**An OR Nurse’s Story**

During ‘nursing apprenticeship’ at Balmain Hospital between 1966 and 1969 came my introduction to ‘Theatre’ in the form of two blocks of 6 weeks each. The first was terrifying as I entered a new world but the second saw the beginning of a career-long passion for operating room nursing. Discipline was strict and some of the personnel intimidating but, if one kept one’s eyes and ears open and towed the line, there was a wealth of knowledge and experience to be tapped.

Remember, these were the days before university courses for nursing, HIV/AIDS, CJD, superbugs, regulation scrub sheets, sophisticated resuscitation techniques and the proliferation of allergies of more recent times.

The count for an operation was listed on a whiteboard in the theatre and items were limited to swabs, sponges, artery forceps and needles. Prep swabs were without radio-opaque thread and not included in the count. Open-back scrub gowns were being phased out as they wore out. The closed method of gloving was a new innovation and the only gloves available were latex. If a surgeon or nurse was allergic to latex, they wore sterile cotton gloves underneath the latex. Anaesthetists had to fend for themselves and yell, literally, when they needed assistance.

Then, as now, trauma was a regular part of the theatre scene and occasionally the surgeon would not wait to dress for theatre or scrub before demanding a scalpel and suction! For Ophthalmic surgery, neither the surgeon or scrub nurse wore gloves as they were considered too coarse for the delicate surgery. It’s a wonder they had any skin left on hands or arms after the prolonged scrubbing process – with brushes. Tucked away in one corner of a theatre was a glass jar filled with alcohol, in which ampoules, also of glass, containing lengths of catgut in alcohol, were stored. This was a sop to very old-fashioned surgeons as all suture material was available in sterile pre-packs. Difficult to get some to change the habits of a life-time even now, eh?

Most of the instruments were pre-packed in trays and sterilised in linen wraps with single items packaged in ‘steri-peel’ packaging. When a very nervous student unsterilised anything, the item was hastily cleaned and popped into the nearest autoclave. On completion of the cycle, the scout would take it to the scrub with forceps the tips of which has been soaking in an antiseptic solution. ‘Disposables’ were things of the future.

So taken was I with the world of the Operating Theatre that, in 1971 after a brief flirtation with Midwifery, I embarked upon the theatre course offered at St Vincent’s Hospital, Melbourne, under the beady eye of Sr Mary Felix. This opened a new vista of experience in surgical specialties. Imagine my horror when, for the first time, I saw a patient, anaesthetised, in a bath of iced water! For the surgeon involved this was an efficient way of inducing hypothermia. For Caesarean sections, the scrub and scout nurses would don overgowns, collect sterile instrument and linen packs and trundle across the tramlines on Victoria Parade to the Obstetric unit. When the Private Hospital opened next-door to St Vincent’s this process was repeated but in the underground tunnels which connected the hospitals. ‘Closed’ gloving was definitely on the agenda and scrubbing brushes were not!
In 1972 I commenced work in Cameron Wing (cardio-thoracic) theatres, St Vincent's Hospital, Sydney. There were always two scrub nurses for each open-heart operation and back to scrubbing (past the elbow) with brushes again. Tubing for the cardio-pulmonary bypass machine was made up by the technician and nursing staff for the following day’s operations and sterilised by ethylene oxide in what looked like large lunch boxes. The senior scrub nurse would scrub and set up the equipment, including the bypass lines, cover the trolleys, unscrub and head for the tearoom for breakfast. In this environment I learned the true value of teamwork. Here, too, I was introduced to pre- and post-op visiting by OR nurses.

My next excursion into OR nursing was in a country town. There were a few visiting surgeons and a resident Orthopod who performed hip replacements in addition to the usual run of trauma and bunions. This is the first time I had seen latex gloves washed, dried, powdered and re-sterilised. Could be called a ‘retro culture shock’!!!!!!!!!

Next stop and final workplace before retirement was in the secondary referral hospital in Wagga Wagga in 1984 (no apology to George Orwell). Here was the introduction to donor surgery, flexible endoscopy, and laparoscopic surgery as well as a large dose of high speed road trauma. The likelihood of knowing donors and trauma victims is heightened in a smaller community and this can add another dimension to anticipation. At this time, flexible endoscopes were not fully immersible and were fickle beasts at best. Laparoscopic instruments did not have disposable components and were a nightmare to clean and sterilise. The development of both of these classes of instruments is an ongoing story.

This period saw many changes, innovations and challenges in the realm of OR nursing; the proliferation of joint replacement options and associated ‘loan sets’, the increase of the breadth of laparoscopic surgery, the advent of HIV/AIDS and CJD into the equation and the challenges of sterilisation, not to mention the increasing burden of regulation and documentation.

I was introduced to the OTA in 1984 and went on to become an office-bearer and Life Member, an honour indeed. Throughout my membership, the advice, assistance, friendship and camaraderie that I found within the organisation has been invaluable. I wish that more of our colleagues could see the benefits of joining the OTA.

Would I go through all this, given my time over again? You bet!

Thank you OTA.

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