THE
EIGHTH DECADE

1981-1989

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INTRODUCTION

Every decade, it seems, is characterized by rapid and dramatic changes, changes that affect not only society's institutions and traditions, but the people who have lived through the decade.

The 1980s had their fair share of changes. Advances in technology catapulted change into the way health care is practised in Canada. Changes in illness patterns that had been developing throughout recent decades came to the fore, as concerns about the health of our elders and of the young—even the unborn—gained attention. Increasingly, science was tempered by considerations of ethics, as what was once impossible—genetic engineering and organ transplantation, to name two—became not only possible but commonplace.

Through it all, Canadian nurses sought not only to adapt to change, but to look well beyond the present, past the horizon of the beginning of the next century, to prepare for what would be needed of them.

As a record of one decade in the life of the Canadian Nurses Association (CNA), *The Eighth Decade* is also the history of Canada's nurses throughout the 1980s. The CNA is the official, national professional association for over 110,000 registered nurses in Canada. Each of these nurses is a member of one of the nine provincial or two territorial member associations. *The Eighth Decade* is a companion volume to two previous records, *The Leaf and the Lamp* and *The Seventh Decade.* The chapters that follow outline important trends and events, according to the principal initiatives and goals of the CNA's membership.

The eighth decade of the CNA was a time of transition, a time of passage from the world that was, into the future. In each of its endeavours—whether encouraging nursing research, strengthening health policy, or enhancing nurses' working lives—the CNA's gaze was fixed clearly on the future.

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1 NURSING ADMINISTRATION

At the beginning of the CNA's eighth decade, the field of nursing administration had already achieved greater recognition than before among both nurses and other health professionals. Changes in hospital administration during the 1970s meant that nurse administrators had taken their place at the policy-making level in hospitals and other institutions. But the work had really just begun. The field of nursing administration warranted further development, and the preparation of nurses for management was in its infancy.

The new commitment to nursing administration was evident in several events in 1980. The Canadian College of Health Service Executives (CCHSE) sponsored the first national conference on nursing administration that year. At the CNA Annual Meeting in June, CNA members passed three pertinent resolutions: that the CNA should reaffirm that the executive responsible for the department of nursing in any institution should be a qualified, registered nurse; that the CNA should request that the Canadian Council on Hospital Accreditation (CCHA) include this criterion as a standard; and that the CNA should hold a national forum for nurse administrators to discuss the issues related to nursing management. The members also asked that the CNA study the administration issues relevant to the education of nurses. These resolutions were to have a significant outcome in the years that followed.

There was a real need for programs in administration, and increasing the number of such programs would have a positive impact not only on the nursing profession, but also on the health care system in general.

Action was swift. The resolutions on hospital administration and accreditation were referred to a special task force of the CCHA. The Board of Directors approved the forum of nurse administrators as a priority. They commissioned Dr. Peggy Leatt to identify the issues in education for administration and to make recommendations.

In 1981 the CNA released *Education for Nursing Administration in Canada,* which contained both a discussion of the critical issues in nursing preparation and an outline of strategies for the future. The discussion paper served as a road map for other activities: an ad hoc committee was formed to clarify the role of the nurse

administrator on its various levels, and to review—critically—the quality and availability of educational programs for nursing administration. Two years later the *Position Paper on the Role of the Nurse Administrator and Standards for Nursing Administration* was published; it subsequently enjoyed a wide circulation because of its value at a time when the entire health care system in Canada was under review.

Also in 1981, the first CNA forum on nursing administration was held in Ottawa, attracting 207 participants. A month later, representatives of the CCHSE, the Canadian Hospital Association (CHA), the Canadian Association of University Schools of Nursing (CAUSN) and the Canadian Public Health Association (CPHA) met with CNA representatives in Montebello, Quebec. All groups were willing to continue in a joint action to help solve the problems related to nursing administration.

The first CNA-sponsored national conference for nurse administrators was held in 1984, thus fulfilling the members' resolution from 1980. A joint conference for administration, education and continuing education, the meeting was dubbed "Playing Our Aces" and was attended by 440 nurses.

That same year, 1984, the CNA Board of Directors made nursing administration a priority, in accordance with the corporate objectives. In their words, they would endeavour "to promote high standards of nursing administration in order to create an environment that facilitates the provision of quality nursing care for the people of Canada." Lorine Besel, president of the CNA for 1984 to 1986, described why nursing administration had become a priority: "Our profession urgently needs politically and economically astute leaders who have a solid background in management, a broad philosophical perspective on health services, and a clear vision of the type of health care system we want to see in place."[1] A committee was struck to develop a new, national plan of action.

In 1985, the National Plan for Nursing Administration in Canada was presented to and accepted by the CNA Board. In brief, the plan outlined the goals, objectives and strategies necessary to promote high standards of nursing administration. There were five principal objectives:

- to promote implementation of the CNA *Position Paper on the Role of Nurse Administrators and Standards for Nursing Administration* (1983) by encouraging its use in health care agencies and promoting awareness of the paper among nurse-administrators;
- to enhance opportunities available for nurse-administrators by promoting increased accessibility to degree-granting programs in administration and by facilitating opportunities for professional development;
- to enhance leadership in nursing administration by supporting nurses with leadership potential, fostering better communication among nurse-administrators, promoting opportunities for leadership development and strengthening the visibility of the present leaders in nursing administration;
- to promote the development of research in nursing administration by stimulating a supportive climate for research and identifying sources of financial support for research efforts; and
- to support improved preparation for nursing administrators by increasing

sources of financial assistance for educational programs in nursing administration, by making nurse-administrators aware of sources of funding and by seeking funding to support opportunities for nursing administrators to improve knowledge and skills relative to government policy and program development.

The Board also decided to encourage the Academy of Executive Nurses in their efforts to produce a Canadian journal of nursing administration.

The Board's plan was badly needed. Statistics that year indicated to what degree action was needed: 46 per cent of directors of nursing and 60 per cent of all nurse administrators had no additional academic preparation beyond the basic nursing education.

As a sign of the continuing commitment among nurses to the importance of the developing field of nursing administration, a second national conference was held in 1986, again in Ottawa, with "Collaboration in Action" as the theme.

The CNA, CHA, CAUSN, CPHA and CCHSE also met again that year, as a follow-up to the 1981 meeting. The five groups discussed the CNA's position paper on nursing administration to identify issues that would have an effect on its implementation and generally to aid in the development of nursing administration. The associations agreed that there was a real need for programs in administration, and that increasing the number of such programs would have a positive impact not only on the nursing profession, but also on the health care system in general.

2 NURSING EDUCATION

Health care in the 1980s had changed dramatically, even over the decade before. Rapid advances in medical and diagnostic technology had resulted in a virtual revolution both in the types of illnesses being treated in acute care settings, and in how health and illness were managed. With the advances came new ethical problems, adding to the dilemmas already faced by health care professionals.

To keep pace with the demands put upon the profession, it was obvious that nursing had to look further ahead. Preparation had to align with practice—current and future.

In 1980, members resolved at the annual general meeting that the CNA would develop a statement on the minimal educational requirement for entry to the practice of nursing. Several months later, a task force was appointed by the CNA Board. The task force's background paper and position statement were submitted to the Board in 1982, with a recommendation that a baccalaureate degree be the minimum educational requirement for entry to nursing practice. The task force believed that the requirement would promote high standards of nursing practice and allow the profession to continue to provide excellent care in a changing world.

According to the task force's report, the baccalaureate degree was chosen because that level of education would provide the depth of preparation necessary for professional practice. Current and projected trends in health care clearly indicated the need for broader preparation. Changes in health care delivery, illness patterns and health care policy were already affecting nursing. The Board acknowledged that trends included a dramatic increase in knowledge in the physical, biological and social sciences; changes in technology such as in biomedical engineering; increasingly complex ethical problems; and the need to develop research-based nursing practice.

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The CNA Board adopted the position unanimously; further, because the CNA recognized its leadership role, the Board made the landmark decision that the year 2000 should be the turning point. From the year 2000 onward, nurses who were commencing practice would be required to hold a baccalaureate degree in nursing.

Later that year, at the annual meeting, the members asked the CNA to take immediate action, providing leadership and consultation to the provinces on entry to practice. An ad hoc committee was appointed in the fall to establish a national plan; members of the committee were from nursing education and nursing service, with the esteemed Dorothy Kergin, member-at-large for nursing education, serving as chair. Within a year, the proposed plan was tabled before the CNA Board, and the final version was adopted in February 1984. The CNA used the new national plan as a guide for action on entry to practice, developing objectives and planning activities.

Response to the CNA position was not wholeheartedly favourable. Indeed, many nurses who held nursing diplomas believed that their preparation was being downgraded; they worried that their chances for advancement would suffer when the entry-to-practice requirement was implemented. In truth, the CNA position stipulated that a nurse practising in the year 1999 would not be required to attain a degree in order to continue being recognized as professional nurse. Obviously, information was a much needed component of the plan and was key to the acceptance of this important proposal by nurses as well as others in the health care professions.

A coordinator was hired in 1984. Norma Murphy, MSN, set to work immediately informing nurses and others about the entry to practice requirement. Newsletters were produced and distributed regularly; articles and editorials on the subject appeared in *The Canadian Nurse/L'infirmière canadienne.* The CNA offered resource people to speak about the position to groups from nursing, other health care professions and government agencies such as the Health and Welfare and the Secretary of State. By 1989, the CNA position was supported by all its member associations and also had the approval of several other health associations.

Transition was of the utmost importance. As Norma Murphy wrote, "There are many areas to be investigated: increasing the enrolment in and numbers of university schools of nursing; . . . securing facilities for clinical experience for students; assisting those nurses in the work force who choose to seek baccalaureate education; setting curriculum standards; and developing innovative methods of nursing education."[2]

The entry-to-practice position promised nurses not only that the profession would keep pace with the developments in knowledge and technology, but also that these developments would extend to the practice of nursing itself. By 1986, more than 30 per cent of all nurses employed in nursing had preparation beyond the diploma level, either a certificate or a degree, which was a signal that nurses had indeed perceived a need for additional education. In 1987, 12.3 per cent of Canadian RNs had baccalaureate preparation, an increase of more that 4 per cent since 1975.[3] Moreover, figures in 1987 showed that more that 50 per cent of the nurses with baccalaureate preparation were providing direct patient care in hospitals, homes for the aged, nursing homes and the community. Such figures were evidence of a slow but steady trend toward higher education for nursing practice. Practising nurses

clearly saw the demand for more comprehensive preparation.

Yet another important trend had surfaced during the eighth decade, that of nurses' increasing interest in continuing education. In 1980, the Task Force on Continuing Education was appointed by the CNA Board to develop a position paper and to make recommendations. In 1982, however, in light of the overshadowing importance of the issues of entry to practice and credentialling, both of which had been named as priorities, the Board postponed further action on continuing education.

Nonetheless, access to continuing education, especially credit courses, continued to grow in importance as the decade passed. For the 1988-90 biennium, continuing education was again named as a priority by the Board. As the decade came to a close, the CNA was developing a position paper to detail further activities.

3 NURSING PRACTICE

Nursing practice was the centre of attention during the 1980s not just for nurses, but also for many people outside the profession. Several important issues demanded resolution.

CERTIFICATION IN NURSING SPECIALTIES

One of the highlights of the CNA's eighth decade was the development of the certification in nursing specialties program, which was a quick and direct response to the needs of Canadian nurses.

The policy development began in June of 1980 at the CNA biennial convention in Vancouver. Members passed a resolution that the CNA study the feasibility of developing examinations for certification in major nursing specialties. In response, CNA staff prepared information on the certification program of the American Nurses Association (ANA), including the number of Canadian nurses who had sought certification through the ANA.

It quickly became evident that certification was only one form of a larger issue: the need for a CNA policy on credentialling in nursing. Licensure and registration were two other forms of professional credentials. The Association needed to examine what the relationship would be among all forms of credentialling in nursing.

In 1981 the CNA Board of Directors established an ad hoc committee on credentialling. The committee's report was presented a year later. The report consisted of a policy statement on credentialling in nursing, a background paper outlining the rationale for the policy and a recommendation. The report constitutes an important document in the CNA's history. It describes not only the mechanisms for credentialling in Canada, but also the Association's commitment to promoting the development of certification in nursing specialties.

The 1980s will go down in history as a decade marked by dramatic societal changes, changes that affected both health care and the professionals who delivered it.

The process of developing policies and criteria took a step further with the hiring of a project coordinator early in 1983. This coordinator organized the CNA-sponsored conference on certification in September 1983, a meeting that brought together 16 national nursing groups to share their views on the development and operation of a national-level certification system. The CNA coordinator amalgamated those views into the report, *Guidelines for a National Certification Mechanism in Nursing Specialties*, which she presented to the CNA Board soon after the meeting. The Board then appointed an ad hoc committee on certification, composed of a clinical nurse-specialist, the member-at-large for nursing practice, a CNA member who had been on the Committee on Testing, a specialty nurse-educator and a representative of the Ontario Occupational Health Nurses Association (OOHNA).

The committee was asked to perform six responsibilities:

- clarify the purpose of certification;
- establish criteria to designate emerging specialties;
- categorize nursing specialties;
- interpret minimum knowledge requirements to "practice" as opposed to being "certified in" nursing;
- define criteria for formal education programs; and
- establish criteria for eligibility of candidates for certification and recertification.

The CNA defines certification as a voluntary and periodic process by which an organized professional body confirms that a registered nurse has demonstrated competence in a nursing specialty. Certification provides an opportunity for nurses to validate their expertise in a specialty, promotes high standards of nursing practice in order to provide excellent nursing care to Canadians, and identifies through a recognized credential those nurses who have met specialty standards.

The occupational health nurses offer a clear example of what certification was all about; indeed, they became the first nursing specialty in Canada to achieve certification. The Canadian Council of Occupational Health Nurses (CCOHN) was formed in 1981 with the objective of implementing a program of certification for occupational health nursing. For the next three years, the Council worked closely with the committee of the Ontario Occupational Health Nurses Association that had originated the concept and with the CNA's Testing Service. The first examination for occupational health nurses was developed and written by nurse candidates in 1984; a bilingual examination was first available in 1986.

A second ad hoc committee was struck in 1984 to examine and recommend policies on the national certification system; it was disbanded, however, due to philosophical differences between the committee's recommendations and the Board's goals. The committee had recommended that certification should follow the entry-to-practice decision; in other words, nurses who wanted to become certified in a specialty should already have a baccalaureate in nursing. The Board realized that Canadian nurses did not want to wait for such a long-term goal in certification; they wanted a mechanism to be used immediately. As coordinator Virginia Levesque stated, it was more important to "serve our members' needs right now, especially in view of the fact that some of these members have been waiting for a certification mechanism since the 1980 meeting."[4]

A third committee, formed in 1985, fulfilled this mandate. Within a year this committee developed a booklet on certification, specifying procedures and guidelines for the CNA's certification program.

Early in 1987, the CNA Board approved the implementation of a certification program within the CNA. Later that same year, the application of the Canadian Association of Neuroscience Nurses for designation as a specialty for certification was accepted; CANN would be the first group to go through all the steps of the CNA certification program.

STANDARDS OF NURSING PRACTICE

Standards of practice had been named as a priority in the 1970s, and by 1980 a special task force had issued the "Definition of Nursing Practice and Standards for Nursing Practice". The standards identified independent, interdependent and dependent roles of nurses.

The CNA hosted a meeting of representatives of the member associations in 1981 to determine what effect the standards were having and to assist in coordinating work that was being done across the country. The meeting was also the occasion when recommendations were made for phase two of the project. Phase two would interpret and implement the standards of practice.

One of the decisions made at the 1981 meeting was that the standards be published in the CNA journals; the document subsequently appeared in the September issues.

A follow-up meeting with the 11 member associations was held in November 1983 to update information on the development and implementation of the standards. Significantly, the meeting would also provide important feedback on the relationship between the CNA and provincial standards. The objective was to aid in the coordination of activities between the national level and the provincial or territorial level.

In a watershed decision some four years later, the CNA Board decided that the Association should no longer actively or passively illustrate the nurse in a dependent role in health care. Because nurses are individually responsible and accountable for their actions, they are independent professionals. To this end, all references to a dependent role were removed from the "Definition of Nursing Practice and Standards for Nursing Practice".

In another significant move, the CNA Board recommended that, in future, entry to practice was to be considered a concern of nursing practice, not nursing education.

THE CODE OF ETHICS

Since 1954, Canadian nurses had used the code of ethics generated by the International Council of Nurses. Late in the 1970s, however, CNA members resolved that a Canadian code of ethics be developed, and in 1979 work on the project began.

In 1980 a code was presented to the CNA Board, approved and subsequently

presented to membership at the general meeting. The code met with unfavourable response, however, mainly due to the implications of one section. (The section stated that it was unethical for nurses to withdraw their services under any circumstances.) Simply deleting the section was not an acceptable course of action, and the Board, acting on the recommendation of a committee that had studied the code, determined that a new code should be written. The Board also decided that an ethicist should be hired to work with the committee; Dr. Benjamin Freedman of the Westminster Institute for Ethics and Human Values was appointed in 1982.

A second draft code was presented to members through the CNA journals. The new code was approved in February 1985, with the proviso that it be reviewed every five years.

MATERNAL–INFANT CARE

In 1981 the CNA Board passed a motion to examine the roles and functions of nurses working within maternal and perinatal care. The CNA recognized that the delivery of nursing care in this area was crucial to the overall health of Canadians, and that due to the emergence of primary care concepts, the roles of nurses warranted redefinition and expansion. In addition, the Society of Obstetricians and Gynaecologists of Canada (SOGC) had expressed concern about overlapping roles and about the need to ensure adequate educational preparation for all members of the reproductive health care team.

The Ad Hoc Committee on Roles, Functions and Educational Preparation of Registered Nurses in Maternal Child Care was established in 1981. By the end of the year, a draft position paper was presented, and the final version was accepted in 1984. Published as the *Position Paper on Specialist Roles in Maternal–Infant Nursing*, the paper represented the first such position on an area of clinical specialization to be adopted by the CNA Board of Directors.

CARE OF THE ELDERLY

One of the signal trends of the eighth decade was the gradual increase in the proportion of the aged in Canada's population. It was obvious that as the population aged, Canadians would require more—and possibly different—health care services. Moreover, considerable resources would be required to meet the needs of the elderly. Because nurses are pivotal in the planning, provision and evaluation of health care, nurses had to take a critical, future-thinking look at what would be needed.

In 1985, Dr. Dorothy Hall presented a discussion paper to the CNA Board on the subject of care of the elderly; the Board subsequently asked Dr. Hall to prepare a CNA position paper, which was then presented to the Ad Hoc Committee on Health Care Reform.

The paper was published in 1987 as *The Nursing Contribution in Health Care for Older Adults.* This nursing perspective on the health care of seniors included information on the contribution that nurse practitioners could make as well as a review of pertinent issues in practice and education.

CNA POSITIONS RELEVANT TO PRACTICE

The 1980s will go down in history as a decade marked by dramatic societal changes, changes that affected both health care and the professionals who delivered it. Although many other important issues were dealt with by the CNA during its eighth decade, the Association remained steadfastly aware that issues in practice—issues of the immediate problems faced by practising nurses—were its *raison d'être.*

The attention to such issues saw formal results in 1987 when the first report of the Special Committee on Health Issues was released. Among the topics touched on in this important report was acquired immunodeficiency syndrome (AIDS)— both the care of AIDs patients and the issues involved for nurses working with such patients.

Over the decade, the CNA revealed strong positions on a variety of health care concerns, including neonatal resuscitation, drugs and the elderly, care of patients with terminal illness, requests for nurses to do body cavity searches on prison inmates, organ transplantation, domestic violence and the role of the clinical nurse-specialist.

4 NURSING RESEARCH

Nursing research in the 1980s concentrated on two areas of activities: research activities themselves, and efforts to establish a Canadian program for a doctorate in nursing.

RESEARCH ACTIVITIES

The renewed interest in nursing research was evident when the CNA Board approved a revised position statement on the subject in 1981. Later that year, the Board also accepted an important background paper that detailed the history and current status of nursing research in Canada.

But "The Development of Nursing Research in Canada: A Background Paper" described more than the past and present; it also listed recommendations to guide the future of nursing research in Canada. All the recommendations were accepted by the Board:

- The CNA should act on the resolution passed at the 1981 annual meeting to define nurse researchers and nurse educators, and to establish a national database of nurse researchers.
- The CNA should accept as a priority the promotion of nursing research.
- The CNA should include nursing research as one of its corporate objects.
- Major national funding agencies, councils, federal government ministers and members of parliament should all be informed about nursing research.
- The CNA should pursue its recommendation to the Health Services Review that a Health Sciences Research Council be established to focus on the study of health services.
- A pamphlet on nursing research should be developed for distribution to the membership.
- The CNA journal editors should be asked to consider a regular column on nursing research.
- Media coverage should be actively sought for nursing research projects.

Nursing research in the 1980s concentrated on two areas of activities: research activities themselves, and efforts to establish a Canadian program for a doctorate in nursing.

– The CNA should establish an information system to cover nursing research and researchers.

At the very next annual meeting, nursing research was made a CNA corporate object. In 1983, the CNA Board approved new guidelines on ethical considerations in research, which were developed by the Nursing Research Committee. "Ethical Guidelines for Nursing Research Involving Human Subjects" was published later that year.

A five-year plan for the development of nursing research, which was developed and approved in 1984, was a significant step in the movement to identify nursing as a unique element in health care. "The Research Imperative for Nursing in Canada: A Five-Year Plan Toward Year 2000" gave specific, detailed strategies for the actions needed to achieve a scientific foundation for nursing research. Essential to the plan's success, its authors noted, was the collaboration among the various organizations—namely, the Canadian Association of University Schools of Nursing (CAUSN), provincial and territorial nurses associations, the CNA and governments. Three goals were clearly laid out in the plan: the development of nurse researchers, the development of nursing research and the sustainment of research. The largest challenge, said Research Committee member Dorothy Pringle, was the development of nurse researchers.*

Another of the recommendations of the 1981 background paper was accomplished in 1984, when the pamphlet "Nursing Research and You" was published.

In 1987, a Nursing Research Workshop was held—a two-day program of collaboration and consultation held for two nursing research teams. Because nursing research was evidently gaining more than a foothold, the CNA that year allocated funds for a public relations campaign to increase the visibility of research.

The last of the 1981 proposals was implemented in 1988, when the database of CNA members holding higher degrees was initiated.

THE PHD PROGRAM

The CNA had high hopes for establishing a doctorate program in nursing in Canada in the 1980s. They started in the first year of the decade by submitting a proposal to the W.K. Kellogg Foundation to obtain funding for starter grants, nursing fellowships and research projects. The proposal was not successful, but the CNA forged ahead with other initiatives.

*The approved definition of a nurse researcher was "a nurse with advanced preparation in research methodology and development of theory, who systematically investigates any of the following: biological and behavioral responses to health and illness; nursing practice and its effect on individuals, families, groups or communities; administration of nursing; education for nursing; and the structure of the discipline."

In 1982, CNA's president and executive director met with the president of the Medical Research Council of Canada (MRC). They wanted to establish a committee to investigate not only a doctoral program for nurses, but also the whole issue of the

MRC and the funding of nursing research. They met with greater success than they had with Kellogg, and in January of the following year the MRC's Working Group on Nursing was established. The Group reported to its Board within a year. The CNA had also believed for a long time that nursing ought to be represented on the Board of the MRC, and this goal was accomplished in 1986 with the appointment of CNA executive director Ginette Rodger to the Board.

Throughout the decade, the CNA continued to lobby funding agencies and to support every school of nursing that attempted to establish a PhD program. The result of this work, which was crucial to the development of a strong infrastructure, was evident in 1988 when the MRC and the NHRDP announced a joint program to provide funding to universities developing their nursing research capabilities and PhD programs in nursing. By the close of the decade, several universities had demonstrated interest in a doctoral program in nursing.

5 WORKING LIFE

Nursing was often in the news in the 1980s, perhaps most often in headlines that contained the word *shortage*. Clearly, factors that affected nurses' working lives were of the utmost importance to the profession, and the CNA took action early in the decade, on both the national and the international levels.

After a formal study of CNA activities, the CNA Board decided in 1981 that the CNA Department of Labour Relations should broaden its focus to include issues related generally to the working life of Canadian nurses. Examples included occupational health and safety, retirement planning, contract negotiations and career management.

That same year, the CNA presented a brief to the Parliamentary Task Force on Employment Opportunities of the 1980s. The brief outlined the changing trends in health care delivery, and the effects these changes would have on the requirements for nursing staff and the utilization of nurses.

Another brief was presented to the Commission of Inquiry into Part-time Work, which had been appointed by the federal Minister of Labour to investigate the possibility of improving the lot of part-time workers in Canada. The following year, the CNA presented a third national-level brief, this one to the Parliamentary Task Force on Pension Reform.

Many of the actions taken by the CNA relevant to working life originated in requests from the membership. An example is the resolution from the 1983 meeting that the CNA urge the federal Minister of Labour to have nursing included in the Designated National Occupations List. The CNA subsequently lobbied the Minister of Employment and Immigration for increased funding for nursing specialty courses under the National Training Act.

Clearly, factors that affected nurses' working lives were of the utmost importance to the profession.

Another example involved the nurses at Pearson International Airport, Toronto, who requested assistance in a labour dispute: the nurses were to be replaced by paramedics. The CNA lobbied the Minister of Transport on their behalf, and the nurses retained their jobs.

As in the 1970s, the CNA continued to provide information on the employment and working conditions of nurses in Canada by compiling data on salaries and membership fees in unions and professional associations for Canadian nurses. In addition, the CNA continued its leadership role by providing courses and workshops in labour relations. The Association ensured that nursing was represented at all labour-related conferences.

The CNA was also active in working affairs on the international level in the 1980s. In 1983, the CNA Manager of Work Life Affairs, Glenna Rowsell, was seconded to the International Council of Nurses (ICN) in Geneva. She was to assist in the reorganization of ICN's social and economic welfare program and then to develop a six-year plan for it. Rowsell spent a year in Geneva, returning to the CNA to prepare documents on student rights and a pamphlet on employment contracts for nurse administrators.

Also with the ICN, the CNA prepared the "Settlement of Disputes" chapter in the ICN publication *Cooperation and Conflict.* In another area of the world, the Department of Work Life Affairs provided expertise to a CNA project in Peru, which was funded by the Canadian International Development Agency (CIDA).

6 CANADIAN NURSES PROTECTIVE SOCIETY

In the mid-1980s, nursing associations throughout Canada were having problems with their commercial insurers on the issue of professional liability. The problems included dramatically increased premiums (even in jurisdictions where claims had never been paid), limitations on coverage, deductible clauses and even total loss of coverage.

A signal event of the decade came from a resolution at the 1986 general meeting that the CNA, in conjunction with its member associations, investigate the development of a national, self-directed fund for professional liability. Nurses wanted insurance that would be available year after year. The plan should protect all nurses and not just those with employer coverage. The cost of the plan should reflect the low claims history of Canadian nurses.

Nurse-lawyer Pat McLean was hired in late 1987 to coordinate development of the program, and in January 1988 the Canadian Nurses Protective Society (CNPS) became a reality. The nurses associations of Alberta, Saskatchewan, Manitoba, Nova Scotia and Newfoundland were the first five to commit to the scheme, but within a few months the Northwest Territories, Ontario, New Brunswick and Prince Edward Island had also subscribed.

Under CNPS, nurses who are members of one of these nine member associations are automatically eligible for professional liability protection. This protection includes advice, defence or settlement of lawsuits, payment of court-awarded damages and payment of legal costs. In addition, the CNPS strives to inform and educate nurses on the management of risks related to the delivery of nursing services.

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7 INTERNATIONAL AFFAIRS

Interest and involvement in nursing on a world scale has always been a concern for the CNA; in the eighth decade, the CNA's international activities reached higher levels of intensity than ever before, as the CNA offered support to national nursing associations in developing countries.

The CNA's motivation was the strengthening of the profession globally. Besides providing guidance to developing nursing associations, the CNA strived to expand the nurse's role in primary health care throughout the world.

An encouraging endorsement of the CNA's activities was the grant for international projects from the Canadian International Development Agency (CIDA), following an evaluation of the CNA's work.

CNA's international activities reached higher levels of intensity than ever before.

INTERNATIONAL PROJECTS

The Caribbean. During 1980 to 1984, the CNA assisted in the development of examinations for entry into the practice of nursing in the Caribbean. While funding came from CIDA, the CNA Testing Service personnel provided the necessary expertise. The project, dubbed CARICOM, concluded in 1986 with the completion of preparations of a standard examination to be used in 13 countries; the countries were to administer the nursing examinations themselves.

Colombia. In 1982, the CNA was asked by CIDA to conduct a study in Colombia to discover how Canada could help Colombian nurses in the fields of education, administration and specialization. Within two years the CNA submitted a proposal to CIDA for funding a project to develop the nursing profession and strengthen the national nursing association in Colombia.

With CIDA's prompt approval, the two-year project began. It had five objectives:
– Enhance the self-image of nurses as professionals.

- Prepare nursing leaders in service and administration to develop a conceptual framework for nursing.
- Develop the editorial content and improve the production of publications available to nurses in Colombia.
- Review and recommend possible socio-economic programs, and develop the means to implement them.
- Establish guidelines for the regulatory functions of the nursing profession in Colombia.

The CNA Work Life Affairs Manager, Glenna Rowsell, assisted in the development of a plan to promote socio-economic welfare among the Colombian association's membership; as a follow-up, five Colombian nurses visited Canada in 1984. In addition, Anne Besharah, editor of *The Canadian Nurse/L'infirmière canadienne*, travelled to Colombia to conduct two workshops on writing articles for publication in professional journals. Four Colombian nurses later visited the CNA Library to help them in organizing their country's own national nursing library.

The Colombian project was completed in 1986.

Burkina Faso. The CNA submitted a proposal to CIDA late in 1982 requesting funding to help educate nurses in Upper Volta. Funding was granted, and the project proceeded in 1983. A number of workshops were held on primary health care topics.

West African College of Nursing. Funding was received from CIDA in 1981 for a project to assist in the establishment of a nursing college in West Africa. The states involved were Nigeria, Ghana, Sierra Leone, Liberia and Gambia. In 1982, the Nursing Development Program of the West African College of Nursing, located in Nigeria, was complete.

Further funding was granted in 1988 toward the development of primary health care training centres to be associated with the college.

Europe. In 1984, the CNA received a request for assistance in the development of nursing programs in the European Region of the World Health Organization (WHO). In Finland, the CNA helped in the development of a degree program. In Portugal, the CNA helped in three projects: evaluations, primary health care and entry to practice. All four projects were completed in 1985.

Bolivia. On behalf of CIDA, the executive director of the CNA carried out a feasibility study in 1984 to propose a project for strengthening the nursing profession in Bolivia. The three-year project received funding in 1985.

Activities included a workshop on continuing education, plenary meetings of regional representatives of Bolivian nurses, development of a national registration system and the production of a nursing journal. Also accomplished was the establishment of a post-graduate course in public health, for which the CNA provided a consultant.

Peru. When nurses in Peru requested help in planning human resources in nursing services, CIDA funded a feasibility study and eventually a project. The CNA helped the Peruvian nurses to develop a national manpower plan for nursing; the project was completed in 1986.

Thailand. In response to a request from the Thai nurses association for a project on primary health care in pediatrics, the CNA developed a CIDA-funded project called "Promoting the Role of the Nurse in PHC". The ultimate aim was to improve the health of Thai children under the age of five.

Benin. Following a visit to Benin by the CNA executive director and director of professional services, the CNA submitted a proposal to CIDA for a project in continuing education. The project's aim was to enable graduate nurses in Benin to implement primary health care. The project began in 1986, with six workshops held throughout the country.

Zaire. The CNA involvement with Zaire nurses began in 1987 with the establishment of a continuing education centre for nurses in Kinshasa. In 1988, the CNA provided consultation in the development of the first Zaire program of continuing education.

Haiti. A CIDA-funded project, the training program for community health workers saw graduation of the final group in 1981; Dr. Alice Girard had served as project consultant.

China. In response to a request from the Chinese Nurses Association in 1987, the CNA carried out a feasibility study in China with funding from CIDA.

Nepal. The CNA was asked to help Nepalese nurses in the areas of association management, nursing standards, registration and nursing education. CIDA approved a three-year project that included strengthening the national nurses association and assisting with continuing education.

Mexico. Late in the decade, funding for a feasibility study to assist in reinforcing the profession in Mexico was approved. Following the ICN meeting in Seoul, Korea, in May 1989, the CNA received a flood of requests for assistance.

It was evident from the range of requests for CNA assistance in the 1980s that the demand for work in the international arena was increasing. Therefore, the CNA Board decided in 1982 to investigate the idea of creating an international affairs department. After an ad hoc committee studied and reported on the idea, the Board decided to establish a department to develop, manage and evaluate the CNA's international activities.

Joan MacNeil, the first manager of the Department of International Affairs was hired in 1984. Demand continued and as the 1980s drew to a close, seven new feasibility studies for early 1990 were being investigated.

INTERNATIONAL ORGANIZATIONS

International Council of Nurses. The huge international ICN Congress held in 1981, with its theme "Health for all by the Year 2000", attracted 300 delegates representing 95 countries, Canada among them. The CNA also sponsored the Cuban Nurses Society so the group could become a member of ICN. At the meeting, the CNA presented a resolution on the role of the nurse in caring for prisoners and people in detention; the motion was passed.

The CNA was indirectly honoured when Dr. Helen K. Mussallem, former CNA executive director, was appointed the North American representative to the ICN.

From 1980 to 1982, the CNA received more than 60 nurses through the Nursing Abroad Program, and helped more than 50 Canadian nurses to experience nursing outside of Canada.

Recognizing that political conditions affect nursing in many other countries, the CNA Board resolved in 1983 to contribute $7,500 to the ICN revolving fund to help nursing associations that were unable to pay their ICN dues for political reasons. The CNA continued to contribute to the fund for many years.

At the ICN Congress in 1985, Canadian nurse Dr. Helen Glass was elected first vice-president of ICN. At the same meeting, the CNA presented several significant resolutions: one concerning the dangers of alcohol consumption during pregnancy, and another on the need to clarify the place of nursing in primary health care. A further resolution, to place nursing administration among ICN's priorities, was referred to the ICN Board and eventually approved.

The Commonwealth Nurses Federation. Using guidelines from CIDA, CNA representatives developed a proposal for restructuring the Commonwealth Nurses Federation. The proposal to review the organization was referred for consideration at a meeting held in New Zealand in 1988, attended by the CNA executive director.

World Health Organization. Before the 1983 WHO Assembly, the CNA strenuously lobbied the federal Minister of Health, asking that a nurse be included in the Canadian delegation. Their efforts met with success; Dr. Helen Glass was included in that delegation, and in the delegation to the WHO assembly in 1985. However, despite the CNA's request that a nurse be part of all future delegations, nursing was not represented in 1986.

Pan American Health Organization. In the summer of 1982, Helen Glass, the CNA president attended a PAHO meeting in Washington. The meeting focused on the trends in nursing education as they related to the goal of health for all by the year 2000. As a result of that meeting, the CNA agreed to assist Caribbean nurses by planning a workshop for them (detailed above under "International Projects").

The CNA also participated in preparing a paper on the function of nurses in primary health care, which was presented by the Canadian government at a PAHO meeting in 1983.

INTERNATIONAL ISSUES

A sign of Canadian nurses' increasing concern with the health issues in other countries was the resolution at a CNA annual meeting early in the decade to support an international boycott of Nestlé products. A controversial move, the action was taken to protest the sale of breast milk substitutes in countries were water supplies were not sanitary and should not be used for infant formula.

By 1983, all provincial departments of health had adopted the WHO code on the marketing of breast milk substitutes, due in part to lobbying by CNA member associations.

In the area of professional development, the CNA protested to the International Labour Organization when nurses were reclassified from professional to para-professional and technical workers; the ILO decided to reconsider its decision.

8 HEALTH POLICY

The CNA decision to become more active in national health policy aimed to ensure nurses' inclusion in policy-making and to improve the visibility of the profession. Over the decade, the CNA was actively involved in political activities, particularly in lobbying the government for health care reforms. In addition, recognizing the need to respond to issues immediately, the CNA in 1983 designated the executive director as its second spokesperson.

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REFORMING CANADA'S HEALTH CARE SYSTEM

Although Canada's system of delivering health care is widely recognized as one of the best in the world, it is vulnerable to political factors and always needs adaptation to current social and health conditions. The CNA assumed a highly active role early in the decade to ensure that certain basic principles remained entrenched in the health care system and to try to develop changes that would improve the system.

The timing was crucial: The government of Canada was itself concerned with the quality of health care delivery. Through the Health Services Review (HSR) the government was seeking to identify problems and areas that required change. The CNA's brief—"Putting Health into Health Care"—was well received by the HSR, and presented several new ideas.

Although the CNA's ideas were innovative and based on real need, their implementation presented a problem. The CNA therefore took two actions: the appointment of a committee to define and elaborate strategies for promoting its proposals, and the employment of a consultant to review legislation and identify the barriers to the application of the CNA recommendations.

The chief concern of the government was the fact that the costs of health care in Canada were rising dramatically. The government wanted changes that would curtail costs, perhaps even at the sacrifice of such principles as universality and equal accessibility to care.

In 1981, the CNA presented a brief to the Parliamentary Task Force on Federal–Provincial Fiscal Statements. The brief reiterated the CNA's statement to the HSR that nurses could provide excellent health care at a low cost. In 1982, the CNA published a position statement outlining its support for maintaining the five basic principles of the health care system.

The CNA Board had also endorsed the idea of a national health council, a concept suggested by the Canadian Hospital Association (CHA). Both financially and through the presence of a CNA advisor, the CNA supported the CHA ad hoc committee formed to develop the idea.

In 1982, the federal government proposed a new act to govern health care in Canada; the minister for National Health and Welfare stated in an address to the conference of health ministers in 1982 that "government must respond to the widespread concern about current or potential erosion of access to high quality care." CNA members were enthusiastic, but still concerned. At the next annual meeting, in 1983, they passed a motion that the Association intensify its efforts to lobby the government both on the need for the new Canada Health Act and for certain reforms that nurses believed ought to be included. The CNA went on record as stating that the need for maintaining and improving the health care system transcends geographic and political boundaries. Members also asked that the CNA embark on a concentrated analysis of health care policy and develop the strategies necessary for lobbying by the CNA and member associations. Within a few months, the CNA had produced an information package detailing its recommendations and outlining suggested activities.

The new Canada Health Act was tabled in the House of Commons in December 1983. Subsequently, the CNA presented a brief to the Standing Committee on Health, Welfare and Social Affairs that proposed 11 amendments to the Act. The CNA believed that the system of health care that would result from the new Act was too dependent upon costly medical and hospital-based acute care—indeed, *illness* care—and offered no support for less expensive alternatives such as home care, community health centres and occupational health services. The CNA position focused on insuring nursing services, insuring extended health care services and banning extra-billing, user fees and health insurance premiums.

In March 1984, the Standing Committee agreed to the CNA's amendments on the concept of the health care practitioner; the amended bill received royal assent in April.

Pleased with the success of the CNA's lobbying efforts, the members resolved at the 1984 annual meeting that the CNA continue to promote the concepts of self care and primary health care as appropriate approaches for the delivery of comprehensive health services. At a subsequent Board meeting, the CNA allocated $84,000 to continue efforts to establish nursing's voice when health policy decisions were made.

In 1985, the CNA Board accepted a recommendation from the Executive Committee to adopt the framework for health care reforms described in *A New Perspective on the Health of Canadians* by the Honourable Marc Lalonde. Four issues were chosen for the initial efforts: the care of the elderly, self-care, consumer rights and responsibilities, and mental health care.

The Ad Hoc Committee on Health Care Reform was created to address issues concerning the long-term health care needs of Canadians. The Board also adopted the idea that the CNA should persevere in the push for health care reform. The CNA would continue to lobby for the implementation of amendments to the Canada Health Act that had been proposed but not adopted.

Accordingly, in 1986, the CNA presented a brief to the Legislative Committee on Bill C-96, which involved changes to the federal–provincial fiscal arrangements. The brief stated that the funding restraints proposed by the federal government did not acknowledge the need for a new direction in health care in Canada.

The CNA Ad Hoc Committee on Health Issues was formed in 1986 to formulate statements on current issues in health care. The committee subsequently produced statements on tobacco and health; the use of the drug Depo-Provera®; organ and tissue donation, retrieval and transplantation; the care of patients with acquired immunodeficiency syndrome and serological testing for HIV antibodies.

The CNA maintained its support of the five principles that formed the basis of Canada's health care system. In 1986, the CNA condemned the action of the Canadian Medical Association (CMA) in calling for physicians outside the province of Ontario to refuse to honour patients' cards from Ontario's health insurance plan.

The Minister of National Health and Welfare released the important document, *Achieving Health for All, A Framework for Health Promotion,* in 1987. The document emphasized health promotion and the prevention of disease as crucial elements of health care. This approach coincided with the CNA's, and therefore the members resolved that the CNA should urge the federal government to implement the concepts outlined in the document.

In 1987, the final report of the CNA Committee on Health Care Reform was presented, entitled "Background and Framework for Health Care Reform in Canada". In it was an outline of the CNA's role in reform, and the strategies and activities that could be implemented by the Association.

HEALTH CARE AND NURSING POLICY

In keeping with its proactive stance, the CNA took a number of actions throughout the decade, making statements on behalf of the nursing profession and meeting directly with government and other national groups. For example, having received input from member associations, the CNA issued a statement in 1982 that registered nurses should not be forced to carry out body cavity searches on prisoners and detainees. Also in 1982, the CNA received letters of support from 10 national health organizations in support of a CNA proposal for a national health survey to be conducted at five-year intervals. This proposal and details of the health system's support were sent to the Minister of National Health and Welfare.

In 1983, CNA recommended to the National Advisory Committee on Epidemiology that neonatal herpes be made a reportable communicable disease; in 1985, a surveillance system was developed by the federal Bureau of Epidemiology, and reporting began in 1986.

Many other resolutions were promoted: The CNA urged the government to require warning labels on alcoholic beverages regarding the risks of alcohol use by pregnant women. The CNA lobbied for legislation requiring mandatory daytime running lights on all motor vehicles. They exhorted the federal government to include all pertinent information on product packages, following which CNA was requested to forward information on inadequately labelled packages to the Bureau of Medical Devices for action.

The range of interests is striking evidence of nurses' concerns for the health of Canadians. At members' requests, the CNA was involved in such diverse issues as pornography, disarmament, the use of heroin to manage chronic pain caused by cancer, restrictions on television broadcast times for rock videos, the storage and safe use of sterile single-use devices and the use of smokeless tobacco products.

The CNA collaborated with numerous other organizations on activities related to health issues, including the CMA, the Canadian Council of Hospital Accreditation, the Victorian Order of Nurses, the St. John Ambulance, the Canadian Red Cross and the Canadian Public Health Association. An example of such cooperation was the joint statement by the CNA and the CMA asking the government to establish a committee to investigate problems in the administration of drugs to the elderly. Together with 11 other national organizations, the CNA was also involved in a consensus statement on family life and sexuality education in Canada.

9 ASSOCIATION STRUCTURE

While the 1980s proved to be a decade of vigorous activity on the political scene for the CNA, activity that strengthened the role of nursing in Canada, internal political events were bringing the CNA a major disappointment.

The most significant event in CNA's structure was, without a doubt, the disaffiliation of the Ordre des infirmières et infirmiers du Québec (OIIQ) from CNA. This dramatic chapter in the CNA's history was really the culmination of a series of episodes that had begun in 1979. At that time, the OIIQ had requested that CNA examine several issues of particular importance to the OIIQ, including the improvement of CNA services available in French, the introduction of bilingualism as a condition of employment for senior positions at the CNA's national office, and the assurance that Quebec nurses could have reciprocal membership in other provincial nursing associations.

The CNA responded positively to these requests, but in 1980 the OIIQ made a further request: that the CNA lower its fees because the OIIQ was experiencing financial difficulties. The CNA set up a Task Force on Fees and Representation, which recommended in 1981 that the fee ceiling be lowered for 1983 and 1984. A motion to disaffiliate was put before the OIIQ that fall and was defeated; in 1984, however, following a motion at the CNA annual meeting to return the fees to the normal level, the OIIQ voted to disaffiliate.

The OIIQ was not the only member association having a problem meeting its financial obligations to the national Association. As a result, the CNA Board struck an ad hoc committee to study the CNA's corporate objects and member associations' financial and political concerns related to membership in CNA. The committee's mandate was to propose alternatives for funding, structure and the objects of the Association.

In a major shift in emphasis, the CNA moved away from dependence upon member-ship fees as the chief source of income, toward revenue generation.

The committee presented a full report to the CNA Board in April 1985, including a revised set of corporate objects and a new membership system. The revised CNA objects were

- to speak for Canadian nurses and to represent Canadian nursing to other organizations on national and international levels;
- to develop a national perspective on nursing and health related issues;
- to influence national health policy;
- to promote high standards of nursing practice, education, research and administration in order to achieve excellent nursing care for the people of Canada; and,
- to provide leadership on issues related to the working lives of nurses.

The CNA made a special arrangement for the OIIQ to rejoin CNA as a corporate member, if desired, but the OIIQ elected not to take this option.

In 1987, after 11 years of using a complex formula of unit fee, sliding scale and fee ceiling, membership fees became payable on a per capita basis. In effect, then, all members across the country paid the same fee to the CNA.

Because of the implication for the CNA's financial picture, the Association embarked on a program of consolidation and reorganization. In a major shift in emphasis, the CNA moved away from dependence upon membership fees as the chief source of income, toward revenue generation. Existing sources of revenue included examination fees, advertising revenues from the CNA journal, journal subscription fees and fees for conference registration.

In the mid-1980s, the CNA's structure evolved to include an Advisory Council. The impetus for this development came in 1983 when the CNA Board struck a committee to explore CNA's relationship with other national nursing groups. In 1984, this committee presented its recommendation that a system of CNA special interest groups, including the Advisory Council, be established. The Council was to provide special interest groups with representation on the CNA Board and to ensure close communication and cooperation between such groups and the CNA.

Chaired by the CNA president, the Advisory Council meets annually to provide information and advice to the CNA on national issues in nursing and health care, as well as to share experiences and strengthen professional unity. As well, to ensure communication, a seat on the CNA Board is allocated to one representative of a special interest group, who is appointed from the Council.

Groups must meet certain criteria to become CNA special interest groups. Before the end of the decade, 14 groups had met those criteria. The first was the Canadian Association of Neuroscience Nurses, which was accepted in 1987.

National interest groups whose membership is not exclusively registered nurses are also able to establish a formal relationship with the CNA through an affiliate membership. Among those groups currently affiliated are the Canadian Association for Enterostomal Therapy and the Canadian Association of Nephrology Nurses and Technicians.

During the 1980s the CNA developed several tools to help the Association respond to current issues, and to guide its conduct. The first was the CNA Social Policy Function, which established the mechanism for identifying which issues the CNA could properly address, for analyzing issues and for identifying the appropriate courses of action. The CNA was the first national health organization to develop such a statement.

The second tool was *The Canadian Nurses Association: a Philosophical Perspective*, which was published in 1987. This description of the values and beliefs that guide the CNA outlines the philosophical position that forms the basis of the CNA's functional responsibilities.

In 1987, the Board also approved a code for conflict of interest for CNA Board members, committee members and staff. These people asked for the code in recognition of the increasing complexity and political nature of the issues that the Association had begun to address.

10 TESTING SERVICES

The eighth decade for the CNA was the second decade that Testing Services was part of the Association. The service experienced several significant developments during these years.

The principal roles of the service are to develop, administer and process the examinations for graduate nurses and nursing assistants in Canada. The first writing of the new, comprehensive examination took place in 1980. At the same time, the first examination that had been developed in the French language was written; till then, examinations developed and written in English had been translated for francophone candidates.

Throughout the decade, about 25,000 candidates wrote the exams each biennium. To streamline the process and to make the services more efficient, Testing Services made several changes. In 1982 they purchased word processing and test-book packaging equipment. In 1986, they expanded their own computer facilities for scoring test responses, a function that had previously been contracted to outside firms.

The Testing Services staff served as consultants to two other organizations. They helped the Ontario Occupational Health Nurses Association (OOHNA) to develop a certification examination; this was the first examination in a nursing specialty to have been developed in Canada. The staff also provided consultation to the CARICOM project (see chapter seven), which involved the development of a regional nursing registration examination in the Caribbean.

In 1983, the CNA Board approved the idea of revising the structure of the CNA Testing Services. Two new committees were appointed to monitor the steps in test development: the Nurse Registration and Licensure Committee, and the Nursing Assistant Registration and Licensure Committee. Their goal is to improve the overall quality of the examinations.

By 1987, Testing Services was capable of scoring, analyzing and processing nursing examinations completely in-house.

Also in 1983, new terms of reference for the Committee on Testing Services (COTS) were adopted by the CNA Board as a direct result of the review of the CNA's role in relation to testing and measurement. The revised committee structure was effected early in 1984; with its name changed to the Committee on Testing, the committee continues to advise the Board on examination policy as well as to handle procedural issues. Additionally, it is responsible for controlling the quality of examinations.

A revision of the nurse blueprint, started in 1982, was completed by an ad hoc sub-committee task in 1986. The blueprint was based on the model used for the RN examination.

In 1986, the COT adopted a proposal for staff to reduce the test development cycle to three years from five, to enable faster development of the examinations and to ensure that content was current with practice. Other achievements for the COT were the development of the candidate appeal process designed to verify the score achieved by candidates; a mechanism for feedback on performance for candidates who had written examinations but failed; and the development of a policy on the use of IS units in examinations.

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11 NATIONAL OFFICE

Several developments at the CNA's national office were significant in the CNA's history.

ORGANIZATIONAL CHANGES

The decade began with a change in leadership with the retirement of Dr. Helen K. Mussallem after 17 years as executive director. Dr. Mussallem was succeeded by Ginette Rodger, a nurse with extensive administrative experience and the former Director of Nursing at the Notre Dame Hospital in Montreal. Rodger had also served the CNA as the member-at-large for nursing administration on the 1979–80 Board.

In 1981 and 1982, a number of changes were made to the organizational structure at the national office to enable it to meet the priorities of the 1980s. Professional Services, Administrative Services and Testing Services were reorganized, and a new grouping was formed: Communication Services would include the CNA journals, public relations and translation services. In addition to changes in organization, the concept of management by objectives was introduced as a management tool.

The disaffiliation by the OIIQ made a second major reorganization necessary in 1986 due to the reduction in CNA revenues. The new structure included Professional Services, Testing Services, Corporate and Public Affairs, and Administrative Services. Corporate and Public Affairs replaced Communications Services, International Affairs and Corporate Affairs.

In the last year of the decade the CNA welcomed a new executive director, when Judith Oulton succeeded Ginette Rodger. Previously the Director of Strategic Planning for the Department of Health and Community Services of the Province of New Brunswick, Judith Oulton had been active in professional nursing associations at both provincial and national levels, and her practice experience covered a range of settings.

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ADMINISTRATIVE DEVELOPMENTS

The eighth decade of the CNA corresponded with two dramatic changes in Canadian life: the tremendous expansion of the use of computers and the new, energetic approach among Canadians to matters of health.

In 1981, a computerized system of budgeting, payroll and accounting was introduced at the CNA national office. The following year, a study of the CNA's word processing and computer equipment resulted in upgraded systems and new computers. A few years later, a computer feasibility study led to the transfer to in-house test scoring and the creation of the electronic data processing (EDP) department.

A number of events during the decade also affected the working lives of CNA employees. A statement of beliefs was developed as a guide, and a general program of improving internal communications began, including an improved staff orientation program. The performance evaluation system for professional staff was revised, and, in 1984, an in-service program on management skills was provided for staff supervisors.

An Occupational Health and Safety Committee was created within CNA House in 1984 to develop and recommend programs in health promotion, restoration and maintenance, as well as the prevention of accidents. An important accomplishment was the committee's cooperative effort in establishing a smoke-free environment at CNA House.

In 1987, a CNA Employee Day was created in conjunction with National Nurses Week to acknowledge the contribution of the employees to the CNA.

EXPANSION OF CNA HOUSE

The idea of expanding CNA House to enable all CNA services to inhabit one building became concrete in 1978, when the Board began allocating the sum of $50,000 a year to a "house expansion fund". The plan to incorporate all services under one roof would result in savings for the Association: for years, Testing Services had been leasing office space in downtown Ottawa. Communications between departments would also improve.

By 1983, the need to expand had become urgent. The expansion in staff and operations had strained the existing building—an architectural landmark in Ottawa —to its limits. Therefore, in early 1984, the Board appointed a committee to consider the available options. By June, the Board had decided to expand the existing building rather than move. Construction began in 1987 and was completed in 1988. The expansion and renovations resulted in a new wing for Testing Services, new Board and committee rooms, enlargement of the library and additional office space.

THE LIBRARY AND ARCHIVES

Over the course of the decade the collection in the CNA's Helen K. Mussallem Library grew to more than 14,000 books and 500 periodical titles. Simultaneously, access to all that information became faster and easier through the introduction of computer services, including on-line literature searching.

The library also created several new publications, including the *Index to Canadian Nursing Research*, first published in 1982, as well as an annual listing of short-term, post-basic courses for nurses across Canada and a list of the entrance requirements for baccalaureate and diploma programs in the country.

In response to the ICN request that all national nursing associations prepare histories of nursing in their countries, the CNA Board decided in 1982 that the first step would be to organize the Archives. After an extensive review, an archives consultant was hired in 1986; by the following year, the collections were described and catalogued.

The consultant also developed finding aids to the various collections and the *Guide to the Historical Collections of the Canadian Nurses Association*, which was distributed to universities and archives throughout Canada. Funding for the archival project had been received from the Social Science and Humanities Research Council in 1986; further funding was granted by the Canadian Council of Archives for the description and organization of collections not covered originally.

12 VISIBILITY AND COMMUNICATIONS

Society's image of nursing became a critical issue to the CNA in the 1980s, particularly in the wake of the Health Services Review. The Association understood clearly that if the CNA was to take on a greater role in the decisions made about health care policy and the reform of the health care system in Canada, it would have to maintain a high profile and be active in self-promotion.

In December 1980, the Board appointed a steering committee for an initiative called Operation Visibility. A communications action program, it was designed to raise the profile of nursing in Canada. The steering committee was responsible for promoting the image of the CNA not just to the general public, but also among the Association's membership. It would try to maintain awareness of the public relations activities of member associations. It would also promote the specific objectives of the CNA and take on any specific projects referred by the Board.

The committee made a number of recommendations: the Public Relations department at the national office should be expanded, and public relations tools such as an audio-visual presentation should be developed. As well, the committee recommended a pricing policy for CNA publications. The potential for public relations in the CNA strategies for "Putting Health into Health Care" was also recognized, and the committee worked closely with the committee responsible for that initiative.

In May 1982, the Communications Service was established at CNA. The new department included the two CNA journals, the public relations activities and translation services. That same year, staff members addressed the research and development of a new communications program, the principal aim being to increase awareness of the Association among members. Specifically, the staff would look at how CNA activities had an impact on the lives of professional nurses. The department's activities over the years were extensive:

Society's image of nursing became a critical issue to the CNA in the 1980s. The Association understood clearly that it would have to maintain a high profile and be active in self-promotion.

- It reaffirmed the leaf and lamp symbol as the symbol of the Association.
- It established a new editorial plan for the journals, in which journal content was more evidently tied to CNA priorities.
- An extensive media relations campaign throughout 1983–84 promoted an improvement in press coverage of CNA activities.
- Several new tools were produced to disseminate information to members, including a corporate brochure, a nursing career kit, an audio-visual presentation about CNA and two public service announcements about nursing which were distributed to Canadian television stations.
- An annual CNA Media Awards program was launched to recognize outstanding media coverage of issues related to health promotion.

The first Media Awards presentation was held on May 12, 1988—International Nurses Day—in a gala at the National Arts Centre, Ottawa. The awards were presented by the Minister for National Health and Welfare, Jake Epp; winners included producers from CBC Radio and Television for health-related documentary features, as well as a journalist from *Le Soleil*, a Quebec newspaper.

Acting on a recommendation from the Editorial Advisory Panel for the CNA journals, the CNA Board agreed in 1983 that the Association should publish one bilingual, refereed journal. A single issue of *The Canadian Nurse* and *L'infirmière canadienne* was designated, and a jury was appointed to oversee the selection of reviewers and articles to be published in the special issue. The refereed issue was published in August 1984. Afterward, the CNA continued to publish two separate journals, one in English, the other French.

When Communications Services was incorporated into Corporate and Public Affairs in 1986, the CNA journals were again reviewed. A number of options were considered. Among these were the ideas of discontinuing the journals and publishing a tabloid; publishing an English journal with a French-language insert for those who requested it; and publishing a bilingual journal, the content of which would be two-thirds English and one-third French, reflecting CNA membership. The latter option was chosen, and in January 1986, the first issue of *The Canadian Nurse/L'infirmière canadienne* was sent out to the members. The new journal contained articles in both languages with abstracts of the contents published in the alternate language; CNA Connection, the "CNA news" portion of the journal, was published in full in both languages.

Journal staff expanded to include an in-house graphic designer, and typesetting equipment was purchased. These actions, plus the addition of computer word processing capabilities, enabled the Association to produce other publications in-house, as well.

The make-up of the Editorial Advisory Board was reassessed in 1986, with particular consideration of the needs of the new journal, principally to maintain relevant contact with nurses in Canada. A recommendation was presented to the CNA Board to change the mandate and selection criteria for the advisory body.

The new committee was named the Editorial Board, and was made up of nurses representing each CNA member jurisdiction as well as a variety of fields and interests within the profession.

Also in 1986, the Publications Department at CNA assumed responsibility for production and coordination of all the Association's publications, the largest of which was the CNA biennial report. These changes were rewarded in 1987, when the department received an award from the Health Care Public Relations Association for the design of the *1986 CNA Biennial Report.*

The Public and Government Relations Department continued to work on maintaining a high degree of visibility for the CNA. The CNA also continued intensive lobbying on health care reform. Annual meetings with the Minister for National Health and Welfare to keep the government current on CNA priorities and activities was just one such activity. Presentations of briefs to parliamentary committees and task forces on issues related to health care and nursing also continued.

Other activities in the decade included a motion by the Board that the CNA should regularly forward the names of nurses for order-in-council appointments. Significantly, CNA was also successful in having nurses appointed to the Board of the Medical Research Council, the only agency that has included in its mandate a specific responsibility to fund nursing research. The Association also met success in having a nurse included in the delegations to the World Health Organization assemblies.

13 CANADIAN NURSES FOUNDATION

The only national foundation in Canada devoted to providing scholarships, fellowships and research grants to assist in the development of the nursing profession in Canada is the Canadian Nurses Foundation (CNF). It its first 25 years, between 1962 and 1986, the Foundation awarded 300 fellowships and scholarships, for a total of $900,000.

In 1982, while celebrating its 20th anniversary, the Foundation embarked on a three-phase reorganization project involving a revision of its internal organization, plans to increase visibility and a new emphasis on fund-raising. A steady improvement in the financial situation at the CNF made possible the establishment of a full-time secretarial position and a full-time assistant secretary-treasurer.

Extensive bylaw revisions were approved in 1984 at the CNF's annual general meeting. The revisions were designed to modernize the Foundation's structure and to improve continuity between boards. In addition, a new category of Honorary Member was created, and the secretary-treasurer became an ex-officio member of the Board.

The 1980s saw the establishment of several new fellowships, including the provision of funding for advanced studies in gerontological nursing by the Royal Canadian Legion and funding for doctoral studies in child and family health donated by the Hospital for Sick Children Foundation. As well, the CNF responded to the urgent need for funding in nursing research through the establishment of a Small Research Grants Program to provide "seed money" for nursing research projects.

It its first 25 years, between 1962 and 1986, the Foundation awarded 300 fellowships and scholarships, for a total of $900,000.

APPENDIX A
PRESIDENTS OF CNA

Mary Agnes Snively	1908-1912
Scharley P. Brown	1914-1917
Jean Gunn	1917-1920
E. MacPherson Dickson	1920-1922
Jean (Browne) Thompson	1922-1926
Flora M. Shaw	1926-1927
Mabel Hersey	1928-1930
Florence Emory	1930-1934
Ruby Simpson	1934-1938
Grace M. Fairley	1938-1942
Marion Lindeburgh	1942-1944
Fanny Munroe	1944-1946
Rae Chittick	1946-1948
Ethel Cryderman	1948-1950
Helen G. McArthur	1950-1954
Gladys J. Sharpe	1954-1956
Trenna G. Hunter	1956-1958
Alice Girard	1958-1960
Helen M. Carpenter	1960-1962
E.A. Electa MacLennan	1962-1964
A. Isobel MacLeod	1964-1966
Katherine MacLaggan	1966-1967
Sister Mary Felicitas	1967-1970
Louise Miner	1970-1972
Marguerite Schumacher	1972-1974
Huguette Labelle	1974-1976
Joan Gilchrist	1976-1978
Helen Taylor	1978-1980
Shirley Stinson	1980-1982
Helen P. Glass	1982-1984
Lorine Besel	1984-1986
Helen Evans	1986-1988
Judith Ritchie	1988-1990

APPENDIX B
JEANNE MANCE AWARDS

NURSES HONOURED FOR SIGNIFICANT CONTRIBUTIONS TO THE PROFESSION OF NURSING

In March of 1979, CNA Board approved "that, in future, one nurse be honoured every two years at the biennial convention".

1980 (Vancouver)

Dr. Helen Mussallem, for "outstanding contribution to nursing"

1982 (St. John's)

Dr. Verna Huffman-Splane
In 1983, the CNA Board gave the award a name—the *Jeanne Mance Award* after this country's most famous nurse.

1984 (Quebec City)

Dr. Florence Emory/Soeur Denise Lefebvre (co-recipient of Jeanne-Mance Award)

1986 (Regina)

Dr. Dorothy Kergin, Jeanne Mance Award

1988 (Charlottetown)

Dr. Maria Rovers, Jeanne Mance Award

APPENDIX C
ANNUAL MEETINGS AND CONVENTIONS

DATE	EVENT	PLACE
2 April 1981	Annual Meeting	Ottawa, Ontario
20-23 June 1982	Annual Meeting and Convention	St. John's, Newfoundland
6-7 April 1983	Annual Meeting and 75th Anniversary	Ottawa, Ontario
17-20 June 1984	Annual Meeting and Convention	Quebec City
18 April 1985	Annual Meeting	Ottawa, Ontario
22-25 June 1986	Annual Meeting and Convention	Regina, Saskatchewan
9 April 1987	Annual Meeting	Ottawa, Ontario
12-15 June 1988	Annual Meeting and Convention	Charlottetown, P.E.I.
13 April 1989	Annual Meeting	Ottawa, Ontario

APPENDIX D
ABBREVIATIONS

CAUSN	Canadian Association of University Schools of Nursing
CCHA	Canadian Council on Hospital Accreditation
CCHSE	Canadian Conference of Health Service Executives
CCOHN	Canadian Council of Occupational Health Nurses
CHA	Canadian Hospital Association
CIDA	Canadian International Development Agency
CMA	Canadian Medical Association
CNA	Canadian Nurses Association
CNF	Canadian Nurses Foundation
COT	Committee on Testing
COTS	Committee on Testing Services
CPHA	Canadian Public Health Association
HSR	Health Services Review
ICN	International Council of Nurses
ILO	International Labour Organization
MRC	Medical Research Council
OIIQ	Ordre des infirmières et infirmiers du Québec
OOHNA	Ontario Occupational Health Nurses Association
PAHO	Pan American Health Organization
SOGC	Society of Obstetricians and Gynaecologists of Canada
WHO	World Health Organization

NOTES

1. Lorine Besel, CNA Connection, *The Canadian Nurse/L'infirmière canadienne*, 81(6):1985;7.

2. Norma Murphy, Baccalaureate preparation for nurses, *The Canadian Nurse/ L'infirmière canadienne*, 79(7):1983;7.

3. RNs in Canada by highest level of education in nursing (table), *The Canadian Nurse/L'infirmière canadienne*, 84(7):1986;9.

4. A certification policy to reflect nursing today, CNA Connection, *The Canadian Nurse/L'infirmière canadienne*, 82(2):1986;12.