, 1984; Nightingale, 1969; Watson, 1979; Wiedenbach, 1964). There is also an analogy to be drawn between Husserl's expressed need for scientific rigour in philosophy and the call for scientific rigour in nursing research (Burns & Grove, 1987; Woods & Catanzaro, 1988). This dual regard for the subject and the need for scientific rigour, suggest an affinity exists between the science of Husserl's philosophy and the science of nursing and this may offer an insight into why some nurse scholars find inspiration in Husserlian phenomenology (Porter, 1998).

As stated above, it was Husserl's vision that phenomenology would be a first science for all disciplines. The method he developed which would give scientific credibility to phenomenology, he titled 'reductive phenomenology'. Phenomenological reduction, transcendental reduction, epoche or bracketing are all terms that he came to use synonymously with reductive phenomenology. Bracketing was a term Husserl drew from mathematics and adopted to refer to a procedure for the suspending of belief in the existence of the phenomena under investigation for the purpose of revealing the essence or object of the experience. Bracketing in effect, means to lay aside the mental state called the natural attitude which "comprises the complex system of interlocking and mutually supporting beliefs, preferences, commitments, and habits of mind which permeate and regulate our everyday conduct and our everyday understanding of things" (Bell, 1991, p. 164).

Through a process of phenomenological reduction or bracketing, one's intellectual barriers and established preconceptions can be overcome. Bracketing provides a means of entry into what Husserl described as a 'new world' – a world uncontaminated by these intellectual barriers or established preconceptions – providing a crystal clear view

of “transcendentally purified phenomena” (Husserl, 1982, p. xix). To emphasise the degree of clarity with which phenomena could be viewed, Husserl invented the word ‘irreal’ to refer to the characteristics of purified phenomena. Phenomenological reduction as a method, allows the natural attitude to be converted into the phenomenological attitude where presuppositions about phenomenon or objects of consciousness are suspended and the phenomenon are seen in a new way (Husserl, 1982).

Crotty interprets bracketing as a “first person, self reflective process” and he challenges what he believed has been a common misinterpretation by nurse scholars of Husserl’s concept as a second person, reflective process of another’s subjective experience (1996, p. 60). Crotty encourages the use of bracketing amongst nurses in order that they might interpret their own encounter with phenomena, or those intersubjective encounters with other nurses or patients more fully. However, Crotty criticises nurses who bracket their own presuppositions and preconceptions in regard to data provided by others. This he interprets as a complete antithesis of Husserl’s concept. Other nurse scholars do not appear to agree with Crotty in this regard, and consider bracketing an important procedure for isolating bias and assumptions in data generated from other subjects (Ahern, 1999; Streubert & Carpenter, 1999).

The ultimate aim of bracketing is eidetic seeing, which is occasionally referred to as eidetic reduction. This is the method by which all suppositions, preconceptions or known facts are identified and set aside in order to isolate and intuit the phenomena with the purpose of revealing their universal characteristics (Anderson, et al. 1986). Husserl used the words *essence (wesen)* to describe the *What* of an idea or an object of experience and *Eidos*, or its adjective *eidetic*, for naming universal pure essences (Husserl, 1982). Eidetic seeing allows the pure Eidos or essence to become known and eidetic seeing is achieved by experiencing or *intuition of something individual*.

Husserl used the term intuition (*Anschauungen*) to refer to the act of intuiting in which a “phenomenon is contemplated and explored directly” (Spiegelberg, 1982, p. 738). The intuiting of essences is the process for introspective reflection on a subject’s experience. It is a process that will allow one to gain insight into, and comprehension of the uniqueness of, the phenomenon as experienced. According to Husserl the essence

(Eidos) then becomes a new sort of object (Husserl, 1982). In reality, phenomenology as a science of phenomena could be considered a method of making the subjective experience objective. This is the basis for proclaiming the methodology had scientific rigour.

Husserl spent his years constantly redefining his theories in order to seek what he called 'clarity', which is best described as a foundation for all knowledge. He was it seems, initially reticent to define his phenomenology and in his Introduction to his *Ideas: First Book*, he defines phenomenology as simply a "science of phenomena" (Husserl, 1982, p. 1). However, his analysis of the concepts which would reveal the phenomena was considered the master key to understanding his phenomenological theory. This 'key' provides insight into his critique of psychologism (*transcendental idealism*) and the concepts of phenomenological ego, transcendental intersubjectivity, time-consciousness and the life-world (*Lebenswelt*).

The life-world is the immediate personal world, as experienced and understood by the person who experienced it. According to Husserl (1989) the life-world consists of interdependent functioning subjects together in an open circle of other functioning subjects and the life-world is experienced differently by each person. Bell (1991, p. 228) interprets Husserl's vision of the life-world as one that "comprises the sole absolute foundation of all our moral, scientific, philosophical, and everyday practices.

In summary, Husserl's phenomenology was a "science of phenomenon" (1982, p. 1). However, it was a science that sought to reveal and understand phenomena as they appeared to the subjective consciousness, uninfluenced by presuppositions or past experience. This latter point that will be shown to be contested by Husserl's perceived successor, Heidegger. However, other Husserlian concepts will be shown to have influenced not only Heidegger but succeeding phenomenologists. It is for this reason that Husserl should be recognised as the 'Figurehead' of the Phenomenological Movement. To proclaim him the 'Founder' or the 'Father' of the Movement as is the common tendency in the nursing literature (Benner, 1994; Crotty, 1996; Ray, 1985) is to ignore the contribution of Brentano and Stumpf before him.

Martin Heidegger was considered Husserl's legitimate heir, although in his later years he was also to repudiate much of Husserl's phenomenology (Ott, 1993). Although he was not a student of Husserl he served an apprenticeship under his Professorship at Freiberg University from 1919-1923. In 1928 after 5 years at Marburg University, he returned to Freiberg and succeeded Husserl in the position of chair of philosophy. Husserl is accredited with instilling in his successor a passion and insight into phenomenological 'seeing'. Heidegger rewarded his mentor with an appropriate dedication in his first book, *Being and Time (Sein und Zeit)*, which was published in 1927 (Biemel, 1973; Krell, 1993). Ironically, as was the state of affairs between Brentano and Husserl many years prior, there developed an estranged personal and professional relationship between Husserl and Heidegger in later years. This estrangement was thought to have occurred because of increasingly opposed philosophical views, but the estrangement was further compounded by Heidegger's involvement with Nazism preceding and during the Second World War (Ott, 1993).

The major difference between Husserl and Heidegger's theories was that for Husserl, Man [sic] is an entity as determined by his intentionality of consciousness, that is the intentional nature of his subjective thinking of the phenomena to which he is exposed. Central to Husserl's philosophy is the question *what is Being?* Husserl sought to define the originality or uniqueness of Being. Heidegger, on the other hand saw consciousness as an activity of Man [sic], and determined by his presence in the world. The question that most consumed Heidegger was *what is Being-in-the-world?* For Heidegger the uniqueness of Being as manifested in the here and now, is affected by all the cultural and historical influences that impact on the world of Being. The recognition that history and culture impacts on one's life-world was a significant difference between Husserl and Heidegger's phenomenologies. It is also the reason that I have aligned the phenomenological understanding inherent in this study to the philosophy of Heidegger's phenomenology.

Although both Husserl and Heidegger's phenomenologies are fundamental to understanding and revealing *all* the characteristics of *Being*. The decision to align oneself with either approach is dependent on which aspect of *Being* is of most interest to a researcher. A purpose of this study is to describe the lived experience of stomal

therapy nurses. Nursing is generally perceived to be synonymous with caring or enabling behaviours (Marriner-Tomey, 1989). Nursing is an interactionary process between individuals, whether that interaction is between nurse and another health professional or nurse and patient. Nursing involves a human to human event, which is influenced by temporal and historical realities of both the carer and recipient of care. Therefore, for the purpose of this study, I aligned myself with Heideggerian phenomenology in the belief that the stomal therapy nurses would be affected by the cultural and historical realities that impacted on their Being in the world of nursing.

It is however, to the early periods of Heideggerian phenomenology that this study aligns itself. Heidegger phenomenology has also been divided into three distinct evolutionary periods, similarly to that of Husserl and for that matter the Phenomenological Movement as a whole (Spiegelberg, 1982). The first Heideggerian period is referred to as 'a preparatory period', which began in 1909 with Heidegger's commencement at Freiburg University as a Catholic theology student. It was during this period that he was first exposed to Husserl's *Logical Investigations* which had more of a profound effect on him than any other Husserlian texts. The 'phenomenological period' followed and it was during this second period that he expanded his theories on being and time and published his most notable text, *Being and Time (Sein und Zeit)* in 1927.

Heidegger viewed phenomenology as a *concept of method* which was not concerned with the 'what' of the objects of philosophical research in terms of their content but of the 'how' of such research (Heidegger, 1993). During this period he considered phenomenology to be a science – a science of the Being of beings - a scientific method that allowed him to investigate the *experience of being*. In contrast to Husserl's early reticence in defining his interpretation of phenomenology, Heidegger in his introduction to *Being and Time* went to great lengths to explain his interpretation of the concepts he contributed to phenomenology. Heidegger resorted to the original Greek derivatives of the word which are expressed as *phainomenon* - "what shows itself, the self-showing, the manifest ... what shows itself in itself" and *logos* - "to make manifest 'what is being talked about' in speech" (Heidegger, 1993, pp. 73 & 79). Logos is generally translated as 'interpreted' but Heidegger seeks a more profound and expansive meaning as understood by ancient Greek scholars, Plato and Aristotle. A meaning that would illuminate the many nuances involved in speech and unveil what may be concealed.

Phenomenology in this context he translated literally from the Greek *apophainesthai ta phainomena* as “to let what shows itself be seen from itself, just as it shows itself from itself”. To put it more simply, phenomenology relates to his well-known maxim “to the things themselves!” (Heidegger, 1993, p. 81).

Heidegger could be said to have had a love-hate affair with language; an affair that has been viewed as turbulent and contorted by some scholars of his work (Krell, 1993; Steiner, 1978). Primarily, language was recognised to be the conduit that allowed the ontic to question the ontological and therefore uncover the truth in meaning (Steiner, 1978). Language in its various forms is the medium of communication and the facilitator of comprehension. However, Heidegger’s habit of resorting to ancient Greek or Latin, and tortuously distorting modern language to a degree where the literal translation was indiscriminately converted and interpretation was dependent on conjecture to all but a coterie, has challenged many a scholar. There is also an underlying irony to be found in Heidegger’s distortion of language when one remembers how he struggled to achieve phenomenological understanding.

Heidegger in his *The Way to Language* discussed the intent and virtue “to bring language as language to language” (1993, p. 398). Yet this text is an example of some of his most ambiguous language, and he makes no apology for the disorderly use of terminology, nor the interchange of classic and modern vocabulary. This tendency is clearly demonstrated in the following extract.

Our translation consistently understands the *semeia* (that which shows), the *symbola* (that which holds together), and the *homoiomata* (that which approximates) in terms of showing ... which for its part depends on the ruling sway of revealing (*aletheia*) (Heidegger, 1993, p. 401).

Heidegger’s abuse of language was not altogether dissimilar to Husserl’s treatment of vocabulary. Although their ambiguous language has been the cause of great frustration and confusion for many scholars since, it is perhaps indicative of the struggle and passion both philosophers exerted in having to resort to everyday language and common idioms for clarification of new concepts and interpretation of meaning. One can draw an analogy with this struggle and with one who has a need to learn and communicate in a

foreign language. Communication is at first disjointed and often frustrating as one struggles with simple words and phrases and it is not until one develops an advanced vocabulary and verbal proficiency that one is able to be more articulate and clearly understood. Increasing confidence with a new language gives one a sense of a new identity, and so it was with the language of these phenomenologists.

Husserl in his *Ideas: First Book*, talks about the new persona that common language derivatives assume when they conform to new knowledge or to the “essence seized on intuitionally” (1982, p. 152). This new language, which was used to define the intuited essence was for Husserl a system of distinct statements that could be used for later thinking. Language used by Husserl and Heidegger underwent evolutionary changes, generally without explanation and clarification of these changes, throughout the developmental periods of their phenomenologies. Husserl decreed that definitive terminologies could only be agreed upon at a very advanced stage of the development of a science.

It is an error and basically absurd to apply extrinsic and formal criteria of a logic of terminology to scientific expositions which are just emerging and to demand terminologies of the sort which fix the concluding results of great scientific developments at the beginning. For the beginning, any expression is good and, more particularly, any suitably chosen figurative expression which enables us to guide our regard to a phenomenological occurrence which can be seized upon clearly. Clarity does not exclude a certain halo of indeterminateness (Husserl, 1982, p. 202).

The preceding statement gives a free licence for nurse scholars to experiment with language and redefine expressions in order to make them more sympathetic to nursing needs and language. This is not a new challenge for nurses, for the precedent was established when the profession adopted the nursing diagnosis terminology as a means of interpreting nursing care (Carpenito, 1983). A rationale given by Benner and Wrubel (1989) for embracing the phenomenological approach was that it did in fact, give a more appropriate expression to nursing domains, whereas the language of the positivistic social and natural sciences was too impoverished to adequately explain the uniqueness of nursing. I will return to this point in the chapter 8 to discuss the concept of ‘good’ and its use and relationship to nurses and nursing.

Evidence of a trend to adapt phenomenological language for the purposes of researching nursing practice, is found in the increasing use of term 'interpretive' phenomenology as suggested by Benner (1994). Benner's (1989) evolutionary move away from her earlier use of the term 'Heideggerian' or 'hermeneutics' to describe her phenomenology, in favour of the term 'interpretive phenomenology' emphasises the need for nurses to use language to reflect more fully the historical, cultural and social aspects of nursing behaviours. Although interpretative phenomenology still claims to be grounded in the philosophy of the Heidegger's hermeneutic phenomenology, the former term is more sympathetic to nursing's need to interpret the embodied, lived experiences of individuals in a health or illness event (Benner, 1994).

This need it seems was equally familiar to Heidegger for he earnestly dedicated his early period to understanding the concept of being or human existence. More explicitly, it was the *Being* of beings that was central to Heidegger's philosophy, that is a Being that is able and does, question the meaning of Being (Heidegger, 1993). Initially one is tempted to speculate that the need in Heidegger to question the meaning of Being had some spiritual root in his early years as a Jesuit postulant. However, in Ott's (1993) biographical account of Heidegger's life one learns of his increasing hostility towards any Christian inspired philosophy. This was especially the situation during the tumultuous years that preceded the Second World War. In lieu of any Christian connection, Heidegger stipulated that the search for the truth and essence of Being was to be found in the study of the ancient Greek philosophers, Heraclitus and Parmenides. Heidegger's phenomenological philosophy from 1935 onwards differed considerably as a result of this philosophical allegiance, to the phenomenology of his earlier period when he wrote *Being and Time* in 1927 (Kockelmans, 1988; Krell, 1993; Ott, 1993).

Therefore, for the purpose of this discussion it is the philosophy of Heidegger's *Being and Time* that is germane. During this second period he perceived that the meaning of Being could only be interpreted by first looking at the phenomenon through which Being becomes accessible or known (Grossmann, 1984). Heidegger bestowed the name *Dasein* on this Being of beings, in order to refer to the dimension of human being-in-the-world or human existence. "A being which questions Being, by first questioning its own Sein (Being), is a Dasein" (Steiner, 1978, p. 80).

In his search for a definitive meaning of existence during this era, Heidegger sought inspiration in the works of two other ancient Greek philosophers, Socrates and Plato. The reason for this was that Heidegger was convinced that succeeding philosophers throughout history had not only ceased to be sufficiently 'astonished' by Being but had forgotten it entirely. Historically he could find no evidence that philosophy had liberated the concept of Being. Hermeneutic phenomenology was for Heidegger the methodological sword that would cut through the chains that held Being prisoner. He decreed that the "methodological meaning of phenomenological description is *interpretation*" and Dasein has the character of *hermeneuein* which allows the proper meaning of Being and the basic structures of the very Being of Dasein to be *made known* (1993, p. 84).

The literal translation of hermeneutics is 'to interpret' as it is derived from the Greek verb *hermeneuin* and its corresponding noun *hermeneia* (interpretation). In ancient Greek mythology Hermes was thought to have discovered language and writing and he was responsible for "transmuting what is beyond human understanding into a form that human intelligence can grasp" (Palmer, 1969, p. 13). Hermeneutics has been described as a 'science of interpretation' and as such has been used since the seventeenth century in Biblical exegesis and gradually permeated the field of philological methodology as a means for interpreting secular theory. Wilhelm Dilthey, a contemporary German philosopher of Husserl's time, adopted hermeneutics as a discipline for interpreting communication through written language, action and art. As a German student of theology and as a philosopher, Heidegger would have been familiar with hermeneutics and its use (Palmer, 1969, p. 34).

Heidegger embraced the concept of hermeneutics but broadened its connotation and caused it to be synonymous with phenomenology as peculiar to Dasein, or of Being, as existence-in-the-world. Heidegger understood phenomenology to be a "concept of method" rather than a school of thought, and as such it "does not characterise the 'what' of the objects of philosophical research in terms of their content but the 'how' of such research" (Heidegger, 1993, p. 72). Similarly, he understood hermeneutics to be a concept of method – a method that would go beyond the obvious and reveal the true or normally hidden meaning of being. It could be surmised that he emphasised this importance by linking the two synonymous terms - hermeneutic and phenomenology -

together. It is this hidden meaning or rather 'intrinsic' meaning that I sought to define in regard to the essence of *Being* a stomal therapy nurse. It was anticipated that in interpreting the intrinsic experience of stomal therapy nurses it would promote understanding of what it was to *Be* a stomal therapy nurse. Like Heidegger, I also came to appreciate the insight that comes from being 'astonished'.

Achieving hermeneutical 'astonishment' involves the use of what have been described as "anticipatory devices" (Spiegelberg, 1982, p. 385) and one such anticipatory device is best explained by referring once again to Heidegger's emphasis on the Greek word *logos* - which lets something be seen. As is often the case in translation between languages, the nuances of words are often altered in their translation, or the strength of their meaning is diluted. Heidegger's frustration with the limitations of common language is further evident as he seeks to clarify the meaning of *logos* by using the literal Greek interpretation to "take out of their concealment" (Heidegger, 1993, p. 79). He endeavoured to discover the true meaning of *Being* without the presuppositions or preconceptions normally imposed by being in general. "Essentially, nothing else stands 'behind' the phenomena of phenomenology" he said (Heidegger, 1993, p. 82).

Once again a similarity can be seen between the phenomenology of Husserl and Heidegger. Although the latter did not explicitly agree with Husserl's theory of phenomenological reduction he implicitly recognised that a phenomenon could be distorted at first interpretation. He laboured to demonstrate the need to gain access to the phenomenon by traversing preconceptions, in order to promote phenomenological understanding. "The idea of an ... 'intuitive' grasp ... of phenomena must be opposed to the naiveté of an accidental, 'immediate', and unreflective 'beholding'" (Heidegger, 1993, p. 83).

Heidegger's concept of intuitive grasp differs significantly from the common interpretation of intuitive knowing, which has been defined as the "power of knowing without reasoning or being taught" (Australian Oxford Dictionary, 1989). This common definition has a psychic or accidental element of knowing attached to the concept. It alludes to a degree of mystic sensing without a rationale or past experience to support the thinking. Intuition as a word and a concept remains a controversial issue within nursing today because of this previous word association (Cioffi, 1997; King &

Appleton, 1997). In contrast, Husserl and Heidegger referred to an intuitive act as one of deliberate contemplation or reflection of phenomena. Benner (1984, p. 295) also defines the intuitive grasp as one that relies on a “broad base of knowledge and experience” not “wild guesses”.

It is unfortunate that both Husserl and Heidegger did not select a word for the intuitive concept that would have been more acceptable for promoting the professional image that nursing endeavours to portray. Nurses need to be mindful that the Husserl and Heidegger’s use of the word ‘intuitive’ is in reality, just another reflection of their ambiguous use of vocabulary. It might better serve the cause of promoting a professional image and comprehension amongst nurses if they uniformly used the verb ‘intuit’ rather than the noun ‘intuition’. Alternatively, the concept could be re-named ‘clinical judgement’ or ‘intuitive judgement’ for either term infers that there is an element of experiential knowledge to support decision making (Benner, Tanner & Chesla, 1996).

For this reason the term ‘clinical judgement’ will be used in preference to the term intuition in this study. Clinical judgement is defined in accord with the interpretation expressed by Benner, et al. (1996). I agree with these authors’ rejection of the “technical rationality models of clinical judgement” (1996, p. 2), which define clinical judgement as a very analytical and deliberate process. In lieu, Benner, et al. (1996) proposes that clinical judgement be regarded as the application of practical reasoning, which is grounded in a nurse’s past experiences and which is employed to understand a patient’s response to illness or wellness. This type of clinical judgement is synonymous with the activities and behaviours demonstrated by the stomal therapy nurses in this study.

The objective of seeking an intuitive grasp is ‘phenomenological seeing’. This is the deliberate peeling away of the super-imposing layers of the phenomenon with the intent of exposing the original kernel to reflection and interpretation. An analogy can be drawn between one peeling away the many layers of an onion in order to reach the central core. Alternatively, phenomenological seeing could be compared to an archaeological dig that reveals the artefacts and structural relics of super-imposed civilisations. To aid the process of phenomenological seeing Heidegger developed another ‘anticipatory device’ which he called ‘phenomenological destruction’ of ontology.

Although Heidegger did not profess to agree with the concept of phenomenological reduction as described by Husserl, one is left with sense of *deja vu* on reading Heidegger's concept of phenomenological destruction. It refers to the need to eliminate the presuppositions or preconceptions that arise as a result of traditional or metaphysical influences (Spiegelberg, 1982). Heidegger's choice of the word 'destruction', when compared to Husserl's choice of the word 'reduction', clearly emphasises the importance he placed on eliminating any presuppositions or barriers that would prevent unhindered access to the phenomena. Heidegger considered this to be particularly relevant in regard to the concept of temporality.

Heidegger did not provide a definition of what he meant by temporality and it was in reference to this concept in *Being and Time* that his language became exceedingly ambiguous and almost unintelligible. Scholars since have endeavoured to interpret the term and have pronounced it to have various characteristics such as 'possible future existence', 'ecstasies' or the 'future past and present' and 'beyond itself' (Biemel, 1977). It is the very interwoven relationship of Dasein with temporality as a means of realising its authentic self that fascinated Heidegger. Efforts to tease out the threads of that relationship refer one to his statement that "time in the sense of 'being in time' serves as a criterion for separating the regions of Being" (Heidegger, 1993, p. 61).

It could be considered too simplistic to consider Heidegger's concept of temporality as "the setting or matrix of our being" (Spiegelberg, 1982, p. 395), but to do so renders it usable in phenomenology. Spiegelberg's interpretation of Heidegger's concept of temporality, implies that 'historical' time, as it relates to the past and present, impacts on the very essence of Being. This is in keeping with my own interpretation of Heidegger's distorted description of temporality and supports my use of historio-phenomenology as a method for 'phenomenological seeing' within an historical context into the lived experience of stomal therapy nurses in this study. Heidegger's language is open to different interpretation and this has resulted in generations of phenomenologists placing their own, and often disputed interpretations, on Heidegger's meanings.

From 1933 onwards, Heidegger's career was touched by controversy. That year he was appointed Rector of Freiburg University and his appointment was seen to have been

influenced by his membership of the Nationalist Socialist Party. There has been much debate in the literature regarding the extent and counter rejection of Heidegger's anti-Semitism and his role in ostracising Husserl, a Jew, from academic society (Biemel, 1976; Ott, 1993). The extent of Heidegger's anti-Semitic coercion to rid the university of Husserlian phenomenology is open to dispute, but Ott cites some damning correspondence between Heidegger and his colleague, Karl Jaspers, which provides evidence of a personal, if not a phenomenological, disdain (Ott, 1993). One can only speculate about whether it was the effect of these politico-social influences during that turbulent period in history or a natural evolution in Heidegger's philosophy that caused him to enter the third and very different period of his philosophical development.

This third period is most aptly known as 'the turn' (in German *die kehre* which literally means reversal), for his philosophy during this time appears to be an antithesis to that of his earlier years. During this period Heidegger made scant reference to phenomenology in lectures or publications. Many of the concepts and ambiguous terminology he used in his early phenomenology were abandoned in favour of different but equally ambiguous or miss-spelt terminology, which he used to refer to his altered concepts of Being. Even his trademark term 'Da-sein' inherited a hyphen as well as a new meaning – 'Being in its openness or truth'. Furthermore, in complete contrast to his earlier ideals, Heidegger claimed to be disillusioned with science as the foundation for discovering the meaning of being and truth. As an alternative, he sought solace and explanation in the arts, especially poetry, until the end of his life in 1976 (Crotty, 1996; Ott, 1993).

In summarising the phenomenology of Husserl and Heidegger it has been suggested that the latter could never be considered a phenomenologist "in the strictest sense as defined by Husserl's subjectivist transcendentalism ... because he never accepted the phenomenological reduction in Husserl's sense" (Spiegelberg, 1982, p. 408). However, as has previously been pointed out, Heidegger's phenomenological destruction could serve as a synonym for the same venture. This indicates that he at least practiced eidetic phenomenology even if he did not want to declare it. Heidegger proclaimed a *hermeneutic phenomenology* of human Being whilst in contrast, Husserl proclaimed a *descriptive phenomenology* of pure consciousness as the optimal approach for describing the phenomenon of Being. In reality, both philosophers sought understanding

of the experience of Being but both choose different approaches to reveal and interpret it.

Nurse researchers must be mindful of these philosophical differences and consider the appropriateness of either hermeneutic phenomenology or descriptive phenomenology for defining individual research questions.

The French Phase

The philosophers whose work predominated the French Phase of the Phenomenological Movement include: Gabriel Marcel (1889-1973), Jean-Paul Sartre (1905-1980), Maurice Merleau-Ponty (1905-1980), Paul Ricoeur (1913) and Emmanuel Levinas (1906). Of these, Sartre and Merleau-Ponty are perhaps most widely referred to in nursing phenomenological commentaries (Beitz, 1999; Burns & Grove, 1987; Moody, 1990; Moyle & Clinton, 1997; Parse, Coyne & Smith, 1985). Although, the phenomenologies of French Phase philosophers appear to have had more impact on the development of psychology and sociology than general nursing theory.

The infiltration of French philosophy by German phenomenology between the First and Second World Wars is described as a “cultural paradox” and evidence of a “decline of philosophical nationalism” (Spiegelberg, 1982, p. 428). Philosophical patriotism could have been expected to remain staunch during such a turbulent time in European history. Unfortunately, the frontiers of academia and science do not recognise the same political frontiers. As French academics and students from German universities, returned to their homeland or sought refuge in France, they brought with them phenomenological philosophy.

Husserlian and Heideggerian phenomenology in particular intrigued French intellectuals and the French viewed both of these phenomenological philosophies as more cohesive and aligned than their German contemporaries. French novitiates credited both phenomenological viewpoints as having more common elements than either German philosopher could have imagined, let alone acknowledged. The segregation of phenomenology and existentialism that was rife in Germany at the time was ignored by the French and these two terms merged harmoniously into French existentialist phenomenology. The outcome of such a merger was a closer association of both

phenomenology and the arts, particularly literature, at the expense of the physical sciences (Spiegelberg, 1982).

This disconnection of phenomenology from the rigorous physical sciences in preference to the formation of closer bonds with the arts, as well as the political and social sciences, became more evident throughout the French Phase. Sartre and Merleau-Ponty in particular, appear to have repudiated rigorous science in favour of existentialism and this led to a new branch of phenomenology which became known as phenomenological existentialism. Sartre's early commitment to Husserlian phenomenological principles was well known. He embraced the concept of intentionality which to him "expressed the separation and independence between consciousness and its referent" (Cohen, 1987, p. 34). The main concept of Sartre's phenomenology was that of consciousness which he did not perceive as 'transcendental' but as concrete human existence situated in a human world (Sartre, 1969).

There is an analogy to be drawn between "Heidegger's being in the world and Sartre's being in consciousness" (Anderson, et al. 1986, p. 97). This new view of consciousness led Sartre to develop an analytic approach, which although he still referred to as phenomenology, he titled existential psychoanalysis. Such a theory suggests a Freudian and Adlerian influence and existential psychoanalysis was to afford individuals with an intuitive insight into their own subconscious interests. Sartre's inconsistency and flexibility with interpreting the boundaries of phenomenology was further demonstrated in the 1950s. During this decade he could have been accused of phenomenological treachery because of his commitment to Marxism and his philosophical slant became known as existentialist Marxism (Grossmann, 1984).

Merleau-Ponty on the other hand adopted a "biopolar phenomenology" which combined a subjective and objective approach, which was a complete contradiction to Husserl's search for a "foundation for all knowledge in pure subjectivity" (Spiegelberg, 1982, p. 552). Merleau-Ponty was concerned with describing perception and behaviour in relation to human existence in the world and although he adopted Husserlian principles such as phenomenological reduction and discussed the need to 'return to the phenomena' he merged these principles with those more in accord with the field of Gestalt psychology. The overall theme of the French Phase of the Phenomenological

Movement was the concept of “embodiment and being-in the-world” (Streubert & Carpenter, 1995, p. 47), in context to historical, knowledgeable and perceptual relationships and their influence on the individual (Merleau-Ponty, 1962). This external projection of ‘being’ is in sharp contrast to the internal projection of ‘being’ that was so vital a concept during the German Phase of the Movement. Then Husserl’s object was to go ‘back to the things themselves’ in search of clarity and Heidegger’s Dasein was a Being that first questioned its own being-in the-world.

The spread of French existentialism in the United Kingdom following World War II stimulated a revival in academic interest in phenomenology. Prior to World War I, Brentano and Meinong’s philosophies were relatively well known and Husserl himself had lectured at the University of London in 1922. Britain had in fact, produced some noted philosophers such as Bertrand Russell and Royce Gibson who demonstrated a strong interest in phenomenology. The migration of phenomenology to North America began with the trickle of Husserl’s Gottingen students in the early 1900s, but the flow of interest increased as displaced academics from World War II effected Europe sought safe havens in North America (Lopez, 1982; Spiegelberg, 1982). Alfred Schult (1899-1959), an Austrian, is recognised as being responsible for introducing phenomenology into the social sciences of North America (Crotty, 1996). According to Crotty (1996, p. 2) phenomenology in North America was very much influenced by “humanistic psychology” and therefore “became fundamentally distorted”, especially during the 1960s. Phenomenologists of this era, such as van Kaam and Giorgi, appear to have inspired or influenced some nurses with an interest in phenomenological research (Beck, 1994; Natterlund & Ahlstrom, 1999; Streubert & Carpenter, 1999).

Phenomenology and Nursing Research

The art of nursing is one of the oldest arts but the science of nursing is still relatively young (Donahue, 1996). In endeavours to expand the body of scientific knowledge, nurse researchers initially embraced quantitative approaches to research. However, whilst quantitative approaches provided answers to nursing questions from a distinctly physical science perspective (Lewicki, Mion & Secic, 2000; Moore, 2000; Vowden, Mason, Wilkinson & Vowden, 2000), they did not provide answers for the equally important qualitative questions that have interested such a humanistic science as nursing. During the 1980s there was experimental exploration by nurses into

phenomenological research, but such enthusiasm was not initially supported with an adequate backup of nursing guidelines and reference texts (Morse, 1989). As nurses became to appreciate the value of qualitative approaches in nursing research and developed the necessary skills in conducting such research, publications to support such endeavours increased. It seems that succeeding generations of nurse phenomenologists have relied on these publications for phenomenological instruction rather than returning to the work of the founders of the Phenomenology Movement (Cioffi, 1997; Paley, 1996; Porter, 1999; van der Merwe, 1999).

During the 1980s there was an increasing enrolment of nurses into tertiary institutions in either undergraduate or postgraduate programmes (Tinkle & Beaton, 1983). Many of these nurse scholars were exposed to the other human science disciplines of psychology, anthropology and sociology. Within these disciplines qualitative methodologies such as phenomenology and ethnography were well-entrenched and seen as credible methods for researching the questions that affect human behaviour. Nurses began to adopt these research methodologies to provide answers to the qualitative questions that so affected nursing practice (Benner, 1984; Dugan, 1984; Leininger, 1984). Phenomenology in particular, was seen as being a valuable methodology for interpreting the lived experiences of both patients and nurses.

Nurse scholars who aligned themselves with phenomenology could be broadly divided into two distinct groups; either phenomenological purists or phenomenological evolutionalists. The former group proposed that the integration of phenomenology, as expounded by Husserl and Heidegger, within other disciplines such as nursing, has resulted in a detrimental mutation or distortion of the pedigree philosophical phenomenology (Crotty, 1996; Paley, 1997). Whilst the latter group suggested that an evolutionary adaptation of phenomenology within other disciplines, such as nursing, was not only to be expected, but warranted for promoting phenomenological understanding appropriate to each unique discipline (Benner, 1994; Streubert & Carpenter, 1999).

Crotty (1996) cites the assimilation and Americanisation of phenomenology amongst psychologists during the 1960s as a major mutation from the fundamental European philosophy. This he implied, resulted in a form of humanistic social inquiry, which

continued to erroneously bear the label 'phenomenology'. Crotty (1996) argued that the discipline of nursing was also guilty of using phenomenology as a type of social inquiry.

This view is supported by Paley (1997) who claims a gross distortion exists in the interpretation of phenomenology in the nursing literature. He is critical of nurses' failure to understand the concepts of the founders of the phenomenological movement and suggests this occurs because nurses have distanced themselves from the literature and thus, the thinking of the original authors. Instead he claims, as was suggested earlier, that they rely on the phenomenological interpretations of succeeding generations of 'nurse' phenomenologists. To compound this distortion, Paley (1997) accuses nurses of using Husserlian terminology in an unintelligible manner to describe totally new and alien concepts.

One could argue that the use of ambiguous terminology to describe new and different concepts is in fact, in keeping with Husserl's phenomenology, and for that matter the phenomenological language of most of his more eminent successors who include Heidegger and Sartre. The long established habit of re-cycling phenomenological language without adequate explanation of conceptual definitions has been shown to have caused confusion amongst scholars since the nineteenth century. Unfortunately, ambiguity in regards to phenomenological language will continue to confuse all but the most diligent and inquisitive nurse scholars who do return to the primary literature. Even then, clarity can not be guaranteed and Spiegelberg suggests that:

In such cases all that can be done is to point out the difficulty frankly and to interpret such expressions in the light of the context that is, primarily the context of the phenomena to which they point, however ambiguously (1982, p. 71).

In the light of such a statement, how can one be certain that Paley's scholarly interpretation of Husserl's ambiguous terminology is any more an insightful interpretation than that of other nurse scholars whom he claims are misguided?

The difficulties experienced in having to provide a consensual definition of phenomenology have already been demonstrated. Similar difficulties exist within the

nursing profession for there is not one definition of nursing, but many amongst nurses (Moody, 1990). My favoured definition of nursing is “a dialogue – a human to human event. It is an experience that involves a meeting of human beings... a process of human to human relating” (Long & Proffit, 1981, p. 2). Nursing has always been, and shall hopefully always be, interested in the human event and what that experience means to the individual involved. This viewpoint is very much in keeping with the existentialist phenomenological view, as initially purported by Heidegger, and developed more fully by the philosophers of the French Phase. Such a philosophical approach is directed towards understanding the experience of embodiment and relating within this human to human event.

The word ‘experience’ finds great favour in the nursing literature and nursing phenomenologists appear to have laid claim to the term in much the same way as the homosexual community have laid claim to the word ‘gay’. According to Oiler phenomenology is “possessed by a reverence for experience, it conforms to nursing’s valuing” and is concerned with “lived experience ... to describe experience as it is lived” (1982, p. 178). Munhall writes “experience is quantifiable ... and may be consistent with nursing’s stated philosophical beliefs in which subjectivity, shared experience, shared language, interrelatedness, human interpretation and reality as experienced rather than contrived are considered” (1981, p. 177). Omery on the other hand, states phenomenology “attempts to study the human experience as it is lived” (1983, p. 50).

These three authors all use the term ‘lived experience’ liberally, as do more recent authors (Benner, 1994; Streubert & Carpenter, 1999), but none of them actually explains what they mean by ‘experience’, and yet Munhall stated that it is quantifiable. There appears to be a tacit understanding amongst nurses scholars since the publications of Munhall (1981), Oiler (1982) and Omery (1983), that lived experience in relation to phenomenology is an understood concept. However, nurse phenomenologists who fail to return to the source of phenomenological language deprive themselves of a rich insight.

The word ‘experience’ has two meanings in the German language. It has a similar meaning to the English translation and refers to experience in general as one would use it in regard to an event or practice. Its second meaning however, refers to the verb ‘to

live' and according to Palmer (1969, p. 107) "suggests an immediacy of life itself as we meet it". He refers to the German philosopher, Wilhelm Dilthey, and his use of the phrase 'lived experience' and its reference to many encounters over time or of the bringing together of events of various kinds, times and places that unite as an experience (Palmer, 1969).

The term 'experience' is considerably enriched and has more of an expansive connotation in philosophical circles. Heidegger authored a book titled: "*Hegel's Concept of Experience*" and in it he wrote "experience is the beingness of beings, whose determination ... is determined in terms of subjectiveness" and from every experience consciousness receives from it "a new object" (Heidegger, 1970, p. 119). There is an uniqueness in every experience and the goal of eidetic reduction is to reveal the unique essence of the individual experience. Paley (1997) challenges nurses' understanding of this concept and finds fault with nurses who refer to experience as being both universal and unique.

On one hand, an essence is supposed to be something intrinsic to the individual's lived experience of a certain 'phenomenon'; on the other hand it is supposed to be universal – and not only universal, but essential – to all the experiences which can be classified in the same way. It is simply not possible for it to be both at once (Paley, 1997, p. 192).

Paley argues that it is impossible to reveal the "similarities and differences in the accounts of experience offered by a particular sample of respondents" (Paley, 1997, p. 192). The valuing of individuals and their unique responses to experiences sits well within the philosophy of nursing as a caring and humanistic science (Bishop & Scudder, 1999). Whilst the ability to observe and interpret similarities and differences between individuals sits well within the realm of nursing clinical practice (Nightingale, 1969). I would like to propose that it is this very ability to identify and understand the similarities and differences that are potentially common to a given population, which makes phenomenology such a useful and important methodology for nursing research.

The debate in the nursing literature however, centres on whether all the 'similarities' found in the interpretation of the lived experience of individuals should be combined to substantiate a theory in nursing practice or whether all the 'differences' identified

should be combined to emphasise the uniqueness of the individual, their needs and practices. Crotty (1996) is very critical of Benner and her contemporaries (Benner, 1984; Benner, 1985; Benner & Wrubel, 1989) in regard to their interpretation of Heideggerian phenomenology and hermeneutics as a means to determine shared meanings and common practices rather than solely revealing individual experience. Benner on the other hand supports her stance with the argument that individuals have a background that is historical and cultural, it is not individually constructed and that interpretation of an experience is reliant on that background (Benner, 1984). I am of the opinion that whilst the Heidegger of *Being and Time* would have agreed with Crotty, the Heidegger of the late middle period would have agreed with Benner (Plager, 1994).

The important aspect of this dialogue is in determining the best approach for answering questions that concern nursing. Nurses are intensely interested in the uniqueness of the individual and unique interpretation of any lived experience as understood by Heidegger's 'beingness of beings'. Yegdich's (2000) study on the experience of dying as interpreted by a single dying patient provided insight into the uniqueness of that event. But nursing is equally interested in interpreting the significance of shared experiences that result from human to human events (Long & Proffit, 1981). Moreover, it stands to reason that studies that endeavour to interpret the significance of shared lived experiences will firstly, have to interpret the unique individual lived experience before they can find common denominators to explain that shared experience (Odell, 2000; Scannell-Desch, 2000). So it is with this study, although I was interested in interpreting the unique lived experience of individual stomal therapy nurses, it was only through describing those experiences that I could determine whether there were experiences common to the group and nurses in general.

Conclusion

Disagreement amongst nurse phenomenologists is not really surprising for there was dissent amongst the founders of the Phenomenology Movement. This dissent was rooted in the ambiguous language and evolutionary changes of the various phenomenologies, especially those of Husserl and Heidegger. It is ironic that these two individuals who sought so passionately to find 'clarity' in knowledge, left for their descendants a legacy of ambiguity of meaning, which will always be open to variable interpretation. Such variances in interpretation should not in fact be negated, but be

applauded as a sign of vitality as suggested by Natanson (1960). For variation affords opportunities for fresh insights and phenomenological applications. Not least of all within the nursing profession.

Although the founders of the Phenomenological Movement - Brentano, Stumpf, Husserl and Heidegger (during his earlier periods) - may have differed in their individual interpretations, they were in total accord when it came to the need for scientific rigour. It is the rigour in which the phenomena are approached in order to reveal, intuit, analyse and describe the essence of the phenomena that is central to the tenet of phenomenology. Ultimately, it is phenomenological seeing that is the goal, and whether that is achieved by travelling down the Husserlian or the Heideggerian hermeneutical path is dependent on whether one is interested in the epistemological aspect of 'how do we know about mankind' or the hermeneutic aspect of 'what is Being-in-the-world'. For the purposes of this research, it is the interpretation of the lived experience of Being-in-the-world of stomal therapy nurses that is of interest. Therefore, whilst phenomenology is the vehicle which transported this research, the research question directed the phenomenological route it was to travel, and it selected to travel down the hermeneutical or interpretative route.

Chapter 7

The Experience of *Being* a Stomal Therapy Nurse

Introduction

This chapter records the experiences of 19 female stomal therapy nurses who between them completed their general nurse education in the six Australian states. All of the stomal therapy nurses initially completed hospital based diplomas in general nursing, although six of them went on to enrol in tertiary nurse education programmes. Eight of the nurses began their general nurse training during the 1950s, eight began their training in the 1960s and the remaining three nurses in the 1970s.

At the time of interview 12 of the nurses (Meg, Sharon, Nancy, Maxine, Linda, Lorraine, Judith, Anne, Barbara, Joanne, Tessa and Colleen) were actively employed as stomal therapy nurses. Four of the nurses (Esme, Christine, Sabrina and Danni) although employed as stomal therapy nurses during the 1970-80s were at the time of this study actively employed as nurses within management domains of the profession. Their decision to move away from stomal therapy nursing had been influenced by opportunities to advance to more senior positions. Prior to the late 1980s and the introduction of what is commonly referred to as a career structure or pathway, there were few opportunities for nurses in Australia to be promoted to higher ranks unless they moved into management positions. However, these four nurses had maintained a professional interest in stomal therapy nursing and they were recognised by their peers as having contributed significantly to the development of the specialty within Australia. Kate had retired, but she too, had received similar recognition by her peers. Susie and Kylie, who although not actively employed in nursing were working in related health industries.

Four of the stomal therapy nurses (Kate, Sharon, Judith and Christine) had not completed a formalised stomal therapy education programme. It transpired that their interest and practice in stomal therapy nursing occurred prior to the development of formalised courses within Australia and they had been accepted as members of the AASTN as either founding members or because of their prior stomal therapy experience.

The 19 nurses whose interview excerpts and exemplars are used in this study are not identified by their real names but pseudonyms as has been explained in chapter 2. It was also felt that the use of initials would also permit a breach of their confidentiality considering the close professional network that exists between stomal therapy nurses in Australia. Therefore, each stomal therapy nurse has been given a pseudonym and Table 2.7 presented in chapter 2 lists the 19 pseudonyms given to the stomal therapy nurses (STNs), the year they began general nursing training, year they completed a stomal therapy nursing education programme (STNEP) and their status of employment at time of interview.

As outlined in chapter 2 interpretative phenomenology as a systematic approach was used to analyse data obtained from the 19 transcribed interviews. Analysis involved the use of bracketing, reflection and phenomenological interpretation of the data in order to identify the common themes and sub-themes as reported. An example of an interview extract can be found in Appendix A and an example of how this extract was analysed into codes, categories and themes is to be found in Appendix B. Phenomenological analysis revealed five distinct themes which described the *Experience of Being a Stomal Therapy Nurse in Australia*. These five themes were: Seeking to Care, Committed to a Better Way, Seeking Knowledge, Professing Thoroughness and Feeling Good. These themes are presented in the following schematic representation (Figure 7.1).

THE EXPERIENCE OF BEING A STOMAL THERAPY NURSE

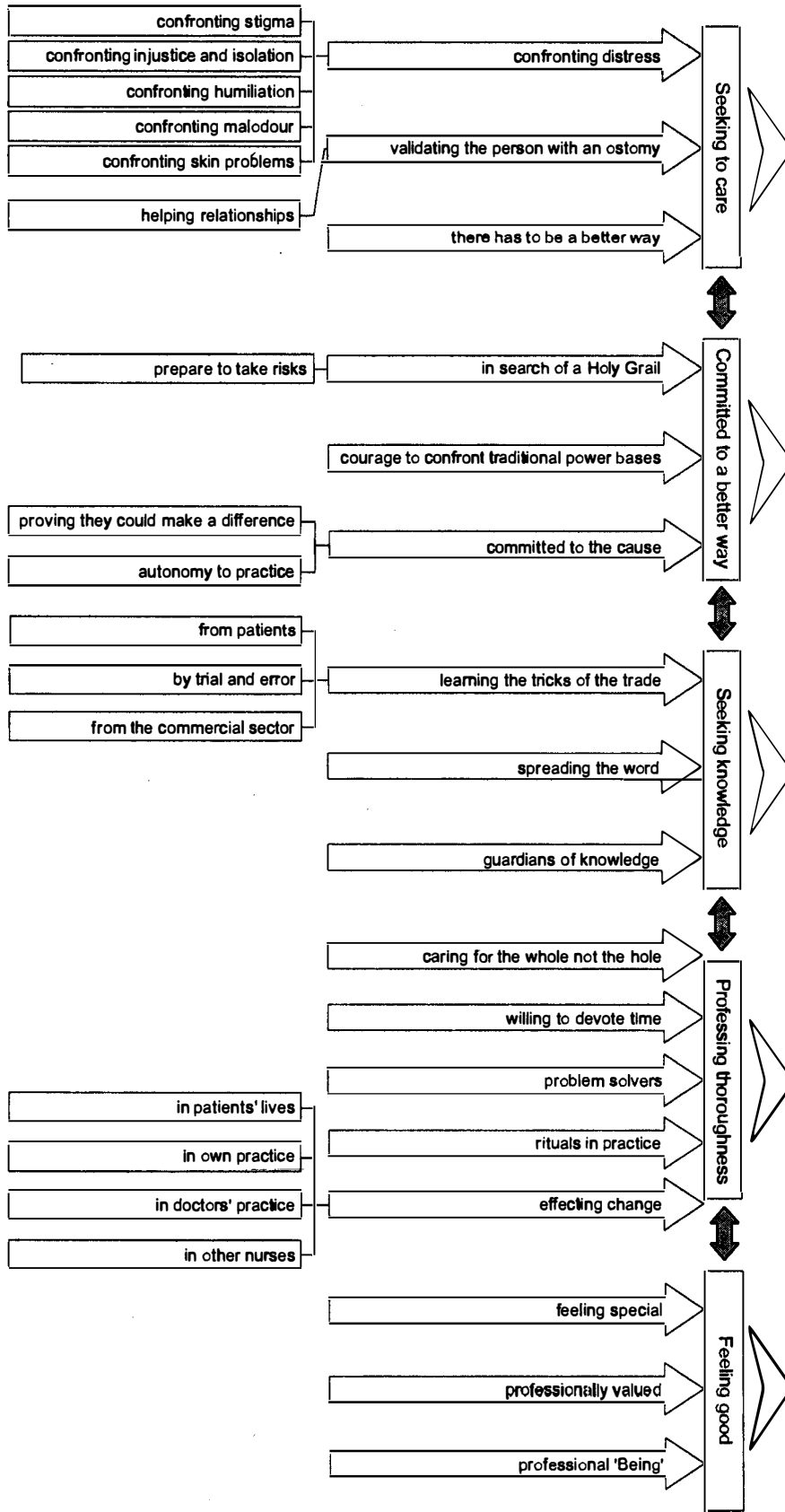


Figure 7.1

Subsequent to the themes that emerged from the data in regards to describing *The Experience of Being a Stomal Therapy Nurse*, the data revealed an independent theme related to the evolution and development of stomal therapy nursing in Australia. The theme that emerged from this data analysis was titled A Corporate Identity.

Because this latter theme gave insight into the corporate world of stomal therapy nurses in Australia, which is intrinsically linked to the individual experience of being a stomal therapy nurse, I have included this analysis under the title *The Specialty of Stomal Therapy Nursing*.

Seeking to Care

The first theme to emerge from the data in regard to what it is to be a stomal therapy nurse was Seeking to Care. Care as a definitive concept generally remains an ambiguous and enigmatic descriptor for all nursing interventions and attitudes. Although this ambiguity tends to be overlooked as nurses rely on this universal term to define the many aspects and behaviours of nursing practice. In analysing the theme Seeking to Care I was able to determine the elements that hindered or improved the delivery of nursing care to people with a stoma or fistula.

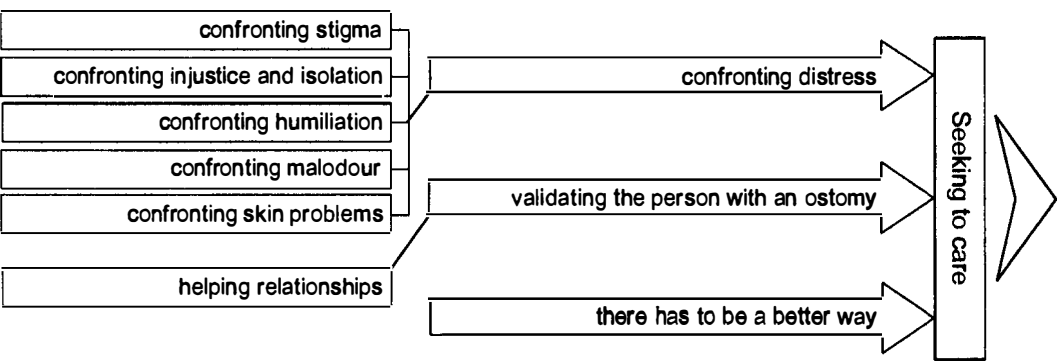


Figure 7.2

Figure 7.2 presents a schematic representation of this theme and the arrows indicate the elements that impacted on the care of patients with a stoma or fistula. It can be seen that the stomal therapy nurses in this study encountered five specific problems, which they recognised to be the cause of patients’ distress. The nurses in this study demonstrated their willingness to validate people with an ostomy, and this they achieved through

helping relationships. The helping relationships involved physical, psychological and social aspects of caring. However, these helping relationships were at times severely hindered because of a dearth of physical care options available. The stomal therapy nurses recognised the need for, and were committed to finding, a better way to care for all the problems that confronted people with an ostomy.

Confronting Distress

Potential life-threatening surgery or illness could readily be perceived to threaten individuals' mortality and morbidity. The nurses in this study however, considered that the problems and difficulties that confronted persons who underwent surgery that resulted in a stoma or fistula and which they perceived were the predominate cause of their distress, were issues specific to living with, and management of, the stoma or fistula. These problems and difficulties were categorised under five distinct headings: stigma, injustice and social isolation, humiliation, malodour and painful skin. Conversely, it was seen that these same five problems had caused professional distress for the nurses prior to the advancement of their knowledge and modern appliance technology.

Confronting stigma

The presence of a stoma marked some people with a stigma that appeared to influence the behaviour of some nurses and was perceived by the nurses in this study to lead to attitudes akin to repulsion and aversion to care for these people. Linda, who had completed a stomal therapy course in the mid-1970s, reflected on the attitudes she perceived existed amongst her medical and nursing colleagues during that era towards patients who had a stoma.

In those days the attitudes towards a patient was absolutely shocking, no one wanted to touch the patient, no one wanted to have anything to do with the patient because they had one of 'those things', which used to aggravate me very deeply. (Linda)

According to the nurses in this study, attitudes of some of their colleagues appear to have been influenced in part by the concern that there might be contact with bodily effluent if one should touch a patient with a stoma. It should be pointed out that many of the latter-day blood borne viruses that cause nurses today to practice stringent

precautions to prevent contact with all bodily fluids, were actually unknown during the early 1970s. However, the principles of infection control and the risks associated with cross-contamination were well appreciated at that time (Madsen, 2000). It was the use of terms such as “poo or wee” and “yucky” (Sabrina) and “undesirables” (Kate) that causes one to suggest that the fear of faecal or urinary contamination was influenced rather by more aesthetic considerations.

We were all very ignorant of stomas and I guess we at that stage still had the same stigma attached to us with stomas that it was poo or wee and yucky and so ...there was sort of no hands, no touch to these patients. (Sabrina)

During the 1960s facemasks were routinely worn whilst nurses performed aseptic wound dressing procedures and occasionally if they encountered acute malodour. Unsterile gloves were reserved for only the dirtiest of tasks (Moroney, 1967; Nash, 1967). Therefore, it was a particular act of defiance against the attitudinal taboos of her colleagues when Kate stated her refusal to wear gloves and a mask when providing colostomy care.

I'd be presented with the mask, the rubber gloves and it was almost as if you know, you were dealing with the undesirables. Well I used to say, “take your mask, you can take your gloves, I'll have the gown. But I don't need those things”. I know people think, well they hear people talk about them “Oh! the colostomy in bed so and so” and they all feel dirty. I said “I'm not going to make them feel dirty”. They're normal people as far as I am concerned. (Kate)

The pioneer stomal therapy nurses had the impression that they too were marked with a stigma because of their willingness to care for these patients.

I used to get it thrown at me: “what on earth do you want to do a job like that for, isn't it awful?” It wasn't unheard of for nurses to look at the patient, and doctors too, and say “oh! that's dreadful, that's disgusting, if I had that I'd kill myself” ... I can remember one quite middle aged sister saying that to a patient and then turning around to me and saying will you fix it up ...she said we never did this type of surgery when I did my training. (Meg)

On reflection, some of the stomal therapy nurses at interview admitted that they too had possessed similar negative attitudes to patients who possessed a stoma. Anne stated that prior to doing a stomal therapy course she “would've died rather than have had a stoma

made”. Whilst Colleen said that she “was horrified and so were they” at the thought of having a stoma. Furthermore, Colleen considered that it was because stoma patients perceived that these attitudes existed amongst nursing and medical personnel that they “hid themselves away and they were very reticent people”. (Colleen)

Confronting injustice and social isolation

The stomal therapy nurses were also confronted by many injustices and the social isolation of patients with a stoma or faecal fistula. There appears to have been entrenched but unwritten hospital policies, that resulted in stoma patients being isolated and frequently deprived of the care of the most senior nurses. Both of these actions could be perceived to have reinforced the stigmatising behaviours discussed previously.

According to Susie, Tessa, Anne and Christine the ostracism of patients with stomas to hospital verandas and single rooms was a common occurrence prior to the availability of effectual ostomy appliances. The reasons given by the nurses for this practice related to concerns about malodour and fears that these patients would contaminate the pristine environment of a surgical ward.

We used to put patients in a single room because the smell was so horrendous. It was really awful. (Susie.)

If a single room or veranda was not available then patients with a stoma were “put at the very end of the ward away from the entrance” (Christine). Some nurses considered ostomy patients to be “dirty” (Tessa) surgical cases long after they left the operating suite and this belief was the grounds for isolating these patients from other post-operative patients. Infection control concerns appeared at times to deprive ostomy patients of the care of the most senior charge nurses. Tessa, Anne, Maxine and Colleen’s exemplars that follow highlight this practice, which occurred within their hospitals during the 1950s, 1960s and early 1970s.

I had no idea how to look after a patient with a colostomy, no idea whatsoever because at that time I was a charge nurse in a clean surgical ward and they were classed as dirty surgery and put in another ward, isolated. (Tessa)

The senior nurses didn't have anything to do with people who had colostomies or ileostomies or anything like that because they were dirty ... it was only the junior nurses, the people at the very bottom of the pile that dealt with these unfortunate souls. (Anne)

There was also an impression that senior nurses were reluctant to care for ostomy patients for other reasons.

My vivid memory of looking after colostomy patients was when you worked in a surgical ward the junior nurse usually got that job to do. (Maxine)

Nobody wanted to (*care for them*) if you were the junior on you got it because you couldn't say no... patients definitely perceived there was a problem. (Colleen)

Initially these comments appear to indicate a derisive attitude of stomal therapy nurses towards the aesthetic sensitivities of the senior nursing ranks. However, one could equally surmise from these comments that the avoidance of these patients by senior nurses could be justified from both an aesthetic and scientific viewpoint. Malodour emerging from leaking ostomy appliances would have been a significant concern for other surgical patients in close proximity. Consideration afforded these patients could have been deemed justifiable grounds for positioning the beds of ostomy patients as far away as possible.

In regard to the allocation of nursing duties, it could have been reasoned that stoma care was but a toileting task that required less nursing skill than the more complex wound dressing procedures one would expect to find in surgical wards. The perceived risk of cross infection in wound sites may have influenced the allocation of stoma care to more junior nurses, whilst senior nurses were allocated the more complex tasks.

According to Kylie it was the norm for patients following ostomy surgery to have lengthy stays in hospital and this compounded their social isolation within the hospital environment. They would spend about 3 or 4 weeks and they always ended up being in a room on their own because of the odour that was associated with a stoma. (Kylie) The nurses made no comment in regard to how other patients or visitors in the wards reacted to malodour that originated from stoma effluent.

It appears that these ostracising practices were not limited to hospitals but continued once a person was discharged. Regardless, such practices were deemed as unacceptable in the eyes of the stomal therapy nurses and such behaviour attracted criticism because they were seen to be unjust. Maxine recalled with emotion an occasion during the 1970s when the ostracism of a child within his school community warranted her concern and criticism.

A mother rang me out of the blue one day and said she heard that I was doing it here (*bowel irrigations as a form of bowel management for the children who had had reconstruction surgery for imperforated anuses and who were socially unacceptable because of their faecal incontinence*), so I asked her to come down and bring her son and they came down from the Blue Mountains, and she very stressfully told me how she had gone to the school – and the mountains are cold in winter – she had gone to the school to wait for her child and looked in the window, saw that he was sitting near an open window with a fan blowing on him. This had gone on for many months and he had accepted it as the norm because he smelt and had never told his mother. (Maxine)

This exemplar conjures up a mental picture of a child being isolated and victimised because of faecal malodour. The teacher's actions were probably intended to reduce all of the student's olfactory discomfort. However, the teacher's behaviour reinforced the child's problems for he became the focus of more attention and further physical distress. The child had apparently accepted his condition as "the norm". One can only speculate as to whether his mother did not recognise a problem existed or chose to deny it did. Scenarios such as this revealed that living with a stoma was for some people, synonymous to living with ostracism and humiliation.

Confronting humiliation

Reticence on behalf of health professionals to care for persons with stomas could be reasoned to have stimulated and reinforced negative self perceptions amongst these patients. Meg recalled that during the early 1970s she sensed that all the stoma patients with whom she had contact, lived with shame.

When I started this everybody was ashamed of it - very, very ashamed. They used to go home and lock themselves in and then after a period of time they became generally depressed, they'd go to the doctor and say they couldn't sleep and save up all the sleeping pills and take the lot. I think anybody, and I would've been no different, that had to have elastic straps holding on a

non-adhesive appliance and relying on your bowel motion to get in there when you knew that if you bent quickly or reached for the top shelf the whole thing might move and you'd end up with a pinny full of poo, would have to be depressed. And they were scared ... we used to say that it was 50% physical help that we were giving the people and 50% psychological support. (Meg)

Anne echoed similar sentiments when she said "I don't know how the people lived with them and many of them in fact didn't." Danni recalled being confronted by the following experience which occurred in a major metropolitan hospital during the 1950s when she was a student nurse and of a similar age to the patient in question.

One of the most impressionable experiences of my nursing training occurred in a surgical ward. There was a young man who had had an ileostomy done for ulcerative colitis. He was 18 years of age and he was very ill he had the ileostomy done some time before I met him but he had come into the ward and was not able to have an appliance that fitted him. I walked behind the screens one day and found him crying and realised just what he must have been going through in terms of being just totally sociably unacceptable and I think his whole masculinity was questionable to him at that time. I'll never forget that. (Danni)

Danni remembered that for years after this event, whenever she came in contact with patients who were having urinary diversions, she sensed that they were "people who where feeling very bad about what had happened to them". Maxine stated that she felt sorry for stoma patients because "I always felt that they were second class citizens". Christine recalled with great concern the "embarrassment" and "loss of dignity" she witnessed during her student years, when a female patient had to endure uncontrolled leakage from bilateral urinary and faecal stomas.

Anne also perceived some people considered the stoma to be a physical handicap rather than social handicap. However, she had the insight to recognise that the real handicap was not the altered body function, but the lack of appropriate appliances and the dearth of professional support available.

We had this funny little man that came from a shop somewhere in town who had a colostomy and he used to talk to these patients and he had a twisted shoulder. I mean the poor man was handicapped besides and he had a colostomy as well and I don't wish to sound as though I'm denigrating him in any way but his visual presentation to somebody who had just had a stoma made was of a person who was handicapped. This was the impression that people generally with

stomas had until as far as I could see, until the event of reasonable equipment and stomal therapy nurses in Australia. (Anne)

Being handicapped by the lack of an appropriate means to contain effluent compounded the humiliation associated with the social taboo of body malodour.

Confronting malodour

The sense of smell affords one with a sense for pleasure and protection. Reactions to various odours invoke sensations of a very personal nature and are subject to preference, past experience and social customs. All of the stomal therapy nurses made mention of acutely unpleasant olfactory experiences associated with the care of patients with stomas and remembered these experiences in terms akin to “they did smell very badly” (Anne) or “the smell was unbelievable” (Susie). Esme readily recalled “there was always the odour and that was the biggest problem.”

Malodour occurred because of ineffectual appliances which frequently failed to contain effluent. In many instances, those early appliances themselves were a source of significant malodour. Anne remembered “the smell of the rubber ostomy appliances that were prevalent in those times”. She recalled with distaste, the practice of cleaning these rubber appliances.

You used to wash out these bags in the pan room and I can remember being nauseated to the degree that I was retching over the pan flush as I cleaned out these appliances. (Anne)

Anne also outlined the practice of soaking the rubber appliances in pungent disinfectants, which in her memory compounded the odour problem rather than diminish the effect.

We used to soak all these things... *in* a substance called Cillin which was based on this phenol ... and the mortuary bundles and stuff were soaked in Cillin 1 in 5,000 because you know you got germs from people who were dead and the colostomy bags were actually soaked in large enamel bowls of Cillin 1 in 10,000. (Anne)

The use of potent pharmaceutical agents to cloak malodour persisted up until the 1980s and these agents were used quite liberally with the long plastic post-operative bags the

nurses used. Susie recalled that the “long bag initially used to be three feet long and actually drained into a bucket under the bed with a pan cover over the top of the bucket”. When asked how she would endeavour to control the malodour from such an open system Susie stated:

It was horrible. It was horrendous. We had a terrible product it was like a ‘Nilodor™¹’ it was really like a toilet smell that they used to clean the toilets with, and we used to put it on the top of the cloth cover and it was awful. (Susie)

Obviously these pharmaceutical agents were considered to be equally as offensive as the faecal odours they were endeavouring to camouflage. The more effective option was to ostracise patients with stomas or fistulae to hospital ward verandas or single rooms. Unfortunately, this offered stoma patients no respite for they were unable to distance themselves from the source of malodour and in fact, were additionally confronted by offensive pharmaceutical agents that “were sprinkled around the room”. (Kylie)

If they had a colostomy they were always nursed on the veranda of the ward and not in the ward because of the odour. Right back in the very early times I guess I was very sorry for these patients because they had to live with this odour that they had. (Maxine)

Living with malodour however, was perhaps preferable than having to endure the pain caused by severely denuded skin.

In the sixties you would just walk into the room and you would know if the colostomy had worked because you could smell it or else you would know that the ileostomy had leaked all over their skin and was hurting them because they would be crying. (Nancy)

Nancy’s experiences during this era taught her to rely on olfactory and emotional responses as clinical indicators for nursing interventions. Sadly, the routine nursing interventions were usually inadequate to deal with the extent of the skin problems that confronted them.

¹ Nilodor™ is a highly pungent room deodorant agent.

Confronting skin problems

The stomal therapy nurses all recalled experiences when they were confronted by patients with extensive and painful skin ulceration. The problems appeared to be exacerbated during the 1960s and 1970s when Meg recalled there was “a very, very high degree of skin problems”. Loss of peristomal skin integrity resulted from contact with highly acidic or alkaline body fluids that drained from stomas or fistulae. In some instances, skin damage resulted from the use of tight belts or metal flanges which were used to secure non-adhesive appliances (Susie). People with skin problems it seems, were either very stoic or had learned to accept that there were no alternative options.

The majority of patients I saw definitely had skin problems... they used to use metal retaining rings on patients particularly with ileostomies and you would have people come in who had the deepest gorges in their skin like you wouldn't believe, people who thought raw weeping skin was a natural part of their lives. (Susie)

Post-operative stoma care during the 1960s was generally aligned with procedures for dressing wounds.

There was not any (*specific*) care for people who had stomas. They had dressings on their stomas in the same way as somebody with a suture line had a dressing on their wound. (Anne)

However, “the person who had a colostomy was always the last dressing to be done because it was considered the dirty dressing” (Maxine). It does not require much effort to imagine the pain and distress that patients endured when effluent saturated dressings were left for extended periods of time on severely denuded skin. Their anguish would have been compounded as they waited for the nurse to complete the clean dressing procedures before attending to their needs.

I remember the feeling of frustration as a junior nurse trying to cope with the sore skin around these things called stomas, which I really didn't know much about and I felt a bit ignorant. We used to paint that dreadful aluminium paste or whatever it was, onto the skin of these people so they looked like something from outer space with all this silver skin. I remember one lady, very upset and crying with the pain of the excoriation, but we seemed as though we were powerless to do much more. (Nancy)

During the 1960s, according to Meg they “didn’t have a great deal of appliances to use” and “it was quite common to have people excoriated from the nipple to above knee with just hardly any skin left just because ileal fluid had poured everywhere and nothing stayed stuck” to the ulcerated skin. Denuded skin as a result of leaking appliances not only caused the patients severe pain but resulted in, or compounded, all the other distressful problems such as malodour, humiliation and injustice.

The nurses vividly remembered their own despair when faced with these problems and used phrases such as: “it was just so pathetic” (Kate) and “there was a lot of distress associated with a stoma” (Nancy). Although the nurses displayed a willingness to care for patients with a stoma and to validate them as “normal” (Kate) people, they were frustrated by a personal and general lack of know-how and reliable treatment options.

Validating the Person with a Stoma

Patients undergoing ostomy surgery and the construction of an abdominal stoma are expected to adapt to a change in altered bowel or bladder habits. The physical changes in the patient’s body are very obvious and physical problems are normally easily identified. Conversely, the changes in the patient’s concept of self and the alterations they perceive to have occurred in their body image, self-esteem, self-actualisation and sexuality are not so obvious. Nor are their fears which are associated with having a life threatening event such as surgery or a disease such as cancer. Compounding these concerns is the fact that they are living with the constant evidence - the presence of a stoma - which declares that they are indeed different.

The need to confirm their patients’ value and worth was demonstrated mostly, in the nurses’ willingness to associate with stoma patients when some of their colleagues declined to do so.

I like my contact with my patients, I think that’s wonderful. You get to know them so well and you know, I don’t know. I just love the people. (Judith)

Throughout all the interviews there was an impression that all the stomal therapy nurses “genuinely liked people” (Sabrina). They all voiced sentiments of enthusiasm about caring for patients with stomas. However, this enthusiasm was not reciprocated by

many of their non-stomal therapy nurse colleagues. Susie recalled her impression of the first stomal therapy nurse she knew who was appointed to the major metropolitan hospital where she worked during the early 1970s.

She bored us insane about looking after these wonderful patients and all we used to say was “Oh! My God imagine enjoying changing... bags”. That’s literally what it was and I thought she was off her tree. (Susie)

The role of the stomal therapy nurses required them to spend time with patients for counselling and teaching purposes.

As a stomal therapist I used to find that I had the extra time to sit and talk to the patients and really get to know them. (Sabrina)

“The extra time” (Sabrina) provided them with an opportunity to come to know and value the person inside the patient exterior. They were able to appreciate that a physical alteration did not reduce the worth of the individual.

My belief is that you really have to like people to do it because you need to forget about that stigma that we all have and it’s the stigma of stomas, faeces. You really need to be able to see through that body change to see that everybody’s the same anyway and it’s only physical. You don’t expect patients to see it, but I mean certainly you have to be able to see it. (Sabrina)

Extending the impression of normality to stoma patients frequently contradicted the normal behaviour of their nurse colleagues. This was evidenced in Kate’s comment when she voiced her refusal to wear a mask and rubber gloves to attend to a patient’s colostomy.

I’m not going to make them feel dirty, there’re normal people as far as I am concerned. (Kate)

Prior to the early 1970s the ability to lead a normal life was greatly compromised by the lack of effectual appliances and adequate professional support. Recalling this era, Meg remembered her frustration and doubt that a person with a stoma could in fact, lead a ‘normal’ life.

I said to the Matron ... I can't keep this going, I can't keep going into people's homes and hospitals and saying you'll live a normal life when I know jolly well I wouldn't. She was a very astute lady and she said well instead of going in and telling lies why don't you do something about it. (Meg)

What Meg did do, was to search for alternative and improved methods of stoma management and these methods she sourced and introduce to her patients.

Helping relationships

Quality time spent with patients resulted in many engaging relationships, some quite enduring. Barbara recalled caring for a particular patient with a stoma in 1967. She stated that this lady had been one of her first stoma patients and she finished the narrative with the comment "but she only died less than 3 years ago". Barbara and her patient had kept in touch all those years.

The relationships that existed between the nurses and the patients involved mutual regard. In some instances, these relationships appeared to have evolved into friendships. The stomal therapy nurses generally perceived that this was because they were approachable and willing to help. (Meg, Anne, Joanne)

In recent years, I think it's sad but you hear a lot of patients complaining about their nurses or alternatively saying "oh! the nurse never had time to do this, that or the other". With stoma nursing you don't get that. You're right back to the basics where the patient gets a relationship and it's a friendliness, they feel they can contact us an any time. (Meg)

Evidenced in the helping relationships were elements of emotional reciprocity and an appreciation of the contribution of both the nurse and the patient in these relationships.

I remember a beautiful man with a fungating carcinoma with all the elements of odour and body image changes, devastation and non-coping with death and his anger and his gruff approach. Oh! He was just so furious when he came to see us for the first time and then how we developed this loving relationship and I just loved that man. He on the outside was so rough and ready and in the inside was the most beautiful person that loved good music and opera. Appeared like a labourer, like a rough, a real rough diamond but he was like butter on the inside. And how much I learned from him. I got his management really well under control, there was no odour and he died with dignity. I did lots for him, I recognise that, but he did so much for me, he just added

another dimension to my life and I think that's the great thing about stomal therapy, that we have the opportunity to develop that rapport with people, that one to one relationship. Nancy

Occasionally, the helping relationship extended into realms outside the normal domain of the nurse's working environment in order to encompass the real world of their rehabilitating patient.

I can recall an experience I had with a little girl, her mother had committed suicide and her father had died from a traffic accident and she lived with her grandmother and she was actually the adult in the family. She was an old imperforated anus (*case*) which had really gone wrong right from the very beginning so she had to end up having a permanent colostomy. Now she was quite happy to have this done because she thought she won't be dirty any longer, there won't be all the dirty washing and she'll be right. So I guided her through this and many sessions with the occupational therapist and it was getting near time to go home and we involved the school that she was going to and I went out and saw the school and got the school teacher to come in and an occupational therapist from the community and we thought that she was very well adjusted. She was very happy with me and was talking very openly to me and the day that she was going home she was having her last session with the occupational therapist and she'd been making this lovely kit and she was so pedantic about what was going in this kit and this is what we wanted her to do, it was her private box and she could do what she liked. She put animals all over it and different things on it and she left the office and she got to the path going up to the ward and she threw it on the ground and she kicked it and she kicked it all the way back to the ward and just didn't want it. She refused to talk or do anything so I was rung up to go down to the ward. The school teacher that was going to be her school teacher had arrived, the community nurse that was going to be looking after her had arrived and she just sobbed and sobbed and sobbed. She didn't want to talk to any of these people, she just had realised that she was going home... it even makes me emotional talking about it, but we kept her for another week and took it very carefully and looked at where we had gone wrong and she's developed into a young adolescent lady who looks after herself very well now. (Maxine)

This poignant narrative offers an insight into the needs of the child and the extent to which the stomal therapy nurse was willing to go to assist in her rehabilitation. The "private box" was to hold her colostomy equipment. By encouraging the child to accept responsibility for decorating and equipping the box, the nurse was able to demonstrate her faith in the child's ability to accept responsibility for her stoma care. The nurse anticipated that the child would need to be supported in the community by informed professionals and she therefore, extended the helping relationship towards the teacher, the community nurse and community occupational therapist. When the child clearly

demonstrated her anguish, the nurse was willing to review “where we had gone wrong” and to “carefully” adapt the helping relationship in order to accommodate the child’s needs.

This exemplar, like others in the study, gives insight into the nature and extent of the helping relationships and reveal the nurses’ willingness to seek a better way to care for these patients.

There Has to be a Better Way

All of the stomal therapy nurses vividly, and sometimes emotionally, recalled a time when they were confronted by inadequacy when faced with the care of a patient with a stoma or a complex draining wound. Expressive comments such as “I didn’t have the faintest idea what to do” (Anne), “we were all very ignorant of stomas” (Sabrina) and “I had no idea how to look after a patient with a colostomy” (Tessa) demonstrated a lack of knowing how to care. Whilst expressions of “we were powerless to do much more” (Nancy), “I felt very inadequate... because I couldn’t help this lady” (Linda) and “I had no idea how they would cope” (Esme) were indicative of a sense of powerlessness and inability to care.

Christine recanted a particularly haunting experience that occurred in 1962 when she was a student nurse.

We had the open Nightingale wards and this lady because she smelt so much she was put at the very end of the ward away from the entrance and away down the back. She had been there for so long that she kept me organised about what the ward routine was and my experience of this lady was that she smelt horrendously. The first time I went to care for her she was soaked, wet from urine and faeces and she had layers of combine and bandages wrapped around her skin all around these holes – what looked as holes – in her tummy were red raw. It was dreadful and I remember thinking her bed linen was wet and there was no dignity to the lady. She couldn’t get up and walk around because the contents of her bowel and bladder would escape. She herself was very embarrassed and she had a wonderful personality. She kept us juniors organised in the ward, she kept us out of harms way of the charge nurse or charge sisters as it was then, and I thought then, there must be a better way, I shall never forget it I can see that lady still clearly to this day. (Christine)

Thirty four years after this event Christine recalled this experience with emotion. Her limited stoma care knowledge at *that* time was revealed in her juvenile reference to the woman's stomas or fistulae as "holes in her tummy". She was distressed that she was unable to care adequately for the woman. In fact, it seems that the patient had reversed the usual nurse-patient roles and was in fact caring for the nurses. Christine was able to appreciate this injustice and it accentuated her concern and commitment. It was her belief that there should be "a better way" to care.

Nancy described her feelings of powerlessness, when as a junior nurse she was unable to adequately care for patients with painful peristomal skin problems. Similar feelings of inadequacy troubled all the nurses at some time during their student years or prior to them undertaking a stomal therapy education programme.

I felt very inadequate...in 1971 when our then superintendent...performed an abdominal resection and I really felt terrible because I couldn't help this lady. (Linda)

Generally, there was a sense of personal distress which was aligned with a sense of professional powerlessness as these nurses recalled experiences where they had been confronted with the physical and psychosocial distress of patients.

If anyone had told me then that one day I would look after people with stomas I would've laughed furiously because it was something that I really didn't want to have anything to do with because it seemed all a bit frightening and horrible. Also we were powerless to help these people. (Nancy)

In some instances, these emotions spurned a willingness to avoid patients with stomas or complex draining wounds.

I used to avoid these patients like the plague because I did not know what to do with them. (Anne)

Universally, the nurses who were working during the 1960s and early 1970s recognised their own ignorance but they were further aggrieved because they also recognised that there was a dearth of help to be gained from other sources. There was a clear impression that "there was really nothing you could do for these people" (Christine). Hospital

institutions, traditionally perceived to be a sanctuary for those who are ill, in some instances became the sanctuary for the nurse instead. Discharge of stoma patients from hospital appeared to solve the nurses' problems rather than the patients' problems.

I knew we sent our patients out of hospital to face problems that were absolutely insoluble and I was glad to get them out because they made me feel inadequate. (Anne)

Esme recalled that she had no insight into how a person with a stoma would cope once discharged from hospital. She was unable to offer any realistic suggestions and presumed that the patients would continue to perform the same method of stoma dressings they had received in hospital

I had no idea how they would cope with it when they went home. I mean unless you had a tree that grew combine and buckets of aluminium paste or gel, it would've been just diabolical. I really had no concept of how they would manage at home. (Esme)

Sharon, when a student nurse during the early 1970s, admitted that she had questioned the value of performing such surgery when the lack of appropriate care or management options resulted in a reduced quality of life for the person.

I used to look at the patients...and think when I was a student, what's the point of doing the operation? It sounds really tripe but I was 18 or 19, what's the point of doing these operations, their lives are terrible. We'd do the operation and then just sort of say go out and cope and it was just awful. (Sharon)

Parents of children born with congenital abnormalities had no choice but to cope and witnessing the lengths to which parents had to go to keep their children clean and dry, was particularly heart-rending for the nurses who worked in paediatric settings.

We had a child who had spina bifida and we also had another child who had an exomphalos both children were in the ward with stomas and both of them had dreadful skin, dreadful care. I don't mean that from a nursing point of view, I mean the limitation of what could be done for them was so inadequate because there wasn't anything there. It hit me so hard to think that these mums and these children were continually wet. Mums just spent their time continually changing wet and soiled children. I thought there must be something better than this. There has to be something better than this! (Christine)

Experiences such as these led to a sense of mutual powerlessness. The nurses, in their early careers could offer little but sympathy (Nancy). On the other hand, feelings of ignorance and inadequacy to care appropriately for patients with stomas motivated some nurses to seek opportunities to advance their knowledge.

We used to get a lot of children in (*the hospital*) who were medical patients with renal problems, and ileal conduits were done. Now I just felt so inadequate with these children because they knew more than I knew and I just felt in my bones that I really needed to get away and do a course and find out more so that I could help these children. (Maxine)

The nurses’ concerns for their patients and belief that “there had to be a better way” and “there has to be something better than this” (Christine) did commit them to seeking a better way to care.

Committed to a Better Way

The second theme that emerged from the data was Committed to a Better Way. As can be seen in the schematic representation of this theme in Figure 7.3 the stomal therapy nurses in their commitment to a better way searched for a ‘Holy Grail’ for solutions to the problems that confronted them and their patients. They were prepared to take risks and try unorthodox remedies when the entrenched practices of the day offered them no solutions for the problems they encountered. The nurses demonstrated a dedicated commitment to the cause of promoting better outcomes for persons with a stoma. Such a commitment they embraced with fervent zeal and it frequently caused them to confront the traditional power bases of the day. Their commitment to the ‘cause’ encouraged them to prove they could make a difference in care and resulted in autonomous practices.

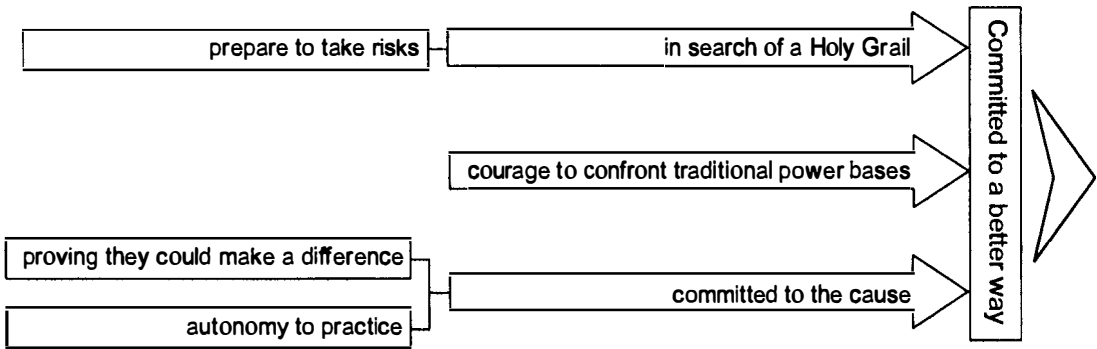


Figure 7.3

In Search of the Holy Grail

The loss of dignity and skin integrity that resulted from the lack of any effectual means to contain ostomy or fistula effluent had been central to the distress the nurses had witnessed in many of their patients. The nurses who were in the work force during the 1960s recalled that at that time colostomies were cared for in the same manner as one would a wound.

They had dressings on their stomas in the same way as somebody with a suture line had a dressing on their wound. You rolled up with a 'sterile' trolley which you had set with cotton balls and sundry items and huckaback towels and all sorts of interesting things like that and you just cleaned the stoma down and put a cotton, it would've been combine even then I think, but it didn't have the cellulose wrapping it was cotton wool with a gauze wrapping over it... They came in long rolls and they were cut by the nurses into squares in the pan rooms or in the sterilising rooms and stuffed into large bins and then they were sterilized in the operating theatre and brought back to the wards for use on the wounds. These pieces of material were about 20cms long and probably 10cms wide. (Anne)

The dressings were secured with abdominal binders which were usually made of a fabric called flannelette (Esme). Stoma 'dressings' was seen to be tedious, repetitive and frustrating procedures.

We used to get this newspaper and put newspaper around and we'd have big roles of combine pads and clean the stoma and then we would wash around it and put these people in a clean bed ...and then put the pads on them and bind them up. The poor things sometimes you'd get them all bound up and the next think they'd say "oh! Nurse I'm dirty again" and you'd go through the whole process again. (Maxine)

Even the highly fluid output from transverse colostomies tended to be contained in dressings.

With transverse colostomies we used to use combine dressings, we didn't have an appliance ... it was the patient with the urinary diversion that actually had a rubber bag ... I don't remember putting bags on 'normal' colostomies. (Susie)

Meg recalled that during those early years she had also used the “old rubber bags and flanges stuck on the skin by cement”² for people with an ileostomy. However, people with an ileostomy or ileal conduit commonly experienced skin damage because of leaking appliances (Anne, Meg and Judith). The focus of skin care was on treatment rather than preventative care. “I don’t remember any sort of skin protection except that silver paste” (Nancy). The “silver paste” was an aluminium compound and according to Anne she used it to treat rather than protect the skin.

The dreaded aluminium paste³ which was sort of a silvery kind of zinc ointment ... was a sort of vile aluminium paste stuff ... it didn’t ever get put on until the skin was actually broken, it wasn’t used to protect the skin, it was used to heal the skin. There was very little, if any that I can recall preventive care for skin in those times. (Anne)

No one nurse who had used aluminium paste remembered it with any therapeutic affection.

Aluminium paste which was absolutely awful, dreadful to get off their skin and you had trouble getting it on because the skin was raw and weeping. Absolutely awful and then you’d put dressings on top of that and plastic liner over the top of that to keep it in. (Susie)

But therapeutic choices for severely ulcerated skin were limited and those treatments that were available were extremely time-consuming and frequently ineffectual.

There used to be dreadful excoriations and they used to use that awful old aluminium paste and that was the only thing that seemed to be around so we’d use warm soap and water to clean the skin and then we’d absolutely plaster the area with aluminium paste. So each time the stoma worked we’d go back and do exactly the same thing. (Maxine)

As a concession to the anticipated pain that a patient with severely denuded skin would experience, the nurses would use tepid water “because it used to hurt if it was too cold or too hot” and occasionally they would administer potent opiate analgesics (Sharon). But treatments such as these did little to overcome the distress that they witnessed in

² Skin cement was an adhesive agent used to adhere appliances to the skin (Cement Bond [™] manufactured by Smith & Nephew).

³ Aluminium paste (Baltimore paste [™] manufactured by Boots) contained powdered aluminium 10%, liquid paraffin 10%, zinc oxide ointment. It was applied to the skin to protect against gastrointestinal fluids (The Australian Physician’s Index, 1964).

their patients. On reflection Maxine did consider that “in those days we did give them the best care that was possible for them”. However, the ‘best care’ treatments of the day were obviously inadequate to overcome the distress that confronted them.

The nurses’ failure to find solutions to these problems amongst available treatments in the clinical setting caused them to try unorthodox treatments. In their frustration, they extended their search for remedies outside the orthodox and familiar clinical domain and experimented with home remedies and foodstuffs. It seems that they were willing to try anything in their search for a miraculous therapy.

The search for skin-healing agents caused some of them to try a variety of common foodstuffs, even the Australian icon, Vegemite™⁴. Some of the foodstuffs trailed would in the light of today’s wound healing knowledge appear bizarre and in fact, the use of these agents could not be supported in the light of current scientific knowledge (Alvarez, 1988; Thomas, 1990). However, in their desperation the nurses were prepared to try most things and the fact that some of their care plans resembled menus did not appear to create too much concern although on reflection, the humour was appreciated.

We used to use all sorts of things including a lot of food products, everything anybody ever said: “try this” and we would do it. So we would have white of egg and Vegemite™ and sugar and all sorts of things. There used to be a doctor at Prince Alfred, and I sent a patient back to him with this skin problem that kept clearing up and coming back. It ended up that there was a suture that was undissolved under the skin and that was what was causing it. But I wrote down what I’d done and he said to her good heavens ‘she had a four course meal on your belly’! (Meg)

The credibility afforded some foodstuffs as topical wound treatments was considerable. The hope invested in some home remedies outweighed the need to scientifically substantiate the therapeutic action and efficacy of treatments before actually using them. Any treatment that was perceived to have a therapeutic effect was immediately endorsed and used widely.

Well we got Sunshine™ (*milk*) powder and made it into a paste. I actually had trailed it on a child who had been born with an imperforate anus⁵...I remember using this Sunshine™ milk

⁴ Vegemite™, manufactured by Kraft, is a black, yeast foodstuff that is applied to sandwiches or toast.

⁵ A congenital abnormality which presents as an abnormally closed or imperforate anal canal.

paste on the children who had severe gastroenteritis. So I thought I would try it on the skin of the ostomates as well...actually the Sunshine™ milk did a wonderful job. The idea came from an old charge sister in the gastro ward and she swore by it and we trailed it and then it became the 'in' treatment for sore skin but it worked very well. (Christine)

One could surmise that the logic of using milk on ulcerated skin was aligned with the medical practice at that time of recommending the ingestion of large amounts of milk for people on peptic ulcer diets. The milk was ingested to denature gastric acids and thus reduce the symptoms related to gastric ulcers (Bloom, 1967). Certain foodstuffs were used alone or in combination with pharmaceutical agents in an effort to prevent 'digestion' of the skin by leaking gastrointestinal body fluids. Oral antacid mixtures were also used topically for this reason.

I was the junior nurse and I used to whip up egg white and aluminium hydroxide⁶ paste. You put the aluminium hydroxide paste down (*on the skin*) then the egg white ...the rationale was that the output from the stoma would digest the egg white before it digested the skin. I have to say that that didn't work! (Sharon)

Some pharmaceuticals were used for purposes other than those recommended by the manufacturer. Oral antacid mixtures were commonly applied as topical agents either alone or in combination with other topical pharmaceuticals resulting in a 'club sandwich' effect. The use of such agents did not always receive medical aegis and one is lead to believe this was possibly because of the aesthetic appearance rather than the clinical effect.

The most common thing we did then was put on Mylanta™⁷ and sprinkled Karaya™⁸ powder and we used to have to put three layers of that on and then you sprayed the whole thing with Nobecutane™⁹ ...and after Stomahesive™¹⁰ became available we used to use Stomahesive™

⁶ Aluminium hydroxide mixture was an antacid (The Australian Physician's Index, 1964). A paste could be made by allowing the heavier components of the mixture to settle to the bottom of the bottle and after draining off the upper portion of liquid, a thicker solution or a paste would result.

⁷ Mylanta™ is an antacid mixture containing aluminium hydroxide, magnesium hydroxide and simethicone (MIMS, 2001).

⁸ Karaya gum powder is derived from *sterculia* and is used for peristomal skin protection (The Australian Physician's Index, 1964).

⁹ Nobecutane™ spray was a transparent plastic topical agent made of an acrylic resin dissolved in acetic esters with inert propellant gases. The manufacturer, Astra, indicated that the main use of this product was as an application to clean surgical wounds as a precaution against subsequent infection caused by bacterial entry to the wound (MIMS, 2001).

on top. That procedure took us 3 hours. It always looked yucky and so it was not uncommon, especially if we did it in a hospital, to spend 3 hours putting all that on and then the doctor would come along and say isn't that disgusting, wash it all off! But it was thanks to a doctor that did that, that I found how very rapid that treatment was (*for promoting healing*). (Meg)

The object behind such treatments was firstly, to protect the skin from contact with the highly acidic or alkaline bodily fluids. Secondly, the available appliances would not adhere to moist denuded skin and the object was to dry the skin or apply pharmaceutical agents that would form a dry crust on the skin and to which the appliances could be adhered (Danni and Susie). Mercurochrome 10% was commonly used for this purpose (Susie).

I remember painting on real strong mercurochrome¹¹ on (*the skin*) and the only thing it really did was discolour everything. It was all there was and people didn't think it should be any better...it was the trend in those days to use mercurochrome on anything that was red or sore. It definitely wasn't appropriate to dry it out. (Danni)

The last statement concerning the inappropriateness of drying the skin, was made with hindsight some 30 years after the event and when nurses in Australia could generally be expected to have been educated in the principle of moist wound healing (Winter, 1962). However, strong mercurochrome solution was considered by those early stomal therapy nurses to have "tremendous drying powers" on broken skin (Danni). It became an important product in their armoury because the prime object as stated above, was to either dry the skin or to form a dry crust in order to facilitate the adherence of an appliance.

The early rubber appliances that were available were rather bulky and some were secured to the skin by using cement bonding agents whilst others depended on tight belts and metal flanges for securing them in place. The belts and metal flanges were also responsible for some of the skin trauma (Susie).

The appliances were about a foot long and probably six inches wide. They were made of something like latex rubber. They probably would've weighed 500 grams at least. They were

¹⁰ Stomahesive™ was produced by Squibb (now ConvaTec) and was a hydrocolloid skin barrier used to protect peristomal skin.

held in place by webbing belts that had a wire cage affair that hooked onto the bag somehow.
(Anne)

Only ileostomies and urostomies were managed with these reusable rubber bags. If an appliance was used to contain a colostomy, it usually consisted of a plastic bag secured to a flange with an elastic band, or belt.

The Wagner non-adhesive colostomy appliance was the norm and that was just a plastic flange, we stuck a plastic bag through it and it belted on ... and everything was re-washed and used over and over again. (Meg)

The nurses' memories of the rubber appliances were vivid and olfactory. Rubber bags had to be emptied regularly and all of the nurses who had to use these appliances remembered with distain the process involved in cleaning them.

You used to wash out these bags in the pan room and I can remember being nauseated to the degree that I was retching over the pan flush as I cleaned out these appliances. (Anne)

Rubber appliances were not easy to apply and could not always be relied upon for security.

This patient had a urostomy and it was in my final years of my training (1971) and it appalled me to see how this man was struggling with rubber bags ... He managed with a rubber flange and rubber white bags and cement and we were trying to manage his stoma and his skin and stop it leaking, it used to leak continually. (Sabrina)

In an attempt to come up with a better solution particularly for post-operative stomas, nurses began making 'long bags' in the late 1960s. The long bags were fashioned out of long strips of plastic tubing and double-sided adhesive tape was used to adhere them to the patients' skin. These bags were described as 'long' because the tubing was cut to a length long enough so that it could cover the stoma at one end and the other end would free drain into a receptacle under the bed (Kate). Malodour remained a significant problem (Kylie) although some years after their introduction, both ends of the bag were secured with a rubber band in order to contain some of the odour (Sharon). Rituals

¹¹ Mercurochrome was an antiseptic agent of sodium salt of o-carboxymethylsalicyl-(3-hydroxy-mercuric-2-methoxypropyl) amide (The Australian Physician's Index, 1964).

abounded in the production and care of these appliances and it could be construed that some stomal therapy nurses actually considered them a Holy Grail for they enthusiastically used them on all post-operative stomas and draining wounds long after commercial alternatives became available (Kylie, Nancy, Sharon and Susie).

The first ‘disposable’ appliances in Australia were little more than plastic bags which were secured to a flange, which was adhered or belted to the skin. These appliances provided little in the way of choice, nor did they appear to solve the significant problems related to malodour.

The appliances we used were absolutely basic, we had plastic bags, which now were not odour-proof, but they were more odour-proof than the crackly plastic..I didn’t have to worry about what I was going to put on a patient, my choices were so limited – they were extremely limited. I could choose a rubber flange¹² or a plastic flange¹³ and if I chose a plastic flange all I had to really worry about was would I use a convex back or a flat back, and I didn’t have to think any further than that. (Susie)

Even so, during the 1970s there remained some people who did not realise that there was even such a thing as an ostomy appliance (Maxine). Some surgeons were no better informed according to Barbara. To demonstrate this point she told of her experience during the 1960s, when she had drawn a picture of a rubber ileostomy bag on her surgical examination paper. The general surgeon who had marked her examination wrote comments on her paper to indicate he had not known what it was she had drawn.

Danni suggested that it was because of this lack of knowledge that often it “was left to the patient to use his imagination” concerning containment of effluent. Esme had known some patients who had resorted to very creative containment methods in a search for a Holy Grail.

¹² A flange was a rubber or plastic device that collared the stoma and was used to secure either a rubber or plastic drainage bag in position. Rubber flanges such as the Down or Birbeck flange were usually secured to the skin of ileostomy or urostomy patients with either skin cement agents or double-sided adhesive plasters (Hughes, Kyte & Cuthbertson, 1971).

¹³ Plastic flanges such as the Wallace flange had belt lugs and these flanges were held in position on the abdomen with belts. Philp’s flanges were attached to the abdominal skin or skin barrier wafer with double sided adhesive discs (Hughes, et al. 1971).

I did see some people put little tins and things over their stomas and they explained to me that they could collect the faeces in these little tins and then wash them out. I can remember seeing modified sardine cans for instance. (Esme)

When recalling the technological and surgical advances that the stomal therapy nurses had observed over the years, most commented on improvements in ostomy appliances. There was a consensus of appreciation for the modern appliances they had at their disposal.

Back in those good old days I remember those flanges that we used to glue on to skin with cement and the plastic bags with no odour-proof qualities. So I suppose the main changes that I remember are the changes in the appliances. How good they are now, what a range we have, how lucky we are in Australia to have an appliance system so that our patients have choice. (Nancy)

Some of the nurses thought that technology had reached its limits and echoed the comments of Kylie who stated, “we really have come as far as we can with appliances”. However, other nurses when asked to express their visions for the future of stomal therapy practice, obviously still sought a Holy Grail for improving the health outcomes and quality of life for their patients (Nancy, Tessa and Linda).

Prepared to take risks

Desperation appeared to be the impetus that motivated the nurses to try any topical agent in the hope that an universal panacea would be found to combat the problems their stoma patients endured. Desperation also anointed the nurses with the courage to step outside of the traditional boundaries that regulated general nursing practice. In their search for the Holy Grail for healing skin problems, they were prepared to experiment and take risks with unorthodox treatments. They were also prepared to experiment with medical devices and often relied on creative ingenuity to solve complex problems.

In fistula management there were no rules. We had to make it up as we went along, and I can remember just about packing death one day, when I had this amazing idea about putting a tracheostomy¹⁴ tube down a fistula. I was desperate to find a tube the right size and shape and it just came to me because I happened to be in intensive care at the time, thinking a tracheostomy

¹⁴ A tracheostomy is a surgically created fistula between the trachea and the skin on the neck, for the purpose of maintaining an airway.

tube would do this and I could probably anchor it with a bit of you know, wafers¹⁵ on this and wafers on that and by that time we had Stomahesive™ paste¹⁶ and all sorts of things that you could build up the skin in these great cavities. Then I did it and I thought afterwards, well if something went awfully wrong they could probably sue me for this, so I packed death for a few days, but it did work, the bag stayed on long enough for that skin to heal enough for us to get a regular wafer on. So there were things there that I think were a bit adventurous and in reality nobody ever challenged us. (Esme)

The ability to implement creative solutions when orthodox practices failed to solve the problems, became a trick of the trade of stomal therapy nurses. As was their willingness to “have a go ... when no one else has been game to” (Linda). Meg shared the feelings and fears she endured when during the early 1970s she tried to introduce colostomy irrigation as an option to the need for colostomy appliances (chapter 5 revealed that colostomy irrigation was only practiced as a means of regulating defaecation to a very limited extent in the United Kingdom and Australia during the 1960s and early 1970s).

We tried to introduce it but most of the doctors were very against it, they didn’t even understand that the cone¹⁷ wasn’t going to create bowel problems. We did the first dozen or so irrigations on people that we advertised for and these were people that had no current doctor or they were no longer in contact with their surgeons. It was quite a real fear that they possibly could sue us if we did do anything wrong. (Meg)

The concept of nurses actually advertising for patients to participate in a treatment trial, especially 30 years ago, is quite extraordinary. It certainly does not reflect the traditional image of the subjugated nurse that prevailed at that time. In this instance, the nurses’ preparedness to take risks paid off and colostomy irrigation grew in popularity with doctors and patients and proved to be a successful alternative management technique for persons with a colostomy as it eliminated the need to wear an appliance.

When stomal therapy nurses observed that products, devices or techniques led to improvements in stoma management, they were motivated to experiment with these interventions in other clinical areas such as wound management.

¹⁵ Wafer is a term synonymous with hydrocolloid skin barrier sheet.

¹⁶ A skin protective hydrocolloid type paste produced by ConvaTec which is used to fill skin creases in order to obtain a level skin surface.

¹⁷ The cone on an irrigation set, the tip is inserted into the stoma prior to irrigating with water. The cone shape prevents the water escaping from the stoma prematurely.

I must be honest, I was using Stomahesive™ in the good old days on leg ulcers and bed sores before there was ever such a word as moist wound healing. I didn't even know what the words meant but we knew that if we put Stomahesive™ wafers on a wound that it would heal and that the patients had pain relief. (Susie)

This exemplar acknowledges possibly the most important advance in wound management in the last 50 years, the moist wound healing principle. Stomal therapy nurses had observed the dramatic improvements in healing peristomal skin when they used hydrocolloid skin barriers and they were prepared to take risks and try them on other wound types in order to improve the outcomes for their patients. Their preparedness to take risks ultimately, resulted in the acceptance of hydrocolloid dressings as a legitimate and valued method of wound management.

There is little doubt that the stomal therapy nurses were generally aware of the risks they took in order to solve some complex problems. Esme and Meg mentioned the risk of legal litigation. Linda recognised that her preparedness to do things other nurses would decline, actually set her apart from her colleagues.

I suppose I've stuck my neck out to do things where other nurses wouldn't touch things. (Linda)

Esme suggested that they "trained in the school of hard knocks and sort of did things and worried about it later". It seems that this training and their willingness to "stick their necks out" (Linda) also enabled them to challenge the professional power bases of the day, in their commitment to find a better way.

Courage to Confront Traditional Power Bases

Nursing is predominately a female gendered occupation that historically built its foundation on the traditional caring activities of lay women and religious orders. Schools of modern nursing were founded in the 1860s. The practice of medicine on the other hand, was traditionally a male dominant occupation that established schools of medicine amongst ancient civilisations. It is only in more recent times that the gender balance in the disciplines of both nursing and medicine has become more equitable. Likewise, many nurses would contend that it is only in more recent times that the power

balance between the disciplines of both nursing and medicine have become more equitable. However, within the discipline of nursing there traditionally evolved a structure where until more liberated times, all power and authority were deemed to be the sole domain of the most senior nurses.

The reader is reminded that all the stomal therapy nurses in this study had began their hospital based nurse training during the 1950s, 1960s and 1970s. The more liberal collaborative attitudes found amongst health professionals today rarely pervaded the hospital wards and departments during these nurses' early careers. Decisions concerning the treatment of patients were made by the professional hierarchy and predominately by the medical practitioners.

The nurses who were confronted by challenges and who were committed to finding a better way to care had to be prepared to confront the traditional authorities and challenge their decisions in regard to care of ostomy patients. Four of the nurses (Kate, Susie, Barbara and Joanne) discussed their experiences and this provided an insight into the fact that it often required more courage to confront their nursing superiors than medical personnel. In some instances, these encounters appeared akin to Daniel having to enter the lion's den.

I had gone to this one private hospital to put an appliance on a man who had a colostomy. If ever I went into a hospital I always went to see the Ward Sister first and explain who I was and why I was there... The Sister who was in charge happened to be at lunch and I spoke with the person acting in charge and said why I was there. When the Ward Sister came back from lunch I don't think I have ever been blasted to such an extent throughout my training. "What right has Mr *name deleted* to send his staff in to see a patient in my ward". It was humiliating for the patient, he felt mortified and I didn't know what to do. (Kate)

This exemplar demonstrates the courage it took for the nurses to enter some of the wards where nurse harridans were in command. It appeared that the best interest of the patient warranted little concern when the exclusive authority of the Ward Sister was seen to be threatened.

Some of the Ward Sisters actually felt quite threatened as well, that they had somebody outside their ward and outside their control actually coming into their ward and deciding what treatment this particular patient was going to have. (Susie)

Barbara recalled that it required some devious behaviour to actually enter some hospital wards in order to care for the stoma patients.

The Matron wasn't very happy about me going into the hospital. From the very outset I told her who I was and what I was and she never actually accepted me, but I used to sneak in quietly ... and show them how to put on their appliances. (Barbara)

Sharon also explained how when in the private employ of a surgeon as a stomal therapist she was not allowed to wear a nurse's uniform in a major hospital, but had to work under the title of a research assistant in order to gain access to the surgeon's patients.

The relationship between the early stomal therapy nurses and some surgeons was not always harmonious. When stomal therapy nurses began to mark a site on patients' abdomens pre-operatively to identify the best site for stomal placement during the late 1960s and early 1970s, some surgeons resented the practice. It was the impression of the nurses that the surgeons' reluctance to avail themselves of this service was because it undermined their total authority in care decisions.

A nurse actually telling a surgeon what to do, was really quite threatening to them, and it was taking away part of their power base. The fact that a nurse could actually tell the surgeon, that really was awful... You had to apply different tactics with different surgeons to actually get in and get their support. (Susie)

Whilst some nurses appreciated the benefits of subtle coercion, others had to deal initially with outright conflict. It was muted that such conflict was detrimental to patients' well-being.

When I first started off I had one person in particular, who shall remain nameless. If I actually sited – had the audacity to site one of his stomas – I felt quite sure he used to site it elsewhere almost out of spite. (Joanne)

As stomal therapy nurses gained acceptance, the nurses began to attract an authority or power base of their own. Joanne gave the impression that in her experience familiarity led to a reversal in the original power politics that had existed between doctors and nurses.

I find the surgeons are fine I don't have any problems with surgeons. Sometimes it is a bit difficult to break new ones in, they get a bit thingy. But the other thing I am finding, is that I have been around for so long that the new ones are registrars and residents from days gone by and I know them as Tom, Dick or Harry anyway, so that is making a big difference. (Joanne)

Interestingly, the possessive behaviour of surgeons or ward sisters that was initially condemned by the early stomal therapy nurses was in some situations replicated by them as they sought to demonstrate their commitment and exert their fledgling authority.

There was one particular surgeon who was the senior surgeon here and he was an excellent surgeon but a very careful man. So he agreed that we would put the bags on his patients and while they were in hospital everything went well. Then he'd come along and he wouldn't be able to see what was there, even though it was a clear bag he'd sort of want to have a look at this stoma. So it would be 'take the bag off, don't worry about putting it back on', so this went on for quite a while plus, when the children went home and the parents would ring the doctor – he would say 'get that bag off, just go back to a pad and a bandage you'll be all right'. So I decided if I wanted to become the boss of this department I would make an appointment to see him and say to him we've got to come to an agreement. 'You look after the body and I'll look after the stoma. I don't want you to tell the parents to take the bag off, I don't want you to take the bags off in the ward and we'll see how we go'. (Maxine)

This exemplar emphasises in part, the depth of commitment that Maxine had towards ensuring that her patient received what she perceived to be, the best care. It is also evident that she had established fierce territorial anatomical claims around the stoma and considered the stoma to be actually off-limits to the surgeon. One could surmise that her demand for control of the stoma was her way of honouring her commitment to caring in a better way.

According to Sharon "we stomal therapists were very firm people in the early days and we really stood up to the opposition that we had". Judith was very philosophical about

her colleagues sensitivities and stated that most nurses “always tread on a few corns”. This implied that it was quite reasonable behaviour for them to exert their authority and thereby communicate the extent of their commitment to the cause.

Committed to the Cause

One of the questions asked of all the nurses was “why did they choose to work in stomal therapy”. I was seeking to understand what was it that made these nurses committed to the ‘cause’, so to speak. The answers were extremely varied but fell into three broad categories.

Kate, Danni, Sharon, Christine and Judith could be considered by a proverbial act of fate, to have been in the ‘right place at the right time’. These nurses found themselves to be confronted by the distress that was common amongst their stoma patients and found themselves committed to improving their care. Neither of these nurses did a formal stomal therapy programme but during the 1960s or very early 1970s they were either offered new positions or found their current positions evolved into stomal therapy nursing roles.

Meg, Susie, Tessa and Kylie on the other hand, could be considered to have been in the ‘wrong place at the right time’. Meg’s response to the question was “I’ve always told people that it was because I didn’t have enough brains to think up a good excuse!” However, her expanded response gave the impression that she was selected to do the work rather than she selected to do so.

All I said was, what is stomal therapy? I got rushed up to the matron’s office and she said I believe you’re interested in being a stomal therapist? By the time I had found out what it was and I said no, I’m not interested at all... she said well I can’t actually insist that you do the work but I can say that you must learn about it and relieve others. (Meg)

Susie, Tessa and Kylie had similar stories to tell but they sensed they had been coerced into filling the role “temporarily”. Anne on the other hand “had no idea what stomal therapy was about” and although she felt that she had been selected as a second choice she had for years been concerned by the care that stoma patients had received.

Sabrina, Esme, Nancy, Maxine, Alicia, Joanne, Barbara, Linda and Colleen had some insight into what stomal therapy involved and thought they would be able to make a difference in their work places.

Although initial rationales for working in stomal therapy were diverse amongst the participants there were two common experiences that they shared. Previously all the nurses had been confronted by problems that challenged their ability to care for a patient with a stoma or complex fistula. The second common experience that they shared related to the immense sense of satisfaction they obtained from the role once they committed themselves to caring for these patients. As Susie so aptly put it:

I was in hook, line and sinker. I'd never done any nursing like that before where you had total involvement with the patient and with their family ... I thoroughly enjoyed it. (Susie)

The nurses that worked during the 1960s and 1970s before dedicated stomal therapy positions became an accepted norm, made mention of the large amount of time they committed to caring for patients with stomas or fistulae outside of their normal working hours.

I started seeing ... the patients in various private hospitals and I was doing this after I finished work on public transport ... I was seeing these people after the visitors went and I was getting home at 10.30 pm ... I'd get up early and I'd go to places ... before I went to work. I did this at my own expense in my own time. It's just that I was interested in people, it became a well I suppose it was almost like a disease that set in. (Kate)

This "disease" seemed to be contagious but according to Kylie not all nurses perceived that the nurses who caught the "disease" warranted the admiration of their colleagues.

I don't think stomal therapy in those days (1979-80) was really seen as a professional role, they were seen more as someone that wanted to work nine to five or someone who didn't want to work shiftwork or want to take responsibility for running a ward. (Kylie)

Judith and Sabrina made mention that some nurses in general thought stomal therapy nurses did "it" (stomal therapy) because of better working hours or financial reward, but both of them had no doubt that this preconception was erroneous.

It's not a job where you can just walk in and just go home ... its something that's always there. You don't forget your patients ... money doesn't come into it. I don't do it for the money, I do it because I care. I think that's what stomal therapy nurses do, they do it because they care. (Judith)

Proving they could make a difference

During the early 1970s the emerging concept of stomal therapy nursing was not immediately embraced by all. According to Judith "people didn't think stomal therapy was any different to what we were doing, it was just a word". The concept of nurses specialising in an area of clinical practice that had traditionally been seen to be part of a generalist nurse role, was frequently met with resistance and in fact, seen as divisive. Sabrina said that "the Matrons or the Directors of Nursing in those days, were always saying no, we want to have total patient care we don't want stomal therapists". Attitudes such as these meant they had to work very hard to prove that stomal therapy nurses could make a difference in outcomes for both patients and colleagues.

Sharon actually found the surgeons to be more accepting of their role than nurses during that early era.

When I first started doing stomal therapy it was a bit of a joke. I found that the people who were most resistant were my peers, my colleagues, nurses ... I got much more support from surgeons and when stomal therapy became established and you could prove that you had a service to offer, nursing accepted us. (Sharon)

Esme stated that persistence did pay off and she was eventually able to prove her credibility and value to surgeons.

Medical staff are not easy to work with and you have to be fairly persistent and I think we had a certain amount of credibility, we were always there when the patients came back from theatre ... Once we proved to the chest surgeon ... that we could actually bag these wounds quite effectively and the patient could still breathe and we could protect the skin, we got called more frequently. (Esme)

Gradually they did prove they could make a difference to patient care outcomes and this ensured that they did get "called more frequently". Linda stated that "when I went back, any person that had an appliance or a stoma, it didn't matter whether it was a drain or anything they'd get me". Alicia recalled that she "became more or less a free range

resource person for the greater (*health*) area and not only for my service but for all the others”. Eventually “it got to the stage where if it looked too hard they’d call us and that was another dilemma” Esme stated. Tessa also made mention that “if anything goes wrong they expect you to fix it”. There was a perception that their ‘tricks of the trade’ had made them indispensable. But this illusion of indispensability was to be the key to professional advancement and autonomy to practice.

Once you had proved yourself and then had the expertise you could then go to another level and look at this as a professional role. (Kylie)

Autonomy to practice

Autonomy involves the ability and willingness to be responsible for one’s own practice. The stomal therapy nurses who were able to prove they had the ability to solve the problems associated with stomas or complex draining wounds were often given *carte blanche* to apply their skills. Furthermore, they demonstrated that they were willing to step outside the usual nursing domain and take risks or if necessary, confront the traditional power bases.

When asked if she had encountered much resistance towards these stomal therapy nursing behaviours, from her nursing colleagues during the early 1980s, Esme recalled:

It was fairly well accepted, which was quite unusual at the time for designated nurses. I think they really let us get on with it, I mean the autonomy we had was phenomenal. (Esme)

Sharon on the other hand, initially thought the early autonomy of stomal therapy nurses would be short lived. But on reflection she was able to draw an analogy between the evolution and autonomy afforded other non-nurse specialists.

I always believed that we would be done away with, that nursing would incorporate stomal therapy into the body of knowledge of nursing. My belief is that the wider body of nursing just let us become specialists in our field and they’ve done it before. It’s not a criticism about nursing, it’s an observation. They’ve let occupational therapists do it and dieticians. Despite all the talk about the philosophy of nursing, that it’s a holistic profession, it doesn’t always (*appear*) that way. (Sharon)

Although the nurses in this study perceived that they were afforded more autonomy than non-specialist generalist nurses during the 1960-70s, it appears that other emerging nurse specialists, such as critical care nurses, were also afforded the same professional opportunities (Wiles & Daffurn, 2002). However, Susie considered her autonomy as a stomal therapy nurse was reinforced when the pioneer stomal therapy nurses gained the approval and support of influential Directors of Nursing to run stomal therapy courses in 1971. Susie implied that this development had a flow on effect for nursing autonomy generally.

When we started getting involved in running the course, the Directors of Nursing were just so supportive ... they really got behind it and supported the nurses quite dramatically which they hadn't appeared to do for any other particular nursing group ... maybe it was the starting change for nurses being recognised in their own rights, that they were no longer the hand maidens of the surgeons. (Susie)

Esme considered the early stomal therapy courses gave some nurses the “clout to push for a designated position” in stomal therapy. The specialised training increased confidence in their ability and provided the impetus they needed to exert their autonomy. The reader is reminded of Maxine’s proclamation to the surgeon: “you look after the body and I’ll look after the stoma”. Sharon identified early a “need to be able to stand up in front of doctors with authority and for them to accept what you say”.

Stomal therapy nurses ranked autonomy as a most highly prized commodity. Kylie stated that she “liked the autonomy and the challenge of being able to nut something out and work it out for the betterment of the patient”. Tessa liked the “autonomy and the trust” she experienced. Nancy on the other hand liked the freedom to practice across clinical settings and the professional interaction with other disciplines. When she recanted the disciplines she regularly interacted with, one could appreciate that she was indeed “practicing at another level” (Kylie).

Stomal therapy gives you the ability to move around the hospital so you meet other nurses, other medical practitioners, you extend beyond the hospital to the community, to the district nurses, to palliative care, to the Ostomy Association, to the Representatives of different companies, health commissions and people like that. (Nancy)

Three decades after the concept of stomal therapy nurses was first muted, Anne firmly stated that she believed that stomal therapy nurses are “probably the most autonomous professional nursing specialists in nursing”. The reasons she gave for this opinion concerned the stomal therapy nurses’ ability to practice within the hospital or community setting and their expanded skills in ostomy, wound and continence care.

Seeking Knowledge

The third theme that evolved from the data was Seeking Knowledge. Figure 7.4 highlights the fact that this theme focuses on the gaining, giving and guardianship of knowledge.

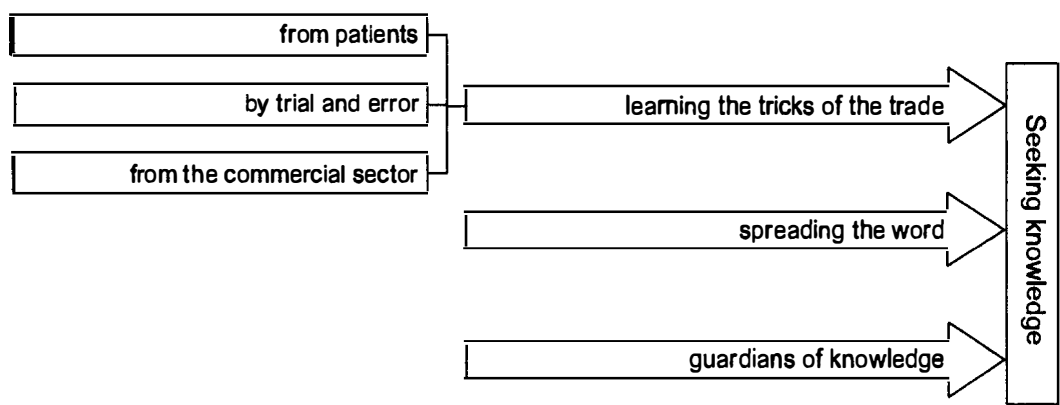


Figure 7.4

Learning the Tricks of the Trade

As previously discussed, it was the enormity of the problems that initially confronted these nurses that committed them to seeking a better way to care. Early stomal therapy nurses had no trouble recognising the need for help, it was the nature of that help that they endeavoured to define. Because there was no formalised body of knowledge to draw upon during the 1960s, information or ‘tricks of the trade’, were either gleaned from patients, trial and error or the manufacturers of the earliest equipment.

Learning the tricks of the trade from patients

When asked about the stoma care education they received as student nurses, the responses revealed very few had any theoretical education on the topic in their student curriculum. All of the nurses, except Susie and Kate, acknowledged that any knowledge

they had possessed had been initially derived from having to care for a patient with a stoma. Kate however, calculated her theoretical education as a student on stoma care to have been miniscule. Susie recalled receiving lectures in ostomy and wound care during her student training from a lay person with a stoma who was invited into the hospital to lecture the nurses. However, she stated that in reality it was the patients who “taught me a lot more than I ever taught them”. Stomal therapy nurses acted as a conduit for the reciprocal sharing of patient knowledge.

I learned a great deal about shelf life of products... this information I passed onto my clients, in return they passed information back to me. I would say “Oh! I don’t think you can do that” and they would say things like well, “I’ve been doing that for the last 3 months and nothing has happened”. So we would try that particular trick on somebody else. In fact, I think that probably all I really know about home care of stomas I have learned from people who have stomas. Certainly not from any innovative or lateral thinking of my own. I just acted like a sponge and absorbing information that people have given to me over the years. (Anne)

Patients were willing to share their hard-won knowledge and their secret recipes for sore skin treatments.

They used to put various concoctions that they’d come up with over the years on their skin and generally speaking they weren’t too bad at all. (Esme)

However, not all the nurses had the advantage of learning from other ostomy patients. Linda recalled being expected to care for patients with a stoma without having any previous clinical experience or education.

I felt very inadequate in approximately 1971 when our medical superintendent... Performed an abdominal perineal resection and I really felt terrible because I couldn’t help this lady ... I couldn’t get information from anywhere. (Linda)

Two years after this event, Linda was sent to her state capital city to hear an hour-long presentation by Norma Gill¹⁸ who was visiting Australia from the Cleveland Clinic in Ohio. On return she was expected to be an instant expert.

¹⁸ Norma Gill (Thompson) the first enterostomal therapist, see chapter 4.

I will never forget, the medical superintendent said when I returned you know it all now, you can look after all my patients. It was a shock to the system!

The expectation that one could “know it all” after only an hour lecture would certainly be a shock and provides the evidence that there really was little knowledge amongst doctors or nurses generally concerning care options for persons with stomas. This lack of knowledge and skills in ostomy management amongst their colleagues resulted in the stomal therapy nurse being awarded expert status. Prior to stomal therapy nurses ‘expert status’ had been awarded to rehabilitated persons with a stoma. It was not unusual for lay people with stomas to be asked to lecture student nurses during their training.

The person who took us for lectures when we were doing our training was Mrs (*name deleted*) who was an ileostomate herself. She actually came into the hospital and gave the student nurses lectures on stoma care and wound care. (Susie)

As the nurses in this study became more involved in stomal therapy they began to explore other options for gaining knowledge. However, these early stomal therapy nurses had no doubt that it was their patients who were responsible for teaching them the “craft” of stomal therapy.

The people who taught me were the patients themselves because there really wasn’t much known about it and we had about 400 patients at that time who I called in to see, and they were the ones who actually taught me really the craft of stomal therapy, not the 3 week course. It was really the patients who were adapting things and using sensible practical things and it really was a practical job in those days. (Susie)

The reader is reminded of the creative use of sardine cans for effluent containment detailed earlier in this chapter by Esme.

Learning by trial and error

Prior to the establishment of dedicated courses in stomal therapy nursing, both the nurses and the patients learned a great deal by trial and error. It was evident that the early stomal therapy nurses perceived they had a very pragmatic approach to learning (Kate, Danni, Meg, Sabrina, Sharon and Susie).

It was obvious that this knowledge was pretty unique and didn't develop overnight and you couldn't read it in books and you had to really do it. (Danni)

The nurses' willingness to try unorthodox treatments or new products in their search for a Holy Grail expanded their knowledge (Meg). Their experimentation with successful peristomal treatments on other wound types was daring, but as is the case of hydrocolloid dressings, heralded great advances in wound management. They really did not know why these dressings did work, they just accepted that they did, as Susie recalled, when discussing the early use of Stomahesive™ on other types of wounds.

We didn't know why it worked and I used to tell people quite facetiously that it's got a magic ingredient that fixes it all up. (Susie)

Esme stated that nurses and patients had to be "fairly innovative in those days". Creative adaptations of devices or equipment occasionally proved to be more successful than the manufacturers original intent.

I put a Wallace flange on the wrong way round and it was so it (*the belt loops*) wouldn't intrude into his incision as it was painful when he bent and when the surgeon asked why did you do that? I said oh! well you know I did it for this reason, and he was impressed actually. (Sharon)

Solutions to problems were conceived by trial and error and if an idea worked it was used again and again until it became a nursing ritual entrenched in clinical practice. Many of these treatments and approaches to care became 'tricks of the trade' for these nurses in their care of persons with draining wounds or stomas. There was obviously a sense of great satisfaction to be able to conjure up some 'trick' or solution to a problem.

I really loved the job, I used to put my little box on my hip and off I'd go around the wards every day and they'd say oh! here she comes again with her box. A box of tricks! I used to have a wooden box, believe it or not, with little compartments in it, and we used to have all our bits and pieces in so you didn't have to run back to your room every so often, you carried it all with you. (Esme)

During the early years it appears that when the nurses could find no means for solving problems amongst the established nursing knowledge, they relied on their rehabilitated

stoma patients to teach them the practical tricks. Frequently teacher and learner roles were reversed as information was offered and assimilated by nurses and patients.

However, learning by trial and error always carries with it an element of failure and risk. On reflection Judith had the insight to appreciate that this occasionally did happen.

I think we've all been very guilty of doing things that we now know were detrimental to our patients, but I guess that's experience and learning and I think there are still many doctors and many nurses out there that don't believe some of these no-no's exist. (Judith)

Examples of detrimental practices would be the use of unorthodox and unsubstantiated treatments such as Vegemite™, egg white and milk powder preparations mentioned earlier.

Learning from the commercial sector

Manufacturers of appliances, or their representatives also played a role in the acquisition of knowledge. The contribution of representatives of manufacturing companies was significant.

They helped us financially too, to get to conferences and we didn't have any money in those days and no way of getting any ... they would always be there and say well look we'll provide a lunch or we'll have our stands there and we can give some free of this and free of that. I mean even just providing a bag with pens and pads and things like that. I mean it wasn't quite as grand as it is now I'm quite convinced, but that all helped. They were very helpful in teaching, they would come over and say if you can get a group of nurses or doctors together we'll come and do a demonstration. I mean we used their slides, we used their bags, we used their equipment, we used their flip charts because we weren't producing anything, so basically we used all their teaching aids and some of them ... really made a difference. (Esme)

Esme's exemplar recalls her experience during the early 1980s. She acknowledged the financial support, nutritional support, equipment support and teaching support that the companies provided. These resources not only assisted her to gain new knowledge but to pass on that knowledge to others. Although there was some early resistance by the nurses to accept even free product samples (Meg) it evolved that the companies were extremely generous at times. Four of the nurses were awarded commercial scholarships

or sponsorships that allowed them to travel overseas to conferences or sites of learning (Kate, Judith, Sabrina and Barbara).

According to Susie, the commercial sector support of Australian professional meetings was fundamental to spreading the word on continence promotion.

Really commerce pushed Australia more than anything else. The commercial people ran the first conferencesthe first workshops ...funded people to go and do courses. That side of it I hadn't been exposed to in stomal therapy but I really saw it happen with incontinence. (Susie)

The company representative, or "Reps" as they were called (Meg, Sabrina, Sharon and Judith) also played a part in the direct education of stomal therapy nurses.

They would come and they would try to teach you how to do it properly so we didn't balls it up because if we ballsed it up it wasn't going to look good then when the medical people viewed it. (Esme)

However, the representatives were also directly responsible for educating other health professionals and occasionally patients themselves. It was not unusual for the early company nurse-representatives to fulfilled the role of surrogate stomal therapy nurses in hospitals which did not have a designated position. Susie remarked on these activities.

There was a lot of lecturing on stomal therapy and even to the extent of being called in to site patients and fit them with appliances. I had a real moral dilemma with that. (Susie)

Whilst the stomal therapy nurse was endeavouring to support patients and colleagues, the representative was often endeavouring to support the stomal therapy nurse. Kylie talked of her experience as being a stomal therapy nurse in a major metropolitan hospital. She found that one of the "hardest things in the stomal therapy role is that we don't belong" to any one hospital ward or department and thus she felt "isolated" and devoid of the "comradeship" of colleagues who worked on the wards. She did however, find solace in the representative.

I think this is where the representative becomes important to the stomal therapy nurse because they can talk to them on a one to one basis about their daily work and they will listen and

understand. Whereas a busy surgical ward doesn't want to listen to the stomal therapy nurse and what she has been doing that day. (Kylie)

The support they offered was appreciated and some of the nurses not only viewed representatives as professional colleagues but friends (Meg, Sharon, Sabrina).

Spreading the Word

As the stomal therapy nurses began to learn more and more about caring for patients with stomas or wounds they had greater demands placed on their abilities and their time. According to Esme, "it got to the stage where if it looked too hard they'd call us and that was another dilemma in a way, because if only you can do it that creates another problem".

Therefore, the need to 'spread the word' that is, the philosophy and practice of stomal therapy, became evident to the nurses at a fairly early stage of their professional evolution. According to Danni most of the non-stomal therapy trained nurses welcomed the opportunity to learn more about stoma care.

I know that nurses really welcomed the knowledge if they had someone that really understood what was happening they appeared to want to know more about stomas and ... I certainly taught a lot of nurses how to look after stomas. (Danni)

Just as the nurses had developed a pragmatic approach to learning they had to develop a similar approach to teaching.

We really had to learn as we went along and then we were teaching as we went along. (Esme)

Although patient teaching was generally considered a component of all nurses' roles (Danni and Anne) stomal therapy nurses considered teaching to be a fundamental part of their role.

There were many facets to the role so not only did you have to learn those practical skills you then had to become an educator. (Kylie)

They saw a need to educate one another.

When I first started, when I knew nothing, there was a daisy bag with yellow flowers all over it and there was some weird and wonderful way that S. used to quickly whip out a bit of this Stomahesive™ and somehow slop a bit of that onto the back of this daisy bag and have it on a patient's skin in a flash. The first time I got in an awful sort of tangle because I didn't know what stuck to what. (Nancy)

They saw a need to educate other nurses.

All I seem to do is teach people how to do it...it has been a real challenge for me to get some other nurses interested and have them trained so that they have a lot of knowledge. (Tessa)

They saw a need to educate doctors.

I did an enormous amount of tutorials in each ward and also did tutorials with the medical students and residents and the registrars. (Maxine)

They saw a need to educate the families and carers.

We would get the relatives in and teach the people. (Esme)

It wasn't educating the client it was the family as well. (Danni)

But most importantly they appreciated the need to take the time to educate their patients.

I used to spend hours with people, fitting their appliances and teaching them...I found that if you were going to really have a patient who was going to successfully manage and be independent then you had to teach them. (Danni)

The stomal therapy nurses were seen to go to exceptional lengths to share their special knowledge with both patients and colleagues (Anne, Linda, Esme and Danni).

I was getting home at 10.30 at night on public transport. And I would get up early and I would go to places....before I went to work. I did this at my own expense, in my own time. (Kate)

We would also have teaching programmes where we would get the relatives in and we would teach the people. (Esme)

I service the private hospitals, I visit the patients in the nursing homes if they need it. I do home visits, I see a lot of out-patients and in my rooms and with the surgeons. I follow up the patients with the surgeons. So its quite busy really for one person. I really run and since we have a colorectal surgeon now, that has doubled my workload. (Tessa)

Even though there was the willingness to spread the word, there was not always adequate time to do so, especially when those early stomal therapy nurses were expected to combine the role with a generalist role.

Stomal therapy started to grow and the staff started to get disgruntled because I'd go off the ward and they thought I wasn't supporting them and it almost made me ill because I was torn between two things. (Tessa)

On the other hand Anne found she became 'disgruntled' when she did not have the necessary time to spend with ostomy patients because of her other work commitments.

I struggled on, I did go and talk to her (*Matron*)...about the distress I felt working as either the charge nurse or as a registered nurse in the surgical ward where there were people with ostomies for whom I could do no more than actually their standard nursing treatment ... people don't need to have a stomal therapy nurse come along and say, "I'm a stomal therapy nurse I will counsel you after I've finished work at 5.30 this afternoon". (Anne)

Anne stated that she found this "singularly unsatisfying" for patients, nurses and herself and attributed the need to "wear two hats" as being a major cause in the attrition rate in stomal therapy nurses during those early years. Eventually, designated positions in stomal therapy became more commonplace. What the nurses perhaps did not foresee was that there would continue to be a need to 'spread the word' and this had the potential to move them away from the patients' bedsides.

I spent a lot of time teaching staff and I know the girl who took my place spent even more time because nursing roles were changing and they were getting into all this restructuring. She had to spend a lot more of her time teaching other nurses rather than actually doing it herself. (Esme)

Guardians of Knowledge

What inspired and enabled the stomal therapy nurses to spread the word was the special knowledge and skill they had developed. All of the nurses discussed the need to share this special knowledge for the “betterment” (Barbara) of their patients and they were able to relate the extent to which they pursued this endeavour (Tessa, Esme, Sabrina). Kylie however, had a concern that there was at times a perception of reluctance regarding their willingness to share the knowledge.

Its just like a recipe when you are making a cake and when you give a friend the ingredients but it never works exactly the same and I feel that’s how I saw it in 1979 and I still see it a bit in 1994. We give the recipe but we don’t always give that secret ingredient that makes the difference. (Kylie)

When asked what she considered the “secret ingredient” to be, she stated that is the “ability to be able to share your knowledge and not feel threatened by someone having knowledge and expertise that you have yourself” (Kylie) .

Any reluctance to share knowledge could have been perceived as a strategy to maintain control and preserve a specialist focus. Conversely, any reluctance to maintain some degree of control could have been a response to ward against a decline in standards of care. The nurses whose stomal therapy careers had their genesis in the 1960s and 1970s had never forgotten the distressing situations they had encountered during that era (Kate, Christine, Sharon, Meg Maxine, Danni, Tessa, Susie, Sabrina and Judith).

I’m quite happy to share the expertise and I think that is the right thing to do, but you do need to have a focus in a hospital ... this is where the expertise disseminates from. (Susie)

Danni recalled that even during the 1960s:

There was certainly a vision that was small in its infancy but there was a vision none the less, that there was a need for better nursing care of people with stomas and there was a feeling... that you needed someone who would specialise in that area and that was pretty unique for you didn’t have nurses who specialised.

Specialisation in nursing is a means of advancing a body of knowledge and promoting quality control of standards. However, Joanne held the view “that a specialist is somebody that is working themselves out of a job” because a nurse specialist is also expected to oversee the infiltration of that knowledge into general practice. There was however, a perception that the future survival of expertise in stomal therapy nursing was subject to ensuring the commitment to care was in the “right” hands (Kylie, Anne and Alicia).

I feel very concerned because we’re the ones who have built up the expertise, we’ve met the challenges, we’ve been there, we’ve done a lot and it does worry me as to who will follow... Who’s going to fill the shoes. I think that we’re like monarchs, we want to be selective and make sure that whoever does take over will be the right King or Queen! (Alicia)

It would seem that the “right king or queen” in Alicia’s estimation is one who is to be a guardian of the knowledge and expertise that is peculiar to stomal therapy nursing.

Professing Thoroughness

The fourth theme that emerged from the data was Professing Thoroughness.

Thoroughness is rather an intangible concept that reflects an element of being able, or willing, to complete things well. The arrows in the schematic presentation of this theme in Figure 7.5 indicate that thoroughness was achieved when the stomal therapy nurses cared holistically and were prepared to devote time to care. They were seen to be problem solvers who relied heavily on ritualised practice, but who used these practices to effect change in others.

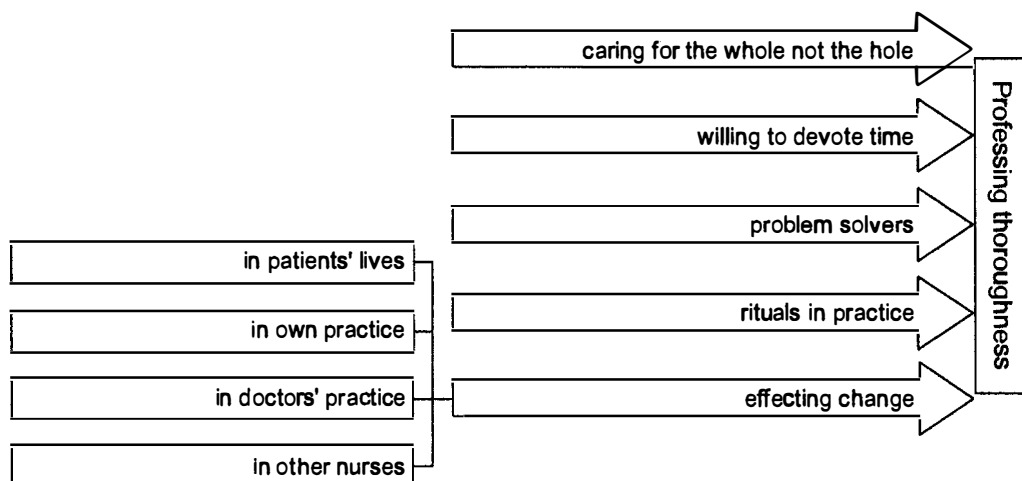


Figure 7.5

Although the term ‘thoroughness’ was not specifically used by the nurses on initial interview, their comments reflected characteristics akin to, or supportive of the term.

They talked of giving quality time (Tessa).

When I see patients they get quality time. (Tessa)

They talked of being committed to solving patients problems.

I was doing a lot of work with fistulas on patients in terminal care. I used to think now what can I do, and I used to dream about it almost, to think now what could you do. (Esme)

They talked of striving for optimal and complete care of patients.

I was determined stomas were going to be sited correctly. I spent a lot of time with *the urologist* and we discussed all the issues related to the correct siting, the pre-operative management. I wrote protocols that had to be followed. (Danni)

They talked of achieving the goal of care.

I believe we have been the instruments of change in people’s lives. (Nancy)

Because there could be found no prescriptive criteria for determining thoroughness, I returned to three of the stomal therapy nurses (Nancy, Anne and Tessa) to validate the

emergent theme. I also sought an understanding of the concept of thoroughness from a participant in the historical study (Julia) as an additional control.

Nancy stated that she considered thoroughness in a stomal therapy nurse to be characterised by efficiency, a holistic approach and advanced knowledge.

A stomal therapy nurse covers every aspect of her role or is efficient ... in a comprehensive manner ... if holistic care is considering the whole person then holistic care is probably thorough care. Thoroughness probably has something to do with knowledge as one can't be thorough if one does not understand the concept of what is at hand - what needs the thorough approach.

Tessa defined thoroughness as being mindful of the individuals' cognitive, psychological and physical needs and abilities. Furthermore, she alluded to an ability to demonstrate empathic understanding.

We look at the person as a whole package ... we include the family, we do not label or judge people we adjust to their situation and talk in their own terms or understanding. We take into consideration their mental, physical and psychological capacity. We listen and talk to our patients, they tell us things they have never told another person. (Tessa)

Anne on the other hand referred to the "core of stomal therapy thoroughness" as the provision of a "complete and helping relationship" across the continuum of a person's needs whether they be "physical, psychological, sexual or spiritual". The thorough stomal therapy nurse Anne perceived:

Moves beyond that of a generalist nurse because of the extremely intimate nature of stomal therapy ... accepts and manages the patient in the context of his/her various systems (self, home, significant others, locality, wider society). Moves through to advocacy when required and will challenge authority figures to extend client well-being. (Anne)

Therefore, stomal therapy nurses could be considered to demonstrate thoroughness when they possess the knowledge and ability to provide holistic care, empathic understanding and a willingness to be an advocate to extend a person's well-being. Such an approach to care could be summarised as 'caring for the whole, not the hole'.

Caring for the Whole Not the Hole

Nurses of today appear to liberally use, and ideally embrace, the term ‘holistic care’. However, it was a term that did not appear in common usage amongst nurses who trained under the apprenticeship model prior to the late 1970s. Under the early apprenticeship model nurses were allocated tasks rather than patients and the more senior the nurse, the more complex or elite the tasks (Russell, 1990; Wiles & Daffurn, 2002). Elimination and hygiene tasks were allocated to the most junior nurse, whilst dressings were allocated to more senior nurses. In some wards stoma care was considered a dressing and thus the responsibility of the senior nurse (Nancy), but in most other wards it ranked as an elimination task and was delegated to the most junior nurse (Anne, Christine and Colleen).

Frequently the stoma or wound has the potential to become the point of focus. The stomal therapy nurses in this study however, recognised the need to deliver patient care as a “whole package”, whilst ‘packaging’ the hole (Tessa). The “whole package” not only involved the patient’s care needs but also extended to the comfort and learning needs of the patient’s significant others. Alicia referred to “thinking about the patient as a whole” as a holistic approach.

Stomal therapy nurses must look further a field than simply looking at stomas ... that’s part and parcel of providing an holistic care, not just looking at the wound (*or stoma*) but thinking about the patient as a whole and their comfort and the comfort of their relative and carers who want to be with them. (Alicia)

Alicia’s comments allude to the stomal therapy nurses’ practice of extending counselling and education to patients’ significant others if the patient desires. Esme, Kate, Linda and Danni talked of the time they devoted to providing education to patients and their relatives, in order to promote the patients’ recovery and rehabilitation. Susie considered the extent to which stomal therapy nurses were involved in planning and implementing comprehensive care different to the care provided by non-stomal therapy nurses or those working in a general capacity during the 1960s and early 1970s.

You did get involved in all their treatment ... we weren’t just the appliance sister ... It really was the holistic approach much more so than had been with other nursing that I’d done before. (Susie)

Judith considered it most important to care for and educate the extended family unit that surrounded child patients. It was her experience that the reward for caring to this extent was respect and regard from the family.

You have that total respect and care of the families, whether it be children, parents, adults, husbands, wives, grandmothers and grandfathers. The whole family. Its not just one person.
(Judith)

It has been a general trend for many years now to hear nurses profess to provide ‘holistic’ care in all its connotations. But according to Anne:

Stomal therapy nurses were dabbling in human life in a way that other nurses did not appear to be doing, that is they were engaging in sexual counselling and they were counselling people about their attitudes and their values. (Anne)

During the 1960s, society at large may have embraced the sexual revolution and abandoned any reluctance to discuss sexuality. But the society that enclosed the nurse-patient relationship was not so liberated and nurses generally did not include a sexual history as part of their nursing assessment until very recent times, if at all.

The exemplars quoted above demonstrate the nurses understanding of holistic care as the provision of care that met the physical needs of the patient (“you did get involved in all their treatment” Susie) and the broader psychosocial needs of the patient and their significant others (comfort, education, sexual counselling and rehabilitative counselling). The nurses in this study considered their practice involved such care, but there were times when they perceived themselves to be totally responsible for the care of the stoma or wound in the eyes of their colleagues (Barbara, Colleen, Anne). What these findings suggest is that the nurses did endeavour to care for the stoma or wound whilst considering the impact of the stoma on the individual and their quality of life as a ‘whole’ person. Although this might appear to limit the concept of holism to the modern day purist, when considered in the historical context it was a far cry from the task orientated care of earlier eras.

Willing to Devote Time

Another aspect of thoroughness that emerged was the nurses' willingness to do things even when it meant more effort and that effort infringed on their own time.

I spent a lot of time with (*the medical consultant*) and we discussed all the issues related to the correct siting and the pre-operative management. I wrote protocols that had to be followed. What happened was that my expertise was recognised and I moved outside the spinal cord area and I went to see all his private patients at St (*elsewhere*) and in my spare time, like weekends and after work, I used to spend hours with other people. Fitting their appliances and teaching them. (Danni)

Danni was recalling her experience from the 1960s and this type of nursing behaviour was not common amongst the rank and file nurses of her day. It was however, common among the stomal therapy nurses' exemplars to find their out of hours commitment equally as strenuous as their paid employment (Kate, Meg, Susie, Esme, Tessa and Alicia). Nancy contended that it is within the compulsive nature of stomal therapy nurses to want to open "Pandora's box" in order to assess all the issues and solve the problems. Even when by "doing the bit extra" they know they will not get off duty on time. Alternatively, she questioned whether it was because of their "third sense, intuition, desire to treat others as they would like to be treated, their belief system or the need to do it for self gratification" (Nancy). There was no lack of evidence that the nurses were prepared to "do the bit extra".

After the meeting they said that if anybody wanted to have a talk to me on a one to one ... and there was a queue like you wouldn't believe for these people just wanted somebody to talk to and just needed some advice. (Susie)

I found a man who had an ileostomy ... he told me he made his own *appliances* ... so each time I got a new patient I would get in my car and go out to the suburbs to the garage at the back of the man's yard. (Maxine)

I suppose I've stuck my neck out to do things, where other nurses wouldn't touch things I'd spend hours. (Linda)

I started going to see the patients in all the various private hospitals. I was doing this after I finished work on public transport. I was very considerate, I didn't believe in going in visiting

hours so frequently I was seeing people after the visitors went and I was getting home at 10.30 at night. (Kate)

We had a boat trip 3 weeks ago and we had 45 *ostomates* on the boat it was great and we are planning another one ...perhaps have an evening meal or something. (Barbara)

These exemplars suggest that at least some stomal therapy nurses possessed an altruistic motivation to care. This they demonstrated by their willingness to devote their time and personal resources for solving the problems that troubled their patients.

Problem Solvers

Reflected in the ability to solve problems, is a 'knowing how' and a 'willingness to' solve the problem. The former quality requires knowledge and the latter quality commitment. Although there appeared no early shortage of the latter quality, the former evolved as a result of learning the 'tricks of the trade' and the gaining of experience. What became evident however, was that these nurses were willing to solve the problems they encountered and were prepared to seek the solutions necessary for them to do so.

I looked at the wounds and I nearly fainted, I didn't have the faintest idea what to do with them. I went away and gathered my wits and looked through the enormous pile of reference material that I'd been given ... I put long bags on these wounds which lasted in place for 3 days and I was made. It was great good fortune because I don't think they ever stayed on for 3 days at a time again. (Anne)

Although the nurses realised that they did not necessarily have all the solutions for problem-solving.

We really had to learn as we went along and then we were teaching as we went along. (Esme)

The thing that struck me about the rubber bags was that they smelt so badly, but they were sure better than nothing ... we thought we had worked miracles when we got this to stay leak-proof for 6 hours. (Christine)

It could be said that during those early years, very few others had the solutions either. Maxine recalled that "even though I didn't have a great deal of knowledge myself I found I knew a bit more than other people". Likewise, Christine stated that during that

era “ours was very limited knowledge, but we were still the experts”. But in reality the gaining of expert status was no sinecure. It could be compared to a professional journey that took them from novice to expert status.

Novice problem solvers it seems, benefited occasionally from beginners luck and frequently had to demonstrate persistence. However, even minor achievements gave them the confidence to try and solve quite major problems.

I did a little bit of looking around to see what on earth was available... Skin Bond, rubber bags and double adhesive wafers... we thought we had worked miracles when we got this to stay leak-proof for 6 hours... I shall never forget that, it was this child's first experience and his mothers' first experience of having the child dry. (Christine)

When I first started, when I knew nothing, there was a daisy bag with yellow flowers all over it and there was some weird and wonderful way that S. used to quickly whip out a bit of this Stomahesive™ and somehow slop a bit of that onto the back of this daisy bag and have it on the patient's skin in a flash. The first time I tried to do it, I got I an awful sort of tangle because I didn't know what stuck to what. (Nancy)

It was really astonishing to find out just how much we didn't know and how much easier it was to look after people with stomas when you did know what to do. (Anne)

I went there green and came back thinking I could change the hospital. (Maxine)

Advanced beginner problem solvers utilised resources and their successes increased their confidence even further.

The first day I returned (*from the course*)... I was wanted in intensive care because they had some wounds that they wanted attended. I looked at the wounds and I nearly fainted. I didn't have the faintest idea what to do with them. I went away and gathered my wits and looked through the enormous pile of reference material that I'd been given, and knowing that my reputation depended on it, I put long bags on these wounds, which lasted in place for 3 days, and I was made. It was great good fortune because I don't think they ever stayed on for 3 days at a time again, but it was quite an exciting beginning. (Anne)

I felt more confident in my role and was able to go into these wards and offer advice of what I thought was sound advice, whereas before that I hadn't. (Kylie)

I think going to conferences every year really helped because I used to get some fantastic ideas from the other nurses. (Esme)

Competent problem solvers relied on perspicacity. They began to appreciate that not all problems could be solved immediately and that quality outcomes were important and required both time and effort.

It can be a challenge... It might take 2 years to see the results of your input, but I like having the results of seeing a patient ... getting on with life. (Sharon)

We implemented a quality assurance programme so that we could look at our practice. (Kylie)

You look at the way you practice, you look at the way they practice, and you either change your way of practice or pick things up from others and just develop new techniques or new approaches. (Nancy)

Proficient problem solvers demonstrated confidence in their abilities to overcome significant challenges and teach others how to problem solve. They recognised their own expertise and it was recognised by others.

I would say to the relative you make sure you tell them if they smell because if they smell there is a problem and we can fix the problem. (Susie)

I'd go and visit the patient in the hospital and then I'd go back and teach the nurses how and what to do. And that was really good... and once nurses got to know that's what you could do and that was your area of expertise, they were very quick to call you. (Esme)

I had people from all over the country ringing me and asking me how I put my bags on and what I did... it got patients out of hospital a lot quicker. (Maxine)

Expert problem solvers revelled in the challenges and had the ability to solve very complex problems. They did not appear to be intimidated by the perceived ruling powers and they were prepared to accept full autonomy for their actions. Expert problem solvers often utilised creative interventions.

I can remember one patient in particular, it was actually a large wound dehiscence in intensive care... they were my greatest challenge every other day. I had great discussions with the registrar

at that time and he said this man is not going to live because we can't do anything with his wound dehiscence. I said "yes we can" and I was determined to do that and... that man had his liver exposed and everything. I can remember that man coming to see us in outpatients 6 months later and I felt that's what it's all about and that was a big challenge and it would take 3 hours every other day to do (*the dressing*) but I was determined that this was going to work. (Kylie)

I had to be absolutely convinced that she could manage the appliance before the *urologist* would agree to the surgery. So I had a polythene case made that resembled an abdomen with a stoma that she could fit onto her body ... and I taught her and she practiced and practiced. It took 3 months ... then the day came when I agreed that she was OK and for her to have the surgery ... her whole life changed she became totally independent. (Danni)

We decided the type of stomas we were seeing was somewhat abominable and we decided we would do a photographic survey ... we had this system where we took a photograph of the stoma on day 1 and day 5 and then on their first appointment back in out-patients. We coded all these stomas and then we finally got the courage to present it at a surgical Grand Round, and with much fear and trepidation we put up the good, bad and the terrible, with no names mentioned and interestingly enough all the surgeons came because ... it was the first time that nurses had presented to a surgical Grand Round ... There was a surgeon there who was doing particularly good stoma formation so we made this award of 'Stoma of the Month' and it actually encouraged a lot of discussion amongst the surgeons. I must say it lifted their game ... they started to take a little pride in their stomas. (Esme)

Much of the problem solving activities was supported by rituals. For instance five of the nurses (Susie, Nancy, Kylie, Sharon and Maxine) commented on the rituals that they performed when caring for a stoma patient wearing a long bag. These stoma bags were made by the nurses out of long lengths of plastic sleeving. They were made long so that they could drain into a receptacle at the side of the bed.

Now I can't believe how lateral thinking never occurred to anybody and the patients used to lie in the bed with these great long bags draining into 24 hour urine collection bottles. It took years for some bright spark to wake up to the fact of putting a rubber band on the other end so you didn't have this horrendous smell everywhere. (Sharon)

By abandoning one ritual, they created another and the humble rubber band became an essential tool of trade. Rubber bands were used to secure the ends of the long bags in a most precise manner.

We actually concertinaed the end of the bag up and we put six folds in it and put the rubber band around it seven times...it was that exact. (Susie)

This routine had been such an entrenched part of Susie's practice that although she had not applied a long bag for more than 10 years she clearly could relate the exact procedure. The ritual procedure for making these long bags continued to be taught to novice stomal therapy nurses long after commercial alternatives made their use all but obsolete.

Even now when I teach students how to make it I teach them the way I learned. (Nancy)

There were rituals for cleaning the long bags.

We didn't wear gloves and washing out those long bags was an absolute ritual. (Nancy)

We used to wash the long bags out every 3 or 4 hours with enema soap. (Sharon)

The long bags were ritually removed "10 days to 2 weeks after their surgery" according to Kylie. Latter day rituals evolved for the application of skin barriers and newer appliances. These practices and behaviours continued to bestow on stomal therapy nurses the recognition and authority of a separate sub-culture within nursing.

I would make a pattern of the stomas, it was very much like a dressmaking pattern and then I would apply this to the Stomahesive and onto the tubing. Then I would put my hand down the inside of the bag and cut out the pattern. (Maxine)

One could ponder whether it was the rituals attached to stomal therapy nursing that caused Colleen's nursing colleagues to say, "they don't have the time for fiddling with this stuff" (Colleen). However, the rituals provided opportunities for refining the solutions to the clinical problems they encountered and gave the beginners an arsenal of interventions for effecting change.

Effecting Change

The ability for the stomal therapy nurses to solve problems had an obvious effect on patients' lives. However, the nurses' actions also had an effect on their own practice and

attitudes and the practice of doctors and their nurse colleagues. Changes in practice occurred as a result of their seeking a better way to care. As is often the case, changes did not necessarily occur spontaneously. Sabrina referred to themselves as “kind of trail blazers” and as they blazed those trails they were often confronted by conflict and had to resort to creative persistence and assertive behaviours.

Effecting change in patients’ lives

There were many exemplars that demonstrated the positive changes stomal therapy nurses were able to make in peoples lives. Not only were the nurses’ endeavours able to effect physical changes but psychological changes.

I believe that we have been the instruments of change in people’s lives. I can think of a girl that I’ve just been looking after recently, a young girl with Crohn’s disease that I spent countless hours with just really being a mother figure to her and telling her she’s okay and how she will be able to cope and how to deal with her stress and anxiety ... and she wrote me a Christmas card that was just wonderful. Just saying thank you for being there and listening and I feel that we really played a part in her life, of making her look at her disease from a different view point.
(Nancy)

Positive outcomes for patients did not occur without a reciprocal benefit to the nurses. The benefits included a sense of personal validation.

In 1977 I was able to help a person come out of a hermit situation back into real life. I think that probably stuck me into stomal therapy. I couldn’t believe that one person, just like myself who is a very average sort of a person, could just by caring a bit and teaching a bit and helping a bit, could assist somebody who’s life had literally been wrecked almost resume normal life again, because his life had been wrecked for 25 years... to have somebody about the place who can help you adopt attitudes that really change that perception of being abnormal back to one of being pretty normal after all, I think is really of great value. (Anne)

The benefits also included a sense of professional validation.

I got an achievement award for what I do...for patients, for stomal therapy and for the hospital.
(Tessa)

Positive outcomes also reinforced the commitment to the cause.

The biggest challenge was not to be over protective with these people as much as we were. I think we had to realise that they weren't our children at all, we were there to help those parents guide them through thick and thin.

Effecting change in own practice

There were reciprocal benefits for stomal therapy nurses when they were able to promote positive change in their patients' lives. These came in the form of intrinsic and extrinsic benefits. The intrinsic benefits were the personal feelings of satisfaction, achievement and increased self worth. Barbara stated that her involvement with her patients had helped her grow "spiritually".

Susie talked of the increased confidence she gained.

It gave me a lot more self confidence than I'd ever had before, it gave me a much better sense of worth because you really did know that you really were helping people. (Susie)

Tessa enjoyed a sense of autonomy and trust in her relationships with colleagues.

Your autonomous and nobody interferes with what you do and they trust me. (Tessa)

Colleen always felt welcomed.

When I walk onto the ward I am very well received.

The extrinsic benefits were evidenced in the community and professional awards received by many of the stomal therapy nurses (Christine, Alicia, Nancy, Barbara and Judith). Positive outcomes reinforced positive behaviours and motivated the nurses to seek ongoing successes. Some of the nurses also sought to advance their practice by learning additional tricks of the trade from their stomal therapy colleagues.

My knowledge was broadened I think seeing other practitioners work doing the same thing but in different ways, that can only be a learning experience ... you pick things from others and just develop new techniques or new approaches. (Nancy)

Effecting change in colleagues' practice

It has already been noted that initially some surgeons were resistant to stomal therapy nurses interventions, particularly the siting of stomas pre-operatively. The major cause of stomal complications and peristomal skin problems arose from either poorly sited stomas or poorly fashioned stomas. Susie recalled that “with some of the surgeons you had to use different tactics” to get them to agree to pre-operative siting of stomas. The advantage of siting a stoma when the patient was conscious and able to adopt different body positions was that it allowed the nurse to avoid marking the stoma site on irregular or inaccessible body surfaces.

This lady had been in the ward 4 days and I knew nothing about it and she was only a young woman...and she had a colostomy. It was only temporary, but nevertheless...had been sited by the doctor during surgery and she was a fat lady and it was right in the waistline and it was gross and this lady was a nurse. I nearly threw my arms up in horror. So when I saw the doctor I just picked up his hand and smacked his fingers and I said “Tut! Tut! Tut!” He said “I am sorry I won't do it again!” (Judith)

Impulsive behaviour such as this could be criticised as being unprofessional and an antithesis of self-discipline, which some might considered to be a criterion for determining autonomous people. However, truly autonomous people are committed to their beliefs and are also committed to achieving optimal outcomes. Occasionally some of the “different tactics” (Susie) required the nurses to resort to creative enterprises to effect change in the practice of their medical colleagues. The following exemplar was used as evidence for expert practice and is further evidence of how expert practitioners can effect positive change in colleagues.

We decided the type of stomas we were seeing was somewhat abominable and we decided we would do a photographic survey... we had this system where we took a photograph of the stoma on day 1 and day 5 and then on their first appointment back in out-patients. We coded all these stomas and then we finally got the courage to present it at a surgical Grand Round, and with much fear and trepidation we put up the good, bad and the terrible, with no names mentioned and interestingly enough all the surgeons came because...it was the first time that nurses had presented to a surgical Grand Round... There was a surgeon there who was doing particularly good stoma formation so we made this award of ‘Stoma of the Month’ and it actually encouraged a lot of discussion amongst the surgeons. I must say it lifted their game ... they started to take a little pride in their stomas. (Esme)

Once the stomal therapy nurses had proved they had a service to offer that would improve the conditions for patients and nurses then they were seen to be appreciated by their colleagues (Sharon). Although Colleen was occasionally wary of this appreciation and suggested that there may have been an alternative motive attached to the enthusiastic welcome she occasionally received on a ward.

Great the stomal therapist is here and you can do the bag change and you can teach the patient.
(Colleen)

Although Colleen stated she endeavoured to have the ward nurse present when she spent time teaching or caring for a stoma patient, she felt they were often reluctant to do so. Her reason for this was that “they say they are too busy, they say they don’t have time for fiddling with this stuff” (Colleen). Tessa had another view and she suggested that “not everybody likes stomas or looking after people with stomas” but that did not stop her from insisting that they did learn to care for them.

It’s taken a long time to get some of them to take any interest in stoma patients ... They call me and I go in perhaps once or twice a week and assess everything but then I have it all set up for the staff because I can’t be there 24 hours a day and otherwise nurses would never learn how to cope if there is no one available. (Tessa)

Feeling Good

The fifth theme that emerged from the data was Feeling Good. Stomal therapy nurses in this study had no inhibitions in regard to expressing their sense of feeling good. It was their enthusiasm about the fact that they *were* feeling good that leaped from the pages of data and made an initial impact on the author’s understanding. It was the search for *why* they were feeling good that demanded more investigative prowess. Figure 7.6 graphically demonstrates that the nurses perceived a sense of feeling special, professionally valued and professional ‘*Being*’.

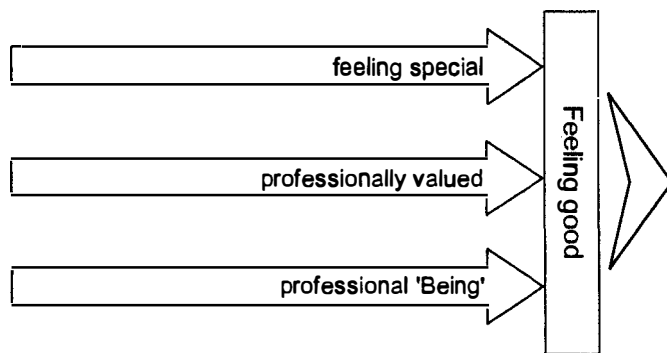


Figure 7.6

The nurses frequently expressed a sense of satisfaction when they were able to solve a difficult problem (Kate, Kylie, Christine, Alicia, Esme and Danni). Their expressions revealed a sense of awe when they realised that they had been “instruments of change in people’s lives” (Anne, Susie and Nancy). They responded in a manner that indicated that they sincerely valued and revelled in the relationships they had established with patients and their colleagues (Judith, Barbara, Sabrina, Colleen, Sharon and Joanne). These feelings and relationships afforded them a sense of feeling special. In addition to feeling special, there was a sense that they felt professionally valued. They voiced their appreciation of the rewards and accolades they had received (Tessa, Linda, Christine and Kate). Both the sense of feeling special and of being professionally valued impacted on the nurses awareness of what it was to be a stomal therapy nurse.

Feeling Special

The following exemplar demonstrates the sense of euphoria and gratification that was felt by Susie. Similar sentiments were echoed by the other nurses when they were able to “achieve the highest of achievable things” (Linda).

It (stomal therapy nursing) was extremely egotistical, patients thought you were a saint, the nursing staff thought you were wonderful ... you were lifted up to a level beyond anything that you’d ever had before ... it was a very heady experience...because everyone was telling you how wonderful you were and I think in real terms the job gave me a lot more self confidence than I’d ever had before...it gave me a much better sense of worth because you really did know that you really were helping people. (Susie)

Some readers of the above exemplar may consider the kudos awarded to those early stomal therapy nurses to be excessively liberal. Until of course, one remembers the complexity and distressing nature of the problems that confronted them. The ability to solve these problems would have attracted exuberant gratitude, especially from patients.

Regard between the nurses and their patients seemed to have been mutual. Judith in particular, had established some binding and lasting relationships with her patients and their families. She alluded to a sense of feeling personally valued and rewarded by the nature of relationships.

I think they're just such lovely people...I'm actually going to a 21st next weekend of a spina bifida boy. I've been to weddings, I'm Godmother of some of their children and, yes, I see them all the time. (Judith)

The nurses described some of the relationships they had with patients in terms of "loving relationships" (Nancy). Although they used the word "love" (Linda, Kylie and Judith) quite liberally, it implied a 'helping relationship' rather than a 'platonic relationship'.

I can give support, friendship and love to them all, not love as love but I just love being able to see that patient rehabilitate, go home, come back for their check up and walk through my door and look just a million dollars... and to know that I have achieved the highest of achievable things to get them back into the workforce, back into society. (Linda)

"Friend and friendship" were other words that were used to define the closeness of the helping relationships (Nancy, Linda and Judith).

That's the great thing about stomal therapy, that we have the opportunity to develop that rapport with people, that one to one relationship. We can use our practical skills but we can be a real friend to the people we deal with. (Nancy)

Friends have a tendency to share their innermost feelings and have open lines of communication. When reapproached for clarification on an experience, Tessa commented:

We listen and talk to our patients they tell us things they have never told another person. Staff have often said to me, “how do you know that?” and I reply, “because I communicate with the people I care for and I know how they feel”. (Tessa)

These comments suggest that the relationships stomal therapy nurses develop with their patients are sufficiently intimate to facilitate communication in a manner that is usually peculiar to friendship.

The nurses’ willingness to commit themselves in such a manner to a helping relationship may appear to require a degree of emotional commitment. This however, does not divorce the carer from the responsibility of their duty of care and all that implies from a legal and ethical point of view. If anything, the freedom to feel concern and ability to respond to the emotional needs of another has the potential to enrich the caring experience for both the caree and the carer.

I remember a beautiful man with a fungating carcinoma with all the elements of odour and body image changes, devastation and non-coping with death and his anger and his gruff approach. Oh! He was just so furious when he came to see us for the first time and then how we developed this loving relationship and I just loved that man. He on the outside was so rough and ready and in the inside was the most beautiful person that loved good music and opera. Appeared like a labourer, like a real rough diamond but he was like butter on the inside. How much I learned from him. I got his management really well under control, there was no odour and he died with dignity. I did lots for him, I recognise that, but he did so much for me. He just added another dimension to my life and I think that’s the great thing about stomal therapy, we have the opportunity to develop that rapport with people, that one to one relationship. (Nancy)

This “dimension in life” correlates to the “spiritual growth” as discussed by Barbara, and is aligned with the feeling of saintliness that Susie experienced. Kylie referred to it as advancing to “another level” and Sabrina described it as “psychological and professional growth”. It would seem that when these stomal therapy nurses experienced a feeling of specialness, it influenced their attitudes and actions in a profound manner.

Professionally Valued

The other aspect that impacted on the nurses feeling good was that they felt professionally valued. The appreciation of their colleagues was acknowledged, and communicated in terms of “everybody seems to respect me and respect what I do”

(Tessa). All of the nurses made mention of the “rapport” or “support” they perceived existed between the surgeons and themselves.

We also had a very close working liaison with the surgeons in the outpatient clinic and if there was any wound care problem or stoma problem they would see them in our clinic, they would come to us. (Kylie)

In Kylie’s opinion it was significant that the surgeons would actually visit the nurses in *their* clinic. It was equally significant that the nurses actually had a clinic in a major metropolitan hospital. Prior to the evolution of stomal therapy nurses, it was virtually unheard of for nurses “to tell doctors what to do” (Susie, Joanne and Judith). Similarly, it was not the norm for nurses to professionally contribute to Grand Rounds (Esme and Kylie) or to be the guest speaker at medical meetings (Maxine). Yet these nurses had experienced the professional respect of their medical colleagues under these conditions.

Some of the nurses had received public acknowledgment.

When I went back (*following the stomal therapy course*) we were all on TV the night we graduated because it was a first course the Health Department had had anything to do with. (Linda)

Eight of the nurses had been awarded travelling scholarships, civil awards or professional nursing awards (Kate, Christine, Sabrina, Nancy, Tessa, Judith, Kylie and Barbara). Such accolades certainly raised the status of stomal therapy nurses and according to Sharon “to raise the status of stoma patients, you do need to raise the status of stomal therapists.

The stomal therapy nurses demonstrated that ‘feeling good’ could reinforce and promote good nursing attitudes and behaviours, which in turn would promote improved outcomes for patients. Linda stated that the rewards she received in training staff and patients were “super”.

Feeling good about one’s job also leads to longevity in the role. Nancy who had been a stomal therapy nurse for 22 years at the time of interview happily announced that she “loved being a stomal therapy nurse, it’s so exciting – a great job”. Meg who had also

been a stomal therapy nurse for over 20 years thought because stomal therapy nurses liked their jobs so much, that any stomal therapy position was a “dead man’s shoes position”, inferring that stomal therapy nurses tended to die in the position rather than resign.

It could be said that ‘feeling good’ was the intrinsic reward that the stomal therapy nurses awarded themselves when they achieved the “highest of achievable things” (Linda) for others, or had been an “instrument of change in peoples’ lives” (Anne).

Professional *Being*

The stomal therapy nurses in this study demonstrated an over-riding appreciation for what could best be described as a perception of ‘professional *Being*’. ‘*Being*’ is deliberately capitalised and italicised in this context to highlight meaning as related to the Heideggarian concept of *Daesin* or Being-in-the-world (Heidegger, 1993). A *Being* that is able and does, question the meaning of being and is able to relate to the dimension of human existence. In the shared experiences of the stomal therapy nurses there was an intrinsic knowing of what it meant to be a stomal therapy nurse. However, the stomal therapy nurses were cognisant of the fact that this awareness was not universal amongst their non-stomal therapy colleagues.

Generalist nurses who were in the nursing boards et cetera did not perceive the broad base for stomal therapy nursing. They could only see that stomal therapy nurses put bags on colostomies. They appeared to be totally unaware of the involvement in continence management, the sexual counselling aspects, the wound care aspects, the care of tissue trauma. (Anne)

The stomal therapy nurses were well aware that they were frequently referred to in rather derogatory terms such as “bag lady” (Susie) or “poo bag lady” (Sabrina). Any concern they had regarding this labelling did not appear to be taken personally, but they did perceive that it constricted the view of the role professionally.

Being a bag lady was not what stomal therapy was about, it is being part of a team within a hospital. (Susie)

It was accepted as the norm during the early years, for there to be some confusion as to what the role of a stomal therapy nurse actually involved. In fact, Meg, Susie and Anne acknowledged that they had no idea what it would involve prior to being asked to fill the position. Nancy recalled her experience as a junior registered nurse when she first came across such a nurse as a “stomal therapist”.

I remember asking someone and they said “oh! well she’s a colostomy sister”. I thought well why would anyone in their right mind want to look after colostomies and what would they do all day just sticking bags onto stomas? It seemed a fairly boring job. (Nancy)

However, it occasionally came as a surprise to the nurses to find that in the 1990s experienced professional nurses did not seem to know what the role involved.

In 1993, a Director of Nursing, a delightful, wonderful woman, spoke of stomal therapy nurses as being ‘towel people’. (Anne)

The reason for this lack of insight on behalf of the Director of Nursing could be attributed to what Sharon termed the “closed shop” aspect of stomal therapy nursing. She was of the view that because they had “to be a really cohesive group” in order to “achieve what they wanted”, which was good patient care outcomes, they directed all their energies toward the patient. Sharon alluded to the shortcomings she perceived in stomal therapy nurses when they failed to project their image further than the patients they cared for or their immediate colleagues. On the other hand, one could speculate as to whether the stigmas associated with “stomas, faeces” (Sharon) that was prevalent during the 1960s and 1970s had truly been quashed. Tessa suggested that even in the 1990s this was occasionally the case.

Not everyone likes stomas. Whereas the staff can cope with breasts (*mastectomies*) and diabetes and all these other things, they really just cannot cope with stoma patients. You still get staff who are petrified or they don’t want to know anything about it. (Tessa)

Although Tessa was rather puzzled to think that “not everyone likes stomas” it is fortunate that other nurses could in fact, have been seen to feel equally committed to the care of mastectomy and diabetic patients. Otherwise breast cancer nurses and diabetic nurse educators may not have evolved. However, the stomal therapy nurses remembered

well the situation for people with a stoma prior to the evolution of stomal therapy nurses (Kate, Christine, Danni, Tessa and Judith). There was a perception amongst the nurses that they had to maintain a corporate and united professional identity, if they were to prevent a return to the lesser standards of previous times (Tessa, Sharon, Judith and Esme).

Some might speculate that this perception was ill-founded in the 1990s in light of the advancements in tertiary education for nurses generally and a broader understanding amongst nurses of the specific needs of the ostomate both pre and post-operatively. The nurses in this study were not specifically asked for their opinions on the current standard of general nursing knowledge and care of ostomy patients. However, the current literature clearly demonstrates that patients who are not seen by a stomal therapy nurse have longer periods of hospitalisation (Walsh, 2002) and experience more complications (Hicks, 2002). Perhaps this is why Nancy considered the role to contain “professional” and “advocate” traits.

These people (*with stomas*) had to rely on other people with stomas to give them support and encouragement and advice and I think our role is very important that these people with ostomies now have a professional nurse that can be their advocate and can help them. (Nancy)

Sharon it appears, perceived the promotion of a “professional image”, could take stomal therapy nurses away from the patients’ bedsides. This view was probably influenced by the trend which was discussed earlier, for nurses to seek employment in administrative roles in order to advance professionally. Fortunately, this was not the view of all the nurses. Nancy, Linda, Judith, Maxine and Esme suggested that there would always be a need for stomal therapy nurses in the clinical setting, regardless of the advances in surgery and technology.

I have to say that we still have a job 20 years after they said well there’s wonderful staples¹⁹ we won’t need you girls anymore. In effect, I think the role will probably change slightly because techniques certainly do improve and the outcomes for surgery are much better and hopefully there won’t be all these disasters we used to see because the surgical expertise certainly has improved. But I still think there’ll always be a role for a stomal therapy nurse, there will always

¹⁹ The invention of the surgical stapling gun allowed the surgeon to perform an ultra low rectal anastomosis which eliminated the need for a permanent colostomy in a significant number of cases.

be (*wound*) breakdowns, there'll always be fistulas, there will always be some form of artificial opening on people's skins or wherever, and that will need attention. (Esme)

Only time can tell of course if there will always be a need for stomal therapy nurses in Australia.

Summary

This chapter has revealed that the five themes that have emerged from the data and that describe *The Experience of Being a Stomal Therapy Nurse* were: Seeking to Care, Committed to a Better Way, Seeking Knowledge, Professing Thoroughness and Feeling Good. An independent theme also emerged, and related to elements that impacted on the evolution and development of the specialty of stomal therapy nursing rather than the experience of being a stomal therapy nurse. Because this emergent theme gave insight into the corporate world of stomal therapy nurses, I have decided to include the analysis of these themes under the title *The Specialty of Stomal Therapy Nursing*.

The Specialty of Stomal Therapy Nursing

Subsequent to the five themes which have already discussed in regard to *The Experience of Being a Stomal Therapy Nurse*, the data revealed an independent theme. It is the intent that the inclusion and analysis of this independent theme will provide an analysis of the experiences of the nurses as a corporate identity and explain how these corporate experiences effected, and possibly continue to effect, the evolution of stomal therapy nursing and the role of stomal therapy nurses in Australia. The theme that emerged from the data in regard to *The Specialty of Stomal Therapy Nursing* is titled A Corporate Identity.

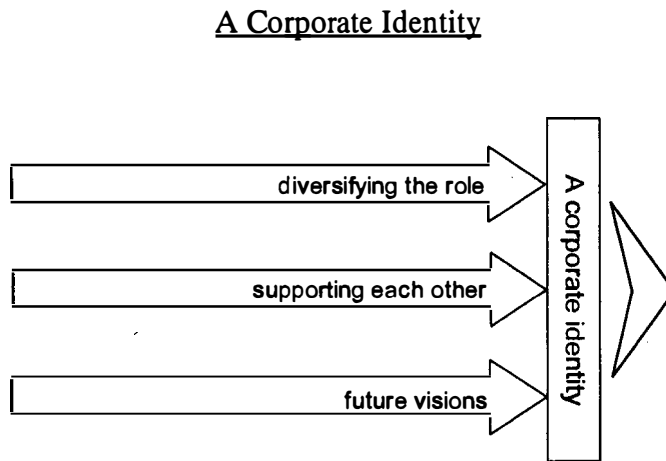


Figure 7.7

It has previously been stated that in the shared experiences of the stomal therapy nurses there was an intrinsic knowing of what it meant to be a stomal therapy nurse. But of equal significance, the data revealed an intrinsic knowing of what it meant to be a stomal therapy nurse *within* the specialty of stomal therapy nursing. Amongst the nurses there was a sense of appreciation of this corporate identity and a sense of responsibility to not only maintain it, but advance a corporate image. The schematic representation of this theme is shown in Figure 7.7 and outlines the elements identified in this study that have done, currently do, and may continue to impact on the specialty of stomal therapy nursing in Australia.

Although the genesis of stomal therapy nursing was found to be in care of patients with gastrointestinal stomas and fistulae as outlined in chapter 5, all of the nurses in this

study commented on how the role of the stomal therapy nurse had diversified since 1971. Generally the stomal therapy nurses' roles involved ostomy, wound and continence care. In Victoria the stomal therapy role in some instances incorporated breast care and mastectomy counselling (this was revealed in chapter 5). All of the nurses described, or alluded to, the need to facilitate advantageous relationships for the common good of stomal therapy nursing through mentorship, preceptorship and clinical facilitation. They perceived these relationships to be fundamental for supporting each another and advancing a corporate standard. Finally, all of the nurses had a vision for the future of the specialty of stomal therapy nursing in Australia.

Diversifying the Role

Chapter 5 revealed that the genesis of stomal therapy nursing was in the care of people with stomas or fistulae of the gastrointestinal system. The movement of stomal therapy nurses into other domains of nursing practice such as wound management, continence promotion and breast care evolved spontaneously. The nurses adopted these clinical specialties either in response to workplace demands (Judith, Colleen, Linda and Maxine) or specific interest (Kylie, Esme, Alicia, Joanne and Nancy). Wound care in particular was considered a "very much an integral part of the stomal therapy role" (Kylie). Anne stated that "even back in 1977 stomal therapy nurses were dealing with wounds". Susie also commented on her involvement with wound management during the early 1970s when she adapted techniques for treating peristomal skin damage to other wound sites.

I was using Stomahesive™ in the good old days on leg ulcers and bed sores before there were such words as 'moist wound healing' ... we were called in for lots of extra things like that because you were involved in healing the skin. (Susie)

The stomal therapy nurses still working in the clinical arena discussed their role in wound management. Judith enthused about the advances in modern wound management during the 1990s. Joanne referred to this as "an explosion in wound care" which she perceived had occurred largely as a result of the advances in wound healing research that occurred during the 1980s. Alicia commented on the plethora of new wound dressings that were available and Susie was concerned about the degree of confusion this caused for some people.

Wound care is a monster of a thing because... if you go into a hospital the number of people who are making decisions about the way wounds are going to be treated is unbelievable and they all conflict. (Susie)

Judith and Maxine were the first of the nurses to formally get involved in the care of urinary incontinent people. Judith recalled that in 1974 she was asked by the surgeon that was looking after children with spina bifida to “start looking into intermittent catheterisation”. She considered this to be a “new era in stomal therapy” and from then on her role involved continence promotion, stoma care and wound management.

Maxine had a similar experience. Joanne referred to the “explosion in continence” and stated that she had been a founding member of the continence interest group in her state. However, as her work load increased and continence advisor nurses developed as an independent specialty then she abdicated that aspect of her work to concentrate of stoma and wound care.

Nancy on the other hand, saw the need to expand her role in continence promotion and had enrolled in a study programme to extend her knowledge on the topic. Colleen’s role embraced wound, ostomy and continence care. Yet Kate, Danni and Meg, who were three of the earliest stomal therapy nurses, only discussed their involvement with stoma patients. Overall, the nurses adapted their roles to the general demand of their workplace and the availability of other clinical resource people.

It was of interest to note that when Kylie outlined how her role had involved “incontinence, breast care, wound care and stomal therapy” she used the term ‘stomal therapy’ to relate to care of ostomy patients specifically. However, earlier she was quoted as saying wound care was “very much an integral part of the stomal therapy role”. This reflects the conflict some of the nurses had in regard to their nomenclature. The historical controversy that was shown to exist in chapter 5 in regard to the selection of an apt title for these nurses in the early 1970s still appeared to haunt them professionally. Although some of them (Kylie and Judith) considered it would be good to change their title to one that reflected their skills in ostomy, wound and continence care, they were not able to suggest a more suitable name.

There was also found to be an ironic analogy between the attitudinal barriers that confronted the early stomal therapists in regard to the establishment of dedicated stomal therapy positions and the attitudinal barriers some of them erected to prevent the establishment of other specialty positions in wound management and continence promotion. There were voiced concerns that if stomal therapy nurses did not diversify their roles into wound, continence and breast care then they would not have a role at all or it would be very fragmented (Christine, Nancy and Susie). There were those nurses who thought it was already too late to prevent that happening (Kylie and Susie).

Kylie felt concerned that stomal therapy was “under threat” because wound care was becoming an area of specialised practice in its own right and she saw it as an integral part of the stomal therapy role. She voiced the need for stomal therapy nurses to promote their practice and by doing so, demonstrate the cost-effectiveness of employing one person with multiple skills. Susie voiced her concerns quite adamantly concerning the development of specialised roles dedicated to wound management and continence promotion.

I think stomal therapists are absolutely crazy; they have let things slip through their fingers. In the bigger hospitals what they're doing is allowing it to go to various different departments and they're losing it and the problem with that is it's diluting the expertise. (Susie)

In Australia, stomal therapy nursing education programmes incorporate aspects of ostomy, wound, continence care. In some programmes, particularly in the state of Victoria, breast cancer care is also included. It is a reality of modern health economics, that the size of the institution and the surgical domains practiced within, dictates the domains of practice for incumbent stomal therapy nurses. Some stomal therapy nurses cover ostomy, wound and continence care. In Victoria breast cancer care may be added to their portfolio. Whereas, the larger hospitals might employ individual wound consultant nurses and continence advisors, many of whom will be qualified stomal therapy nurses. Some of the nurses in this study (Kylie, Sharon, and Susie) thought the title ‘stomal therapy nurse’ did not identify the full extent of their role however, none of them could provide an alternative title that did fulfil this requirement.

Supporting Each Other

Although Christine was initially “very sad to see that wound care went off separate from stomal therapy nursing” she suggested there was a need to work together with the other clinical groups and hold joint conferences. This she perceived would prevent each group from “loosing their identity”. Sharon considered the problem of “self identity” to be a problem universal to the nursing profession and she was philosophical that “society” would ultimately determine what health specialists they wanted and that would determine what stomal therapy nurses would do. But not all the nurses were prepared to wait until society gave them direction. According to Alicia “stomal therapy nurses must look further afield than simply looking at stomas”. All of the stomal therapy nurses discussed or alluded to the amount of ‘support’ they had received from colleagues.

The support that I have received ... from my colleagues as stomal therapists throughout Australia has been phenomenal. (Linda)

The concept of support was found to be aligned with individual and corporate behaviours that reflected mentorship, preceptorship and clinical facilitation. In addition, it was found to relate to behaviours that facilitated attainment of corporate objectives. There were acknowledgements of the importance of this support in shaping their individual development and commitment to the role.

Its great to talk to people who have been doing this thing for so long, to get their advice, to get their support ... its really a good support system. (Colleen)

It was recognised that the giving and receiving of support were integral behaviours associated with being a part of a group of stomal therapy nurses.

They were great days we worked as a team - they were very supportive. Many times I would come up and say: this is my last time, I have to give it up, I can't go on" ... with the encouragement I got from (*named colleagues*) and the whole group, I was able to go on. (Barbara)

The collective responsibility towards supporting individuals and the group as a whole gave them a sense of unitedness.

One thing I always noticed about stomal therapists, they always stuck together and supported each other and I don't know if that still happens, I hope it does, but you know you could always call on them for anything, any advice, talks, we all had different needs and wants and you could always call them, so we all became involved and we all helped each other. (Sabrina)

The united group was often referred to as the 'network'. The concept of a such a productive "network" existing amongst stomal therapy nurses was highly regarded and recognised as the conduit for all supportive group behaviours (Esme, Nancy, Colleen).

There were times when I felt quite on my own in those (*early*) years ... but we had a good network, we had our regular meetings, we could ring each other up and ... we always had a good rapport ... that was really good. It was very positive we could ring around and say help! (Esme)

The network was seen to have both a national and international outreach, which was perceived to be an unique concept during the early years.

You had this incredible network, you had this really good strong Australian organisation and then you were also part of this international network which gave you such a buzz really because it was another dimension that I didn't think you could get anywhere else in nursing. I haven't really seen that sort of support in nursing before and I'm quite frank, I don't think I'll ever see it again, I think it's quite unique. (Sabrina)

Future Visions

During the interviews many of the stomal therapy nurses spontaneously offered, or were requested to offer, their visions for the future of stomal therapy nursing in Australia. Judith, Maxine, Tessa, Anne and Joanne considered that there would always be a need for stomal therapy nurses and focused their comments on the ongoing need for counselling of people who are to have stoma surgery. They voiced concerns that generalist nurses were too busy to fulfil this role.

You listen to people on the ward and they are forever saying we don't have time to talk to the patient and so there is always going to be that counselling role that stomal therapy nurses will pick up. (Joanne)

Various aspects of education held a high profile in the future visions of many of the nurses. Linda, Esme, Alicia, Sabrina and Tessa thought the future vision for stomal therapy nursing was dependant on educating succeeding generations of stomal therapy nurses well. There were expressed concerns that this education had “to keep a balance of theory and practical” (Sabrina) content and be delivered by stomal therapy nurses (Linda), which had been the traditional format of stomal therapy courses since 1971. Sharon, Anne and Christine specified that their visions were centred around tertiary education for stomal therapy nurses. Chapter 5 discussed the issues that arose during the 1990s when the AASTN endeavoured to establish postgraduate programmes for stomal therapy nurses. After the two failed attempts that were outlined in chapter 5, the membership had to settle for a Certificated Programme by distance education, which they helped establish at the New South Wales Royal College of Nurses in 1999.

Christine and Anne also considered that it was necessary for stomal therapy nurses to work towards a professional system of credentialling in order to maintain standards of care. Formalised standards of stomal therapy nursing practice were developed by the AASTN Education Sub-committee in 1997 and were updated in 2001 (Smyth, 2003). These standards were acknowledge by stomal therapy nurses as an important framework for practice. However, there was no formalised process in place for self-directed or peer auditing of practice. In 1997 the AASTN also began work on a process of credentialling stomal therapy nurses (Gibson & Lawson, 1997) and this became a reality in 2000 (Smyth, 2003).

The objectives of these ventures were to ensure high standards of care and professional advancement of individuals and the group. The need for a process and commitment to ensure standards in clinical practice and professional development also featured in the visions of Susie and Maxine. In addition, Maxine could see the time when the AASTN would need to employ “professional secretaries and treasurers” because of the workload and concerns about legal issues. The need for a professional secretariat did become more evident in 2000 when a nationally representative Executive Committee was proposed. Since its founding the AASTN had rotated the Executive Committee between the states however, in 2004 the committee will be comprised of members form all the states and territories.

It was interesting to note that two of the nurses thought aspects of stomal therapy nursing had gone “as far as they can go” (Meg and Kylie). Meg’s opinion was founded on concerns that there would not be dedicated stomal therapy positions for all the nurses who trained as stomal therapy nurses. She perceived a lack of opportunity to practice in the role would make it difficult for trained stomal therapy nurses working in a generalist role to consolidate and retain their knowledge. Obviously the Executive Committee of the AASTN had similar concerns when they instigated the peer credentialling process discussed above, and at the same time a less rigorous process for stomal therapy nurses to achieve continuing professional development status.

Kylie’s visions however, centred around replacing current ostomy appliances with a conjuring act.

What I think should be looked at now are appliances that give a person a quality of life that we have without having to wear a pouch so research should be going into pouchless pouches... What I’m saying is a bag that disappears when you put it on but collects the output! (Kylie)

It was however, Nancy’s visions that were to prove the most astute in the twenty-first century.

I think technology will not only change stoma therapy practice but it will change nursing practice, medical practice, health practice wherever. It’s hard to imagine, I mean thinking back years ago a fax machine for instance we wouldn’t have believed that we could send a letter in this machine and someone would get it that minute and be able to read it, so who knows what we’ll be doing. We might be pressing buttons and we might not be needed, perhaps the patient will tune into a television screen in their lounge room of their home and you could press a button and have a stomal therapy nurse and one of us will pop up on the screen and tell these people what they should do and what they shouldn’t do. Maybe we’ll all be carrying little mini hand-held computers. Maybe we’ll all be jetting around in high-powered vehicles, I really don’t know. From the stomal therapy point of view – flushable bags, bags that you’ll be able to whiz down the toilet so that you don’t have to actually wrap them up and put them in your rubbish bin. Maybe there’ll be some wonderful surgical discovery where there will be synthetic bowel or you know maybe we’ll be out of a job, maybe there’ll be no stomas. But there again we were told that years ago ... but my statistics haven’t changed much over the years. (Nancy)

Nancy voiced her future visions in the excerpt above during an interview in 1994. In the first year of a new millennium many of her visions or quests for a Holy Grail have become a reality. Tele-health systems for diagnostic, management and educational health purposes are becoming increasingly more prolific in Australia and other developed countries. In the United States of America a major manufacturer of ostomy, wound and incontinence products has established a tele-health system for home health care where a two-way camera is left in a person's home and care instructions and advice are given by a specialist nurse from a remote location (Scheurich & Kaloza, 2000).

Hand held computer modules are increasingly used for recording information, particularly in home health care situations. Flushable ostomy appliances (bags) are now a reality and readily available in Great Britain. Although small bowel transplantation is only in the experimental stage in Australia, other centres around the world had performed 325 small bowel and multi-visceral transplants by 1998 (Campbell, 1999). As for jetting around in high-powered vehicles, it is perhaps current economic constraints rather than available technology, that induces one to be content a little longer with vehicular travel of a more modest nature.

In regards to evaluating the individual and corporate impact of the credentialling and continuing professional development processes, it is too soon to say for they are projects of the twenty first century and outside the timeframe of this study.

Conclusion

I have analysed the data obtained from interviews from 19 Australian stomal therapy nurses. These nurses are representative of nurses who have been employed in the domain of stomal therapy nursing from the inception of the specialty in the 1960s until current times. Phenomenological analysis of the data has been used to describe the *Experience of Being a Stomal Therapy Nurse in Australia*. In the five emergent themes: Seeking to Care, Committed to a Better Way, Seeking Knowledge, Professing Thoroughness and Feeling Good, the reader is able to gain insight into what it is to be a stomal therapy nurse in Australia. In particular, I was able to obtain an understanding of what it was to be a stomal therapy nurse during the early years and subsequent evolution of this nursing specialty.

Phenomenological analysis offered a method for interpreting the nature of these experiences. It provided insight into *Being* a stomal therapy nurse and revealed the lifeworld view of the experiences of stomal therapy nurses and ultimately the impact of these experiences on the people for whom they cared. This study has also revealed the genesis of many of the 'tricks of the trade' used by stomal therapy nurses in their craft. Revelation of the origins and intent of these practices allows the reader an opportunity to review them in light of current scientific knowledge.

Furthermore, in describing the experiences of nurses in this study, an analogy can be made between the nurses and the ancient Greek hero Odysseus, as both had to confront myths, monstrous problems and ruling powers throughout their journeys. These obstacles caused the nurses to be extremely resourceful and often combative on occasions. However, these qualities appeared to have reinforced their commitment to their 'cause' rather than detract from it.

This study also revealed an independent theme which was titled A Corporate Identity and to highlight the independence of this theme it was presented under the sub-title of *The Specialty of Stomal Therapy Nursing*. Data analysis of this theme provided insight into the diversification of the role of stomal therapy nurses nationally, the significance of the support the nurses perceived to exist amongst themselves and the visions they hold for the future of stomal therapy nursing in Australia.

The relevance of these findings to stomal therapy nurses and other non-stomal therapy nurses is to be found in revealing what it is to *Be* a stomal therapy nurse in Australia and what it is to *Be* a stomal therapy nurse within the wider scope of stomal therapy nursing. For stomal therapy nurses it allows an opportunity to compare one's own experiences with those of their colleagues. It also reveals the origins of many of the tricks of the trade and allows one an opportunity to review these practices in light of current treatments and knowledge. For non-stomal therapy nurses considering a career in this nursing specialty it provides an objective view of what it truly is to be a stomal therapy nurse within the specialty.

Good Nurses Practice Good Nursing

Introduction

Historio-phenomenological analysis of the data in this study unveiled a key finding, and that was that *Good nurses practice Good nursing*. The word ‘good’ has been used to describe nurses and nursing since the first use of the word ‘nurse’, which was recorded in the Biblical book of Genesis (24:59 and 34:8). Deborah was the first recorded nurse and she was a maid-servant who according to Donahue (1996, p. 44) would have been expected to have performed “nursing duties”. Since the times of Deborah however, there has been little explanation as to what characteristics define a good nurse and what constitutes good nursing. Since the founding of ‘modern’ nursing in the second half of the nineteenth century, the term good has been commonly used by nurses, their medical colleagues, their patients and the community at large to describe nurses and their activities (Ashdown, 1917; Baly, 1997; Miller, 1995; Nightingale, 1881). Few however, appear to have used the term to refer to traits of skill and professionalism (Leininger, 1970). Generally, there is a perception that the term is well-understood and therefore, appears to require no further explanation (Miller, 1995; Nightingale, 1878; Reverby, 1987; Stoney, 1916). Very few seek a consensus of opinion and debate the importance of defining the attributes of a good nurse and good nursing (Edwards, 1999).

However, it is only when one is able to understand the essence of good and how it refers to the innate characteristics that constitute caring behaviours and attitudes demonstrated by nurses, is one truly able to reveal the phenomenon. In seeking to define the essence of good and compare it to the behaviours of nurses in this study I have searched for historical insight into the use of the word good in the Greek language and amongst the writings of Florence Nightingale. I found that there were some relevant comparisons to be made and the nature of these comparisons will reveal the reason for choosing the word good to highlight the relationships and related nursing care of stomal therapy nurses.

Defining Good

Some adjectives in the English language are so commonly used to enrich the meaning of nouns that their very commonality renders them seemingly inadequate. Good is such a word. It is used commonly in formal and colloquial language to describe a multiplicity of objects, persons or behaviours. It could be speculated that such versatility has rendered the word too simplistic, if not inane. But a scholarly review of the linguistic origin of the word good reveals a diversity of meaning.

Broadly speaking good means *better or best* in the English language (Australian Oxford Dictionary, 1989). But the word has its genesis in the Greek language, both the classical and Koinē Greek. Alexander the Great invented the Koinē Greek in an attempt to devise a *lingua franca* across the countries he conquered. Koinē Greek was used to write the old and the new testaments of the Bible and it is due to no lack of inspirational vocabulary that the word good is used 650 times in the Revised Standard Version of the Bible (Bromiley, 1982). The richness of the word can be understood in its three Greek interpretations, which are: *agathos* (serviceable and good), *kalos* (good, beautiful, noble) and *chrestos* (mild, pleasant, kind) (Beyreuther, 1999). Christian theological dictionaries accredit many moral and non-moral nuances of these three interpretations and these relate to: some end purpose that is good for use; advantageous or profitable for the common good; pleasing or agreeable; fitting or appropriate; abundant or full measure; generous or benevolent; free from defects, sound or fine; unobjectionable, excellent in every respect; morally upright and just (Bromiley, 1982, p. 526). It is good as translated from the original Greek by theological scholars that reflected the nature of the caring relationships the stomal therapy nurses in this study were found to have established with their patients and colleagues.

There is also a comparison to be made between the caring relationships described by the stomal therapy nurses and the use of the word good as reflected in the writings of Florence Nightingale in her discussions on nurses and nursing. Good was a word used prolifically by Miss Nightingale in her writings as a descriptor of nurse actions, objects and persons. One could surmise that Miss Nightingale well-understood the diversity of the word as expounded above, for she was an accomplished scholar in history, philosophy, ethics and holy scripture. Furthermore, she was fluent in six languages, amongst them Greek. Miss Nightingale's education was also influenced by the

philosophies of Plato and Dugald Stewart, which were both founded on the respective concepts of the all-embracing and highest ideal (Beyreuther, 1999) and ‘moral good’ (Dossey, 2000).

Miss Nightingale left a legacy of hand written letters and amongst them is a letter she wrote on 6 May 1881 as an address to the nurses and probationers at St Thomas’ Hospital, London. Ironically, she found cause to send a copy of this letter to Sister Alexander and nurses in Hobart, Australia on the 6 May 1884 (Vicus & Nergaard, 1989, p. 385). In this letter she penned the words “nurses should be good rather than clever” (see Appendix J). Some years ago, when I first read these words, I sensed personal disagreement. At that time I had assumed that Miss Nightingale had ranked the quality of goodness as understood by mid-Victorian society above that of cleverness in nurses.

Cleverness is defined as “quick at learning and understanding things or the showing of skill” (Australian Oxford Dictionary, 1989, p. 80). Cleverness is a concept most modern nurses would deem a commendable quality and one presumes would rank equally, if not higher than the moral perception of being good. There has been debate in the literature for many years as to whether it was with moral, religious or societal values in mind that Miss Nightingale should have proposed that virtuous characteristics were not only commendable, but essential, qualities in nurses (Smith, 1964; Widerquist, 1992). On reflective reading of some of her letters and writings however, I have developed a conviction that she used the word good in regard to nurses and nursing in an insightful ‘professional context’, which took into account the many nuances of the word. One could surmise that such use would have been in keeping with her scholarly understanding of ethics, philosophy, history and languages.

In the letter mentioned above, which has been dated 6 May 1881 Miss Nightingale used the word good 10 times. On first reading of this letter one could be excused the assumption that such a repetitive use of a word was indicative of either a limited vocabulary or obsessive Victorian moral values. However, on reflective reading I was to identify five distinct attributes either stated or alluded to by Miss Nightingale and which she defined as good in relation to nurses or their behaviours. It was serendipitous that this revelation occurred to me on 6 May 2002. The attributes Miss Nightingale used to

describe good nurses and good nursing are: caring, thoroughness, training, commitment and mentorship.

It was a startling revelation to see these same qualities reflected in the thematic analysis that described the *Experience of Being a Stomal Therapy Nurse* and *The Specialty of Stomal Therapy Nursing*. These themes were: Seeking to Care, Committed to a Better Way, Seeking Knowledge, Professing Thoroughness, Feeling Good and A Corporate Identity. This chapter explores the relationships that were found to exist between the linguistic origin of the word good, Miss Nightingale's use of the term to define nurses and their behaviours and the key findings of this study. The end result of this exploration is an understanding that *Good* nurses practice *Good* nursing. The characteristics of a *Good* nurse and *Good* nursing are defined and incorporated into a *Good Nurse Model*, which it is hoped will provide a framework for nurses and the profession.

Good Caring.

To be a good Nurse one must be a good woman: here we shall all agree... What makes a good woman is the better or higher or holier nature: quietness – gentleness – patience endurance – forbearance – forbearance with her patients – her fellow workers – her superiors – her equals (Nightingale, 1881).

On reading the above quotation, it could be argued that Miss Nightingale was concerned with defining virtuous feminine qualities, which were deemed important in the late nineteenth century, rather than defining characteristics of caring behaviours for nurses. However, it could equally be assumed that she used the word good with the insight into the Greek interpretation of moral good in mind – that is, that a good nurse should be “morally upright, pleasing or agreeable, benevolent and just” (Bromiley, 1982, p. 526). In this context there is an enriched understanding to be gained in regard to the virtuous manner in which one should care.

Virtue is defined as having moral excellence or a good characteristic (Australian Oxford Dictionary, 1989). Allmark (1998, p. 467) suggests that virtues are necessary qualities, which enables one to reason or function well. Whilst he disputes that caring is a virtue

in itself, he states that having a virtue, in this instance such as being morally good, “involves caring about the right things in the right way”.

Care and good have more in common than the fact that they are simple four-letter words. Both words are used to refer to a multitude of different meanings, for different people, in different situations. It has been said that the concept of good and care cannot be clearly defined (Stockdale & Warelow, 2000). Care in particular, is a paradox in terms for although the domain is not limited to gender, race or occupation, the interpretation of the care concept may differ from all these viewpoints. Historically, the ethos and practice of care is the rootstock from which nursing as an art has evolved. There are philosophic, theoretical and practical aspects of care and caring and many nurse theorists and authors have endeavoured to analyse these components in order to describe nursing actions and relationships (Lea, Watson & Deary, 1998; Nightingale, 1969; Orem, 1983; Watson, 1985).

Care, as a definitive concept, remains an ambiguous and generally inexplicable description for all nursing interventions and attitudes (Aamodt, 1984; Lea, et al. 1998). Although this ambiguity is generally overlooked as nurses and laity alike become involved in giving or receiving care. Then the kaleidoscope of caring attitudes or activities so familiar to nurses, tend to be marshalled under one banner titled ‘care’ and this becomes an universal explanation for all that is given, received or believed. This was certainly the impression I gained from the nurses in this study and I use Judith’s exemplar as an example.

I think you have to be a very special sort of person. It’s not a job where you can just walk in and just go home and leave, it’s something that’s always there. You don’t forget it. You don’t forget your patients, and I think a lot of girls think it’s a money job, but well it isn’t like that. I mean we don’t get – money doesn’t come into it. I don’t do it for the money; I do it because I care. I think that’s what stomal therapy nurses *do* - they do it because they care. (Judith)

The literature identifies various constructs of care and although considerable debate surrounds the epistemological and existential aspects of the concept, there remains a general lack of consensus in definition (Allmark, 1998; Stockdale & Warelow, 2000; Tuck, Harris, Renfro & Lexvolds, 1998). However, most authors refer to three core

aspects of the concept of care and they are cognitive, emotional and physical. The cognitive or moral aspect is concerned with the good of the individual or object and the valuing and respect for dignity and right (Allmark, 1998; Sourial, 1997). The emotional aspect involves the affective response or feelings, whether positive or negative, towards some object or person (Allmark, 1998). The physical aspect of care is concerned with providing for, or meeting the needs of an individual or activity of the profession (Gaut, 1984; Tuck, et al. 1998). Although the nursing profession is concerned with all three aspects, it is the action-orientated physical care that is perceived to be central to the profession's charter.

In this study, the theme 'seeking to care' was evidence of the nurses' behaviours in regard to the cognitive, emotional and physical aspects of care. I have selected Christine's exemplar to demonstrate this point.

My experience of this lady was that she smelt horrendously. The first time I went to care for her she was soaked, wet from urine and faeces and she had layers of combine and bandages wrapped around her skin. All around these holes – what looked as holes – in her tummy were red raw. It was dreadful and I remember ... there was no dignity to the lady. She couldn't get up and walk around because the contents of her bowel and bladder would escape. She herself was very embarrassed. I thought then, there must be a better way, I shall never forget it. (Christine)

As a junior nurse, Christine demonstrated cognitive or moral caring in her expression of concern for her patient's loss of dignity, embarrassment and ostracism. The emotional aspect of caring was demonstrated by her appreciation of her patient's "wonderful personality" and the fact that the patient was regarded as a protector and organiser of junior nurses on the ward. The physical aspect of Christine's caring was centred on her patient's incontinence, malodour, denuded skin and her inability to ambulate independently. Although Christine was able to identify the physical aspects of care that her patient required, she was also aware of her limitations and her inability to provide that necessary physical care. Such recognition is a most important element for effectual caring,

According to Gaut (1984) there are certain conditions that need to be established for caring to be effective. Firstly, there must be an awareness of the individual and an attitude of respect for the rights, dignity and needs of the individual. Secondly, there

must be knowledge or understanding of the needs of the individual and the knowledge of how to respond to those needs in order to bring about a positive change. This requires an understanding of one's own limitations and abilities. Both Gaut (1984) and Sourial (1997) refer to this as competence in caring.

Good Competence

A good woman should be *thorough* thoroughness in a Nurse is a matter of life & death to the Patient. Or, rather, without it she is no Nurse. Especially thoroughness in the *unseen* work (Nightingale, 1881).

The use of the term thoroughness in this quotation could be considered synonymous with competence, which is broadly defined as having the ability to do what is required well (Australian Oxford Dictionary, 1989). In endeavouring to seek further insight into the concept of thoroughness I returned to some of the nurses in this study to seek their understanding of the concept. Julia related the concept to “paying attention to detail and looking beyond the surface of a given situation”. Anne equated thoroughness to be evident when “the stomal therapy nurse is able to comprehensively meet the needs of the individual”. Tessa considered thoroughness to be evident when:

We look at the person as a whole package and we include the family, we do not label or judge people we adjust to their situation and talk in their terms...we take into consideration their mental, physical and psychological capacity, sight and dexterity. (Tessa)

Nancy on the other hand considered thoroughness was also related to having the necessary knowledge to adopt an “holistic” and “thorough approach”. She described it as “a positive characteristic provided it has a caring aspect to it as well as efficiency”. Nancy stated that advanced stomal therapy nurse practitioners:

Can't help ourselves – we probe and poke into wounds, we delve around the mucocutaneous junction, we check out the plain abdo X-ray, we are always opening Pandora's box when we believe the patient has an unresolved unuttered issue, we ask the relevant questions which we know will open the floodgates and we therefore, won't get off on time. We do the bit extra, we act as the advocate and go in to bat for the patient. (Nancy)

I rather think Nancy has described the thoroughness in *unseen* work as stated by Miss Nightingale previously.

Thoroughness is also aligned with the Greek interpretation of good, which is “excellent in every respect and sound or fine” (Bromiley, 1982, p. 526). Optimal as this type of care might be, it does not appear to be universal to all nurses and nursing activities. The reason for this view is that it has been proposed that caring is not an absolute but rather a matter of degree (Gaut, 1984). That is, care can be influenced by different degrees of attitude, knowledge and skill.

There is both a subjective and an objective element to care. Although physical care may appear more attuned to objective measurement, there will always be an element of subjectivity associated with measuring physical care from both a carer and recipient aspect. This is to be expected simply because the carer and the recipient will have intrinsically different attitudes, personal preferences and expectations. Examples of subjectivity and the influence it extends towards determining effective and objective outcomes are seen daily in any nursing practice situation. Two nurses may be equally competent in changing a wound dressing but a patient may prefer, or not prefer, the care of one nurse over the other because of conscious or unconscious reasoning related to personal appearance, ethnicity, gender or interpersonal skills.

Returning to the point that care is not an absolute but rather a matter of degree, it stands to reason that there must be some indicators for determining markers of change in degree. Since the 1970s there has been increasing comment in the nursing literature on measuring nurses' ability to care (Benner, 1984; deVries, 1999; Hall & Jones, 1976). The development of a list of clinical competencies that could be used to identify performance capability at a qualified practitioner level was initially seen to be the answer for measuring practitioner performance (Cameron, 1989). In recent times however, some nurse educators have expressed concerns of focusing on outcome orientated technical procedures at the cost of promoting vocational aspects of nursing practice (Chapman, 1999).

In Australia, individual state nurse licensing boards and professional bodies have increasingly embraced the concept of clinical competency processes as a means of

establishing standards and determining accountability (Parkes, 1992a, 1992b). However, these performance indicators promote the view that caring competence is absolute and therefore, they focus on recording achievement or failure to achieve (Australian Nursing Council Incorporated, 1998). Whilst this 'can' or 'cannot do' approach sets a standard for safe practice it does not identify parameters for nurses who are journeying towards competent recognition, nor parameters for nurses who exceed it.

If nurses are to be individually or collectively encouraged to provide optimal care, then parameters that demonstrate evidence of achieving excellence and expertise are most desirable. It is important therefore, to ascertain at what stage in a nurse's journey from novice to expert is competence achieved or excelled. According to Benner (1984) this skill-developing journey occurs over five stages and these she refers to as novice, advanced beginner, competent, proficient and expert. A novice nurse is one who has no background experience of a given situation. An advanced beginner has enough background experience to recognise aspects of a situation. A competent nurse has sufficient experience and provides evidence of conscious, deliberate planning and efficiency in prioritising and delivery of care. A proficient nurse is able to perceive a situation as a whole and is able to rely on past experiences rather than in terms of aspects, and performance is guided by maxims. An expert is very experienced and is able to immediately focus on the problem without allowing the extraneous variables in any situation to hinder goal achievement.

Benner's (1984) approach to determining individual achievement along this continuum was conceived with the individual nurse in mind. I would also propose that this same model could be used to track the progress of a collective body of nurses as they advance along a professional journey towards specialty status. The rationale for this view is that any group of nurses that is collectively recognised by their peers and patients as having specialised expertise is comprised of cohesive and independent individuals who have travelled that journey from novice to expert. The concept of specialty status implies a level of expertise within a discipline or sub-culture of that discipline, for instance stomal therapy nursing.

Using Benner's framework (1984), the following study exemplars are used to highlight not only the professional journey of individual stomal therapy nurses in this study, but the group as a whole.

The novice nurse

Amongst my patients was a man who was to go the theatre for a colectomy and a colostomy...Everything went wrong, the first thing that I encountered was that his I.V. had stopped and his catheter couldn't void, it was just so pathetic to see this little man who was just so sick. Well here was I trying to work out what to do with a colostomy, I'd never seen one. I knew such things existed but I didn't know what they looked like. (Kate)

Today, most nurses reading this excerpt would presume Kate was very inexperienced or new to the acute care setting, as she had not seen a colostomy. But when the historical context of this event is taken into consideration a different view is gained. Kate began her nurse training 6 years prior to this clinical event, which occurred in 1959. At this time in Australia, surgery resulting in the formation of a colostomy was not common and ileostomy or urostomy surgery was rarely performed. She lacked experience because she had no previous clinical experience to draw upon. Nor was there any specialised body of stomal therapy nursing knowledge in Australia at that time that she could access. Basically there were no rules to guide her care and it is the rules that a novice relies upon for determining actions (Benner, Tanner & Chesla, 1996).

Just as there were no rules for individual instruction, there existed no rules for collective instruction of nurses, for there was little if any dedicated nurse education in the care of people with stomas. The pioneering stomal therapy nurses in this study were challenged by this lack of information. Linda recalled her anguish when she failed to find the necessary information to assist her to care for her first stoma patient in 1971.

I felt very inadequate in 1971 when our *medical* superintendent ... performed an abdominal perineal resection and I really felt terrible because I could not help this lady ... I tried to get information. I could not get any information from anywhere. (Linda)

Linda's contemporaries in this study remarked on the fact that there were no rules or experience to draw upon and like Linda they "had to make it up as we went along"

(Linda). It was not until October 1971 that the first Australian course in stomal therapy nursing was held in Melbourne, but only three nurses participated in this programme.

The advanced beginner nurse

During the 1970s stomal therapy nursing courses, which were held in Melbourne were in demand as numbers of eager nurses from across the country attempted to enrol. However, a course does not an expert make, and the relatively small numbers of nurses who did complete the programme returned to their individual hospitals to practice and advance the art of stomal therapy nursing.

The first day I returned (*from the stomal therapy course*) I can remember ... I was wanted in intensive care because they had some wounds that they wanted attended. Now in those days, even then, back in 1977, stomal therapy nurses were dealing with wounds. And these people had pancreatitis and had enormous draining wounds. I looked at the wounds and I nearly fainted. I didn't have the faintest idea what to do with them. I went away and gathered my wits and looked through the enormous pile of reference material that I'd been given, and knowing that my reputation depended on it, I put long bags on these wounds which lasted in place for 3 days and I was made. It was great good fortune because I don't think they ever stayed on for 3 days at a time again, but it was quite an exciting beginning. (Anne)

Anne had just completed a stomal therapy course when she was expected to solve the complex care needs of this patient in the intensive care unit. As previously stated, the advanced beginner has enough experience to recognise aspects of the situation. The advanced beginner knows there are rules for behaviour or in this instance tricks of the trade that can be followed, but lacks the experience to immediately put them into practice without analysing all aspects of the situation. Anne's comments concerning the fact that when she looked at the wounds "she nearly fainted" demonstrates the complexity of the situation she perceived. Being overwhelmed by "the complexity of the skill and exhausted by the effort required to notice all relevant elements" is a common experience for an advanced beginner (Benner, et al. 1996, p. 38). Anne responded in a manner familiar to advanced beginners, she took time to analyse the situation and reviewed the rules.

Similarly, during the 1970s the fledgling group of stomal therapists, struggled to learn the professional rules in order to practice and promote their identity. Conflict commonly

occurred between the traditional nursing and medical stalwarts and the fledgling AAST. Although they expected resistance from surgeons, they were at times overwhelmed by the resistance they encountered from their nurse peers and superiors. The tactics the group employed to overcome the surgeons' resistance will be familiar to generations of nurses who have found a need to play what has been referred to as the 'doctor-nurse game' (Stein, Watts & Howell, 1990). The rules of this 'game' allowed nurses to make suggestions without appearing to threaten the omnipotence of surgeons and physicians. The tactics the nurses in this study employed to overcome the nursing hierarchical resistance were similar and suggest a junior-senior nurse game was played. The stomal therapy nurses strongest allies were the few supportive surgeons who were pioneering colo-rectal surgery in this country.

Although the literature tends to focus on the advantageous relationships that arise from inter-disciplinary collaboration there remains a dearth of comment in regard to the type of intra-disciplinary conflict they experienced (Corser, 1998; Higgins, 1999; Snelgrove & Hughes, 2000). Historical analysis suggests however, that the intra-disciplinary conflict that arose was founded on a belief held by some nurse leaders during the 1970s that the establishment of a nursing specialty in stomal therapy would fragment and undermine the role of the nurse generalist (AAST Minutes of Meeting, 1 June, 1972). This view continues to be prominent today in some professional arenas even in the light of increased specialisation in nursing, which has occurred as a result of advances in medical specialisation, technology and increased health consumer demands (Fairweather & Gardner, 2000).

With the exception of midwifery, which is considered to have its genesis in the womanly arts, nursing specialties are perceived to have evolved in the shadow of medical specialisation (Whyte, 2000). In this study, stomal therapy nurses were found to be another exception to this scenario for this specialty evolved in the shadow of lay specialisation in stomal therapy care. According to Melbourne surgeon, E.S.R. Hughes, the specialisation of stomal therapy nurses was a "natural sequence" to the increased semi-professionalism of lay ostomates (Hughes, personal communication, 16 March, 1971).

In North America this development was interpreted as an unique response of nurses to consumer demand (Alterescu, 1991). However, the historical findings of this study demonstrated that in Australia the specialisation of stomal therapy nurses occurred as a result of professional power broking in response to consumer involvement. It could be said that the actions of the developing group of nurses mirrored those of advanced beginner practitioners for they 'learned the rules'. In other words, they analysed their situation, rallied their professional resources and advanced their professional standing.

The competent nurse

According to Benner, et al. (1996) the competent stage of a nurse's development is connected with the ability to achieve results and the readiness to experiment with the usual nursing behaviours when necessary. There is an increased understanding that not all situations are the same, and that flexibility in practice behaviours is necessary for achieving desired outcomes in every situation. A competent nurse also has a greater sense of responsibility for his or her actions and a greater emotional involvement. Moreover, successful outcomes provide an increased sense of satisfaction. Nancy's exemplar, which follows demonstrates all the required criteria for achieving competence.

I believe that we have been the instruments of change in people's lives. I can think of a girl that I've just been looking after recently, a young girl with Crohn's disease. I spent countless hours with her, just really being a mother figure to her and telling her she's okay and how she will be able to cope and how to deal with her stress and anxiety ... and she wrote me a Christmas card that was just wonderful. Just saying thank you for being there and listening. I feel that we really played a part in her life for making her look at her disease from a different view point... I think that's the great thing about stomal therapy, that we have the opportunity to develop that rapport with people, that one to one relationship. We can use our practical skills but we can be a real friend to the people we deal with and every day with stomal therapy is different. (Nancy)

Nancy was able to determine a desired goal, which was to enable her young patient to deal with her stress and anxiety. Towards this end, she was willing to experiment or flex the rules relating to the perceived nurse-patient relationship and in so doing, she achieved results. At the same time she expressed a sense of responsibility for her actions and a vivid sense of satisfaction on achieving a positive outcome.

So it was with the early members of the AAST who had a vivid sense of satisfaction when they achieved positive corporate outcomes. Perhaps the most satisfying outcome for the AAST was their contribution to the listing of free appliances on the national Stoma Appliance Scheme in 1975. Not only did this scheme positively impact on quality of life issues for ostomates but also on the professional development of stomal therapy nurses. It was quite exceptional that in the 1970s a group of nurses could have such an influence on government policy and commercial enterprise.

The proficient nurse

The proficient nurse is defined as one who is able to see the big picture and has a perception of the important aspects of a given situation and care interventions (Benner, 1984). Judith's comments which follow, highlight her experiences of caring for children with spina bifida and their families. Like her contemporary stomal therapy nurses in this stage of their practice evolution, they were able to understand the benefits of an holistic approach.

I guess my greatest achievement is having the rapport and understanding, the sharing and caring from the families and to the families and to my colleagues. I think one of the most important issues to think about is that you have that total respect and care of the families, whether it be children, parents, adults, husbands and wives, grandmothers and grandfathers. The whole family. It's not just one person. (Judith)

Nursing theories are enshrined in the maxim that nursing care should be considerate of the holistic needs of the individual and the interdependent relationships that influence the individuals' responses (Hall, 1964; King, 1962; Neuman, 1982). The proficient nurse is able to understand the value of such maxims and uses them as a guide to caring (Benner, 1984).

Similarly, as a united body of nurses the group gained an understanding of the bigger professional picture during the 1980s. They recognised their professional worth as nurses and in 1984 changed the name of their association to reflect their birthright. That same year they awarded the first Life Memberships to Elinor Kyte and Meryl Barrett in recognition of their efforts in forming and advancing the association. During the 1980s they converted the newsletter that was begun in 1973 to a journal format, they formed

an Education Sub-committee and they began negotiations with tertiary educational facilities with the goal of establishing a post-graduate programme. It was a period of professional maturation and readiness to advance the professional standing of stomal therapy nursing practice.

The expert nurse

The expert is said to “not only know what needs to be achieved but also knows how to achieve the goal (Benner, et al. 1996, p. 42). In a nutshell, the expert nurse does what experience shows them will work. There is an immediate focused response and confident skilled performance in addressing a given clinical problem. According to Benner and her colleagues (1996, p. 53) “skilled performance is linked with judgment and is a form of knowing”. Expertise is accorded in relation to the degree of knowing the patient, knowing the problem, knowing what to do and knowing how to do it.

Kylie’s exemplar below demonstrates this kind of ‘knowing’ expertise for she knew what the problem was and immediately knew how to respond because of experience honed by “challenges every other day”. There was confidence in being able to solve the problem and determination to achieve results.

I liked the autonomy and the challenge. The challenge of really being able to nut something out and work it out for the betterment of the patient. I can remember one patient in particular, he actually had a large wound dehiscence in intensive care and I just thought that these things – I just loved them – they were my greatest challenge ever other day. I had great discussions with the registrar at that time and he said this man is not going to live because we can’t do anything with his wound dehiscence. I said ‘yes we can’ and I was determined to do that and I remember that man had his liver exposed and everything. I can remember that man coming to see us in outpatient’s department 6 months later and I felt that’s what its all about. That was a big challenge and it would take 3 hours ever other day to do but I was determined that this was going to work. (Kylie)

If this was what Miss Nightingale had in mind when she said, “*thorough* thoroughness in a Nurse is a matter of life and death”, then one can only concur that it is so.

Thorough thoroughness or expertise involves the possession of extensive experience, in an area of specialised knowledge and skill, that is acknowledged by others within and

outside the profession (Benner, et al. 1996; Hampton, 1994; Jasper, 1994). As individual nurses move towards expert status they refine their experiential knowledge, which is grounded in practical skill and seek to reinforce this with a theoretical base. They learn to hone their knowledge and skill and willingly demonstrate its value to others – both colleagues and patients. Expertise in a given domain usually leads to increased autonomy to practice. Like Kylie in the preceding exemplar, stomal therapy nurses in this study frequently commented on the autonomy they perceived they possessed (this shall be discussed later in this chapter).

Expert nurses tend to be visionary (Hampton, 1994) and as the individual expertise within the group advanced so did the visions of the group as a whole. After 1984, members of the AASTN generally diversified their practice into the domains of wound, continence and in some situations breast care. The association recognised the need to ensure quality outcomes and leadership and during in 1997 standards of practice were developed and a process for credentialling stomal therapy nurses implemented in 2000.

Good Cognisance

Let us be anxious to do well ... to honour & advance the cause, the work we have taken up. Let us value our training not as it makes us cleverer or superior to others but inasmuch as it enables us to be more useful & helpful ... Let it be our ambition to be thoroughly good women, good Nurses. And never let us be ashamed of the name of 'Nurse' (Nightingale, 1881).

In this quotation Miss Nightingale regales two fundamentally important goals for good nurses. They should desire to acquire expertise and to be cognisant of the need to use their expertise for the betterment of others. This philosophy can be aligned with the Greek interpretation, which is training for “some end purpose that is good for use” (Bromiley, 1982, p. 526). It has been suggested that it is the “training and knowledge that isolates members of a profession, and adds mystique which enhances their authority” (Bessant & Bessant, 1991, p. 59). One would not dispute the fact that knowledge does identify members of a profession and inherit in awarding that professional status is a degree of expectation.

The strength of commitment to a cause and the people it serves establishes the foundation on which knowledge can be built and advanced. It is the consolidation of knowledge and skill within a domain of practice and its perceived uniqueness and value, that not only shrouds the practice in mystique, but awards it specialty status. Any mystical power afforded a profession or group is determined in accord with its unique ability to solve problems others cannot.

Initially, it was the enormity of the problems that confronted some of the nurses in this study, that committed them to the cause of seeking a 'Holy Grail' solution. A cause or a crusade becomes apparent when ethical dissatisfaction arises within the ranks of a professional or lay body. Dissatisfaction is usually felt in regard to sub-standard practice or unethical behaviour and this disenchanters crusaders who are not prepared to condone such practices. The nurses in this study experienced such dissatisfaction in regard to the standard of care they had seen given to ostomates prior to the evolution of stomal therapy nursing. Nursing is not unaffected by causes and in fact, the education and skilling of today's nurses was founded on Miss Nightingale's concern for the moral good of people who were forced to endure sub-standard health care. Similarly, the pioneer stomal therapy nurses when confronted with patients' problems diligently took up the challenge to seek solutions.

All of the nurses in this study who practiced during the 1960s and 1970s indicated that they believed there had to be a better way to care. But because there was no formalised body of knowledge to draw upon, clinical care of patients was dependant upon trial and error. Information gleaned from patients about what worked and what did not work was passed from one person to another.

In fact, I think that probably all I really know about home care of stomas I have learned from people who have stomas. Certainly not from any innovative or lateral thinking of my own. I just acted like a sponge and absorbing information that people have given to me over the years.

(Anne)

The courses in stomal therapy nursing that evolved during the 1970s emphasised these experiential aspects of learning. The rituals, or tricks of the trade as they were often referred to, were highly prized for they provided solutions for many clinical problems.

Practice reinforced learning and on occasion, such practice appeared to be at the cost of patient comfort and security as can be seen by Alicia's comments.

They had a lot of spina bifida children there, and so I was able to practice to my heart's content changing the ostomy appliances all day! I mean several times, you know they came back and said look it's come off! So I had another go at doing it again. It was wonderful experience!
(Alicia)

Rituals are symbolic actions that define a cultural group (Silberger, 1998). Nursing is a cultural group that is richly endowed with rituals and this ritualistic behaviour not only defines the profession, but sub-groups within the profession. The rituals found to exist amongst the nurses in this study evolved in response to problem-solving activities. They involved practices such as the hand-made manufacture of long bags, the pedantic use of elastic bands to seal the open ends of long bags and the cutting of radial slits in the aperture of Stomahesive™ skin barriers. Ritualised use of food substances and pharmaceuticals on ulcerated skin were frequently proclaimed to be therapeutic with little scientific support. Examples of these unorthodox therapies were the use of dried milk powder and antacid pharmaceuticals on ulcerated skin. Although many of these treatments originated prior to the development of commercially available skin barrier products, they continued to be used long after commercial options became available. Moreover, some continued to be used long after they were found to be detrimental to wound healing. An example of this latter concern was the use of mercurochrome 10% on denuded skin.

However, not all ritualised behaviours were found to be detrimental. Creative problem-solving solutions when found by trial and error to work, were entrenched in practice and handed on to others. These creative problem-solving rituals identified the sub-culture of stomal therapy nurses amongst their peers, colleagues and patients. Like Holland (1993) who found rituals featured strongly in the work efforts of nurses, I too had the impression that this type of ritual not only identified a culture, in this instance stomal therapy nursing, but unified the commitment to it as well.

Good Comradeship

We will not laugh at the mistakes of beginners – but it shall be our pride to help all who come under our influence to be better women, more thorough Nurses... The influence of a good woman & thorough Nurse with all the raw Probationers who come under her care is untold... Let us each & all, realizing the importance of our influence on others – stand shoulder to shoulder - & not alone, in the good cause (Nightingale, 1881).

Nurses regardless of their professional journey can relate to the rawness of inexperience that is familiar to a novice. The burden of beginning any new experience can be greatly lightened by the support and guidance of a more experienced person. In proclaiming the importance of a nurse's influence on another, Miss Nightingale used the analogy of soldiers fighting shoulder to shoulder and back to back against desperate odds in battle. In this context there is an element of an "advantage for the common good" (Bromiley, 1982, p. 526), which is embedded in the Greek interpretation of good. In current context this could be interpreted as promoting advantageous relationships for the common good of nursing, through mentorship and preceptorship. In this study the nurses described or alluded to the important influence of both of these activities on their professional development. But of even greater significance was an over-riding appreciation for what could best be described as a perception of *professional Being*.

'Being' is deliberately capitalised in this context because there is a relationship to the Heideggerian concept of *Dasein* or Being-in the-world (Heidegger, 1993). A Being that is able and does, question the meaning of being and is able to relate to the dimension of human existence. In the shared experiences of the nurses there was an intrinsic knowing of what it meant to be a stomal therapy nurse within the world of stomal therapy nursing. Anne's exemplar has been selected to demonstrate this point.

I believe that a stomal therapy nurse is probably the most autonomous professional nursing specialist in nursing at the present time. I believe that stomal therapy nurses have roles in hospital, in the community and particularly as private practitioners... In 1993, in Brisbane, a director of Nursing, a delightful, wonderful woman, spoke of stomal therapy nurses as being 'towel people'. Certainly stomal therapy nurses are nurses who do assist others who have problems related to evacuation but that does not really make them towel people. Stomal therapy nurses are professional nurses with a vocation for dealing with people who have problems with body image and they are not necessarily cleaner uppers of dirt. (Anne)

It is appreciated that nurses from other domains may disagree with Anne's claim in regard to stomal therapy nurses being the "most autonomous professional nursing specialist". But Anne perceived stomal therapy nurses to be "professional" and "autonomous" and view their role as a "vocation". In addition, she and her contemporaries had an expectation that other stomal therapy nurses would be there for them, if they should require support. In fact, the concept of 'support' featured strongly in their exemplars when they discussed their professional relationships with each other. I have taken the liberty to highlight certain words in the exemplar below for the purpose of clarifying the point of discussion.

One thing I always noticed about stomal therapists, they *always stuck together and supported each other and I don't know if that still happens, I hope it does, but...you know you could always call on them* for anything. Any advice, talks, we all had different needs and wants and *you could always call them*, so *we all became involved ... and we all helped each other ... you had this incredible network* You had this *really good strong Australian organisation* and they *you were also part of this international network* which gave you such a buzz really because it was another dimension that I did not think you could get anywhere else in nursing. I have not really seen that *sort of support* in nursing before and I am quite frank, I do not think I will ever see it again; I think it is quite unique. (Sabrina) (italics added)

Sabrina's comments reflect her many years of nursing experience in a variety of domains. Her exemplar demonstrates that she had an intrinsic awareness of herself as a stomal therapy nurse and her connectedness with the wider world of stomal therapy nursing. She saw herself both as an individual and as part of a national and international network. The strength of the nurses' commitment to each other and their professional association was very evident. They gave a strong impression of professional dependability – one for the other.

Its great to talk to people who have been doing this thing for so long, to get their advice, to get their support ...it's really a good support system. (Colleen)

The concept of support as expressed by the nurses could be compared to a professional scaffold that strengthened and upheld the individual and the group. It was very much dependent upon, but not limited to, the giving of advice and guidance. These are

attributes which are perceived to be important qualities of mentorship. The concept of mentoring was embraced by nurse educators during the 1980s and has been adopted widely by the profession as a whole (Andrews & Wallis, 1999). Mentoring is said to have evolved in the USA during the 1970s as a by-product of the emerging feminist movement and entrepreneurial schools of business studies (Armitage & Burnard, 1991).

However, mentorship has its genesis in ancient Greek mythology. In his *Odyssey*, Homer wrote of Odysseus entrusting his friend, Mentor, with the care of his son, Telemachus, whilst he left Ithaca to fight the Trojan Wars (Cotterell, 1997; Fields, 1991). Mentor was to be a surrogate father, friend and teacher to young Telemachus. Although Miss Nightingale did not appear to use the term mentor, she herself could be considered to have had a mentor in Sir Sidney Herbert (Dossey, 1999; Fields, 1991).

The periodically quoted definition on mentorship in the nursing literature is “an intense relationship calling for a high degree of involvement between a novice in a discipline and a person who is knowledgeable and wise in that area” (May, Meleis, & Winstead-Fry, 1982, p. 23). This is a rather an emotive and overly broad interpretation that perhaps in trying to define a concept suitable for all disciplines, is in fact ineffectual for any, for it is difficult to objectively determine what constitutes an ‘intense relationship’ or a ‘knowledgeable and wise person’. Other authors align mentorship with such terms as: preceptor, facilitator, supervisor, co-ordinator, advisor, counsellor, guide, teacher, role model, friend, sponsor, intervenor, inspirer, investor and supporter (Andrews & Wallis, 1999; Armitage & Burnard, 1991; Donovan, 1990). A line from the Walt Disney film *Mary Poppins* immediately springs to mind and relates to her description of herself as “practically perfect in every way”. One could be forgiven for expecting that a mentor should be practically perfect in every way. However, it is impossible to determine if a mentor is in fact perfect, unless one is able to clearly determine what mentoring actually involves.

Regardless of the ambiguity, mentorship is a concept that appears to be lauded by professional nursing bodies as a means to bridge the theory-practice gap that can occur when novice nurses enter the clinical arena (Andrews & Wallis, 1999; Armitage & Burnard, 1991; Donovan, 1990). Therefore, regardless of the nature of support or the relationship through which it is provided, mentorship is an investment in the

professional development of the individual, which as a consequence will have an impact on the professional development of the entire group.

This was certainly the opinion of Kylie in the following exemplar who was reflecting on the developments in stomal therapy nursing since the 1960s. Kylie identified a practice-theory gap in nursing knowledge. The succinct definition she gave for bridging this gap with a mentoring relationship was “nurses learning from other nurses who are expert”.

There was certainly a vision that was small in its infancy but there was a vision none the less that there was a need for better nursing care of people with stomas and there was a feeling ... that you needed someone who would specialise in that area and that was pretty unique for you didn't have nurses who specialised. But it was obvious that this knowledge was pretty unique and didn't develop overnight and you couldn't read it in books and you had to really do it. When you do something like that there is always this need to have *nurses learning from other nurses who are expert* and the AASTN has done that. It has enabled nurses to learn from other nurses and I think as an association it has done the most wonderful things for people with stomas in this country. I also know it has had an international influence and I think that is something that nurses in this country can be proud of. (Kylie) (italics added)

“Nurses learning from other nurses who are expert” infers that there is an onus of responsibility for expert nurses to be there for their less experienced colleagues. So it was for the nurses in this study who used a range of terms to demonstrated their willingness to mentor and preceptor less experienced nurses (Kate, Susie, Anne and Sabrina). Some of the nurses expressed their appreciation in regard to the mentoring they had received from more experienced colleagues (Tessa, Maxine, Esme and Colleen). The more experienced nurses were seen to be role models, educators and professionally committed to the building of a body of knowledge. This was particularly evident in the emergent theme A Corporate Identity, where the reader will note later in this chapter that there existed amongst the nurses a sense of professional connectedness and responsibility.

Good Commitment

To our beginners good courage, to our dear old workers peace, fresh courage too, perseverance: for to preserve to the end is as difficult & needs a yet better energy than to begin new work (Nightingale, 1881).

It is hard to imagine that anyone would not consider courage good, as diametrically opposed adjectives are rarely used as descriptors of such a virtue. However, the use of the term “good courage” causes one to ponder about Miss Nightingale’s intent in choosing the word good to add emphasis in this context. Once again I returned to the concept of good as that defined by the Greek use in order to comprehend the intent. All of the nuances were found to be relevant in this instance, however, it is the meaning attributed to “abundant or in full measure” (Bromiley, 1982, p. 526) that appeared most applicable for defining courage. Such an interpretation could be considered synonymous with enthusiastic commitment.

The stomal therapy nurses’ understanding of what it was to be a stomal therapy nurse in the world of stomal therapy nursing, appeared to have strengthened their commitment to each other and the practice domain in general. It could be assumed that one demonstrates a commitment to a project or role simply by being involved in that endeavour. Any investment in time and energy is seen as a commitment to a cause however, it could be rationalised that there are degrees of commitment, as there are degrees of caring. Kierkegaard alludes to this view.

It is not enough to toy with possibilities without committing ourselves to their reality. We are judged on how we commit ourselves, on the energy, earnestness and feeling with which we choose our role in life. We may, of course, choose wrongly, but the energy of our commitment will make our mistakes clear (Kierkegaard, as cited in Altschul, 1979, p. 125).

The energy, earnestness and feeling of commitment exerted by the nurses in this study not only contributed to their degree of success but also portrayed a sense of responsibility for both their successes and their mistakes. This willingness to be responsible for one’s actions is a construct of autonomy, which although discussed often in the nursing literature, remains an abstract concept that defies succinct definition (Ballou, 1998; Dwyer, Schwartz & Fox, 1992; Keenan, 1999). Attributes more frequently linked with autonomous practitioners are those of ability, capacity and competence in decision-making and performance (Ballou, 1998). If a practitioner possesses these qualities they are seen to be able to function independently and are able

to make conscious decisions with the potential consequences for those decisions in mind (Keenan, 1999). It could be said that such behaviour takes courage.

Courage was certainly a requirement for the pioneer stomal therapy nurses who endeavoured to practice autonomously. Frequently they discussed experiences when they were stymied by hierarchical confrontation. Kate, Susie, Barbara and Joanne all described events that provided insight into the nature of the confrontation and the courage they employed to overcome it. As Susie recalled:

A nurse actually telling a surgeon what to do was really quite threatening to them, and it was taking away part of their power base and the fact that a nurse could actually tell the surgeon, that really was awful! And with some of the surgeons we had to use different tactics, you had to apply different tactics with different surgeons to actually get in and get their support. And some of the ward sisters actually felt quite threatened as well that *they* had somebody outside their ward and outside their control actually coming into their ward and deciding what treatment this particular patient was going to have. (Susie)

Some of the tactics employed by the nurses in order to prove their commitment to better patient outcomes were quite creative and at times outside their scope of practice.

Examples of both the former and the latter practices were evident in their “search of a Holy Grail” solutions for the problems they encountered. Their commitment frequently had to be supplemented with resourcefulness, in order to achieve desired outcomes.

We decided the type of stomas we were seeing was somewhat abominable and we decided we would do a photographic survey. In those days we had access to hospital photographers, so we had this system where we took a photograph of the stoma on day 1 and day 5 and then on their first appointment back in out-patients. We coded all these stomas and then we finally got the *courage* to present it at a surgical Grand Round, and with much fear and trepidation we put up the good, bad and the terrible, with no names mentioned and interestingly enough all the surgeons came because another interesting thing was it was the first time that nurses had presented to a surgical Grand Round. We picked out a couple of slides that were particularly good. There was a surgeon there who was doing particularly good stoma formation so we made this award of ‘Stoma of the Month’ and it actually encouraged a lot of discussion amongst the surgeons. And I must say it lifted their game ... it certainly did change their technique. It definitely improved, they started to take a little pride in their stomas. (Esme) (*italics added*)

Ironically the possessive and tyrannical behaviours of surgeons or ward sisters that were initially condemned by the pioneer stomal therapy nurses were in some situations replicated by them as they sought to demonstrate their commitment and exert their fledgling authority.

There was one particular surgeon who was the senior surgeon here and he was an excellent surgeon but a very careful man. So he agreed that we would put the bags on his patients and while they were in hospital everything went well. And then he'd come along and he wouldn't be able to see what was there, even though it was a clear bag he'd sort of want to have a look at this stoma. So it would be 'take the bag off, don't worry about putting it back on', so this went on for quite a while plus, when the children went home and the parents would ring the doctor – he would say 'get that bag off, just go back to a pad and a bandage you'll be all right'. So I decided if I wanted to become the boss of this department I would make an appointment to see him and say to him we've got to come to an agreement. 'You look after the body and I'll look after the stoma. I don't want you to tell the parents to take the bag off, I don't want you to take the bags off in the ward and we'll see how we go'. (Maxine)

Maxine's exemplar emphasises the view expressed by Altschul who said that "people who share the same commitment also share a perspective on the world which is distinctive in its selectivity, in its ordering of priorities and in its motivation for action" (1979, p. 126). In this instance, commitment to problem-solving became a priority. Anatomical claims were staked around stomas by some stomal therapy nurses and it appears that once fashioned, the stoma was actually considered off-limits to surgeons. One could speculate that such a claim had its genesis in the practice of stomal therapy nurses siting patients pre-operatively for the stoma.

The application of a mark on the patient's abdomen to identify the most appropriate site for a surgeon to construct a stoma, was visible evidence that nurses were "telling doctors what to do". Although this stomal therapy nursing practice began in the latter years of the 1960s, some surgeons were initially slow to solicit this assistance from nurses, regardless of the possible benefits to patients. In some instances animosity between the disciplines also arose as the traditional decision-making and teaching roles were perceived to be reversed.

When I first started off I had one person in particular, who shall remain nameless. If I actually sited – had the audacity to site one of his stomas – I felt quite sure he used to site it elsewhere

almost out of spite. But by the time he retired he was quite happy for me to site his stomas. I *now* find the surgeons are fine I don't have any problems with surgeons. Sometimes it is a bit difficult to break new ones in, they get a bit thingy. (Joanne)

Increased familiarity advanced professional accord of personage and role, and this contributed to the dissipation of much of the inter-disciplinary animosity. It was also noted to empower the nurses and anoint them with fresh courage to challenge practice on many occasions.

I was very angry about this because this lady had been in the ward for 4 days and I knew nothing about it. She was only a young woman, she was 49 years old and she had a colostomy. It was only temporary, but nevertheless it had been sited – it hadn't been sited by a nurse, it had been sited by the doctor during surgery. She was a fat lady and it was right in the waistline and it was gross and this lady was a nurse. I nearly threw my arms up in horror. So when I saw the doctor I just picked up his hand and smacked his fingers and I said "Tut! Tut! Tut!" He said: "I'm sorry I won't do it again!"

Impulsive behaviour such as this is criticised as being an antithesis of self-discipline, which is considered by some, to be a criterion for determining autonomous people (Ballou, 1998). Yet Ballou contradicts herself by alluding to the fact that truly autonomous people are committed to their beliefs and by stating that autonomy refers to a "condition of freedom and independence worth fighting for and achieving" (Ballou, 1998, p. 105). This appeared to be the situation in this study for the nurses demonstrated earnest efforts in order to practice autonomously. Furthermore, it appeared that the degree of autonomy bestowed upon them was equitable to the degree of commitment demonstrated. This assumption could explain in part, why the eminent surgeon, in the exemplar above would render himself subservient.

Feeling Good

There was found to be such an obvious sense of satisfaction and specialness experienced by the stomal therapy nurses in this study when they described their positive care outcomes or relationships with patients. I was left with a distinct impression that at such times they were feeling good. Feeling good could be considered to be an incidental reward for altruistic caring. Altruism is popularly considered to relate to self-sacrifice and subservient behaviour (Gleitman, 1995). This understanding is

entrenched in the historical panorama of caring and is influenced by the perception that caring was a virtue instinctive to mothers and women in service or founded in the ethos and self-sacrifice of the early Christian carers (Donahue, 1996). It is this understanding that has caused some to assume that altruism is the foundation and motivator for caring (Reverby, 1987).

In contrast, Benner and Wubrel (1989, p. 367) present an oppositional opinion and “maintain that caring is the basis for altruism”. They dispute the fact that concern for others must be at the expense of self-sacrifice. Their rationale for this view is founded in the hermeneutic phenomenological understanding of being and the cultural and historical relationships that define that being. These authors argue that there are mutual benefits to be gained, in expressions of concerned caring for others. The stomal therapy nurses in this study acknowledged a sense of mutual realisation as evident in Nancy’s statement, “but he did so much for me, he just added another dimension to my life”.

Nurses, as do all healthcare professionals, recognise a duty of care for their patients. But nurses have been criticised for engaging in a “ministry of mateyness” and for failure to recognise that “care for a healthcare professional is not primarily about feeling, but about doing” (Saunders, 1999, p. 61). Many would consider it a sad indictment of any person if they should fail to demonstrate emotional sensitivity towards another person’s need or situation. A person is also emotionally poorer if they should fail to allow themselves the privilege of feeling good as a result of care that positively alters the life of a fellow human being. Although such an experience might come as a surprise, as it did to Anne.

In 1977, I was able to help a person come out of a hermit situation back into real life. I think that probably stuck me into stomal therapy. I couldn’t believe that one person, just like myself who is a very average sort of a person, could just by caring a bit and teaching a bit and helping a bit, could assist somebody who’s life had literally been wrecked almost resume normal life again, because his life had been wrecked for 25 years. (Anne)

Physical activity without emotional commitment is a mechanistic approach to care. Emotional commitment does not divorce the carer from the responsibility of their duty of care and all that implies from a legal and ethical point of view. However, empathetic

concern in response to the care needs of another has the potential to enrich the caring experience for both the recipient and the carer. This was obvious in Nancy's experience of caring for an "angry patient with a malodorous cancerous wound". She did not abdicate her duty or commitment to care because of her patient's "foul odour and disfigurement". Nor did she shirk her responsibility because of his "anger and abrupt demeanour". All of these physical presentations could and possibly did, evoke distasteful sensations. However, she focused on caring for his physical and emotional needs and in doing so she came to know the "most beautiful person" and had a mutually beneficial "loving relationship".

Immanuel Kant, the eighteenth century philosopher, defined love as either practical or pathological.

It is precisely in this that the worth of character begins to show – a moral worth and beyond all comparison the highest – namely, that he does good, not from inclination, but from duty. For love out of inclination cannot be commanded; but kindness done from duty – although no inclination impels us, and even although natural and unconquerable disinclination stands in our way – is practical and not pathological love, residing in the will and not in the propensities of feeling, in principles of action and not of melting compassion, and it is this practical love alone which can be an object of command (Kant, as cited in Saunders, 1999, p. 61).

Saunders (1999) contested that Kant inferred that if care was dependent on the possession of positive regard for an individual then those one did not feel such regard for, would be devoid of care. This philosophy might sit well with the laity or less humanistic sciences but it is an anathema to the philosophies that underpin nursing, and which support the concept that all people are equally worthy of care (Kikuchi, 1997; Tuck, et al. 1998).

I would like to offer an opposed interpretation of Kant's words and for the purpose of explanation, would like to return to the point discussed early in this chapter in regard to the virtue of moral worth which "involves caring about the right things in the right way" (Almark, 1998, p. 467). It was previously argued that it is precisely because of this moral worth that the stomal therapy nurses were motivated and were 'seeking to care'. Inclusive in that care was a fundamental commitment to care for the physical, cognitive and emotional needs of *all* individuals under their charge, regardless of the nurse's

inclination. Although action is not necessarily stymied by compassion, it is empathic understanding “which consists of active listening, accurate observation, empathic response and validation” (Lindberg, Hunter & Kruszewski, 1998) that nurses endeavour to develop. In this study, empathic understanding facilitated the entry of the nurses into the private worlds of their distressed patients. It did not cause them to detach themselves from the reality and responsibility of their roles or from their own feelings.

The ability to be in touch with one’s own feelings allows insight into the feelings of another and this is a fundamental priority in the establishment of a helping-trust relationship (Watson, 1985). Empathetic understanding is also the motivator for stimulating moral perception, moral judgement and moral action (Reynolds, Scott & Austin, 2000). But fundamental to this activity is the possession of what Kant described above as “moral worth”, which is reflected in good care as discussed earlier in this chapter. The nurse’s commitment to good care, supersedes the duty to care and forcefully quashes any disinclination to care.

The humanistic values that stomal therapy nurses demonstrated caused them to be “committed to a better way”. This I suggest, is aligned with the “practical love” alluded to by Kant above, and referred to as “love” (Linda, Kylie and Judith) “loving relationships” (Nancy), “support” (Colleen, Sabrina, Barbara and Linda), “rapport” (Nancy and Judith) and “friendship” (Linda) by nurses in this study. I believe Linda’s comments paraphrase the “kindness done from duty” inherent in Kant’s quotation above.

I can give support, friendship and love to them all – not love as love, but I just love being able to see that patient rehabilitate, go home, come back for their check up and walk through my door and look just a million dollars and say I’ve been to bingo, I’ve been to dinner and to know that I have achieved the highest of achievable things, to get them back into the workforce, back into society. (Linda)

This relationship demonstrates all the aspects of good caring that were discussed earlier in this chapter and indicates Linda’s sense of feeling good as a result. Normally, such overly emotional expressions are not normally favoured by Western health cultures, particularly those that have a tendency towards Anglo-Saxon restraint. But emotional sensitivity should not be underestimated. Carpenter (1994, p. 759) in her discourse on

ethical decision-making proposes that emotions have the potential to be either tutorial or tyrannical. She expands her argument by suggesting that it is only through feeling can one discern “injustice, maleficence, and dishonesty and correct these failings in ourselves, fellow workers, and the health care system”. This study revealed the ‘tutorial’ opportunities afforded the nurses when they were confronted by stigmatised, isolated, humiliated, malodorous and suffering patients. The extent of their emotional involvement caused them to ‘seek to care’, be ‘committed to a better way’, to ‘seek knowledge’ and to ‘profess thoroughness’. In retrospect, their feelings towards their patients and their circumstances led to good nursing attitudes and behaviours and ultimately, a personal sense of feeling good.

It could be theorised therefore, that feeling good is the intrinsic reward one gives oneself when one has achieved the “highest of achievable things” (Linda) and when one realises one has been an “instrument of change in peoples lives” (Anne). It is perhaps the most inexpensive reward, but with the greatest value to many.

Good Nurse Model

Historical-phenomenological analysis of the evolution of stomal therapy nursing in Australia and the experience of being stomal therapy nurse has I believe, unravelled the mystery of what is a *Good* nurse and what constitutes *Good* nursing. Reflected in the experiences of the stomal therapy nurses in this study were five professional attributes that described the essence of *Good* nursing and these are caring, competence, cognisance, comradeship and commitment. It is proposed that if nurses demonstrate *Good* caring, *Good* competence, *Good* cognisance, *Good* comradeship and *Good* commitment as discussed in this chapter then they could be said to be *Good* nurses. *Good* has been capitalised and italicised to emphasise the significance of this finding and differentiate the interpretation from common use and less insightful meaning.

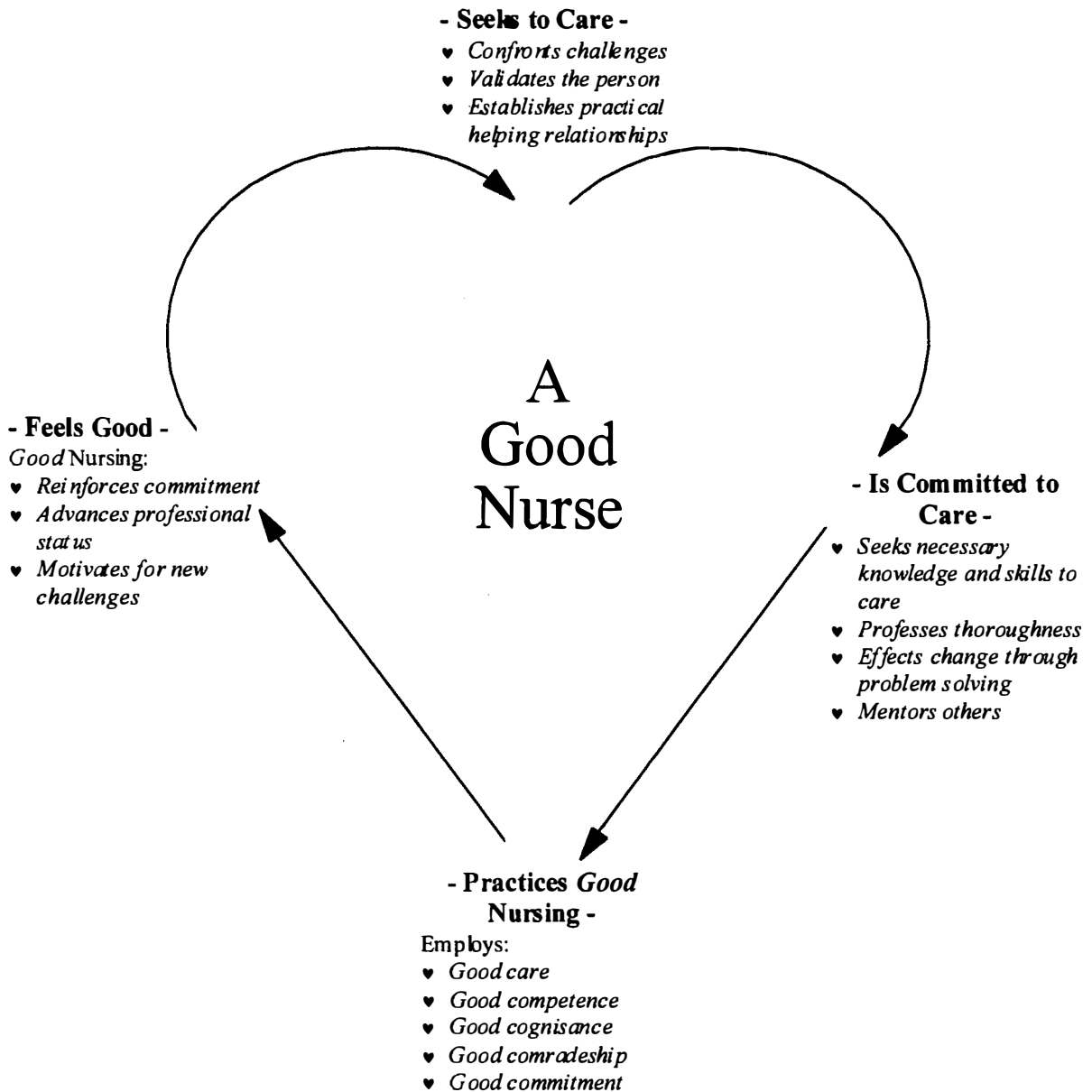
Furthermore, I believe that these same five attributes are also to be found in Miss Nightingale’s writings and projected vision for nurses and the profession generally (Nightingale, 1881). This suggests therefore, that *Good* nurses practice *Good* nursing regardless of their practice domain. Because this study sought to analyse the experiences of stomal therapy nurses within the historical context of the years 1959 to 2000, it stands to reason that these professional attributes are just as significant for

today's nurse practitioners as they were for nurses in times past and hopefully, will be for nurses in times to come.

In keeping with the steps adopted from Foster (1997) and discussed in chapter 2 for contextual triangulation of the results of both the historical and phenomenological studies, a model has been constructed that explains the key findings of this study (see Figure 8.1). The *Good Nurse Model* is a graphic presentation of the attributes, behaviours and attitudes discussed in this chapter and found to describe a *Good* nurse and *Good* nursing. Primarily, a *Good* nurse seeks to care in a manner that is concerned with the cognitive, emotional and physical elements of care. In seeking to care the *good* nurse is prepared to confront challenges that impact upon the patient and the nurse's ability to care. Furthermore, the *Good* nurse is prepared to validate the person and establishes practical helping relationships (as defined in this discussion). Secondly, the *Good* nurse is committed to care. The extent of commitment to care is demonstrated by the nurse's willingness to seek the necessary knowledge and skills to care, their willingness to mentor others, their thoroughness in caring and their ability to effect change through problem-solving activities.

The third stage of the model indicates that a *Good* nurse practices *Good* nursing and in so doing employs: *Good* care, *Good* competence, *Good* cognisance, *Good* comradeship and *Good* commitment as outlined in this discussion. The final phase of the model emphasises that when a *Good* nurse practices *Good* nursing then he or she feels good. The flow on effect of feeling good is that it reinforces commitment, advances the professional status of the nurse and motivates the nurse for new challenges.

A Good Nurse Model



Good Nurses Practice Good Nursing

Figure 8.1

Conclusion

Historio-phenomenological analysis of the data obtained in this study has resulted in a privileged insight into the embodied experience of stomal therapy nurses within the historical context of stomal therapy nursing in Australia. Furthermore, it has revealed an insight into the essence of the attitudes and behaviours that define a *Good* nurse and *Good* nursing. The word *Good* has been italicised and awarded an upper case introduction to highlight the significance of the attitudes and behaviours of the nurses in this study in regard to caring, competence, cognisance, comradeship and commitment. I would like to suggest that the findings in this study, which have led to the construction of the *Good Nurse Model* could be used to provide a professional framework for nurses and the profession generally.

Chapter 9

The Journey's End

Introduction

The purpose of this study was to describe the historical events that led to the development of stomal therapy nurses as a specialty group and the evolution of stomal therapy nursing in Australia, and to describe the lived experiences of stomal therapy nurses within that historical context. Historio-phenomenology was the bipartite qualitative approach used to define the phenomenon. Independent historical and phenomenological studies were conducted and the uniqueness and philosophical foundations of both approaches were preserved. Comparative and contextual analysis of the historical and phenomenological findings was then carried out in order to gain a fuller understanding of the phenomenon. This was in keeping with the systematic approach adapted from Foster (1997) and discussed in chapter 2.

Although not a formal component of the study timeframe, chapter 4 provided the reader with an insight into the historical background of the phenomenon studied. The objective of this chapter was to afford an expanded understanding of the extended historical developments that impacted on the need for stomal therapy nurses and the importance of stomal therapy care both nationally and internationally. Chapter 5 recorded the historical development and evolution of stomal therapy nurses in Australia from 1959 to 2000. This chapter detailed the events, forces and personal contributions, that significantly influenced the evolution of stomal therapy nurses as a specialty group. Furthermore, it outlined the origins of practices that define stomal therapy nursing practice.

Chapter 7 recorded *The Experience of Being a Stomal Therapy Nurse in Australia*. Thematic analysis of the data revealed five themes, and these were Seeking to Care, Committed to a Better Way, Seeking Knowledge, Professing Thoroughness and Feeling Good. Subsequent to these themes there emerged an independent theme that described the *Specialty of Stomal Therapy Nursing*, and this theme was titled A Corporate Identity. Although the historical and phenomenological findings of this study were

interpreted independently, it was distinctly evident to me that the historical findings were greatly enriched by the insight gained from the phenomenological findings and vice versa. Comparative and contextual analysis of the findings from both the historical and phenomenological studies revealed a key finding, and that was *Good* nurses practice *Good* nursing and this was discussed in chapter 8. In this chapter, the independent and interdependent findings will be used to succinctly answer the five research questions, which were:

1. What was the genesis of stomal therapy nurses in Australia?
2. What events and forces influenced the evolution of stomal therapy nursing in Australia?
3. What are the origins of the practices that define stomal therapy practice?
4. What is it to be a stomal therapy nurse in Australia?
5. What is it to be a stomal therapy nurse and a member of the Australian Association of Stomal Therapy Nurses Incorporated (AASTN)?

In order to refresh the reader’s memory of the historical and phenomenological findings, the following summary is presented in table form.

Table 9.1 Summary of historical and phenomenological study findings

Historical Findings	Phenomenological Findings
Ostomates found no one with the knowledge to care prior to the development of stomal therapy nurses (STNs) in Australia.	Australian pioneer STNs were confronted by distressed patients and a lack of professional knowledge and skill to care.
Ostomates were committed to self-care and care of other ostomates.	STNs were committed to care for ostomates.
Ostomates sought knowledge from one another to assist them to care.	Pioneer STNs sought knowledge from ostomates and one another to assist them to care.
The early ostomates experimented to find solutions to their problems.	Pioneer STNs were prepared to take risks in order to find solutions to problems.
Ostomates as lay persons crossed the lay-professional boundary and were recognised for their expertise and experiential problem solving abilities.	STNs crossed the nurse-surgeon boundary and were recognised for their expertise and ritualised problem solving abilities.
Ostomates adopted a semi-professional role and established peer relationships with surgeons and STNs. They were accepted by the nursing and medical hierarchies of the day.	STNs stepped outside the traditional professional role and established peer relationships with surgeons and lay ostomates. They were prepared to confront the nursing and medical hierarchies of the day.
Ostomates effected change in the lives of fellow ostomates and ultimately health professionals.	STNs effected change in the lives of ostomates and ultimately other health professionals.
Ostomates gained a sense of autonomy, which caused them to advance the lay cause. They sought good outcomes for recovery and rehabilitation.	STNs gained a sense of feeling good, which reinforced their commitment to care and caused them to advance professionally.
Ostomates established a corporate <i>ostomate</i> identity known as the Australian Council of Stoma Associations (ACSA).	STNs established a corporate <i>nurse</i> identity known as the Australian Association of Stomal Therapists, (latter known as the AASTN).
ACSA adopted a Bill of Rights.	ASSTN adopted a Code of Ethics, Standards of Practice, and credentialled STNs (see Appendix K).

The Genesis of Stomal Therapy Nurses in Australia

Chapter 5 revealed that the genesis of stomal therapy nurses as a specialty group of nurses in Australia had an informal and a formal beginning. The informal beginning can be traced to an experience of Elinor Kyte, a registered nurse from Melbourne. Kyte's first experience in caring for an ostomy patient in 1959 had a profound and on-going effect that led to her being recognised as the first Australian stomal therapy nurse. Kyte's experience resulted in an exceptional and enduring commitment to care. That commitment was recognised by past Melbourne surgeon, Edward Stuart Reginald (E.S.R.) Hughes, who's own commitment to the care of ostomy patients had resulted in the establishment of the first lay ostomy support group in Australia in 1957.

In 1960 Kyte was employed by Hughes as a nurse in his private rooms. In this position Kyte developed expertise in the care and rehabilitation of persons with ostomies and fistulae. These developments resulted in many requests from Hughes' colleagues to send nurses to learn from Kyte. Gradually there evolved a small informal network of nurses with an interest in stomal therapy. They were to formalise this network on the 27 March 1971 in the Maitland Lecture Theatre at Sydney Hospital, when six of these nurses and five surgeons met. The outcome of that meeting was the establishment of an association of nurses with an interest in stomal therapy nursing. The association was named the Australian Association of Stomal Therapists. The title stomal therapist was chosen to identify these nurses in the initial belief that such a title would endow them with more autonomy than at that time afforded nurses generally.

The title stomal therapist emphasised the fact that the genesis of stomal therapy nursing in Australia was in the care of patients with gastrointestinal or urinary stomas. However, as stomal therapy practice evolved over the years into domains of wound, continence and in some states, breast care, this title failed to reflect the diversity of skills and activities of these practitioners. An effort to reclaim their birthright as nurses resulted in a name change of the association to the Australian Association of Stomal Therapy Nurses in 1984. However, this change did little to reflect the evolution of their practice domain, and this was found to be a current issue for stomal therapy nurses in this study.

The Events and Forces that Influenced the Evolution of Stomal Therapy Nurses as a Specialty Group in Australia

The study has revealed that the significant events and forces that have impacted on the evolution of stomal therapy nurses as a specialty group in Australia are related to: increased frustration amongst early ostomates in regard to the lack of professional services, which led to the establishment of the first ostomy self-help group in 1957; advances in colo-rectal and urological surgery from 1952 onwards; the changing role of the nurse in the latter 1960s to current times and all that change held for advancing autonomous and specialised practice, and advances in technology.

Evolution of ostomy self-help groups

During years between 1950-60 surgical advances improved morbidity and mortality rates, but there was little advance in the level of stoma care knowledge found amongst the nursing and medical professions. The experiences of nurses and ostomates in this study revealed that ostomates tended to be ostracised and stigmatised by some health professionals. Chapter 4 revealed that it was the norm for ostomates to be discharged from hospital poorly prepared to cope with their alterations in body image and function. When the support they sought from the majority of health professionals was not forthcoming they had to depend upon their own resources.

In Australia, the unification of ostomates into state groups and later a national association, was led by a small number of Australian doctors and nurses. E.S.R. Hughes's contribution to the formative development of these groups has been outlined. The contributions of Sydney surgeon, Edward Wilson and his nurse-ileostomate patient, Betty Hughes, are also recorded in chapter 5. By 1971 all states and territories in the nation had established ostomy associations and a national Australian Council of Stoma Associations had been formed.

During the early years of the ostomy self-help groups the ostomates themselves adopted a semi-professional image and established collegiate relationships with surgeons. They readily accepted the mantle of responsibility for educating and supporting not only fellow ostomates, but they were also asked to extend these services to nurses and doctors. The increased autonomy afforded ostomates by the health professionals had both a negative and a positive effect. Initially surgeons and charge nurses were more

than happy to ask experienced lay ostomates to offer a rehabilitative hand to an ever increasing number of new ostomates. However, the gradual commercialisation of some of these lay ostomate services did not sit well with all surgeons. Hughes in particular was convinced that stomal therapists should be “fully trained, professional nurses”. Although he did acknowledge the contribution of lay people in “filling a gap, pending professional nurses becoming interested” (Hughes, personal communication, 21 June 1971). This conflict strongly motivated Hughes to add his support to the development of an association of nurses interested in patients with stomas.

A sociologist might ponder the conscious or unconscious intent behind this transference of power and authority. Especially when it was the lay group that had initially identified the need for professional support at a time when the professionals had failed to do so. A vested interest in the commercialisation of elements of stoma care was an ethical anathema to Hughes and his like-minded colleagues. It was also debated that exclusive actions of credentialled health professionals were a means of ‘gate-keeping’ or restricting the non-credentialled lay ‘professionals’ from obtaining the credibility, knowledge and authority, normally reserved for professionals. Nurses were shown to be the beneficiaries of these gate-keeping behaviours and as a result, those with an interest in the care of ostomy patients were encouraged by Hughes and his colleagues to form an association.

Advances in colo-rectal and urological surgery

Chapter 4 revealed that mortality rates of 22.2% to 90% were reported in patients with inflammatory bowel disorders who underwent surgery for colectomy and formation of an ileostomy in the United States during the years 1928 to 1955 (Cattell, 1953; Grimes, et al. 1955). Although there are a dearth of early Australian statistics with which to make a comparison, one can assume that parallels existed. A major cause of death was ileal dysfunction, which occurred as a result of stomal stenosis. In 1952 Dr Bryan Brooke, a surgeon from Birmingham, solved this problem when he published his relatively simple surgical technique for everting an ileostomy stoma (Brooke, 1952). This same technique was then used to evert colostomy and urostomy stomas and problems related to stenosis in these stomas were largely solved. Other surgical procedures that resulted in an increased need for stomal therapy care were shown to

include Eugene Bricker's ileal conduit procedure in 1950 and advances in intestinal and urinary continent reservoirs that occurred from the 1970s onwards.

The changing role of the nurse

During the 1960s and early 1970s the hospital wards in most major hospitals had changed little from the open plan 'Nightingale' wards of the nineteenth century. Similarly, the uniforms of nurses reflected the symbolic image of nurses of bygone eras, with the only apology being higher hemlines. Moreover, the practice traditions and professional behaviours of the day could be found to mimic those endorsed by previous generations of nurses. Nurses paid due homage to those with nursing or medical hierarchical status, and they submitted to the strict discipline that regulated their daily lives (Russell, 1990). The emerging Women's Movement of the 1960s had not yet impregnated the stronghold of male doctor-female nurse politics and hospital environments at that time (Bullough & Bullough, 1984). Autonomy amongst the rank and file nurses was virtually non-existent and the strict discipline that was imposed did not encourage dissent. Nurses were ruled from above and the throne of power was firmly positioned under the medical personnel or a select number of nurse rulers. Nurses below these ranks had a strict pecking order and like the ripples on a pond, they were less significant the more distant they were positioned from the source of authority.

It was therefore rather exceptional behaviour, and evidence of the risk the pioneer stomal therapy nurses were prepared to take, when they challenged established authorities and crossed role boundaries. The courage they displayed in confronting the nursing hierarchy was only surpassed by the courage they displayed in confronting the medical priesthood. Chapters 5 and 7 revealed the extent of this covert and overt confrontation. Strangely enough, these confrontations appeared to have engendered respect and co-operation amongst the surgeons. Assertive nurse behaviours appeared to have been interpreted as commitments to care and this forged collaborative relationships between the stomal therapy nurses and many surgeons with aligned patient interests. As a result the nurses were afforded more autonomy to practice and this led to the development of specialised knowledge and skills that awarded them recognition as specialised practitioners.

Technological advances

Technology has been defined as: “a complex body of knowledge and know-how, and the activity of a group” (Daly, Speedy & Jackson, 2000, p. 165). These authors expand their debate by suggesting technology has three components and these are: machinery and equipment, knowledge and skills and the inter-relationship of the former two components with a myriad of professional and societal factors. This view reflects well the advances, or in some instances lack of advances, in technology that have impacted on the evolution of stomal therapy nursing in Australia.

Early ostomates manufactured appliances in their backyard sheds or work environments. The Philp flanges and the Wallace appliances were shown to be examples of the kind of enterprise. Other creative problem solving activities were employed by surgeons and nurses. Hughes’ experimentation with cryovac tubing to make ‘long bags’ and Kyte’s discovery that Orahesive™ bandage made an excellent skin barrier were demonstrated to be examples of these endeavours. The establishment of the National Stoma Appliance Scheme in 1975 and enthusiastic commercial enterprise accelerated access to improved appliances and diagnostic equipment. As related technological developments became more specialised, it reinforced the need for specialist nurses in stomal therapy.

The Origins of the Practices that Define Stomal Therapy Practice

The origins of the practices that define stomal therapy nursing practice have their genesis in the problems that confronted the nurses. Chapters 5 and 7 provided an acute insight into the nature and extent of these problems. Ostomates who had their surgery prior to the evolution of stomal therapy nurses, largely learned to cope by trial and error. Those lucky enough to come in contact with a rehabilitated ostomate supplemented their own experiential learning with that of their fellow ostomate. Similarly, the pioneer nurses stated that they learned everything they knew from their patients. Learning occurred as a result of trial and error and any proven remedy became a practice ritual. These rituals became known as ‘tricks of the trade’ and these mastered tricks, which were shared amongst nurses and ostomates were the foundation for a body of specialised nursing knowledge.

What it is to Be a Stomal Therapy Nurse

Phenomenological analysis revealed six distinct themes which described *the experience of Being a stomal therapy nurse in Australia*. These six themes were: Seeking to Care, Committed to a Better Way, Seeking Knowledge, Professing Thoroughness and Feeling Good. These six phenomenological themes were presented and discussed in chapter 7 and chapter 8. In reality the theme titles answer the research question 4.

What is it to Be a Stomal Therapy Nurse and a Member of the AASTN

Phenomenological analysis revealed an independent theme that was titled A Corporate Identity. Chapter 7 revealed that an *esprit de corps* existed among the members of the AASTN and this was evident in the manner in which they networked and supported one another. Amongst the nurses there were visions for the future and these involved professional visions such as the implementation of processes for credentialling of stomal therapy nurses, plans for tertiary education and an elusive search for a Holy Grail for problem solving. Just as the answer to research question 4 was found in the theme titles, so it is with the answer to the research question 5. As stomal therapy nurses and members of the AASTN they were found to have A Corporate Identity.

Coming Home

This thesis began with an allegory of a traveller's journey to a mountain. The traveller's journey and his exploration of the phenomenon represented a quest for the fullness of experience. Similarly, this study was for me a personal and professional quest for a fuller revelation of the historical developments that led to the evolution of stomal therapy nurses in Australia, and a fuller understanding of the experience of stomal therapy nurses within that historical context.

Like Odysseus' fabled journey to Ithaca, my research odyssey has been subject to the winds of change. The study began as an historical study, but in recording and reviewing the oral histories of the stomal therapy nurses, it became obvious that the nature of the data lent itself to both historical and phenomenological analysis. Both history and phenomenology have been shown to be interested in interpreting experience, albeit in different ways. My decision to use an historio-phenomenological approach has proved to be the right decision. The historical findings have revealed the history of Australian stomal therapy nurses and stomal therapy nursing and the relationships that existed

between generalist nurses, surgeons and ostomates. Not only did this study open a window to the past, but it provided an opportunity for contemporary comparisons and it hints at future possibilities.

The phenomenological findings have revealed an insight into what it is to *be* a stomal therapy nurse and a member of the AASTN. This study expands and enriches the profession's understanding of a fairly unobtrusive group of nurses who were trail blazers in stomal therapy practice in Australia. The phenomenological study offers a mirror for reflection and comparison, for both current and future nurses. The comparative and contextual analysis of the findings from both the historical and phenomenological studies has resulted in a prism that reflects the fullness of the nurses' experience and its relationship to the historical context of time, place, events and forces that impacted on that experience.

As a result of conducting this historio-phenomenological study, I personally have developed a sense of 'professional home-coming'. Like the traveller in the allegory, I have been provided with an expansive and privileged view. I have discovered my professional roots and I truly acknowledge the contributions of ostomates, stomal therapy nurses and surgeons who made it possible for me to practice within the specialty of stomal therapy nursing. I have also gained an understanding of what it is for others to be stomal therapy nurse and to be a member of the AASTN. But most especially, I have developed a sense of what Heidegger (1993) termed 'astonishment' when historio-phenomenology revealed the essence of what it is to be a *Good* nurse who practices *Good* nursing.

Implications for Clinical Practice

In defining the attributes and attitudes of *Good* nurses and the behaviours that constitute *Good* nursing, nurses and the profession as a whole are offered a framework for practice and professional development. Since the birth of modern nursing the use of the word good to define nurses and their activities has been liberal, but not clearly defined. This has led to ambiguity and lost possible opportunities for practice and professional development. It is anticipated that neophytes to the profession in particular, will benefit from instruction grounded in these findings.

Other clinical implications of this study relate to the revelation of the origins of certain clinical practices that have been entrenched in stomal therapy nursing. In particular, the use of scientifically unsubstantiated products in the treatment of skin ulceration, such as food stuffs and inappropriate use of pharmaceuticals. By highlighting the rituals involved in stomal therapy nursing it allows the practitioner an opportunity to review their practice in light of current best practice.

Of equal importance is the professional implication this study offers for due acknowledgment of individuals who have contributed to the development and evolution of stomal therapy nursing in Australia and overseas. In particular, the acknowledgement long overdue to Elinor Kyte for her discovery that Orahesive™ bandage provided an excellent skin barrier product and promoted healing of ulcerated skin. The impact of Kyte's discovery has had wide implications to clinical practice in the domains of ostomy, wound and continence care. Furthermore, the implications for improving the quality of life for individuals who require skin protection has been, and remains, immense. The profits generated from the commercial sector as a result of this discovery have also facilitated ongoing product developments for the care of persons and the skilling of nurses.

Nurses who are considering a career path within stomal therapy nursing will also have a privileged insight into what it is to be a stomal therapy nurse in Australia. This information will help guide the decisions of potential students and employers who are called to appoint nurses to these positions. Finally, all nurses are personally and professionally richer when they gain an understanding of their practice domain's roots and professional evolution. Historical nursing studies in Australia are limited, particularly those that record the development of nursing specialties and the persons who significantly contributed to the development of those specialties. It is hoped that this study will in part, fill that void.

Implications for Further Research

Nurses are immensely interested in understanding all aspects of experience and its relationship to clinical practice, healthcare outcomes and professional development. Historio-phenomenology offers opportunities for expansive understanding into the

fullness of experience and the nature of that experience within the historical context. A further and most obvious implication for further research is the testing of the proposed *Good Nurse Model* discussed in chapter 8. It is envisaged that this model would be applicable to testing in all domains of nursing practice and by nurses at all points on their professional journey.

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Appendix A: Interview Extract

- K During your general nurse training, what experiences did you have in caring for people who had colostomies, ileostomies, or urinary diversions?
- N Well probably it was minimal, and I suppose the memories I have relate to odour because I remember these poor people with flanges and strange things on their abdomen. And I remember the feeling of frustration as a junior nurse trying to cope with the sore skin around these things called stomas which I really didn't know much about and I felt a bit ignorant. And we used to paint that dreadful aluminium paste or whatever it was, onto the skin of these people so they looked like something from outer space with all this silvery skin. And I remember one lady, very upset and crying with the pain of the excoriation, but we seemed as though we were powerless to do much more. This was in the '60s and anyway I was only the junior nurse and the senior nurse used to do 'the dressings' and she used to whisk this woman off into some treatment room and do something with her. But I remember there was a lot of distress associated with the stoma and if anyone had told me then that one day I would look after people with stomas I would've laughed furiously because it was something that I really didn't want to have anything to do with because it seemed all a bit frightening and horrible. And also we were powerless to help these people. And I suppose the appliances in those days were dreadful. But I suppose at the end of my training I remember hearing about this nurse being a stomal therapy nurse and I had no idea what that meant and not many of my other nursing colleagues did. And I remember asking someone and they said oh well she's a colostomy sister. And I thought well why would anyone in their right mind want to look after colostomies and what would they do all day just sticking bags onto stomas. It seemed a fairly boring job. But of course, now, further down the track I love being a stomal therapy nurse, it's so exciting. Great job. And I think things have changed so much over the years.
- K You said things have changed over the years, what are some of the changes that you remember most of all?
- N Well I suppose back in the good old days I remember those flanges that we used glue on to skin with cement. And the plastic bags with no odour-proof qualities. So I suppose the main change that I remember is the changes in the appliances. How good they are now, what a range we have, how lucky we are in Australia to have an appliance system so that our patients have choice. And I suppose also the development of stomal therapy nurses. These people had to rely on other people with stomas to give them support and encouragement and advice, and I think our role is very important that these people with ostomies now have a professional nurse that can be their advocate, can assist them and help them.
- K You mentioned the aluminium and zinc paste how did you use these products?

Appendix B: An Example of the Codes, Categories and Themes

Codes	Categories	Themes
I think our role is very important that these people with ostomies now have a professional nurse that can be their advocate, can assist them and help them.	Professional advocate – committed to the cause.	Committed to a better way
My knowledge was broadened I think seeing other practitioners work doing the same thing but in different ways, that can only be a learning experience, you pick things from others and just develop new techniques or new approaches.	Experiential learning and learning from other nurses –spreading the word.	Seeking knowledge
I think I felt sorry for the patients because they seemed to be powerless.	Prepared to validate the person with an ostomy.	Seeking to care
I wonder if we avoided these patients because it was unpleasant for us.	Avoiding patients – confronting stigma.	Seeking to care
In the sixties you'd just walk into the room and you would know if the colostomy had worded because you could smell it or else you would know the ileostomy had leaked all over their skin and was hurting them because they'd be crying.	Poor clinical indicators in the sixties – there has to be a better way to care.	Seeking to care
There was some wonderful way that she used to quickly whip out a bit of this Stomahesive™ and somehow slip a bit of that onto the back of this daisy bag and have it on the patient's skin in a flash.	Learning the tricks of the trade.	Seeking knowledge
The first time I tried to do it I got in an awful sort of tangle because I didn't know what stuck to what.	Learning the tricks of the trade.	Seeking knowledge
We used long bags on all.	Ritual practice.	Professing thoroughness

THE EVOLUTION AND EXPERIENCE OF STOMAL THERAPY NURSES IN AUSTRALIA

RESEARCH INFORMATION SHEET

My name is Keryln Carville and I am a registered nurse who is currently enrolled in a Doctoral Degree in Nursing at Edith Cowan University, in Western Australia.

I am researching the history and experiences of stomal therapy nurses in Australia and I would like to invite you to contribute to this research project. Participation in this research will involve an interview/s which will be recorded on a tape recorder. The purpose of the interview is to obtain an oral history of your experiences and memories related to stomal therapy nursing.

Some time following the interview, you will be given a copy of the tape recording to allow you to review the interview. Permission will be sought for the use of the material for research and archival purposes. You may contact me on [REDACTED] on if you require further information.

It is hoped that this research will provide a valuable historical record and insight into the development and contributions of stomal therapy nurses in Australia.

Please be assured that your participation in this study is entirely voluntary and you have the right to refuse to participate or withdraw from the study at any time. Approval for this research has been given by the Ethics Committee of Edith Cowan University.

Thank you for your assistance,

(Keryln Carville)

**THE EVOLUTION AND EXPERIENCE OF STOMAL THERAPY NURSES IN
AUSTRALIA**

CONSENT FORM

Please complete this form and return in the enclosed addressed envelope.

I _____

of _____

agree/do not agree to participate in the proposed study to be conducted by Keryln Carville into the history and experiences of stomal therapy nurses in Australia. The study has been explained to me and I reserve the right to withdraw at any time.

Signed _____

Date _____

Appendix E: The copyright release form for participant consent for use of the data for ongoing research purposes.

THE EVOLUTION AND EXPERIENCE OF STOMAL THERAPY NURSES IN AUSTRALIA

COPYRIGHT RELEASE FORM

Please print except for signatures:

I _____(full name of interviewee)
of _____

give permission to Keryln Carville (the interviewer) who interviewed me on
_____ (date/s of interview)

to lodge copy/ies of this interview in the archives of the Australian Association of Stomal Therapy Nurses and either the Battye Library of Western Australian or the National Library in Canberra, for the use of other researchers.

Signed _____(Interviewee)

Date _____

Interviewer's Signature _____

THE EVOLUTION AND EXPERIENCE OF STOMAL THERAPY NURSES IN AUSTRALIA

INTERVIEW INSTRUMENT FOR STOMAL THERAPY NURSES

The interviewer will abide by the Guidelines of Ethical Practice as stated by the Oral History Association of Australia. The following questions will be used to begin and guide the interview:

1. Could you please state your full name and date of birth.
2. In what year and where did you begin your training as a nurse?
3. What made you take up nursing as a career?
4. What memories do you have of caring for people with ostomies during your general nurse training?
4. What education do you remember receiving in regard to the care of people with ostomies?
5. Can you describe the ostomy equipment, appliances and pharmaceuticals you used to care for people with a stoma?
6. What year and where did you begin your training as a stomal therapy nurse?
7. What memories do you have of the training course?
8. Who were the other students and educators?
9. How did you use this knowledge and skills when you returned to your workplace?
10. Were there other stomal therapy nurses working there prior to you or with you?
11. How would you describe the stomal therapy nurse's role at that time?
12. Do you believe the role is different today, and if so, how?
13. Who or what has influenced your practice as a stomal therapy nurse?
14. What do you (did you) most enjoy about working as a stomal therapy nurse?
15. What do you (did you) least enjoy about working as a stomal therapy nurse?
16. What has been your greatest achievement within your practice?
18. What is your vision for the future of stomal therapy nursing in Australia and the world at large?

THE EVOLUTION AND EXPERIENCE OF STOMAL THERAPY NURSES IN AUSTRALIA

INTERVIEW INSTRUMENT FOR SURGEONS

The interviewer will abide by the Guidelines of Ethical Practice as stated by the Oral History Association of Australia. The following questions will be used to begin and guide the interview:

1. Could you please state your full name and date of birth.
2. In what year did you begin your training as a doctor?
3. What made you take up medicine as a career?
4. When and where did you train as a colorectal surgeon/urologist?
5. During those training days what do you remember about the care of ostomates?
6. What are your memories of nursing care for people with ostomies?
7. What involvement with the Ostomy Association/s did you have in the founding days?
8. What do you remember about the establishment of stomal therapists and later stomal therapy nurses?
9. What do you think are the major diagnostic advances of recent years for people with diseases or trauma of the gastrointestinal/urinary system?
10. What do you think are the major surgical advances of recent years in colorectal/urological surgery?
11. What is your perception of the role of stomal therapy nurses today?
12. What is your vision of stomal therapy nursing in the future?

THE EVOLUTION AND EXPERIENCE OF STOMAL THERAPY NURSES IN AUSTRALIA

INTERVIEW INSTRUMENT FOR OSTOMATES

The interviewer will abide by the Guidelines of Ethical Practice as stated by the Oral History Association of Australia. The following questions will be used to begin and guide the interview:

1. Could you state your full name and date of birth.
2. In what year did you have your stoma surgery?
3. In what state did you have your stomal surgery?
4. What surgery did you undergo and why?
5. What are your recollections of the nursing care your received?
6. Did you see a stomal therapy nurse before your surgery?
7. Were you seen by a stomal therapy nurse after your surgery?
8. What are your memories of the care you received under the stomal therapy nurse?
9. In what way did this care influence your recovery and rehabilitation?
10. What are your perceptions of the role of the stomal therapy nurse?

Appendix I: Illustrations of ostomy appliances.

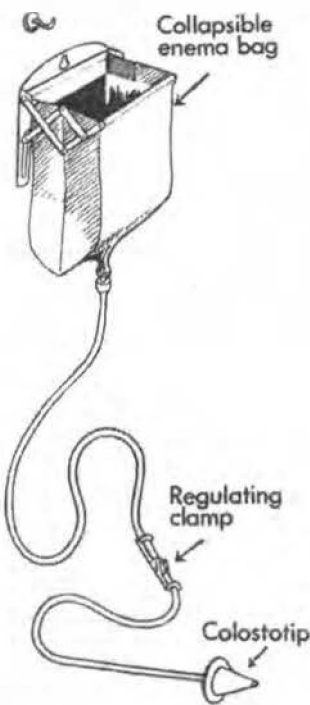


Figure 1: The Greer colostomy irrigation set (Hughes, Kyte & Cuthbertson, 1976, p. 36). The colostotip replaced the need to use a catheter and prevented the escape of water around the stoma.



Figure 2: The first disposable, self-adhesive plastic appliance was devised by Danish nurse, Elise Sorensen, in 1954. It was manufactured by Danish, plastics engineer, Aage Louis-Hansen. The company evolved into Coloplast A/S a major manufacturer of appliances (Coloplast A/S product literature, undated).

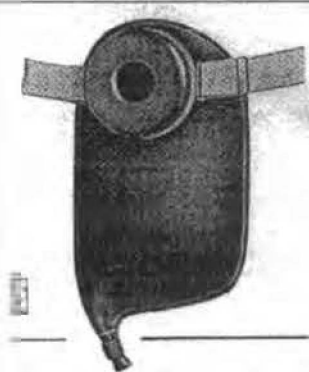


Figure 3: The Koenig-Strauss-Rutzen appliance, which was designed by Mr Koenig, an ileostomate from Chicago with the assistance of his surgeons, Alfred and Siegfried Strauss in 1944. It was produced by the H.R. Rutzen Company in Chicago (Strauss & Strauss, 1944).

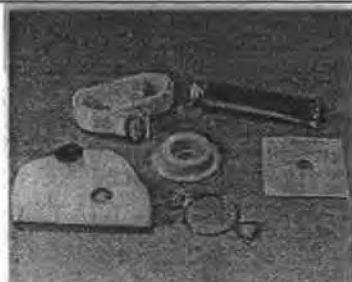


Figure 4: The Chiron rubber colostomy and ileostomy set with flange, metal ring and belt. Also shown is double-sided adhesive plaster and surgical cement, which was used to adhere the flange to the skin (Hughes & Wilson, 1967, p. 32).

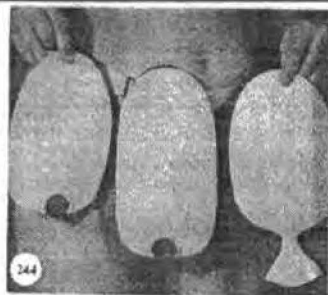


Figure 5: The rubber bags available in Australia during the 1950-1970s were produced by Downs, Birbeck and Bullen. The picture shows the Downs' rubber bags for a colostomy, ileostomy and urostomy (Seidel, 1972, p. 76).



Figure 6: The rubber bags were attached to a rubber flange and cemented or belted to the peristomal skin (Seidel, 1972, p. 80).



Figure 7: Karaya gum washers and gel. Karaya is derived from the gum of *sterculia urens* trees. In 1952 Rupert Beach Turnbull first used Karaya powder on peristomal skin as a protective agent. It was later manufactured as washers and gel for use around stomas (Journal of the Ileostomy Association of Great Britain and Ireland, 1969, p. 26).

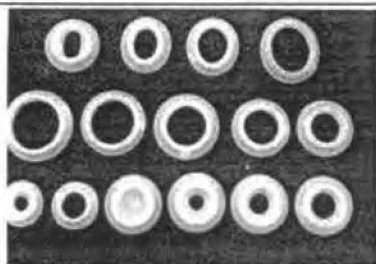
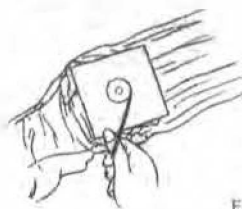


Figure 8: The Philp flanges, which were produced by Mr Ken Philp, a Sydney ostomate, in his backyard shed in 1960 (photography reproduced with permission).



Figure 9: The Wallace flange and belt, which was produced in Melbourne by Nylex during the 1960s. A plastic bag was wrapped around the flange and held in situ around the stoma with the belt (Hughes & Wilson, 1967, p. 28).



F



G



H



J

Figure 10: The 'long bag', which was devised by Melbourne surgeon, Mr E.S.R. Hughes and constructed of a length (approximately 1 metre) of cryovac plastic tubing. A double-sided adhesive disc (Stomaseal™) was applied close to the upper end of the tubing (see Figure F).

A Stomahesive™ wafer was then applied to the outside adhesive layer of the disc. Radial slits were cut in the aperture which was cut to fit the size of the stoma (see Figure G).

The backing paper that covered the adhesive side of the Stomahesive™ wafer was removed (see Figure H).

The long bag was then applied to the peristomal or perifistula skin (see Figure J) (Hughes, Kyte & Cuthbertson, 1976, p. 18).

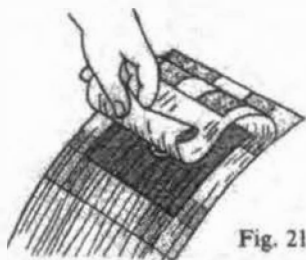


Fig. 21

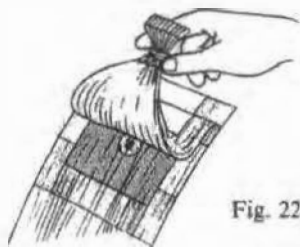


Fig. 22

Figure 11: The Stomahesive™ wafer when attached to the long bag was then reinforced to the skin with adhesive water-proof tape.

The upper end of the long bag was folded or pleated and a rubber band was used to secure the end. The lower end of the long bag was either pleated in a similar manner or allowed to drain into a receptacle (Hughes, Kyte, & Cuthbertson, 1976, p. 20).



Figure 12: The photo shows a rubber flange being adhered to a Stomaseal™ and a Stomahesive™ wafer in a similar fashion to that described for adhering a long bag (Seidel, 1972, p. 33).

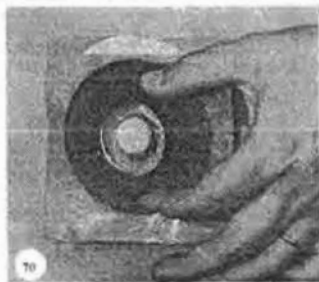


Figure 13: The rubber flange once adhered to the Stomaseal™ and Stomahesive™ is adhered to the peristomal skin (Seidal, 1972, p. 34).

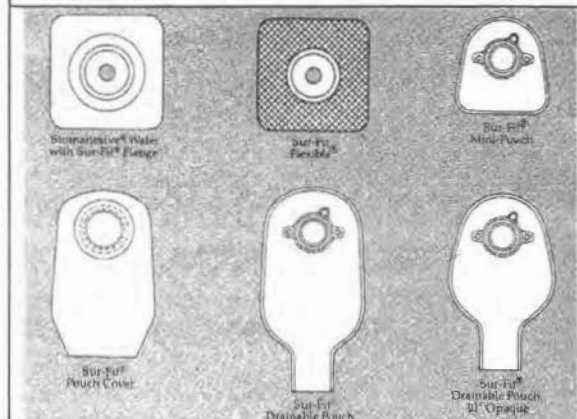


Figure 14: The ConvaTec Surfit Flexible System™. The closed bag was used for colostomies and the drainable for ileostomies (ConvaTec product literature, undated).

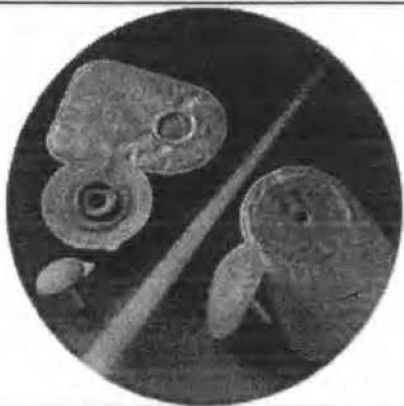


Figure 15: The Coloplast A/S Conceal Plug™. The tampon end of the plug is inserted into the colostomy stoma and removed when defaecation is anticipated. It is available in a one and two-piece system as displayed (Coloplast A/S product information downloaded from www.coloplast.com)



Figure 16: Modern flexible ostomy appliances are produced in one and two-piece systems and these are available from most manufacturers of ostomy appliances (Coloplast Easiflex™ downloaded from www.coloplast.com)

London May 6 1881

My very dear friends

Now once more "God
speed" to you all; "my
very best-greetings, ^{& thanks} to you
all, all:—to our beginners
good courage,—to our
dear old workers peace,
fresh courage too, perse-
verance: for to persevere
to the end is as difficult
& needs a yet better energy
than to begin new work!"

To be a good Nurse
one must be a good

women, here we shall all
agree. It is the old, old story
But some of us are new
to the state.

What is it to be "like a
woman"? "like a woman"
"a very woman" is
sometimes said as a word
of contempt: sometimes
as a word of tender
admiration.

What makes a good woman
is the better or higher on
holier nature: quietness -
gentleness - patience
endurance - forbearance
forbearance with her

patients - her fellow workers
her superiors - her equals
We need above all to
remember that we come
to learn, to be taught.
Hence we come to obey.
No one ever was able to
govern who was not able
to obey. No one ever was
able to teach who was
not able to learn. The
best scholars make the
best teachers - those who
obey best the best rulers
We all have to obey as well as
to command all our lives.

Who does it best?
As a mark of contempt

for a woman is it not
said, she can't obey? - she
will have her own way?

as a mark of respect -
she always knows how to
obey? how to give up her own way.
You are here to be trained
for Nurses - Attendants
on the wants of the sick
helpers, in carrying out
Doctors' orders (not Medical
Students) though Theory
is very useful when
carried out by practice.
Theory without practice
is ruinous to Nurses.

Then a good woman
should be thorough
thoroughness in a Nurse

is a matter of life &
death to the patient.

Or, rather, without it there
is no Nurse. Especially
thoroughness in the unseen
work. Do that well
& the other will be done
well too. Be as careful
in the cleaning of the
used poultice basin as
in your attendance at an
Antiseptic dressing.
Don't care know about
what meets the eye &
gains attention.

"How do you know you
have grace"? - said a

Minister to a housemaid
"Because I clean under
the mats." was the
excellent reply.

If a housemaid said that
how much more should
a Nurse, all whose
vessel mean Patients.

Now what does "like a woman" mean when it is said in contempt?

Does it not mean what is petty, little selfishnesses, small meanesses: envy: jealousy: foolish talking: unkind gossip: love of praise.

Now, while we try to be "like women" in the noble sense of the word, let us fight as bravely ^{against} all such womanly weaknesses. Let us be anxious to do well, not for selfish praise but to honour & advance the cause, the work we have taken up. Let us value

our training Not as it
makes us cleverer or
superior to others, but
inasmuch as it enables
us to be more useful -
helpful to our fellow
creatures, ~~who~~ the sick,
who most want our help.
Let it be our ambition
to be thorough good women,
good Nurses - And never
let us be ashamed of
the name of "Nurse".

This to our beginners, I
had almost said. But
those who have finished
their year's training will
be the first to tell us
they are only beginners,-
they have just learnt
how to learn & how to teach.

When they are put into the
responsibility of Nurse or Sister,
then they know how to learn
& how to teach something every
day, & year, which, without
their thorough training, they
would not know. This
is what they tell me.

Then their battle cry is:

"Be not weary in well doing
- we will not forget
that once we were ignorant
timid Probationers -
we will not laugh at the
mistakes of beginners.
but it shall be our pride
to help all who come
under our influence to be
better women, more thorough
nurses'. What is influence?
- the most mighty, the
most unseen engine we
know. The influence of
one a year or two in the
work over one a month
or two in the work is more

mighty, altho' narrow, than
the influence of Statesmen
or Sovereigns. The influence
of a good woman &
thorough Nurse with all
the raw Probationers who
come under her care is
untold. This it is - the
wielding such influence,
for good or for bad, which
either raises or lowers the
tone of a Hospital.

We all see how much easier it
is to sink to the level of the low,
than to rise to the level of the high -
but dear friends all, we know how
soldiers were taught to fight in
the old times against desperate odds.

standing shoulder to shoulder.
& back to back. Let us
each & all, realizing
the importance of our
influence on others -

Stand shoulder to shoulder
& go alone, in the good cause
But let us be quiet:

What is it that is said
about the leaven? Women
influence ever has been &
ever should be quiet &
gentle in its working like
the leaven - Never noisy or
self asserting

Let us seek all of us
rather to be good than
clever & quick.

Now I am sure we will
all give a grateful cheer
to our Nation & to our
Sister our Medical
Instructors.

God bless you all, my
dear, dear friends And
I hope to see you all,
one by one - this year.

Florence Nightingale

Appendix K: The Australian Association of Stomal Therapy Nurses Code of Ethics
June, 2003.

- The stomal therapy nurse must at all times maintain the highest standards of nursing care and professional conduct.
- The stomal therapy nurse will provide needed services to persons irrespective of their race, colour, creed, sex, sexual preference, age and political or social status.
- The stomal therapy nurse must respect the beliefs, values and customs of the individual and maintain his/her right to privacy by maintaining confidentiality, sharing with others only information relevant to that person's care.
- The stomal therapy nurse will not participate in unethical practice.
- The stomal therapy nurse must maintain competency by keeping abreast of new developments in the theory and practice of stoma care and related fields.
- The stomal therapy nurse will participate actively in professional, inter-professional and community endeavours in order to meet the highest professional standards.
- No full member shall be in the employ of a company or self employed in the manufacture or sale of products, prostheses or pharmaceuticals where it could be perceived that the use or selling of products prostheses or pharmaceuticals could disadvantage or contradict the personal preference of clients or be construed to result in unethical conflict of interest.

References for the Australian Association of Stomal Therapy Nurses Standards of Practice.

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