The Leaf and the Lamp

The Canadian Nurses' Association and the influences which shaped its origins and outlook during its first sixty years.

CANADIAN NURSES' ASSOCIATION
50 The Driveway
Ottawa 4, Canada

1968
THE LEAF AND THE LAMP
How it Began

The name of Jeanne Mance evokes the reminder that the practice of nursing in Canada is as old as the country itself. A roll-call of the most recent graduates offers ample evidence that this vital, tradition-rich profession is progressive, still young, and an essential element in the colorful mosaic of peoples, cultures and events which have elevated Canada to her contemporary position in the world family of nations.

The reputation of nursing as an occupation is enshrined in its long history of service. Its current stature as a profession in Canada was made possible by the formation in 1908 of the Canadian Nurses’ Association, an organization capable of exercising professional responsibilities.

As the CNA approached its diamond anniversary, the decision was made to prepare a sequel to *The First Fifty Years* — an abbreviated record of significant events — that was published by the CNA in 1958. The accelerated pace of nursing events in the intervening decade, and the risk of some historical facts receding beyond recall, suggested that a sequel to *The First Fifty Years* could be made most useful if it amplified certain aspects of the past and present. From this concept emerged *The Leaf and The Lamp.*

*The Leaf and The Lamp* is a contemporary and historical overview of the Canadian Nurses’ Association and, as such, records some events not basically part of CNA activities but pertinent to them. The main purpose of the book is to identify the functions of nursing in Canada at a time of rapid change in our society and, by reference to the past, to indicate the consistency of the organized profession’s approach to present and future situations.

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Introduction

The present era is characterized by the explosion of knowledge that is rapidly applied to every facet of Canadian life, including education and the health sciences. More than ever, preparation for the future requires the ability to utilize new scientific knowledge as it is discovered. Today's focus must be beamed at the next decade and beyond.

Society has undergone profound changes within a short space of time and the nursing profession has been alert and responsive to this momentum. Integrated as it is in the very fiber of society, responsible to a considerable degree for the physical and mental well-being of that society, the nursing profession in Canada has become involved in the shaping of events affecting its future. Canadian nursing aims at providing a high quality of nursing care to those who need it. To this end the profession is re-examining the educational processes which are required to develop the desired competence. It is also seeking to secure and maintain the economic status of nurses at a level competitive with comparable professions.

The future is built upon achievements of the past. The devotion, efforts and vision of many distinguished nurses have brought Canadian nursing to a point where it is facing the challenge of change to maintain high standards of service. The goal of excellence can only be achieved by continuous self-examination, redefinition of aims, and searching for the most adequate means to achieve them. Towards this end the Canadian Nurses' Association undertook a survey in the late 1950's to determine the practicality of instituting a program of accreditation for schools of nursing in Canada. This project revealed stark weaknesses in the preparation of nurses. As a result certain convictions became crystallized and were put forth with a unity and force hitherto lacking. These are reflected in this triple objective:

That the preparation of nurses be controlled by educational institutions rather than service units.

That the educational levels in the profession reach a proportion of twenty-five per cent university-educated nurses to diploma nurses.

That economic returns and working conditions be sufficiently appealing to attract and retain the number and quality of nursing personnel to meet the needs.

The success of these endeavors requires nation-wide unity of purpose, qualified personnel and sufficient facilities for implementation. As a national federation of the ten provincial associations, the 80,000-member Canadian Nurses' Association has
the means to provide effective research and consultant assistance to the provinces in their pursuit of present and future nursing objectives as well as on all matters pertinent to the profession.

Sister Mary Felicitas, B.Sc., M.Sc.
President
Canadian Nurses' Association

Montreal
1968
I. Commitment to Service

The usefulness of the profession of nursing emerges from the service its members provide to an increasingly health-conscious society. The usefulness of the Canadian Nurses’ Association emerges from the nature and extent of the assistance it provides to nurses and others devoted to high-quality nursing service. Simply stated, the CNA is an organization formed by nurses as a means to achieve the ideals of Canadian nurses and Canadian nursing. It is a challenging, many-faceted, constantly changing task.

NURSING SERVICE

The essential purpose of professional nursing is to contribute, to the fullest extent made possible by nursing science, to the care of people and communities in sickness and in health. To achieve this, the profession must advance its knowledge and skills to keep pace with rapidly advancing knowledge and techniques in all phases of health and medicine.

The nurses of Canada have continuously directed their knowledge and resources to the quest for excellence in nursing practice and service. The profession has established — in the Ottawa headquarters of the Canadian Nurses’ Association — research and advisory facilities in nursing service which are available to member associations. Much of its current activity in this area is derived from recommendations of the CNA Project for the Evaluation of the Quality of Nursing Service, completed in 1965 and published by the CNA in 1966.

To arrive at tenable conclusions on what constitutes ideal or acceptable standards of nursing care, it is necessary to have some method for measuring current practice. This was a major contribution of the 1966 report: a preliminary phase of the study was to try to establish criteria which would make such measurement possible. In this effort, the first of its kind, the criteria inevitably fell short of the absolute, but did establish a basis for further progress.

The ultimate assessment of nursing service comes into focus in the relationship between nurse and patient, but many circumstances affect the manner in which the nurse can exercise her abilities. Among these influences are the philosophy and objectives of the unit providing the care, the relation of nursing service to the total agency or institution, the administration of the nursing service, the personnel providing the service and the physical facilities available. All these factors affect the quality of patient care and the effective utilization of professional nursing skills.
Among those attending a case-study session during a nursing service workshop, conducted by the CNA in Halifax in April 1967, were: Edrie Jean Dobson, Nova Scotia Sanitorium, Kentville; Anne Estabrooks, Saint John General Hospital; Mrs. Christine O'Neill, Nova Scotia Hospital, Dartmouth; Frances M. Howard, CNA nursing service consultant; Corrie Nebuccette, James Paton Memorial Hospital, Gander; G. A. Hillier, group leader for the workshop, who is industrial relations officer, Nova Scotia Light and Power Company, Halifax; Margaret A. Beswetherick, nursing advisor, Registered Nurses' Association of Nova Scotia.

The resolution of problems revealed by studies in these areas of nursing service may fall within the field of action of nurses themselves, or may be under the jurisdiction of related professions or organizations in the health field. Thus, the CNA research and advisory unit for nursing service conducts a two-fold program. It makes available to CNA members a consulting service which can be invited to assess a nursing service unit, indicate weaknesses, and suggest courses of corrective action within the jurisdiction of nurses. It also seeks co-operation and support from related groups such as government, medical and hospital authorities by interpreting to them how nursing service can be improved by the correction of weaknesses in areas beyond the jurisdiction of the nursing profession. In effect, these matters impinge
on all aspects of nursing, from selection and education and employment of nurse practitioners, to the efficient lay-out and operation of health service units.

The processes of the acquisition and the application of nursing skills have changed over the years and will change more in the future. Technological advances, with overtones of automation, will continue to make special demands on nursing. Inevitably, higher standards of education will be required to obtain maximum advantages from highly sophisticated health units.

There is no evidence that advancing health techniques will reduce the number of nurses needed in Canada. The CNA believes that the current shortage of nursing personnel can be alleviated in part by having non-nursing functions — including clerical and housekeeping duties — administered, supervised and carried out by non-nursing personnel.

Among subjects of continuing concern and study within the CNA are the kinds of nursing knowledge and skills that will be required in the years ahead; the number of nurses that will be needed; the allocation of functions in the doctor-nurse and other para-medical relationships; and the co-operative development with other health agencies of plans to enable the nursing profession to satisfy the demands of a high standard of patient care in the future.

**NURSING EDUCATION**

Three contemporary statements made to different audiences by different people serve to bring into focus the long-standing concern felt by the professional nurses of Canada towards the educational processes designed to prepare them to provide the highest possible standards of patient care.

Dr. Margaret Mead said in the *Harvard Business Review* in the November/December 1958 issue:

*Change has become so rapid that adjustment cannot be left to the next generation; adults must — not once, but continually — take in, adjust to, use, and make innovations in a steady stream of discovery and new conditions . . . No one will live all his life in the world into which he was born, and no one will die in the world in which he worked in his maturity . . . In this world, no one can ‘complete an education’. *

Dr. Katherine E. MacLaggan, who conducted a study for use in the development of nursing education in New Brunswick, said with reference to her report, published in 1965 as *Portrait of Nursing*:

*The commitment is in favor of intelligent, well-educated people in nursing. This is not to say that the present nurses are unintelligent. They are under-educated. It must be recognized that women are not as restricted in educational opportunities as in the past. They need not continue to be satisfied with a*
system of education which is divided against itself because of service commitments and which requires its members to be largely self-educated. If nursing will not provide that type of education which is necessary to assure self-directing individuals, then it must be satisfied to attract in future primarily the intellectually limited members of society. Society in turn must be prepared to accept the inferior type of nursing care which such a group will offer.

Dr. Helen K. Mussallem said of nursing education in Canada in her report to the Royal Commission on Health Services:

*Today (1964), 75 per cent of hospital school instructors are unqualified and a large percentage of instructors in university schools require further graduate preparation for their positions.*

Here, indeed, is a predicament requiring for its solution the intelligent self-analysis of the profession and the understanding and support of related segments of society. To honor their professional purpose, nurses must be educated to practice their profession with competence in a world of rapid change. Human and physical facilities and instruction as they now exist are, in a large measure, unsatisfactory for the preparation of the nurses of today, much less the future.

This situation impelled the provincial associations, through their national CNA organization, to undertake several projects to identify basic educational problems and to recommend corrective courses of action. In broad terms, the conclusions of these efforts were:

- The service-oriented school — i.e., the hospital school of nursing — is not and has not been an appropriate institution for the education of professional nurses.
- Like members of any other profession, nurses should be educated in institutions with a basic purpose of providing education rather than training through service.
- To maintain the required standards of nursing practice in the future, two types of nursing personnel should be prepared in a 3:1 ratio:
  - a. The diploma nurse, who would be a graduate from an educational institution. Her post-secondary education would be within a two-to-three year framework.
  - b. The university-educated nurse, who would obtain a baccalaureate degree within a four-to-five year framework.

In a large measure, agreement has been reached within the profession on the desirability of the two-stream concept of nursing education, as well as the necessity of developing the kind of schools and the level of instruction to make these processes effective.

To give perspective to the action now being undertaken by the Association with respect to nursing education, it is necessary to dip back, briefly, into history.
The voice of criticism of leading nurses has been raised in protest against the service-oriented type of preparation of professional nurses for more than half a century. The first definitive survey of such programs was co-sponsored by the CNA and the Canadian Medical Association and was completed in 1931 by Dr. G. M. Weir, professor of education at the University of British Columbia. His report, published the following year, revealed many weaknesses in the system of nurse preparation and suggested remedial courses of action. Although helpful, such corrective measures as were actually undertaken proved inadequate.

In the mid-1940's, Nettie D. Fidler, a member of the nursing faculty at the University of Toronto, was representative of those who continued to voice the concerns of the nursing profession. In her 1944 report to the CNA general meeting, she identified three problem areas: the need for factual knowledge of the nursing requirements of the country; the probability that these would reveal the need for varied types of nursing services and of preparation for them; and the need for educational, i.e., financial, independence of nursing schools.

In an effort to stimulate constructive progress, the CNA in 1956 initiated and financed a project to identify the weaknesses and strengths of existing nurse-

*Dr. Shirley R. Good, CNA consultant in higher education, discusses curriculum revisions with Sister Françoise Robert, director of the school of nursing, University of Ottawa.*
preparation systems and in turn point the way to specific goals. The first step was to explore the feasibility and desirability of a national, voluntary accreditation program for schools of nursing. Criteria were established for measuring the quality of preparation of nurses. This undertaking was identified as the Pilot Project for the Evaluation of Schools of Nursing in Canada. Completed in 1960, the study revealed that the standard of preparation desired by the profession as a basis of accreditation could be met. It also revealed that 84 per cent of the participating schools were not, at that time, meeting accreditation standards and that many hospital schools lacked the necessary facilities and qualified instructors to meet them.

As a consequence of these findings, the development of an accreditation program was postponed and nursing resources were re-directed towards an examination and study of the whole field of nursing education. Linked to this were simultaneous projects to develop school improvement programs and to evaluate quality of nursing service, together with new development work on an accreditation program.

These large and expensive programs occupied the energies of the national association during the years 1960-1966, and the conclusions drawn from them form the philosophical and practical base from which the CNA now functions. Essentially, the CNA is committed to provide all reasonable help for effecting curriculum improvements in all schools of nursing. A consulting service is provided by national headquarters to work on request with provincial groups seeking to examine and improve educational processes.

Meanwhile, through provincial and national associations, nursing educators seek general acceptance, within and beyond the profession, of the principle that nurses should be prepared in educational institutions. Inseparable from this objective is the necessity of having educational programs developed and conducted primarily by educators and separated entirely from the requirement of providing service in exchange for training—an outmoded practice in conflict with modern concepts of education. Measurable evidence of progress towards this end was observed in 1966 when the Saskatchewan legislature made nursing education a responsibility of the province's educational system.

CANADIAN TESTING SERVICE

As the Canadian Nurses' Association approached its 60th anniversary, there developed a situation related to educational processes which will add a new dimension to the service the Association provides to the profession. At the request of the provincial associations, the CNA initiated the establishment of a national testing service to provide tests for the registration and/or licensing of nurses in Canada.

In nine provinces, the provincial nurses' association determines the method or standard by which nursing practitioners are registered or licensed. The College of Nurses of Ontario is responsible for registration in that province. In all ten provinces, graduates of approved schools of nursing are required to pass a registration examination before being entered in the register and receiving a certificate of registration.
Margaret E. Steed, CNA nursing education consultant, meets with some of her counterparts from the provincial nurses' associations during a nursing education conference held at CNA House in September 1967.

Left to right: Kathleen E. Arpin, College of Nurses of Ontario; Anna A. Christie, New Brunswick Association of Registered Nurses; Myrtle Cummings, Association of Registered Nurses of Newfoundland; Miss Steed; Sister Beatrice Wambke, Manitoba Association of Registered Nurses; Miss F. A. Kennedy, Registered Nurses' Association of British Columbia; Sister Thérèse Castonguay, Department of Education, Saskatchewan.

As early as 1947, dissatisfaction with locally prepared tests and the difficulties in obtaining qualified examiners in Canada led to agreements with the National League for Nursing in the U.S. for use of its test services developed for state boards of nursing. Eight provinces were using the NLN service when, in October 1966, the American Nurses' Association gave notice that starting in 1969, the use of NLN tests would be restricted to the U.S.

In response to requests from provincial associations for concerted national action, the Board of Directors of the CNA in September 1967 agreed to proceed with the development of a Canadian testing service to provide examinations in English and French for nurse registration in all provinces. As machine-scored tests had previously been developed by the Registered Nurses' Association of Ontario, negotiations began immediately for their adaptation and transfer to a national testing service scheduled to begin in 1970.
SOCIAL AND ECONOMIC WELFARE

The years immediately before Canada's Centennial of Confederation were highlighted by a growing concern for social and economic welfare in most segments of Canadian society. A manifestation of this concern was aggressive action by employee groups, both professional and non-professional, to organize and through organization to seek equitable standards of living and working conditions. Few segments of Canadian society were immune to these influences and, inevitably, it came to involve nurses.

The abiding concern of the nursing profession is with the highest possible standards of patient care. Inseparable from the achievement of this objective are:

- The recruitment into the profession of personnel in the required quantity and quality;
- The effective use of professional nursing skills;
- The retention of professional staff to provide the stability of personnel necessary to maintain this standard of care.

In the years during and following World War II, developments in Canadian society began to change the framework in which professional nurses work. Among these developments were the emerging patterns of government involvement in health services and the increasing proportion of registered nurses employed by hospitals. Also influential were the widening opportunities for professional women, which dictated that nursing either be competitive in its appeal to recruits or accept the loss of many potential recruits to other occupations.

Another influence was the mounting strength of other employee groups, particularly in the large hospital units. By virtue of this strength, they were able to command larger proportions of the available budget; lacking such representation, professional nurses tended to share less in the rising standard of living than most other employee groups.

The need for national policy on matters in this field was made evident by the labor relations activities of several provincial associations during World War II. The CNA responded to requests for national action in November 1943 by forming the first CNA committee on labor relations which led ultimately to the CNA's endorsement of collective bargaining. In the structural reorganization of the CNA which took place in the early 1950's, the labor relations committee disappeared as a major entity within the Association, but the social and economic influences that had brought it about did not disappear.

The effect of these social and economic influences on nursing were made apparent at the time of the Royal Commission on Health Services in 1962. Studies for the Commission revealed for the first time that, although Canada enjoyed an excellent nurse-to-population ratio, the percentage of eligible young women entering the profession was actually declining rapidly, foreshadowing an intensive shortage of registered nurses in the future.
The social and economic welfare standing committee of the CNA meets at national office at least once a biennium. Among those attending the February 1967 meeting were Evelyn E. Hood, Registered Nurses' Association of British Columbia (chairman); Glenna S. Rowsell, CNA consultant on social and economic welfare; Sister Thomas Joseph, Halifax Infirmary; Gertrude Hotte, St. François d'Assise Hospital, Quebec City; Mrs. Margaret R. Page, Port Arthur District Health Unit.

It was against this background that Canadian nurses in the mid-1960's again decided to exercise and make effective the declared principles of their national association that the profession is responsible for the welfare — and hence the salaries and working conditions — of its members; and that the responsibility for applying this principle should remain in the hands of the profession itself. The CNA undertook to support and assist provincial associations in this work, and as a result, the CNA social and economic welfare committee was formed in 1964. The first effective meeting with provincial counterpart committees was convened in national headquarters on September 14, 1965.

Two particular aspects were of concern at that time: the available courses of action were not the same in each province, as health matters fall within provincial jurisdiction and provincial collective bargaining processes are controlled by provincial labor legislation; and many nurses still harbored reservations regarding the
appropriateness of a profession participating in collective bargaining. In a large measure, this reservation has since been dissipated by the precedents established by other professions in collective bargaining and by the manifest need to establish the standard of living available to nurses on a level comparable to that existing in other occupations requiring similar education, experience and responsibility.

Shortly after the 1965 conference, the CNA established in national office a social and economic welfare consulting service available to all provincial associations. This function now provides several basic services, including consultant services to the provinces on specific situations, development of educational programs for use by the provincial associations, and workshops for interested nurses in any province. An early project of the new service was to produce a booklet of guidelines for those engaged in collective bargaining. A secretariat was established to provide a flow of information pertinent to collective bargaining processes, and for this latter purpose the newly established statistical and library services proved most useful. A qualified labor relations consultant was retained to examine and advise on technical aspects of labor relations.

At this point in history there is evidence that the nursing profession is making progress towards goals that will equate the economic and social status of nursing with that of other comparable professions. It is also evident, as in so many professional achievements, that the necessary initiative and sustained effort to achieve these goals must come from within the profession.

CANADIAN NURSES' FOUNDATION

Emphasizing the determination of the profession in Canada to provide leadership in nursing education and research — a prerequisite to the greater scientific knowledge that will be a necessity in the future — was the decision made by the Canadian Nurses' Association in 1960 to build a fund to provide financial support to nurses seeking higher education. The sources of revenue for such a program were visualized as contributions from the members of the profession and the public. The fund was to be the only means at the national level for the profession to receive funds for the promotion of nursing knowledge and practice.

After the early organization work was done by the CNA it was realized that such an enterprise could function more effectively if donors could contribute funds on a tax-exempt basis. Accordingly, the Canadian Nurses' Foundation was incorporated in 1962 with these stated purposes:

Provide bursaries, scholarships and fellowships for nurses studying at the master's and doctoral levels.

Provide grants for research in nursing service which may help to advance the knowledge and art of nursing.

Solicit and accept gifts, donations, bequests or subscriptions for the above purposes.
Membership in the Foundation was made available to any member of the Canadian Nurses’ Association who chose to subscribe to its support. Incorporators were Helen G. Carpenter, Alice M. Girard, Ella M. Howard, Katherine E. MacLaggan, E. A. Electa MacLennan, Sister Madeleine de Jésus, Lillian E. Pettigrew, Mary L. Richmond and M. Pearl Stiver.

An early contributor to the Foundation was the W. K. Kellogg Foundation which provided a grant in 1962 of $150,000 to be spread over a six-year period. Many nurses in Canada also contributed, with the result that by the beginning of 1968, a total of nearly $170,000 had been used to assist some 60 nurses towards master’s and doctoral degrees.

The Foundation functioned at first with a considerable amount of corporate and economic autonomy, but in 1965, it was decided to effect closer administrative liaison with the CNA. As a result of this decision, the executive director of the CNA became, in 1966, the executive secretary-treasurer of the CNF. At the same time, the CNA assumed responsibility for the Foundation’s administrative expenses.

As originally conceived, the Foundation was permitted only to provide awards to nurses seeking degrees beyond the baccalaureate level; but in 1966, the annual meeting of the Foundation voted to make awards possible for selected candidates seeking baccalaureate degrees while, at the same time, authorizing priority for applicants enrolled in master’s or doctoral courses.

INFORMATION SERVICES

The need and the means of communication in our society have been strongly influenced by the rapid social and technological changes which began after World War II. Among the more urgent obligations of a national association is the responsibility to keep members informed of developments in professional practice, and aware of the educational, social and economic influences that constantly change living and working environments. Implicit also in this responsibility is the desirability of having an informed membership to achieve, by democratic processes, the cohesive group support necessary to influence the course of events in a direction compatible with the ultimate purpose of the profession.

As a national organization, the CNA has been effectively responsive to these needs and influences. It has become the repository of all pertinent and available information and the focus of national nursing objectives.

As an operating axiom, the Association believes that if a course of action is right and understood, it will be accepted; if it is wrong and understood to be wrong, it will be corrected. Thus, the CNA has come to accept the responsibility of using valid information, not only as a source of internal professional unity, but also as a means of achieving understanding and support beyond the profession. As a consequence, in the mid-1950’s, the CNA began to expand and formalize its
The CNA magazine L'infirmière canadienne began publication in 1959 and has an editorial staff completely separate from the English edition. Here Mrs. Nicole Beaudry-Johnson, associate editor, discusses material for future issues with Claire L. Bigué, editor.

procedures for obtaining and disseminating information in English and French. This process has developed to the point where it constitutes a comprehensive program conveying information to members and non-members who do or could exercise an influence on the profession in Canada.

The facilities for communications developed by the CNA have many facets, but function as an integrated operation. Thus, the library and statistical services at national headquarters represent a continuing source of information, flowing in a two-way stream to obtain and provide useful data. These services, developed in the mid-1960's, make it possible for the first time in history for the Association to formulate its projections and base its plans on measured data.
Up-to-date news on nursing developments reaches over 86,000 nurses per month through the combined circulations of The Canadian Nurse and L'infirmière canadienne. Discussing some of the news items are, left to right, Mrs. Valerie Beveridge, CNA public relations officer; Virginia A. Lindabury, editor of the English-language journal, and Mrs. Loral A. Graham, editorial assistant.
The public relations and editorial personnel maintained by the Association use professional techniques and avenues to communicate CNA objectives. Press, radio and television are supplied with pertinent background and news material. The CNA sponsors, prepares and distributes films, special articles, pamphlets, manuals, brochures, reports, bulletins, exhibitions, speeches—in fact, most of what is necessary for an effective program by a national organization. It is a principle within the organization that communications from the Association are carefully considered with respect to purpose and audience-interest before a decision is reached on means and method of distribution.

The CNA’s two professional magazines, The Canadian Nurse and L’infirmière canadienne, are part of the total communications effort. These publications are issued monthly in their respective languages, English and French, and have a combined circulation of more than 86,000. Each CNA member receives the magazine as a membership benefit and subscriptions from non-members are welcome. Each publication exercises a choice in the selection and presentation of articles of particular interest to each language-group of readers. In response to the need for up-to-date information, the Association was successful during the mid-1960’s in changing the printing deadlines for some sections of the magazines, thus making possible a reasonably late news section in each monthly issue.

A brief history of the CNA professional magazines is included under the chapter Footnotes to History.

INTERNATIONAL

Eagerness to join the International Council of Nurses was the catalyst which brought about the formation of the CNA in 1908, and an affinity of interests and principles has supported a warm, rewarding relationship between the two organizations during the first 60 years of CNA activity. The Canadian Nurses’ Association has the responsibility of representing Canadian nurses at the international level, and through this international affiliation to develop a global view of nursing which can be used to help in the solution of nursing problems in Canada. It is also a route by which Canadian nurses can assist other nations. In 1968, Canada was the second largest member organization in the ICN and was represented there by the CNA president, who is a member of the Council of National Representatives.

The formation of an International Council of Nurses was first proposed by Mrs. Bedford Fenwick in 1899. At that time, she said, “The nursing profession, above all things at present, requires organization; nurses above all things at present, require to be united.” The ICN came into being in that year and the events of the intervening decades have emphasized rather than diminished the need for organization and unity within the profession. The ICN is a federation of more than 60 national nurses’ associations and provides an international forum for discussion and a medium through which member associations can share their common interest in the promotion of health and the care of the sick. Headquarters of the ICN are in Geneva.
In 1965, Alice M. Girard, a past-president of the CNA, was elected president of the International Council of Nurses. In 1967, she became the most recent of ten Canadian nurses who have received the Florence Nightingale Medal since its inception in 1912. The only international award specifically for contributions to the field of nursing, the medal is presented by the International Committee of the Red Cross. Miss Girard is seen here with Samuel A. Conard, president of the ICRC.
The ICN is the voice for its members in speaking to other international organizations including the United Nations and its specialized agencies such as World Health Organization, UNESCO, and UNICEF, and is on the Consultative Register of the Economic and Social Council of the UN. The ICN also has an association with the International Hospital Federation, World Federation for Mental Health, International Committee of the Red Cross, League of Red Cross Societies, World Medical Association, International Confederation of Midwives, and Union of International Associations.

Canadian participation in the ICN has been active, steady and contributive. CNA members have held elective offices, been members and chairmen of standing committees, served in consultant capacities for specific projects and studies, and participated in the exchange of privileges program by which arrangements are made for nurses from member countries to obtain professional experience in other ICN member countries.

The CNA was the host organization to the ICN congress in 1929 and Canada's invitation to hold the 1969 congress in Montreal was also accepted. Plans were immediately undertaken by the CNA to facilitate and welcome the largest nursing congress in history.

OTHER INTERNATIONAL GROUPS

The CNA also co-operates with WHO, the External Aid Office of the Canadian government, Canadian University Service Overseas (CUSO), The Canadian Red Cross Society, and other lay and religious organizations, in the assignment of Canadian nurses to services abroad.

Under the auspices of religious sisterhoods, government and private organizations, Canadian nurses work in many countries around the world. Illustrating the efforts of Canadians is WHO public health nurse consultant, Jeannette Sylvain, in 1967 responsible for nursing aspects of a public health program in Abidjan, Ivory Coast. Miss Sylvain is a graduate from l'Hôpital de l'Enfant Jésus, Quebec City; Institut Marguerite d'Youville, Montreal; and Teachers College, Columbia University, New York.
SOME STATISTICS

One of the recent achievements of the CNA was the establishment at national office of a statistical unit to seek, find and provide meaningful statistical information about the nursing profession and its practice in Canada. This unit, which co-operates with both government and non-government agencies in the collection of data, conducts annual and periodic studies on various aspects of nursing.

An extensive annual study carried out by this unit, with the co-operation of the provincial nurses' associations and the College of Nurses of Ontario, is the national inventory of all currently registered nurses. Initiated in 1965, it makes available consistent yearly information on age, sex, marital status, employment status, educational qualifications, field of employment and position of nurses in Canada. The 1967 inventory provided data on 94.3 per cent of all nurses registered in that year, and from it much of the following information was derived.

According to the CNA national inventory, adjusted to 100 per cent, there were more than 127,000 registered nurses in Canada in 1967. This is slightly less than the total number of nurse registrations in the same year, since over 2,000 nurses were registered in more than one province. Of the 127,000 registered nurses, more than two-thirds were members of the CNA by virtue of their membership in a provincial nurses' association.

Not all registered nurses work full-time at their profession — in fact, the 1967 inventory showed that only about 52 per cent were employed full-time; 18 per cent were employed part-time; 20 per cent were not employed in nursing; and 10 per cent did not report their employment status.

Where do they work? Of the registered nurses employed in nursing, 81.1 per cent work in hospitals or other institutions; 6.0 per cent are in public health (other than schools); 4.1 per cent are employed in schools of nursing; 3.5 per cent are in private practice; 2.4 per cent work for doctors and dentists; 1.7 per cent are in occupational health; 0.6 per cent are in school health; 0.3 per cent are in other specified fields; and 0.3 per cent did not report their field of employment.

A comparison of this distribution with figures published in the Survey of Nursing Education in Canada by Dr. G. M. Weir in 1932, in which was reported data obtained from provincial registrars of nurses and from other official sources, reveals a striking change in employment patterns. In 1930 only 58 per cent of the 18,174 registered nurses were employed in nursing; of those 10,530 active nurses, 61 per cent were employed in private duty, 25 per cent by institutions, and 14 per cent in public health.

As late as 1940 married nurses were not encouraged to work at their profession, but in recent years marriage has not proved an insurmountable obstacle to the practice of nursing. More than 50 per cent of nurses employed in the profession are married.
Mrs. Lois Graham-Cumming, director of research and advisory services, with Mrs. Janet Martinusen, CNA statistician, at work on the first edition of Countdown, a CNA publication containing annual data on Canadian nurses.

Men are a minority, numbering less than one per cent of all registered nurses employed in the profession.

The largest percentage of registered nurses employed in nursing, 70.6 per cent, are general duty or staff nurses; other groups are head nurses or assistants, 11.7 per cent; supervisors or assistants, 6.4 per cent; instructors, 3.7 per cent; directors or assistants, 2.9 per cent; other specified positions, 4.4 per cent, and positions not reported, 0.3 per cent.

The number of nursing graduates from basic diploma and baccalaureate programs has continued to increase slightly during the 1960's, from 6,188 in 1961 to 7,522 in 1967. The percentage of qualified young women entering the profession is declining. In 1944, about 23 per cent of female students at high school junior
matriculation level enrolled in nursing education programs. By 1960, this figure had declined to about 11 per cent, and in 1966, to about 8 per cent.

In 1967, there were a total of 206 schools in Canada offering 212 basic programs in nursing. Of these, 186 were diploma programs, 19 were integrated university baccalaureate degree programs, and 7 were non-integrated university baccalaureate degree programs.

In 1967, nine provinces had one or more university school of nursing: New Brunswick 2, Nova Scotia 3, Ontario 8, Quebec 3, and the remainder 1. Prince Edward Island had no university school of nursing. At these 21 universities were offered 93 programs, consisting of 26 basic baccalaureate degree programs, 20 diploma/certificate programs for graduate nurses, 41 post-basic baccalaureate degree programs, and 6 master's degree programs.

The ratio of university to diploma students who were graduated in 1967 was 1:9. The desired ratio has been stated as 1:3. While the actual ratio is still far from what is desired, the current graduating ratio is improving the work force ratio of baccalaureate to diploma graduates, which in 1967 was 1:18. Up to 1930 in Canada, only about 40 registered nurses had ever received academic degrees; by 1967, the number of currently registered nurses with academic degrees had risen to more than 6,000.

In 1967, there were 102 provincially approved schools for nursing assistants in Canada, graduating 3,800 students. The number of registered nursing assistants in 1967 was 31,341. Registration of this group of health workers is voluntary in Quebec and does not exist in Newfoundland.

CNA—HOW IT WORKS

The work of the Canadian Nurses' Association is an extension of the wishes and will of nearly 80,000 members dispersed throughout a large country. It is an instrument of national nursing policy, emerging from a confederation of the ten provincial nurses' associations to which individual nurses belong. To work effectively at its assigned tasks and to remain truly representative of all its members, the CNA is organized in such a manner that it draws its strength and authority from the provinces while remaining national in outlook and conduct.

Authority and responsibility for the direction and operation of the CNA are delegated to the Board of Directors by CNA members. Board members serve voluntarily, without remuneration. They come from provincial nurses' associations, but at the national level are committed to exercise independent thought and judgment as participants in the formulation of national policies. The Board is composed of:

A representative from each of the ten provincial associations. This is normally the president, an elective office in the provincial association.
The chairman of each of the CNA’s three standing committees — Nursing Service, Nursing Education and Social and Economic Welfare. The chairman of these committees, each a leading nurse in her field, is appointed by the Board.

Two members from nursing sisterhoods. One of these is elected at large at each biennial general meeting; the other may be appointed by the Board, providing no other member of a nursing sisterhood is already a Board member by virtue of holding another office.

The president-elect, who is elected at each biennial meeting.

Two vice-presidents, who are elected at each biennial meeting.

The president, an office assumed by the president-elect at the beginning of a biennium. In effect, the president is elected to office two years before it becomes open — a procedure which assures continuity in the event of the incapacity of the president.

The functions of the Board of Directors are to establish policy, revise policy, appoint the executive director, delegate authority and responsibility to the executive committee and to the executive director, approve extraordinary expenditures, and assure that the work of the Association goes forward on schedule.

The Board of Directors has two instruments for the execution of policy: an executive committee and a national office organization. The executive committee is composed of seven members: the CNA president, president-elect, first vice-president, second vice-president and the chairmen of the three standing committees. It may meet to administer delegated affairs of the Association between meetings of the Board.

The national office staff — under the direction of the executive director — has two functions: it carries out the day-to-day operations and special projects assigned to it by the Board of Directors or the executive committee; and it prepares and submits for approval to the Board the biennial budget for operating expenses, which is later ratified or modified by delegates at the biennial general meeting. The executive director’s function includes acting as corporate secretary to the CNA, with total responsibility for the administration of the national office organization.

In addition to the executive committee and national office, special committees with broad terms of reference, and ad hoc committees for a specific purpose, may be appointed at the discretion of the Board of Directors.

The three standing committees of the CNA are, generally speaking, composed of the chairmen of the corresponding standing committees in each provincial association. These provincial standing committees provide a regional forum for the review of events and changing needs in the three fields of action and propose revisions in policy based on these examinations. Their conclusions are brought for discussion at the national level by the provincial chairmen. In this manner, a direct line of communication and representation is established between individual nurses and their national association.
Revenue to operate the CNA comes from three sources:

Membership fees which are collected and remitted on a per capita basis by the provincial association to which the individual nurse belongs.

Revenue generated by projects within the Association, which defray their costs to a limited extent. The major source of this type of revenue is the advertising which appears in *The Canadian Nurse* and *L'infirmière canadienne*. However, the goal of being self-supporting is elusive, since — in being professional magazines seeking to serve the members of the Association and being influenced by ethical considerations — there are limitations on the advertising that may be accepted.

A minor source of income is the charge made for certain books, brochures and pamphlets that are produced for particular areas of interest within the membership. This charge helps to defray some of the publication costs, but none of the preparation costs. Here, too, the good of the profession takes precedence over the profit motive.

By virtue of being a national professional association, the CNA acts as the voice of the Canadian nursing profession at the national and international levels. As such, it becomes associated with a number of other organizations and is usually represented by the CNA president, executive director or their deputy. Internationally, this activity is officially channeled through the International Council of Nurses, the federation of national nurses' associations that maintains liaison with other international bodies.

At the national level, the CNA is represented on a number of committees in other national organizations. Generally speaking, there are five types of Association involvement: where the CNA appoints a representative to another organization; where CNA representation is requested by another organization; where CNA has actual affiliation or membership in another organization; where a member of the CNA has actual affiliation or membership in another organization; where a member of the CNA is selected for appointment to a governmental body.

The desire to provide the best possible representation for its individual members is a serious one within the CNA, and such representation must be achieved through democratic, elective processes. The pathway to individual participation in national Association work starts with involvement in district, chapter and provincial organizations. Though the process of achieving the recognition which makes elective office possible can be slow, the spur of modern problems can often propel competent people forward to provincial and then national office in relatively few years. The effectiveness of an individual's contribution to the national Association is in a large measure dependent upon an ability to broaden one's outlook, and to envisage and identify activity on a national basis. While each member active at the national level is expected to transmit and interpret views of her respective provincial association, each must also think nationally in the formulation of CNA policy. A composite perspective can thus be derived from the knowledge and experience of all who contribute at the national level.
Group photo taken in CNA House at the September 1967 meeting of the CNA Board of Directors. In the front row, left to right, are the Executive Committee for the 1966-68 biennium: Kathleen E. Arpin, chairman, committee on nursing education (Ontario); Evelyn E. Hood, chairman, committee on social and economic welfare (British Columbia); E. Louise Minor, first vice-president (Saskatchewan); Sister Mary Felicitas, president (Quebec); Dr. Helen K. Mussullem, executive director; Marguerite Schumacher, second vice-president (Alberta); Margaret D. McLean, chairman, committee on nursing service (Ontario).

Second row: Dr. Margaret Hart, president, Canadian Conference of University Schools of Nursing (guest); Jean Church, president, RNANS; Mrs. Agnes Gunn, president, SRNA; Mme Gertrude Jacobs, president, ANPQ; Mrs. Katherine Wright, president, NBARN; Mrs. Helen P. Glass, president, MARN; Sister Mary Xavierius, president, ARNN; Sister Thérèse Castonguay, Nursing Sisterhoods representative.

Third row: Jean MacMillan, ANPQ (non-voting); Grace Motta, registrar, SRNA; Helen Reimer, secretary-registrar, ANPQ; Mrs. Gwendolyn Hermann, executive secretary, NBARN; Margaret E. Cameron, executive secretary, MARN; Pauline Laracy, executive secretary, ARNN; Eleanor S. Graham, executive secretary, RNABC; Sister M. Hermina, president, ANPEI.

Fourth row: Nancy Watson, executive secretary, RNANS; Mrs. Helen M. Sabin, executive secretary, AARN; Sister Ann Marie, president, AARN; Albert W. Wedgery, president, RNAO; Laura W. Barr, executive director, RNAO; Mrs. Margaret Lunn, president, RNABC.
NATIONAL OFFICE—CNA HOUSE

In 1966, the national headquarters of the Canadian Nurses' Association was moved into its own building at 50 The Driveway, Ottawa, eight years after the first formal plans were made for CNA House and 44 years after the first national office was established in Winnipeg.

The functions and facilities of the first CNA office were modest. The membership of the national nursing organization in 1922 was approaching 10,000 when it was decided that an administrative headquarters and permanent staff were needed. An office was rented in Winnipeg and the first full-time staff member, an executive secretary, was appointed. Ten years later, the CNA national office was moved to Montreal, an event coincident with the appointment of the first full-time editor of *The Canadian Nurse*. In 1954, the CNA moved its headquarters to the nation's capital at Ottawa, where it opened new offices at 270 Laurier Avenue West; the staff of the Association's magazine remained in Montreal. In 1959, CNA activities had expanded to the point where larger facilities were a necessity and the offices were moved to 74 Stanley Avenue, Ottawa.

The first official recognition of hopes for a CNA building took place at the 29th biennial meeting in 1958. Initial plans were set up for financing the structure in a resolution which said in part, "1958 marks the fiftieth anniversary year of the Canadian Nurses' Association, an organization looking forward to marked growth in the next fifty years."

The first sod for CNA House was turned on April 1, 1965; in November of that year a capsule containing historical documents and artifacts was deposited in a retaining wall. On April 1, 1966, the national office staff moved in, and were joined from Montreal by the editorial, production and advertising staffs of the two professional journals, *The Canadian Nurse* and *L'infirmière canadienne*. CNA House was officially opened on September 25, 1967 by His Excellency Roland C. Michener, Governor General of Canada.

The enlarged facilities have made possible the present range of activities which, for administrative purposes, have been consolidated into five functional areas:

- Research and Advisory Services, which includes the areas of nursing service, nursing education and social and economic welfare.
- Information Services, which consolidates all public relations and publication activities of the Association, including the two monthly magazines.
- Library Service, which includes circulation, library research, repository collection of Canadian nursing studies, and archives.
- Secretariat Services, which supports the corporate activities of the CNA, the Canadian Nurses' Foundation and the Exchange of Privileges Program of the International Council of Nurses.
- Office Services, which provides mailing, typing, filing, duplicating, and statistical and accounting services to all functions.
1 Dignitaries at the official opening of CNA House in September 1967 included, left to right, Governor General Roland C. Michener, ICN President Alice M. Girard, CNA President Sister Mary Felicitas, Mrs. Michener, and Dr. John N. Crawford, deputy minister of health, Department of National Health and Welfare.

2 Facilities at CNA House provide ample room for national nursing library service.

3 Sister Mary Felicitas, CNA president, and Dr. Helen K. Mussallem, executive director, on the day of the official opening of CNA House.

4 A major functional area in CNA House is Office Services.
SUMMARY AND PREFACE

There can be no conclusion to the efforts of an active profession committed to the progress of the service it provides and the members who provide it. This concept was vividly expressed in the preface to the report of the executive director of the CNA to the 33rd general meeting of the Association in Montreal on July 4, 1966. These remarks, therefore, are reproduced as a summary of immediately past activity and as a preface to a future which will continue to command the intelligence and energies of the nursing profession in Canada.

The past biennium (1964-1966) has been one of the most significant in the history of the organized nursing profession in Canada. During this period, the cumulative efforts of our predecessors reached a level of intensity powerful enough to overcome, to a measurable degree, the apathy of the public, government, and allied professional groups. A critical choice had to be made by your Association at this time. It could either exert every effort to keep pace with the whirlwind activities of society and its health services, or huddle comfortably in a quiet corner of ineffectuality. Your elected officers did not falter in the decision. Activity, both nationally and provincially, was intensified in nursing service, nursing education and employment relations. In addition, new enterprises were undertaken and organizational and procedural patterns were overhauled to increase their effectiveness.
II. Traditions and Unity

Tradition-rich is the history of nursing in Canada. This tradition emerges from two sources: the work of the French nursing sisters in the earliest pioneer days when these devoted practitioners set remarkably high standards of service in a new continent that was inhospitable and unexplored; and the later work of the English-speaking nurses who followed the principles of Florence Nightingale, often also in a pioneering milieu. This section refers briefly to the proud past of Canadian nursing and the unifying influence of a devotion to service and health.

THE EARLY YEARS

Nursing in Canada is far older than the nation itself, beginning as it did about 350 years ago following the arrival of French colonists. Although not a trained nurse, the person credited with being Canada’s first nurse is Marie Rollet, who had come to the new land with her first husband, Louis Hébert, a Paris surgeon-apothecary who arrived in Canada in 1607 and moved to Quebec in 1617. Following his death she married Monsieur Hubou, and in the 1630’s began to devote much of her time to caring for the sick commended to her care by Jesuit fathers.

The first trained nurses arrived in Canada a few years later, sent as a result of the urgent requests of the Jesuit missionary fathers in their recordings of events in New France in the journals called Jesuit Relations. Among the readers of the Relations, first published in 1633, was the Duchess d’Aiguillon, a niece of Cardinal Richelieu. Her social conscience had already been stirred by the work and teachings of Vincent de Paul, who effected radical reforms in the care of the sick and whose efforts profoundly influenced the creation of modern social service systems in hospitals and prisons in France and far beyond.

It became a project of the Duchess d’Aiguillon to finance, establish and staff a hospital in New France. It was to be in Quebec and called the Hôtel Dieu. The idea of such a hospital was sparked by the concepts of charity preached by Vincent de Paul, which, among other things, advocated that nursing sisters not be cloistered, and that nursing responsibility rest with the doctor rather than the religious superior. The Duchess did not follow all his precepts in setting up her hospital. To staff the New France venture, she chose three nursing sisters from Dieppe, belonging to the cloistered order of the Hospitaliers of the Mercy of Jesus (Hospitalières de la Miséricorde de Jésus), which followed the rules of St. Augustine.

These first Canadian nursing sisters were heirs to traditions imposed by a strict monastic system. Through the years, nursing had become of primary concern
to the religious orders, and in the process, there had developed an apprenticeship method of preparation based on religious motives and ideals of charity and service. In the medieval period, women had found within the Church, and therefore in nursing, a vocation and status that were not open to them elsewhere. Women of wealth, social status, intelligence, and dedication were attracted to what was considered noble work.

The three nuns chosen to go to New France were Marie Guenet de St. Ignace (aged 29); Anne Lecointre de St. Bernard (26) and Marie Forestier de St. Bonaventure de Jésus (22). The strictness of religious vocation and the tradition of nursing as a religious duty were dominating influences in the pattern of early nursing in New France; even the Jesuit priests looked with awe upon the devotion of the nursing sisters to duty. Here, in translation, is how their arrival in August 1639, after a voyage of three months, was described in the Jesuit Relations of 1640:

*The sick arrived from all sides in such numbers, their odour was so insufferable, the heat so great, the means of refreshment so scarce and so poor in a country so new and so novel, I do not know how these good women, who had, so to speak, not enough leisure to take a little sleep, withstood all these travails.*

This is how their winters were described by Francis Parkman in *The Old Regime in Canada*, published in Boston in 1910:

*Their chamber, which they occupied for many years, being hastily built of ill-seasoned planks, let in the piercing cold of the Canadian winter through countless cracks and chinks; and the driving snow sifted through in such quantities that they were sometimes obliged, the morning after a storm, to remove it with shovels. Their food would freeze on the table before them, and their coarse brown bread had to be thawed on the hearth before they could cut it.*

Late in 1641, there arrived in Quebec one of the most celebrated figures of early Canadian history. Jeanne Mance, educated at an Ursuline convent in Champagne, France, and with some practical experience obtained through a nursing organization similar to those established by Vincent de Paul, had been asked by a wealthy French philanthropist, Mme de Bullion, if she would take charge of a hospital in New France. At the same time in France, the Société de Notre Dame de Montréal was planning to establish a colony on the island of Montreal. Leading this group was Paul de Chomedey, Sieur de Maisonneuve, who arrived in Quebec City ten days after Jeanne Mance. The following spring, in 1642, about 50 people traveled up-river to Montreal, then known as Ville Marie. By the end of 1642, there were 65 people living inside the fort; by 1643, a small cottage hospital had been built and named Hôtel Dieu; in 1644, the Iroquois began attacking the new colony. It is said that the total hospital equipment at the disposal of Jeanne Mance consisted of a mortar, scales, a syringe with an ivory tube, razors and a lance. In 1659, she arranged for three members of another order of Augustinian Hospitalers, the nursing sisters of St. Joseph de la Flèche, to operate her hospital. Jeanne Mance remained administrator for life.

Although the two original nursing orders in Canada came from France and had French training, they soon became essentially Canadian in character. By 1671,
the Commissioners of the Hôtel Dieu in Quebec City felt they were no longer dependent on imported personnel. Uninvited sisters from France were not welcomed, and a letter to this effect was sent out to the French orders. By the end of the 1600’s, Canadian-born nursing sisters in Canada outnumbered those of French birth. Historians still marvel at how these courageous women managed to survive and be effective, confronted as they were by repeated smallpox and typhus epidemics brought by the immigrant ships, fires which demolished their hospitals, crop failures and Indian massacres.

The quality of nursing care achieved by nursing sisters in Canada after a century of Canadian nursing was indicated by Peter Kalm, a Swedish scientist who visited Quebec in 1749. He was quoted in A Travers l'Histoire de l'Hôtel Dieu de Québec by Pierre Georges Roy:

> The hospital comprises two large wards and some rooms near the dispensary. The wards contain two rows of beds on each side. The beds near the wall are framed with curtains, the others have none. All are furnished with good blankets and double sheets, very clean. As soon as the patient gets up, his bed is made so as to keep the hospital in a state of cleanliness and good order. The dormitories are warmed with excellent stoves of cast iron and numerous casements let the light through. The nuns take care of the sick, bring them their meals and look after their needs.

The first entirely Canadian nursing order was founded in Montreal in 1738 by a philanthropic widow, Marguerite d’Youville, niece of the famed French explorer La Verendrye. Known as Les Soeurs Grises or the Grey Nuns, they were Canada’s first non-cloistered order, formed one year after the canonization of Vincent de Paul, who, a century before, had founded the first non-cloistered orders in France. The Grey Nuns were a group of charitable women who began by pooling their resources to found a home of refuge for the poor. From this, they moved on to caring for the sick in hospitals and in patients’ homes. They may be considered the precursors of Canada’s visiting and public health nurses. This order was one of the first to push westward in Canada, setting up Indian missions and community hospitals as they went.

THE BRITISH ARRIVE

Through the war of 1756-63, the nuns tended and protected as best they could both English and French wounded, earning the gratitude and admiration of all who came in contact with them. The change from French to British rule in Quebec reduced the nursing sisters to poverty; their sources of income had been largely from private philanthropists, and most of the wealthy citizens who had lived in Canada returned to France; those who had contributed from France ceased to do so.

Quebec City under the new regime remained the chief summer port of Lower Canada, with a steadily increasing population. It thus became advisable to reconstruct the Hôtel Dieu which had been destroyed during the war, and one of the leading figures in the reconstruction was Mother Marie Angélique Viger de Saint-Martin.
Aristocratic, robust, sympathetic and well-educated, her reputation spread across the country and patients came from as far away as Halifax to receive her prescriptions, which were her specialty.

Such was the devotion to duty, quality of care and type of nurse that had already become well-established in French-Canadian society by 1760. Later these and newer sisterhoods were to begin their courageous missionary travels, taking their skills westward and northward across the country.

LARGE-SCALE IMMIGRATION

The British settlers to Canada were not so fortunate in nursing traditions as the early French settlers had been. Because of Henry VIII's break with Rome and the consequent diminishing of the religious sisterhoods in Britain, nursing had fallen into disrepute and English hospitals were left to indifferent hands. Nursing in English-speaking Canada remained primitive for many years, and it was the acute and vast health problems of the thousands of immigrants arriving in the 1800's, bringing cholera, typhus, smallpox and trachoma with them, which finally gave the impetus to increasing the numbers of health personnel. In 1832, cholera swept the Montreal area, killing one-seventh of the population. This led to the setting up of a quarantine station and hospital at Grosse Isle in the St. Lawrence River. Lay nurses began to assist medical staff, but they were largely uneducated and unqualified for their jobs. Outside of the sisterhoods, there were no institutions that taught a co-ordinated system of nursing skills and there was little to attract intelligent lay women to nursing. In the effort to fill the gap of nursing personnel, both French and English-speaking sisterhoods were established during the 1800's, several of them influenced by the Sisters of Charity, an American order started in 1809 by Mother Seton.

Gradually, English-speaking non-secular hospitals began to appear to care for the poor, but conditions in these hospitals were not good. As late as 1870, a representative situation at the Montreal General Hospital was described by Dr. F. J. Shepherd in a history published by the MGH nursing school alumnae association:

> In my day (the late sixties and after), age and frowsiness seemed the chief attributes of the nurse, who was ill-educated and was often made more unattractive by the vinous odor of her breath. Cleanliness was not a feature, either of the nurse, the ward or the patient; each one did as best pleased her, and the "langwidge" was frequently painful and free. Armies of rats frequently disported themselves about the wards, and picked up stray scraps left by the patients, and sometimes attacked the patients themselves.

FLORENCE NIGHTINGALE AND LATER

It was the influence of Florence Nightingale which brought to Canada a training system that permitted the eventual development of nursing into a profession. The Nightingale influence came to this country both directly from England and through
the United States, and the story of its beginnings is one of the courage, tenacity and brilliance of just one woman.

Nursing was not an acceptable occupation for Anglo-Saxon women in the mid-1800's, and it was against her family's wishes that Florence Nightingale spent some time at Kaiserwerth in Germany where Protestant deaconesses under Pastor Fliedner were making advances in nursing care to fill the gap left by the earlier suppression of the monastic orders. She later spent some time in Dublin where Roman Catholic sisters ran a hospital, and in Paris with the Sisters of Charity.

Thus by the time the Crimean War broke out in 1854, through self-instruction and some training, she had prepared herself for her life's work. From the Crimea, British reporters wrote back to England adversely comparing care of the English wounded to that of the French, whose Sisters of Charity were at the front. Accordingly, Florence Nightingale led to Scutari a contingent of about 30, consisting of Roman Catholic sisters, Anglican sisters and practical nurses. From there, she organized all the British hospitals and about 200 nurses eventually passed under her command. She emphasized sanitation and total health care and was reported to have brought down the death rate by 75 per cent. Her administrative and medical successes were so amazing that her fame spread quickly and widely and her nursing practices eventually influenced the course of nursing not only in England but all over the western world.

Meanwhile, the work of Florence Nightingale captured the imagination of the British people, and one of the ways they sought to reward her was by raising a fund to organize a training school for nurses. This she believed to be the best method of raising the status of nursing. In 1860, she organized a training school for 15 lady probationers at St. Thomas's Hospital in London. Although it was associated with the hospital for training purposes, it was administratively and financially independent. These first Nightingale nurses were trained to become teachers of nursing and hospital management, rather than private duty nurses. Eventually, however, in the course of their later work, they found that hospital expenses could be cut by using student nurses on the staff, and this led to the practice which is still in existence.

IN NORTH AMERICA

The urgent need for schools on the pattern of the Nightingale school in London was shown by the American Civil War, just as the Crimean War had exposed it to England and Europe. The first school in North America to be set up on principles advocated by Florence Nightingale was the Bellevue Training School for Nurses, established in New York in 1873 by Sister Helen Bowden, an Anglican sister who had been trained at University College Hospital in England. This New York hospital became a model for the American training schools that soon emerged throughout the U.S. in response to the needs of expanding populations. Because adequate training facilities were not yet available in Canada, many Canadians went to the U.S. to study during this period; some returned to become leaders in the establishment of training schools for nurses in Canada and in the formation of the provincial and
national nursing organizations. Close contact was maintained with Canadian colleagues who remained in the United States and who played significant roles in the development of the profession in America.

In particular, there were among this group three nursing educators and leaders, each of whom was to receive national and international acclaim as author and speaker on nursing subjects: Isabel A. Hampton, M. Adelaide Nutting and Isabel Maitland Stewart.

The first to achieve prominence was Isabel Hampton, a native of Ontario, a graduate from Bellevue Hospital, New York, later superintendent of the Illinois Training School of Cook County Hospital, Chicago and then first principal of the nursing school at Johns Hopkins Hospital, Baltimore. While at Illinois, she pioneered in America a system of affiliations for her students so that they would receive experience of the types lacking in their home school. She was among those instrumental in the creation of the first course for graduate nurses at a university in America — the hospital economics course established in 1899 at Teachers College, Columbia University.

One of Miss Hampton’s students at Johns Hopkins, M. Adelaide Nutting from Quebec, succeeded her as principal of the school. Among Miss Nutting’s accomplishments there were the reduction of students’ working hours to eight, lengthening the course of study to three years, and establishing a course of training preliminary to actual ward practice. Miss Nutting became the first full-time director of the Department of Nursing and Health at Teachers College, Columbia University from 1907 to 1925, and the first nurse in the world to hold a professorship in nursing. Under her leadership, the National League of Nursing Education published its first curriculum guide for nursing schools in 1917.

Miss Nutting’s assistant in 1909 and later her successor in the Columbia University post was Isabel Maitland Stewart, one of the early nursing graduates from the Winnipeg General Hospital and the first nurse to earn an M.A. from Teachers College, Columbia. Among her many accomplishments were revisions in 1927 and 1937 to the 1917 proposed curriculum for U.S. nursing schools; in 1950 she completed a study of post-graduate nursing education for the International Council of Nurses.

FIRST CANADIAN SCHOOLS

The first training school for nurses in Canada organized on the Nightingale principles was opened by Dr. Theophilus Mack at the General and Marine Hospital in St. Catharines, Ontario, in 1874, and two nurses trained by Florence Nightingale came to Canada to direct the school. Dr. Mack, in building up his practice among the Irish laborers working on the Welland Canal, concluded that the best way to overcome the prejudice of many sick people against going into a public hospital was to create a group of trained lay nurses. At the time, it was a popular
belief that if a patient went to hospital for an operation, he would never come out alive.

It was several years before other training schools for lay nurses were established in Canada, but after 1880, many began to develop: several schools were established in industrial areas of Ontario, beginning with the Toronto General Hospital in 1881; the first major school in Manitoba was opened in 1887; in New Brunswick, in 1888; Nova Scotia, Prince Edward Island and Quebec, in 1890; British Columbia, in 1891; Alberta, in 1894; Saskatchewan, in 1901; and Newfoundland, in 1903. During the intervening years, many other hospital schools had been opened across the country, some of them in special institutions for the treatment of tuberculosis, mental illness and sick and crippled children. Subsequently, many of the small schools were closed, so that by 1930 there were approximately 220 schools of nursing in Canada.

Until 1919, graduates from Canadian schools of nursing seeking further nursing education were forced to go to the United States, which by 1918 had 21 schools affiliated with universities. With the evolving concept of nursing as a profession, nursing leaders in Canada, concerned for some years with raising of training school standards, began about 1910 to seek higher education for nurses at Canadian universities. The goal was for nurses to obtain a liberal arts education as well as practical training. In 1919, the first basic baccalaureate program was established at the University of British Columbia, ten years after the first basic program affiliated with a university had been initiated in the U.S. The following year, the first course for graduate nurses in teaching and supervision was established at McGill University. In 1920 and soon after several Canadian universities established diploma courses in public health nursing, and three began to offer basic baccalaureate programs, so that by 1926, eight Canadian universities were offering at least one type of course for nurses.

The largest proportion of early nursing graduates in Canada were absorbed into private duty nursing, first in homes, and later in hospitals. General duty nurses were not employed in the early years, since students were used as staff, and graduate nursing positions in hospitals were largely supervisory. In a large measure, well-to-do people received medical and nursing treatment at home; the poor went to hospitals. The demand for private duty nurses far exceeded the supply and to assist in making available private duty nurses, most hospitals operated a registry for their graduates. Increasing demands for nurses' skills led to the establishment of central registries, first in Montreal and Toronto, and later in other centers. Upon payment of a fee, these registries were open to graduates of recognized training schools. They were operated by graduate nurses on a non-profit basis, and helped to differentiate in the public mind between the trained nurse and the practical nurse — who was often available through commercial registries.

By the end of World War I, district, school, municipal, industrial and other public health nursing functions were on the upswing, providing new outlets for skilled nurses. Voluntary district nursing organizations were developing, and government departments of health were establishing nursing service branches.
Continued progress in the sciences brought medicine and nursing to the point where the quality of care received in the hospital was as good as in the home, and this was a factor in reversing the ratio between private duty and hospital-employed nurses. Another factor in the changing ratio was the depression which started in the late 1920's; fewer people could afford nurses at home and thus went to hospitals, which in turn required the hiring of more bedside nurses. During the depression years, hospitals were urged to limit the number of students entering schools of nursing and to hire graduate nurses to give them employment; payment was modest, but often included board and lodging. This custom of having graduate nurses reside in the hospitals continued for some years, but towards the 1940's, nurses began to live outside in larger numbers and were faced with higher living costs. This in turn led to the first pressures for higher salaries. At the same time, there were other pressures to reduce students' working hours to free them for more academic preparation, and more graduate nurses were hired to make this possible; governments were entering the health picture with various forms of assistance, which permitted more people to obtain hospital treatment.

By the mid-1930's, most of the major pressures that exist today in Canadian nursing were in evidence. Registered nurses had become well established as professional people. The patterns of service-training were being extensively challenged by nursing leaders, and the report of the first major study on nursing education in Canada had been completed by Dr. G. M. Weir. Through the depression, the basic motivations for the move towards collective bargaining had taken root, and governments were beginning to provide social measures which would cause vastly increased demands for competent health services.

EMERGENCE OF NATIONAL GROUPS

As an occupation, nursing is as old as the human race. Its status as a profession, emerging from organization and the responsibility of the organization for such essentials as ethics, standards of preparation and practice, is new in this century, although it has its roots in the last century.

After the middle of the 19th century, life spans increased and hospital construction was accelerated, with a consequent increase in the requirements for nursing personnel. This occurred first in England, then in the United States and then in Canada — all within about 20 years. Efforts to formalize the registration of professionally trained nurses and the control of nursing practice became matters of concern in the three countries and their development in many respects followed parallel courses.

One of the leaders in this movement was Mrs. Bedford Fenwick, a nurse, wife of an English gynecologist, and editor of what was to become The British Journal of Nursing. Mrs. Fenwick was a delegate to the 1893 Congress of Charities, Corrections and Philanthropy which was held that year in Chicago during the World's Fair, and among her hostesses were Isabel Hampton, Adelaide Nutting and
Lavinia Dock. All were impressed by Mrs. Fenwick and her story of the efforts to achieve nursing registration in Britain. The three pioneers of American and Canadian nursing organizations took action by calling a meeting of representative nurses attending the Congress. Their enthusiasm resulted in the immediate formation of the American Society of Superintendents of Training Schools for Nurses of the United States and Canada, with its purpose being to promote the interchange of ideas and the establishment of high educational standards. Membership was restricted to qualified nurses who directed schools of certain standards. This organization included non-nurses involved in leadership positions, and in 1912 became the National League of Nursing Education. At this time its main undertaking was to work for higher standards of nurse preparation. In this connection the curriculum for nursing schools published in 1917 afforded a new basis for raising national standards.

The first nurses’ alumnae associations in the U.S. were formed after 1890 at large, established hospital schools, such as Bellevue in New York, Illinois Training School in Chicago, and Johns Hopkins in Baltimore. In 1896, the American Superintendents Society was responsible for the national organization of these alumnae groups into the Nurses’ Associated Alumnae of the United States and Canada. Its first president was Isabel Hampton Robb, who had previously headed the Superintendents Society but had resigned when she married Dr. Hunter Robb, a Johns Hopkins doctor. The Associated Alumnae became, in 1911, the American Nurses’ Association.

One of the main purposes of the Associated Alumnae was to secure legislation to differentiate between trained and untrained nurses. Membership was voluntary and limited to those alumnae associations connected with hospitals having at least one hundred beds and whose training course was at least two years. The stated objectives of the Associated Alumnae group were to establish and maintain a code of ethics; to elevate the standards of nursing education; and to promote the usefulness and honor of the profession as well as financial and other interests of its members.

The Associated Alumnae first attempted to control the caliber of all nursing schools, but this proved beyond the scope of a voluntary group. Instead, they redirected their energies towards achieving state legislation which would assure supervision of nursing schools and the licensing of nurses after theoretical and practical examinations. A unifying influence which gave impetus to this movement was the American Journal of Nursing, which first appeared in 1900.

At this point in history, it became necessary for the Canadian groups to withdraw from the alliance with their American colleagues. This occurred because health legislation in the United States — and hence the proposed nursing registration acts — were under state control. To obtain their objectives, the associations found it desirable to become incorporated and as such could not include members from other countries. A further consideration was the single-nation concept of eligibility for membership in the International Council of Nurses.
Nurses of Canada were thus without formal national or international affiliations. They had, however, made the first steps toward national unity through the formation of alumnae associations, local and regional groups. Among the first nurses’ alumnae associations in Canada was that founded at the Toronto General Hospital in 1894. Then the largest school in Canada, it had by that year graduated a total of more than 250 nurses. Similar organizations followed rapidly across the country. As the number of these associations grew, the advantages of amalgamation into local and regional groups were realized and the activities were broadened by the establishment of graduate nurses’ associations in centers such as Toronto, Ottawa, Vancouver and Montreal.

Meanwhile, in England, Mrs. Bedford Fenwick had pursued the idea of an international association of nurses. As this idea took form, the National Council of Trained Nurses of Great Britain and Ireland became the nucleus of the International Council of Nurses formed in 1899 by Britain, Germany and the U.S. Other countries were represented by leading individual nurses until they could form their own national nurses’ association. Among this latter group was Mary Agnes Snively, a graduate from Bellevue Hospital, who, in 1884, had taken charge of the embryo school for nurses at the Toronto General Hospital. She became the first honorary treasurer of the ICN.

Miss Snively soon was actively engaged in the organization of Canadian nurses into a national group. Her objective was to have Canada represented in the ICN. One of the first concrete steps in this direction was the formation of the Canadian Society of Superintendents of Training Schools for Nurses in 1907, with Miss Snively as president. The constitution gave its objectives as:

... to consider all questions relating to nursing education; to define and maintain in schools of nursing throughout the country minimum standards for admission and graduation; to assist in furthering all matters pertaining to public health; to aid in all measures for public good by cooperation with other educational bodies, philanthropic and social; to promote by meetings, papers, and discussions, cordial professional relations and fellowship; and in all ways to develop and maintain the highest ideals in the nursing profession.

In 1908, representatives of all the organized nursing bodies in Canada were invited by the Superintendents Society to meet at the Lady Stanley Institute in Ottawa to consider the formation of a national nurses’ association. As a result of this meeting in October 1908, the Provisional Society of The Canadian National Association of Trained Nurses was formed and immediately applied for membership in the ICN. Miss Snively was president and the honorary secretary-treasurer was Flora Madeline Shaw of the Montreal General Hospital.

Membership in the new national organization was through the affiliated member societies, which by 1911 reached 28. The temporary constitution of the provisional society that was presented at the first meeting included these purposes:
To promote mutual understanding and unity between associations of trained nurses in the Dominion of Canada.

Through affiliation in the International Council of Nurses, to acquire knowledge of nursing conditions in every country, to encourage a spirit of sympathy with nurses of other nations and to afford facilities for national hospitality.

Promote the usefulness and honour of the nursing profession.

More than 20 Canadian nurses attended the ICN meeting in London in July 1909 at which Canada was accepted as a member, along with Holland, Finland and Denmark.

The Canadian National Association of Trained Nurses had come into being essentially to represent Canada in the ICN and did not immediately achieve form and identity as a national body. To overcome this deficiency, the CNATN set up a committee to suggest an effective nursing organization that would conform to the terms of the British North America Act, which placed health matters under the jurisdiction of the provinces. The beginnings of the Canadian nursing organization system can be seen in a report given by Mrs. E. G. Fournier, convenor of a CNATN committee formed to suggest a system of nursing organizations suited to Canada's needs. Mrs. Fournier was a native of St. Thomas, Ontario who had trained in Detroit, become a director of the American Superintendents Society and the National League of Nursing Education, and returned to Canada to become superintendent of the Hospital for Consumptives, Gravenhurst. She reported to the Canadian Superintendents Society in 1912, as recorded in the published minutes:

Your committee would suggest ... curtailing the number of associations and enlarging the undertakings of those remaining. One provincial society, with its superintendents section, entirely planned and arranged and presided over by superintendents. A private nurses' section, arranged in the same way; a visiting nurses' section under the management of a visiting nurse; a nursing extension section, with its Council, who would present to the annual convention, from time to time, many new departments that would later become sections of their own . . .

The well-organized Provincial Association back of the superintendent, or back of the school nurse, or back of its individual members, will stimulate and strengthen the work of all.

Will a Provincial Association, properly carried on, be sufficient? . . . Your committee would advise a National Association, constructed along the same lines as the Provincial Societies, so that each department might readily cooperate . . . It should be the object of the National Association to organize the unorganized provinces, to strengthen the weak ones, to encourage the disheartened, bind all together, inform all of the nursing achievements, and suggest work to be taken up.
A major force in the development of the provincial graduate nurses' associations was the increase in the number of nursing personnel that took place at the end of the 19th century. Nurses who were trained professionals found themselves competing for status and wages with nurses who had received little or no professional training; also, because there were no legal controls, there was no way of establishing uniformity in nursing service standards.

To rectify this situation, groups of professional nurses in each province organized themselves to work for provincial registration acts which would give the trained nurse permanent, legal status both inside and outside the hospital in which she was trained. Such acts would also have the effect of forcing schools to maintain uniform, minimum standards for admission and graduation.

The nurses of Nova Scotia in 1910 became the first in Canada to secure nursing legislation, but it established a procedure of voluntary registration only which could include non-graduate nurses. A more regulatory nursing act, setting out minimum standards of admission, curriculum in schools of nursing, registration and discipline of practicing nurses, was obtained in 1913 in Manitoba, three years before the passage of legislation granting the franchise to women.

By 1922, all nine provinces had some form of registration act, which in almost all cases included educational requirements for admission to schools of nursing and made the provincial nurses' association responsible for maintaining the standards of nursing education and nursing practice in the province. These laws had the effect of identifying the registered nurse as one who had met specified educational and other requirements, but did not prevent others who did not meet these qualifications from working as nurses.

Work towards the goal of registration was also undertaken on a national basis by the Dominion Registration Committee which was set up in 1911 by representatives of the Superintendents Society.

MODERN ORGANIZATION

In the meantime, organizational work had been going forward in the CNATN. A Public Health Nursing Section was formed in 1920; a Private Duty Section in 1921; and when the Canadian Association of Nursing Education (CANE) joined the CNATN in 1924, a Nursing Education Section was formed. Similar sections were being developed within the provincial associations so that the national and provincial efforts could be supported and co-ordinated. Although over the years there have been changes in the various committees within the CNA, the basic idea of having committee counterparts in the provinces has remained.

In 1924, each province had a provincial nurses' organization with membership in the CNATN, and in that year, the national group changed its name to the Canadian Nurses' Association. There were then 52 nursing organizations affiliated with the national association.
At this time, non-registered nurses could be members of the CNA by virtue of their membership in some of the alumnae clubs and local associations; there was also some duplication of memberships and membership fees when nurses belonged to more than one organization within the CNA — which made difficult the accurate compilation of statistics.

To correct the problem, the CNA in 1930 became a federation of the nine provincial nurses' associations. This made the provincial association the official representative of registered nurses in each province and automatically ensured that all members of the CNA were registered nurses. The fee to the CNA paid by a provincial association for each of its members was increased from 50 to 75 cents.
III. Ten-to-One

Most of Canada's provincial nurses' associations emerged before the present era of high-speed transportation and communications and, in some measure, their course and character were formed by a response to geographical and social needs. Thus, throughout the ten associations in Canada, there are many similarities but also some characteristics peculiar to each province. The national association mitigates, in a large degree, the divisive effects of distance and limited population which is a continuing reality in a country with a breadth of 4,000 miles and a population of about 20 million.

The story of Canada is a story of a westward-flowing tide of humanity, fabricating a nation from a vast variety of conditions and human circumstances. The provincial nurses' associations emerged from this human mosaic — influencing regional developments and being influenced by them. This background, rather than chronological development, is the focus of the sketches which follow.

NEWFOUNDLAND

Newfoundland's shores were familiar to the Vikings almost 1,000 years ago and more familiar to western European fishermen at least half a century before Columbus recorded his arrival in America. The land was claimed for England by John Cabot in 1497 and reaffirmed by Sir Humphrey Gilbert in 1583. For almost 300 years Newfoundland was without a central government; during much of this period local law was made and enforced in the individual fishing hamlets along the coast by the captain of the first fishing vessel to arrive in the spring. Newfoundland was also caught in the squeeze of the long wars between the French and the English and the last French effort to capture St. John's was made in 1796. The land was officially claimed as a British colony in 1824 and in 1867 was on the brink of joining Canada — but an election changed these plans and retarded them for almost 90 years.

Early medical and nursing care in Newfoundland was primitive and health facilities developed essentially along the pattern necessary to provide services to isolated, low-income fishing settlements along the rocky coast lines of Newfoundland and Labrador.

The first civilian hospital on the island was opened in 1814 in St. John's at the instigation of Dr. William Carson, who had arrived in Newfoundland only six years
earlier. Later it became a government institution. In 1870, when the military garrisons were removed from the town, the military hospital was handed over to the government, and the staff and equipment of St. John’s General Hospital were moved there. Until the establishment of the Grenfell Mission Hospital at St. Anthony in 1900, it was the only institution of its kind in Newfoundland and had only 100 beds for more than 200,000 people. In 1903, a school of nursing was opened under the direction of Mary Southcott, a graduate from London Hospital, England; the first class of four was graduated in 1906. St. Clare’s Mercy Hospital and the Salvation Army Grace Hospital were opened in 1922 and 1923, respectively.

Still prominent in the Newfoundland health picture is the Grenfell Mission which was founded by Sir Wilfred Grenfell before the end of the 19th century and now provides hospital, medical and nursing services in many of the outports of Labrador and northern Newfoundland.

Many other missionary and public service enterprises engaged in providing health and nursing service and among these efforts was the Outport Nursing Committee, established in 1920 by Lady Harris, wife of the governor of Newfoundland, to place public health nurses in outports. A few years later, it was renamed NONIA, and its function was to provide public health nurses to those regions in which the people, by the production of handicrafts, were able, at least partially, to support the nurses.

The development of government public health services began after 1930. In 1931, comprehensive public health legislation was passed and today, among other activities, the Department of Health operates in remote areas more than a dozen cottage hospitals that have from 15 to 75 beds as well as out-patient facilities. There are also government-operated nursing stations, staffed by a registered nurse with some assistance, which provide a general nursing program together with two or three in-patient cases. Outport district nurses rely heavily on their own skill and resourcefulness but have access to cottage hospitals which may, however, be a hundred miles away. All district nursing, including that in St. John’s, is under the jurisdiction of the director of public health nursing in the provincial health department. Specialized nursing services are carried on also by various voluntary visiting organizations. In 1967, the staffing of cottage hospitals became the responsibility of the director of nursing in the Cottage Hospital Division of the Department of Health.

As early as 1910, there was an affinity of interests between Newfoundland and Canadian nurses, evidenced by the membership of Miss Southcott in the Canadian Society of Superintendents of Training Schools of Nurses.

The National Association of Graduate Nurses of Newfoundland was formed in 1913 and applied for membership in the Canadian National Association of Trained Nurses, but was not accepted as Newfoundland was not then part of Canada. The minutes of the July 1914 CNATN general meeting show, however, that Miss Southcott was an active participant in the meeting, and continued to be a member of
the editorial board of *The Canadian Nurse*. The first act concerning nursing was obtained in 1931 and in 1935 the Newfoundland Graduate Nurses' Association was incorporated. A new act of registration and incorporation was obtained in January 1954, less than five years after Newfoundland became a province of Canada. In the same year, the provincial association joined the CNA. The first president of the re-organized association was Elizabeth R. Summers.

In 1966 a basic baccalaureate program in nursing was inaugurated at Memorial University in St. John's.

**PRINCE EDWARD ISLAND**

The discovery of Prince Edward Island is usually attributed to Jacques Cartier in 1534, but it was nearly 200 years later that the first recorded colonists from France arrived at the island then called Ile St. Jean. Subsequently, there was an influx of Acadians from Nova Scotia, so that by 1758, when it was taken over by the British, there were more than 5,000 inhabitants on the island. With the exodus of the Acadians in the following years, the population decreased, and the present inhabitants are mainly of English, Irish and Scottish descent. In 1763 the island was annexed to Nova Scotia, in 1769 became a separate colony, and in 1799 was renamed Prince Edward Island in honor of Prince Edward, Duke of Kent, the father of Queen Victoria.

The first health legislation was passed in 1832 when the erection of an asylum for the insane was authorized. Local boards of health were legally established in 1851, along with a provision for the establishment of hospitals, but little action was taken. When P.E.I. joined Confederation in 1873, the federal government took over the supervision of sanitation of ships, but it was not until 1879 that the first hospital in the province was established. This was done through the efforts of Bishop Peter MacIntyre, who asked the Bishop of Quebec to send nuns to open a 12-bed hospital and to visit the sick. Thus, Charlottetown Hospital was opened by the Sisters of Charity, who were succeeded in 1925 by the Sisters of St. Martha, an order founded a few years earlier in Nova Scotia.

Prince Edward Island Hospital, opened in 1883 to care for the sick of all classes of Charlottetown and the surrounding country, was governed by a board of trustees. Mrs. Hannah Robinson was the first superintendent. The province's first school of nursing was established there in 1891, with Jessie M. Sheraton, a graduate from Saint John, New Brunswick, as director. The first nurse graduated in the province was Sarah Jean Arthur, who later took charge of three pioneer hospitals in British Columbia.

The province's other hospital is the Prince County Hospital, opened at Summerside in 1912. A school of nursing with three students was opened there the same year with a graduate nurse, Grace B. Beattie, as superintendent.
Although the island did not suffer from the epidemics brought by immigrants to the mainland, tuberculosis was a serious problem. In 1906, the Anti-Tuberculosis Society was formed, and this group was influential in bringing about improvements in the province’s health services.

Following World War I, when the commission of the International Red Cross was enlarged, The Canadian Red Cross Society, through its provincial branches, offered assistance to provincial governments and national voluntary agencies interested in public health. The offer was accepted in many provinces but the role of the Red Cross in Prince Edward Island was unique in that the entire public health service of the province was set up and maintained for a number of years by the Red Cross.

In 1920, the P.E.I. Red Cross Society took the first step in the public health field by forming a child welfare section. The following year, Amy McMahon, a nursing graduate from Johns Hopkins Hospital who had served with the Canadian Expeditionary Force in the Boer War, became P.E.I.’s first public health nurse. She also introduced Junior Red Cross branches into the schools. In 1923, she was succeeded by Mona G. Wilson of Toronto, also a Johns Hopkins nursing graduate who served during World War I with the American Red Cross and later took the public health nursing course at the University of Toronto. In 1931, through the efforts and financial support of the Canadian Tuberculosis Association and the Canadian Life Insurance Officers Association, a provincial department of health was formed which took over the province-wide public health service of the Red Cross and retained Miss Wilson as provincial director of public health nursing.

In 1922, the Graduate Nurses’ Association of Prince Edward Island obtained an Act of Registration and joined the national nurses’ association. The first president was Bessie B. Beer, a native of P.E.I. and a graduate from Newton Hospital, Newton, Mass. The P.E.I. organization was incorporated in 1950 as the Association of Nurses of Prince Edward Island and a licensing act was obtained. Some financial support for administrative costs has been received from the provincial Department of Health since 1950.

In 1960, the proposal to establish a single school of nursing on the island was discussed at a meeting of the schools of nursing advisory committee of the Association. This was followed by several studies in the province. Among these were a 1963 CNA survey of the schools of nursing, conducted by Glenna S. Rowsell; a 1964 cost study of nursing education, by Dr. Hessel Flitter and Harold Rowe of the National League for Nursing, financed by the U.S. Public Health Service; and a 1966 study of transition in P.E.I. nursing education, conducted by Harold Rowe, now at the University of Kentucky.

**NOVA SCOTIA**

The first mainland settlement in Nova Scotia was established in 1604 at Port Royal by the French; at that time the area was called Acadia and the settlers Acadians.
The story of this territory was to be one of tribulation for the settlers, climaxed by the expulsion of the Acadians a century and a half later when Halifax was founded and colonized by the British.

During the wars of the American and French revolutions, Halifax and the surrounding area grew rapidly; Scots settled in large numbers, and Germans made their homes around Lunenburg. Fisheries, timber and the building of wooden ships, trade with Britain, and the Reciprocity Treaty of 1854 with the United States enabled Nova Scotia to prosper and develop quickly.

Under the British regime, hospitals and quarantine stations were erected for the settlers, but, as in the rest of Canada, there were no trained nurses and the settlers were dependent on self-taught practical nurses. This situation was to remain even with the arrival of 30,000 United Empire Loyalists during and after the American Revolution.

Nova Scotia was hit by the cholera epidemic of 1832 that created havoc in most of Canada and Dalhousie College was turned into a temporary hospital. A few years later, a Sisters of Charity order was formed by William Walsh, the first Catholic archbishop of Halifax. Like many such groups, the sisters were originally teachers but became nurses in response to the needs of the populace. When a shipload of sick immigrants docked at McNab's Island in 1866, these teaching sisters were called upon to accompany the doctors to care for the ill. Among them was Sister Mary Vincent Palmer who later was active in the establishment of the Halifax Infirmary, in 1887, which evolved when the sisters were requested to accept surgical cases at a home they maintained for aged women.

Meanwhile, the McNab's Island experience led to the establishment in 1867 of the Provincial City Hospital in Halifax which in 1887 was renamed Victoria General Hospital. Three years later, Julia A. Purdy, previously superintendent of nurses at Saint John General Public Hospital, opened Nova Scotia's first training school for nurses.

In 1893, the Anglican Church established All Saints' Hospital at Springhill to care for injured miners, and soon other hospitals began to appear in the province. Following the trend of the period, many were specialized institutions. The Public Health Department was formed in 1904 and with the opening of the Kentville Sanatorium the same year, Nova Scotia became the first provincial government to open an institution for the treatment of tuberculosis. The second children's hospital in Canada was established at Halifax in 1909, with Frances Fraser, a graduate of Canada's first Sick Children's Hospital in Toronto, and of New York's Roosevelt Hospital, as superintendent.

After the end of World War I, the provincial Red Cross society held a conference to determine its peacetime program. The plan included the training and development of public health nursing personnel. The proposal was approved, and the medical faculty at Dalhousie proceeded to organize a public health nursing course in co-operation with several groups including the Massachusetts-Halifax

The first full-time public health nurse was employed by the province in 1920—Margaret E. MacKenzie, a graduate of the first public health nursing class at the University of Toronto. The same year the provincial branch of the Canadian Red Cross agreed to finance a public health nurse in each county for one year. After the financial assistance given by the Red Cross was withdrawn, the communities were encouraged to continue the service.

In the latter part of the 19th century, Nova Scotia was one of the more developed provinces in Canada, and thus pressure for social services were more advanced than elsewhere in the country. Nova Scotia nurses were among the first to become an established group. During 1909, preliminary meetings were held in Halifax to form the Nova Scotia Graduate Nurses' Association, and the provisional president of the group was Evaline M. Pemberton, a native of British Columbia and a graduate from Montreal Western Hospital, who had taken additional training at Edinburgh and Liverpool. This group became incorporated as the Graduate Nurses' Association of Nova Scotia in 1910 with Mrs. Frances Forrest as president. The nursing legislation that was passed in 1910 was the first in Canada and provided for a board of examiners and an examination for nurses; non-graduate nurses could be included on the nurse registry by passing the examination. The GNANS joined the national organization in 1912 and changed its name to the Registered Nurses' Association of Nova Scotia in 1922.

By the 1966 revision of the Registered Nurses' Association Act, the association continues to be responsible for prescribing the nature and extent of education for the practice of nursing; for the examination and certification of registered nurses; and for negotiating on behalf of its members in matters pertaining to their welfare.

NEW BRUNSWICK

The first settlers arrived in New Brunswick in 1604 when Champlain landed 79 colonists on Ile St. Croix in the Saint John River. Shortly after the transfer of French possessions to Britain in 1763, all the New Brunswick area became a county of Nova Scotia, and at this time the population was still very small: probably about 800 or 900 new British settlers in the southern portion, and about 1,000 French Acadians in the north and eastern shores — where they had fled after having been expelled from Nova Scotia proper.

Real colonization did not begin until 1783 with the sudden influx of over 12,000 United Empire Loyalists from the New England States. By 1874, New Brunswick had become a separate political entity and the largest of the maritime provinces. The hinterlands created problems of isolation and primitive conditions, and the sea coasts brought problems of transient populations, congestion, and
disease. The province thus developed unevenly and so did its social and medical services. The older, larger communities organized to serve themselves to some degree, but before the mid-1800's there were no general hospitals and no training schools for nurses in New Brunswick. Nurses worked according to their own ideas, and knowledge was picked up by experience.

At Saint John, the earliest hospital for sick and disabled seamen was Kent Marine Hospital, opened in 1822; a primitive quarantine station was set up at Partridge Island in 1832; in 1836, the Provincial Lunatic Asylum was opened, to separate the mentally ill from the prisoners in the jails; an institution for lepers was established at Sheldrake Island at the mouth of the Miramichi River in 1844.

In 1865, the General Public Hospital in Saint John was opened, the first in the province. In 1888, Julia A. Purdy, a graduate from Boston City Hospital, was appointed superintendent of nurses and established the province's first training school.

Between 1868 and 1873, religious sisterhoods became active in nursing. The leper institution was moved to Tracadie and was taken over, with assistance from the federal government, by the Hospitallers of St. Joseph from the Hôtel Dieu in Montreal. The same order also opened two other hospitals, one at Chatham and the other at St. Basil.

Like many Canadians who lived near the borders of the United States in the late 1800's, New Brunswick girls often went to the United States for training at a time when nursing schools were rare in Canada. Among these was Elizabeth Robinson Scovil who went to the Massachusetts General Hospital in Boston in 1878, five years after that school had opened and four years after the only training school in Canada had opened. She became a prolific writer on nursing and child care, became associate editor of the Ladies Home Journal in 1895, was a member of the staff of the American Journal of Nursing at its inception in 1900, and later was on the staff of The Canadian Nurse.

The Victorian Order of Nurses was the pioneer organization undertaking public health nursing in New Brunswick, starting in Saint John, and this organization as well as the Red Cross continued the work in the province for some years. Gradually, some of the public health nursing duties were taken over after the government organized the public health nursing service in 1921 under Harriet T. Meiklejohn.

Members of the Saint John General Public Hospital Nurses' Association took the initiative in the development of a provincial nurses' association, which in 1914 joined the CNA. In 1916, the first legislation for nurses in the province was passed and this included the incorporation of the New Brunswick Association of Graduate Nurses. Arthuretta Branscombe was the first president and there were 59 members. By 1919, the first registration examinations were held in the province. In 1924, the name was changed to the New Brunswick Association of Registered Nurses and Maude E. Retallick became the first secretary-registrar.
In the years following World War II, the federal government began to subscribe more and more to the philosophy of supporting health services, and as a result of this the New Brunswick government in 1948 undertook a study of existing health services. Alice L. Wright of Vancouver conducted the nursing portion of the program, and among her recommendations was that a school of nursing be established at the University of New Brunswick. A few years later, a study of ways and means of reorganizing provincial nursing education to provide more adequate nursing service was sponsored by a group of Atlantic province health organizations, including the NBARN. Conducted by E. Kathleen Russell of Toronto, the study was published in 1956.

A school of nursing offering a basic baccalaureate degree in nursing was established at the University of New Brunswick in 1959. Katherine E. MacLaggan, a graduate of Royal Victoria Hospital, Montreal, and Columbia University, was appointed to head the department, and she subsequently earned a Columbia University doctoral degree. Her dissertation, Portrait of Nursing: A Plan for the Education of Nurses in the Province of New Brunswick, was published in 1965 by the NBARN. Another event of importance at about the same time was the opening in 1965 by the University of Moncton of the province’s first baccalaureate nursing program for French-language students, under the direction of Sister Jacqueline Bouchard, a graduate from Hôtel Dieu, Edmundston, Institut Marguerite d’Youville, Montreal, and Catholic University, Washington.

QUEBEC

Following the change of controlling government in Quebec in 1763, the French-speaking nursing sisterhoods continued to aid the sick and the destitute. Quebec City and Montreal became the main ports for receiving the immigrants bound for Upper Canada and the far west, and with the immigrants came epidemics and pestilence. By 1816, the population of Montreal was about 12,000 French and 4,000 English, and in that year some 5,000 immigrants passed through the city. The only hospital in the city open for general care was the Hôtel Dieu, with a capacity of 30 beds, but the efforts of the sisters never ceased, coping with epidemics as best they could in temporary quarters. Other efforts to care for destitute and ill immigrants were made by the Female Benevolent Society, which in 1819 formed the Montreal General Hospital.

Existing facilities proved inadequate during the cholera epidemic of 1832 when more than 50,000 immigrants arrived at Quebec from Great Britain and Ireland. The Hospitalers of St. Joseph and the Grey Nuns, as well as groups of sisters from a newly-founded order—Sisters of Charity of Providence who were trained at the Hôtel Dieu in Montreal—helped with the typhus epidemic of 1847, brought by the Irish fleeing their homeland. That year, more than 7,000 immigrants died in Montreal, and many of the young sisters also died on duty. In the following few years, cholera epidemics were frequent, and several hospitals were opened by the nuns, many of them temporary structures later destroyed by fire. One of the first
hospitals in the rural areas was opened by the Sisters of Charity — Grey Nuns — at St. Hyacinthe in 1840; after 1850, many more were established, including those at Joliette, St. Jean and Sorel.

The disciplined traditions within the sisterhoods continued to result in a degree of control of nursing training and practice that was not yet available to the English-speaking, non-sectarian institutions. It was not until 1874, at the time when the influence of Florence Nightingale was first being felt in North America, that a group of the doctors and management at the Montreal General Hospital tried to start a nurses’ training school, which they hoped might raise nursing standards. Conditions at the hospital were so difficult that it was not until 1890 that the school actually began, under G. E. Nora Livingston, a graduate of New York Hospital. Four years later, the Royal Victoria Hospital and its training school (under a native of Ontario and a Bellevue graduate, Edith A. Draper) were opened, and also the Western and Homeopathic hospitals.

As English-language nursing began to develop in the province, it became important to differentiate between trained and untrained lay nurses at a time when this was not yet subject to legislation and tradition. One of the first groups to pursue this end was a small, local group of nurses named the Canadian Nurses’ Association that was formed in Montreal in 1895 and incorporated in 1907. The following year, it became a charter member of the CNATN and in 1924 changed its name to the Montreal Graduate Nurses’ Association.¹

In 1917, the Graduate Nurses’ Association of the Province of Quebec was formed. Its president was Grace M. Fairley, a native of Edinburgh, who had trained at Swansea General Hospital in Wales. The secretary was Mabel F. Hersey, a graduate of the Royal Victoria Hospital and, for 28 years, its superintendent of nurses. In 1920, the GNAFQ was dissolved and through a provincial registration act, it became the Registered Nurses’ Association of the Province of Quebec. To obtain membership, a nurse must have graduated from an approved school of nursing within the province; minimum standards for these schools were set out in the act, and it was the responsibility of the RNAPQ to examine and approve the schools.

At this stage, the common objectives of the French and English nurses became more clearly defined. These two groups, products of vastly different backgrounds and pursuing in many cases separate but parallel courses, began to work together in the newly formed provincial association to promote the improvement of nursing and the welfare of nurses. Among the French-speaking pioneers in this co-operative movement were Sister Fafard and Sister Duckett of the Grey Nuns, and lay French-speaking nurses including Milie Guilmette.

In 1922, the RNAPQ became affiliated with the CNATN. The same year, the RNAPQ published its first minimum curriculum guide for use in nursing schools.

Reflecting the interests of the nursing sisterhoods in promoting high standards of education, two RNAPQ members received honorary Doctor of the University of

¹ The Canadian Nurse, March 1933, Page 127
Montreal degrees in the 1930's. Founder of Institut Marguerite d'Youville, the first French-language school for graduate nurses in Canada, Mother Marie Virginie Allaire's citation in 1933 read in part: "For outstanding services and scientific contributions to the development of the Catholic nursing schools". Mother Louise Allard, Hôtel Dieu, Montreal, received her degree in 1938 as a "distinguished leader in local and national hospital and nursing organizations; an acknowledged author of many important articles, including Cours de Techniques".

In 1946, with the passing of the Quebec Nurses' Act, Quebec became the first province in Canada to have a mandatory licensing act for nurses. The same year, the association changed its name to the Association of Nurses of the Province of Quebec, and Sister Valerie de la Sagesse was the first religious sister to become president of Quebec's provincial group.

ONTARIO

Although widely explored by French fur traders and missionaries, Ontario had many unsettled regions when it became a British possession in 1763. Loyalist and other settlements brought a large English-speaking population to the area and, following the War of 1812, immigration became mainly English.

One of the first organizations in the province that was instrumental in the formation of civilian hospital services was the Loyal and Patriotic Society of Upper Canada, whose funds were used in 1819 to open York Hospital, later Toronto General Hospital. At Kingston, efforts were made at about the same time to care for destitute immigrants by the Kingston Compassionate Society, and from these efforts came the General Hospital. This eventually proved inadequate and, at the request of the bishop, five nursing sisters from the Hôtel Dieu in Montreal opened a second hospital at Kingston in 1845. The same year the Grey Nuns — Les Soeurs Grises de la Croix — began to provide nursing services at Bytown, later called Ottawa, and this was the origin of the Ottawa General Hospital. Headed by Mother Elisabeth Bruyère, these nuns cared for both local citizens and the desperately ill immigrants in Ottawa and later opened hospitals in other areas.

One of the major events which brought the development and improvement of hospitals was the immigration in the mid-1840's of nearly 100,000 Irish to various parts of Canada — more than 20,000 of whom were to die of typhus (ship's fever) and other diseases en route to their destinations. These immigrants were largely Roman Catholic and in recognition of this, the teaching order of the Sisters of St. Joseph, with origins in France but, through its branches in the U.S., came to Toronto in 1851. As well as teaching, this order was responsible for the founding of several hospitals in Ontario, the first of which was St. Joseph's Hospital in Guelph in 1851.

It was not until 1874 that the first nursing school in Canada for lay students was formed at the General and Marine Hospital in St. Catharines. It was about this time that many Ontario towns began to industrialize and require the services of
urban communities. To meet the growing need for training facilities in Canada, Harriet Goldie, lady superintendent, initiated a school of nursing in the Toronto General Hospital in 1881. Miss Goldie was not a nurse, but had experience in the Franco-Prussian war and in British and European hospitals. The position of lady superintendent of nurses at Toronto was assumed in 1884 by Mary Agnes Snively, who succeeded in attracting a new type of person into Canadian nursing, and to some extent stemmed the flow of Canadian women to American nursing schools.

In 1891, an epidemic of scarlet fever and diphtheria broke out, and the teaching sisters of St. Joseph in Toronto were persuaded to open yet another hospital. Two of the nuns were sent to the Hôtel Dieu in Montreal for training prior to the opening of St. Michael's Hospital in 1892. Its training school, opened the same year under Miss A. Harrison from Bellevue Hospital, was one of the first nursing schools operated by Roman Catholic orders to be open to lay students.

The early outlines of an organization of nurses emerged among the alumnae associations in Ontario's urban centers, and these became the nucleus of the Graduate Nurses' Association of Ontario, which was formed in 1904 with Elizabeth Campbell Gordon, superintendent of nurses at the Kingston General Hospital, as president. Incorporated in 1908, this group became a charter member of the Canadian National Association of Trained Nurses the same year.

In the early 1920's, the Ontario Government formed an Advisory Council of Nurse Education (later Council of Nursing), and appointed as the first chairman Edith MacPherson Dickson, a graduate of the Toronto General and lady superintendent of nurses at the Hospital for Consumptives in Weston. She was instrumental in the reorganization of the GNAO to become the Registered Nurses' Association of Ontario in 1922. At about the same time, a survey of Ontario training schools was made which paved the way for their regular inspection and for the publishing of the first minimum curriculum for schools of nursing in Ontario in 1925.

In 1920, the University of Toronto began to offer an eight-month course in public health nursing under the direction of E. Kathleen Russell, a graduate of King's College, Halifax, Toronto General Hospital and University of Toronto. Thirteen years later, a grant from the Rockefeller Foundation made possible at U of T the first basic baccalaureate course in nursing in Canada that was not under hospital control. In 1933, the act governing the registration of nurses in Ontario was revised to include schools of nursing in universities.

The Nurses's Act that was passed in 1961 marked a unique departure, the first in Canada, of statutory responsibilities from the provincial association. The College of Nurses of Ontario was created to be responsible for registration of graduate nurses and nursing assistants. The College was also to approve schools of nursing and set minimum standards for entry into the nursing profession.

In 1967, Albert W. Wedgery, a graduate of Ontario Hospital, Whitby; University of Western Ontario, and Columbia University, was elected president of the
RNAO, the first male nurse to hold the senior elective position in a provincial nurses' association in Canada.

MANITOBA

The first recorded white men to visit the territory of what is now Manitoba were with the expedition of Henry Hudson, who in 1610 discovered Hudson Bay during his search for the Northwest Passage. Fur traders and explorers came later. The first large settlement in the area started near the junction of the Red and Assiniboine rivers in 1812, when Lord Selkirk brought groups of Scottish immigrants to develop farms to provide food for the fur traders.

As in the other Canadian provinces, the missionaries were among the first to realize that nurses were needed. Many of the settlers were Roman Catholic, and so Bishop Provencher, concerned about the lack of educational, spiritual and medical facilities available to the white and half-breed Méts population of the Red River colonies, traveled to Montreal to seek help. At this period in history, the Roman Catholic sisterhoods, with their mother-houses, were the only established groups available to organize hospitals in outlying areas. In Montreal, Bishop Bourget suggested to Bishop Provencher that he request help from the Grey Nuns; they responded by sending four pioneering nurses to Manitoba from Montreal: Sisters Valade, Lagrave, Coutlee and Lafrance, who traveled much of the way by birchbark canoe and arrived in St. Boniface in June 1844 after a two-month journey.

In the 1860's, settlers flowed into the Red River valley, and in 1870 Canada purchased the territory from the Hudson’s Bay Company. The following year, Manitoba joined Confederation. The Red River Rebellion, accidents incurred during the building of the CPR railway, and a typhoid epidemic, all strained the facilities of the Grey Nuns' permanent hospital opened in 1871 and brought about the formation of the Winnipeg General Hospital the following year. The first matron of the hospital, Mrs. Colville Brown, was appointed in 1882. She was succeeded as lady superintendent in 1891 by WGH graduate Margaret Laidlaw and then by Elizabeth Holland (later Mrs. A. W. Moody, mother of Mrs. Lester B. Pearson).

The first Manitoba training school for nurses was organized at the Winnipeg General in 1887 and at that time there were on staff five Toronto General graduates plus Grace Reynolds who had been trained at Leeds Infirmary in England by a pupil of Florence Nightingale. The first class of six was graduated in 1889 and included Sarah and Mary Ellen Birtles.

An influence on the early development of life in Manitoba, as in other parts of the Prairies, were the distinctly ethnic immigrant groups, who according to *A Friendly Adventure*, published by the Home Missions Board, United Church of Canada, "were hurled at the country by trainloads". These included Mennonites and Doukhobors from Russia; Icelanders driven from their homes by volcanic eruptions, Ukrainians and Germans. There were few doctors and nurses among them; the first
nursing services were organized by religious and voluntary groups, including those associated with the Methodist and Presbyterian churches, the Grey Nuns and other Roman Catholic sisterhoods.

Among the early efforts in public health nursing was the service set up by the City of Winnipeg, following the arrival of central European immigrants between 1905 and 1913. In 1916, Manitoba became the first province to employ public health nurses and pay their salaries from public funds. The first permanent chief nurse assistant to the public health officer was Elizabeth A. Russell, appointed in 1917; her title later became director of nursing services.

Meanwhile, in 1904, the alumnae of the Winnipeg General Hospital formed the first lay nursing organization in the province. The following years, three groups of nurses — the alumnae associations of St. Boniface Hospital, Winnipeg General Hospital and the Trained Nurses Association — met to hear an address on registration by a member of the Ontario provincial association. Following this meeting, the Manitoba Association of Graduate Nurses was formed and began working for the general welfare of the profession and the achievement of registration. Its first president was Miss Reid, a graduate of Boston General Hospital. In 1908, MAGN affiliated with the CNATN.

Beginning in 1905, nursing leaders of the province including Ethel I. Johns and Isabel M. Stewart sought to arouse public concern about the need to establish standards for the preparation and practice of professional nurses. A committee on legislation began to collect information concerning registration and, in 1911, submitted its proposal to the MAGN, which in turn sent the proposal to the superintendent and board of managers of each hospital, asking for suggestions. Through this move, the MAGN received wide support for the registration act that was passed in 1913, which set standards for admission, training and registration of nurses. Examinations were conducted under the direction of the Council of the University of Manitoba. By the 1913 act, nurses graduating from a school of nursing in a qualified institution in the province were able to qualify by examination to be certified as registered nurses. A qualified institution was listed as one which cared for an average of not less than 20 patients per day. An 1921 amendment required that students have grade 9 for entrance to nursing schools, and this was later changed to grade 10 and then grade 11. In 1929, the MAGN changed its name to the Manitoba Association of Registered Nurses.

A 1954 revision of the Manitoba Nurses Act redefined the responsibilities of the Association in the approval of schools of nursing, prescribing the nursing school curriculum, management of registration examinations and promotion of MARN activity at the district level.

SASKATCHEWAN

Fur traders began to visit Saskatchewan late in the 16th century but settlement in the area did not begin until about 1870, after the territory was purchased by Canada.
from the Hudson’s Bay Company. The building of railways and waves of immigration into Canada brought settlements to the prairie farming lands but the communities remained overwhelmingly rural until the end of the 19th century. Between 1901 and 1911, the population of Saskatchewan increased from 91,000 to 492,000. This rapid growth brought about the development of municipalities and the organization of educational, professional and social services. Problems of organization were compounded by the diversity of ethnic groups among the pioneers.

The first nurses in the province, arriving in 1860 and thus predating most settlements, were three Grey Nuns who traveled two months from St. Boniface to reach an Indian mission at Île-à-la-Crosse, 200 miles north of Prince Albert. During the first 30 years of white settlement in Saskatchewan, medical and nursing care was extremely limited. Nursing care for the epidemics of smallpox, diphtheria, typhoid, and scarlet fever was mainly provided by sympathetic neighbors.

In 1895, Regina had a population of 1,800 and was the center of Assiniboia district with 38,000 people, yet the closest public hospital was at Medicine Hat, 300 miles to the west. Two years later, the Regina Council of Women had raised enough money to open a seven-bed hospital and in 1898, Mary McCullough, a member of the first class to be trained in VON work, took charge; this was the first cottage hospital in Canada to be assisted by the Victorian Order of Nurses. A training school was established at the Regina hospital in 1901 by Lily E. Bristow, a Manchester Royal Infirmary graduate and a VON staff nurse. In 1907, the institution became the Regina General Hospital. Meanwhile, other VON hospitals had been established at Prince Albert and Yorkton.

Continued arrivals of large immigrant groups and typhoid epidemics of 1906 and 1907 spurred the building of hospitals, including the first two in Saskatoon, opened in 1906: Saskatoon City Hospital, which employed Miss Sisley, a graduate of St. Thomas’s Hospital, London, as matron; and St. Paul’s, opened by two teaching sisters from the Grey Nuns at St. Boniface and later staffed by Grey Nuns from Montreal, headed by Sister St. Dosithee. During this period, several religious groups established hospitals. Among them were the Women’s Missionary Society of the Presbyterian Church; the Austrian Franciscan Order of the Sisters of St. Elizabeth; the Sisters of Charity of Saint John, New Brunswick and of Kingston; and the Sisters of Providence from Montreal.

The scarcity of trained nurses and the lack of funds to pay for them compelled most of the new hospitals to open training schools for nurses. In 1908, a health department officer, Dr. M. M. Seymour, submitted a report on the training of nurses, alerting the public to the lack of control of nurses and recommending uniformity of training, course of study and examinations. From the 1912 minutes of the Canadian Superintendents Society, it can be concluded that Dr. Seymour’s report resulted in 1912 in one of the earliest pieces of legislation in Canada to govern the operation of nursing schools. According to these minutes, the Act restricted nursing schools to hospitals where there were at least 30 beds; admissions
of at least 20 patients per month; at least four resident doctors within a mile; no less than two graduate nurses employed; at least 10 per cent of bed capacity for each of obstetrics, infectious diseases and tuberculosis.

A small group formed the Regina Graduate Nurses' Association in 1911— with Mrs. J. A. Westman as president—and was the impetus behind the formation of the Saskatchewan Graduate Nurses' Association, which affiliated with the CNATN in 1914. The SGNA leaders gave priority to the passage of a registration act, and this was achieved in 1917. Along with other stipulations, the bill required graduating nurses seeking registration to submit a diploma from an approved school and write an examination conducted by a board of examiners appointed by the senate of the University of Saskatchewan.

In 1918, the name of the association was formally changed to the Saskatchewan Registered Nurses' Association, of which Jean E. Browne became president. First paid secretary-treasurer of the SRNA was Mabel F. Gray, a graduate of Winnipeg General Hospital and later professor of nursing at the University of British Columbia, who was appointed on a part-time basis in 1920. In 1937, a part-time advisor to training schools was appointed who, because of illness, was succeeded a few months later by Kathleen W. Ellis, a graduate from Johns Hopkins school of nursing and from Columbia. The following year, Miss Ellis, who was also part-time SRNA secretary-treasurer/registrar, became the director of education of the new school of nursing at the University of Saskatchewan. In 1950, Lola Wilson became the SRNA's first full-time advisor to schools of nursing. Active in research for the SRNA, she supported both an experimental centralized teaching program and prepared the first cost study of nursing education attempted in Canada.

In 1966, Saskatchewan became the first province in Canada to transfer jurisdiction of hospital schools of nursing from the Department of Health to the Department of Education.

ALBERTA

As the railway moved west across the prairies in the mid-1870's, the settlers, from Canada and abroad, followed. Among the earliest of these were the French, from eastern Canada, who established the first civilian services in Alberta.

At the request of the Oblate missionary Father Lacombe, Grey Nuns from Montreal established, in 1881, the territory's first nursing facilities at a tiny hospital at the St. Albert Mission near Edmonton. It was not until 1889 that the first general public hospital west of Winnipeg was opened at Medicine Hat, with Grace L. Reynolds as matron and Mary Ellen Birtles as her assistant. Both previously worked at the Winnipeg General Hospital. Agnes Miller, a graduate of the Royal Infirmary of Edinburgh, opened the first training school in the province in 1894, also at Medicine Hat.
In the years 1890-91, two hospitals were opened in Calgary: Calgary Civic Hospital, where in 1895 Mary Ellen Birtles established the province's second nursing school; and Holy Cross Hospital, staffed by Grey Nuns.

In the last decade of the 19th century, Alberta received more than 50,000 immigrants. Edmonton, reached by the northern rail route in 1891, had already become a prospectors' supply base, with a population that required nursing and hospital services. St. Albert Mission's Grey Nuns nurses were persuaded to move to Edmonton in 1895 and opened what later became the Edmonton General Hospital; Father Lacombe was instrumental in establishing the Miséricordia Hospital in 1900, staffed by the Soeurs de Miséricorde from Montreal; and non-sectarian Edmonton Public Hospital, later Royal Alexandra Hospital, was opened in 1900 as a municipal undertaking.

In the succeeding years, nursing services in Alberta continued to be provided to a large extent by religious groups, including Roman Catholic orders, Eastern Orthodox and Anglican churches, and Home Mission Boards of the Methodist and Presbyterian churches. In addition, voluntary groups such as the VON and the Red Cross later established outpost nursing services and cottage hospitals.

Alberta became a province of Canada in 1905. The public health service of the Northwest Territories was transferred immediately to the new province, and the first public health act was passed two years later. A public health nursing branch was formed in 1918, headed by a Toronto General graduate and former VON nurse, Christine Smith, who in 1900 had taken charge of the Good Samaritan Hospital in Dawson City, Yukon.

As in the other provinces, the desire of graduate nurses to set professional standards in education and care was the determining factor in the formation of provincial nursing organizations. This need arose from the proliferation in Alberta of two types of nurses whose standards varied greatly: immigrant nursing personnel from many countries with vastly differing backgrounds, education and experience; and graduates from the small, isolated cottage hospitals, whose opportunity for exposure to professional training and education was limited.

Among the first efforts to improve the situation was that taken by the Calgary Association of Graduate Nurses, which was formed in 1904, and in the same year wrote to the Toronto Medical Society inquiring about the possibility of a nursing journal, which would serve to keep nurses in isolated areas informed of nursing developments. This query appears to have been one of the reasons behind the action taken by the Toronto General alumnae in the same year which eventually brought about publication of The Canadian Nurse.

By 1912, the Edmonton Association of Graduate Nurses and the Calgary group were endeavoring to unite to work more effectively for registration; in 1914 a group known as the Graduate Nurses Association of Alberta reported, to the CNATN general meeting, its progress in drafting nursing legislation. The Alberta Association
of Graduate Nurses was incorporated in 1916 and its first president was Victoria
Winslow, a graduate of the Winnipeg General, and the secretary-treasurer was
Eleanor McPhedran, a New York Hospital graduate. Among the new organization's
objectives were a standard examination for registration, standard curriculum for
schools of nursing, and a minimum of 50 beds before the establishment of a school
of nursing. Uniform registration examinations were achieved in 1919, and were
placed under the control of the senate of the University of Alberta.

In 1917, the AAGN federated with the national nursing association and in
1921 changed its name to the Alberta Association of Registered Nurses. In 1922 the
AARN was host at the eleventh general meeting of the CNATN at Edmonton, and
among the resolutions presented by the Calgary chapter was one condemning the
long-established practice of hospitals sending out student nurses on private duty
and keeping the fee. In 1934, the entrance requirement to schools of nursing was
raised from grade 8 to grade 11.

The first extensive survey of nursing resources and nursing needs for Alberta
alone was undertaken in 1949 by Rae Chittick, then associate professor of nursing
education at the University of Alberta, and a graduate from Johns Hopkins school of
nursing, Columbia and Stanford universities.

In 1967, the first two-year diploma nursing program in the province was
opened at Mount Royal Junior College, Calgary.

BRITISH COLUMBIA

The early history of British Columbia is a story of Anglo-Saxon adventurers looking
for furs and gold, and explorers such as Cook, Vancouver, Thompson and Fraser
adding to the geographical knowledge of this rugged and picturesque part of Canada.
Although the first claimants of the area were the Spanish, B.C. history began to take
form in 1778 with the landing of Captain Cook at Nootka on Vancouver Island.
Heavy American immigration into Oregon in the 1840's made it seem likely that the
Americans would occupy the land up to the Russian holdings in America, but the
British government was able to preserve the province by negotiating the Oregon
Treaty in 1846, which established the border at the 49th parallel.

In 1857, Victoria was still a hamlet of a few hundred people and the mainland,
known as New Caledonia, was largely unsettled. The following year, many things
happened. New Caledonia was renamed British Columbia by Queen Victoria, the
first gold rush occurred and more than 20,000 miners, merchants, jobless and specta­
tors poured into Victoria; the first hospital in the province, set up for the indigent
sick, was established in Victoria and would later become the Royal Jubilee Hospital.

In 1869, the Legislative Council of the Colony of British Columbia made its
first attempt to provide machinery for public health measures. The resulting
ordinance made provision for the appointment of a health officer, the definition of
health districts, making of sanitary regulations, establishment of local boards of health and for the enforcement of such rules and regulations as might be put into effect. Little action was taken, however, probably because B.C.'s population tended to be on the move following discoveries of gold. Victoria and New Westminster were practically the only towns with permanent residents.

When British Columbia entered Confederation in 1871, one of the terms of the union was that a railway be built to the west coast from the east within ten years. The necessity for medical care for the construction crews resulted in the establishment of hospitals along the route, and among these was the publicly-supported Kamloops Hospital, established in 1883, the first in the B.C. interior.

Earlier, in 1858, four Sisters of St. Ann had set out from the east to do missionary work in the far west. They left Montreal on April 14 and arrived in Victoria on June 5, after a trip via New York and the Isthmus of Panama to San Francisco — where there were nearly 2,000 men and many hundred head of cattle waiting to get passage north. After repeated requests, the sisters opened St. Joseph's Hospital in Victoria in 1876. Two of the sisters were sent to Portland, Oregon, to study nursing and later returned to Victoria; the first nursing sister and superior of the hospital was Sister Mary Bridget.

In 1890, the first school of nursing in the province was opened at Royal Jubilee Hospital with Anne Grace Mouat, a Toronto General Hospital graduate, as matron. This development was spurred by a smallpox epidemic, and a school was one way to increase the numbers of nursing personnel required.

The Graduate Nurses' Association of British Columbia was formed in 1912, with over 60 members drawn mainly from three large units, the Vancouver Graduate Nurses' Association, the Victoria Nurses' Club and the New Westminster Nurses' Association. The first president was Sharley P. Wright. In 1913, the GNABC affiliated with the national association. An act of incorporation was obtained in 1918, the same year that a central office was opened in Vancouver with Helen L. Randal as registrar. In 1920, the inspection of schools of nursing was introduced, administered by the provincial nurses' association. In 1920, Miss Randal undertook the first survey of training schools in the province.

The first course in Canada and the Commonwealth leading to a university degree in nursing was offered at the University of British Columbia in 1919. It was a five-year course, leading to a B.A.Sc. (Nursing), composed of three years university study at UBC and two years hospital training at the Vancouver General. Ethel I. Johns, who was superintendent at Vancouver General Hospital, became assistant professor of nursing and was succeeded at the hospital by Kathleen W. Ellis. Provision was also made for the training of graduate nurses in a one-year course for a diploma in public health nursing, and Mary Ard. MacKenzie became a lecturer in this course.

A public health nursing committee was formed within the GNABC in 1916. The examinations for registered nurse certification were first held in 1921, the year
that the private duty committee was formed within the association. In 1943, Alice L. Wright, a native of Prince Edward Island, a graduate from Vancouver General Hospital and Columbia University, became executive secretary of the GNABC. The association changed its name to the Registered Nurses' Association of British Columbia in 1935. In 1946, the British Columbia provincial association, in the same year as Quebec, approved the principle of collective bargaining. By 1967, the RNABC had been certified as bargaining representative for 78 groups of nurses in the province.
IV. On the National Scene

Many organizations contribute to the national environment in which the CNA operates, and an overview of the CNA would be incomplete without acknowledgement of the contributions of such groups to the fabric of Canadian nursing. Following is a brief review of some of them.

A FEDERAL FRAMEWORK

The terms of the British North America Act with respect to health were rather meager, primarily because in 1867 there was only a limited view of the role that governments could play in respect to public health and welfare. Thus, the federal government was given jurisdiction of “quarantine and the establishment and maintenance of marine hospitals,” and also responsibility for veterans, Indians, penitentiary prisoners, sailors and passengers arriving from foreign lands. The provinces were given powers relating to “the establishment, maintenance and management of hospitals, asylums, charities and eleemosynary institutions”. The basic idea appears to have been that health measures were needed only when emergencies such as epidemics occurred, and these activities were largely undertaken by local governments and private organizations.

The bacteriological studies of Pasteur and Koch in the late 19th century, together with other scientific and technological advances, changed the basis of government health services. Provincial boards of health and regulatory measures to control diseases began to appear in the latter part of the century. Nevertheless, prior to World War I, the development of health services was largely a matter of voluntary, private initiative.

Medical examinations of personnel recruited for military service in World War I revealed that public health needed to be improved in the interests of a healthier nation. As a result, public health services developed rapidly after the war and the need for special preparation for public health nurses was recognized.

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

In 1919, a federal Department of Health was formed, bringing together more than a dozen government departments and commissions. At about the same time existing provincial boards of health were gradually replaced by provincial departments of health, the first being in New Brunswick in 1918. Provincial public health nursing services were developed, beginning in Manitoba in 1916, to assist with municipal programs of immunization and child health protection. The federal health department, which merged in 1928 with the Department of Soldiers’ Civil...
Re-establishment to form the Department of Pensions and National Health, was replaced in 1944 by the Department of National Health and Welfare. It has charge of all federal matters relating to the promotion and preservation of health, social security measures and social welfare of the Canadian people, some aspects of which are emergency health and welfare; provision of health, medical and hospital services to Indians, Eskimos and other elements of the population in the Yukon and Northwest Territories; and provision of various assistance and consultative services to the provinces upon request.

Since 1945 nursing positions have been established in the department to provide advisory service to the department, consultant service to the provinces, and direct service to special groups of the population.

Nursing advisory service to the department as a whole began in 1953 with the appointment of Dorothy M. Percy, a graduate of Toronto General Hospital, as chief nursing consultant. With Miss Percy's retirement in 1967, a new position, nursing adviser to the deputy minister of health, was created. Verna M. Huffman, a graduate from Peterborough Public Hospital, Columbia University and University of Michigan, was appointed to the post. In each case the position was established to provide advisory service to the deputy minister on matters pertaining to nursing within the department, the country, and the international field.

Consultant service to the provinces is provided by specialist nursing consultants, each attached to a division of the department under a medical director. The role of the consultant is to assist the provinces in the development of nursing service and education, setting standards, evaluating programs, assessing needs, stimulating and assisting with studies and research.

Six federal-provincial nursing conferences have been held since 1960 providing a national forum for the consideration of major nursing issues.

Direct nursing service is given through the Medical Services Branch. This branch provides medical and health services or arranges for the provision of medical and health services to designated groups of the population who, for one reason or another, are not covered by provincial or local authorities. These groups include registered Indians in the provinces, all of the citizens in the Northwest and Yukon Territories, federal civil servants (the employee health service is expanding), immigrants upon arrival at seaports and airports in Canada, health screening of European people planning to emigrate to Canada, people emigrating from the orient who come through Hong Kong, services to sick mariners and examining air and ground crews in the Civil Aviation Medical aspects of the services provided by the branch. The senior nursing positions in Medical Services are Adviser, Nursing Services, and Adviser, Nursing Education.

In 1945, the administration of medical services for both Indians and Eskimos became the responsibility of the Department of National Health and Welfare. Medical Services now administers health and treatment services for approximately 260,000 residents — about 225,000 registered Indians, 12,000 Eskimos and the remainder non-native residents in the north. Medical Services acts as a Department of Health for the Yukon and Northwest Territories.
The department operates a combined total of 15 hospitals for the Indian and Northern services along with 64 outpost nursing stations and 88 health centers. Each health center is operated by a registered nurse who provides public health services and teaches the care of the ill at home. The nursing station is a larger unit, which combines health center facilities with a few beds. Usually two nurses, with supporting staff, carry out a public health program including home visiting, caring for maternity cases and emergencies in the station.

Nurses in these regions may travel by plane, dog-team, boat, snowmobile, or even snowshoes; but there is nothing primitive or makeshift about either the standard of nursing care they give or the quality of the equipment they have at their disposal. To cover areas not adequately provided with outpost health services, mobile health teams carry out patrols during the spring and summer months. Many of these medical surveys are carried out by plane, but the best known is probably the annual visit to the eastern Arctic region by the government ship, with its staff of medical doctors, radiologists, dental officers, X-ray technicians and nursing personnel.

The nursing personnel in Medical Services number about 1,200, about 800 of whom are registered nurses. More than 300 of the registered nurse positions are in the field of public health.

DEPARTMENT OF VETERANS AFFAIRS

Another government department concerned with health matters is the Department of Veterans Affairs. It was originally established as the Department of Soldiers Civil Re-establishment, merged to become the Department of Pensions and National Health, and in 1944 became the Department of Veterans Affairs. Among its many duties the department provides medical, dental and prosthetic services for entitled veterans and others throughout Canada. The first matron-in-chief, appointed in 1945, was Agnes J. Macleod, a graduate from the University of Alberta and Columbia University. The title of the position was later changed to director of nursing services. The second and present incumbent is Grace E. Johnson, a graduate from Winnipeg General Hospital and McGill University.

NURSING IN THE ARMED FORCES

Probably the first acknowledgement of the value of professional nursing skills by the military in Canada was made during the Northwest (Riel) Rebellion of 1885, when two small groups of civilian nurses served with the army in Saskatchewan. It was as a result of the work of Florence Nightingale and the lessons learned during the American Civil War that the Canadian general wired: "No volunteer nurses. If you can send an organized body under a trained head, they will be welcome." From the Anglican order of St. John the Divine in Toronto went nurses headed by Mother Hannah Grier, who had received training at Trinity Hospital, New York. Another group, headed by Nurse Miller of the Montreal General Hospital, and at the time head nurse at the Winnipeg General Hospital, served at the temporary hospital in Saskatoon.
The next call for civilian nurses was made in 1898 when the Canadian government authorized the attachment of a volunteer group of four VON nurses to the Yukon Military Force.

In November of the following year, the first Canadian troops to serve on foreign soil went to South Africa to join the British forces. All the Canadians were volunteers equipped and transported by the Canadian government, and among the first to be transported were four nurses, led by Georgina Fane Pope, who held the rank of Senior Canadian Nursing Sister. Miss Pope, a native of Prince Edward Island and a graduate from Bellevue Hospital, New York, became the first Canadian nurse to win the RRC (Royal Red Cross).

These four nurses were followed by four more in January 1900 and in this second group— that were chosen from more than 190 volunteers— was Margaret Clothilde Macdonald, a native of Nova Scotia and a graduate from New York Hospital. A total of 16 Canadian nurses served in South Africa and were accredited the relative rank and pay of lieutenant.

In 1901, the nursing service was organized as an integral part of the Army Medical Services of the Canadian Militia. In 1904 the service was reorganized as the Army Medical Corps with permanent and non-permanent units; the non-permanent element could include a reserve of 25 nursing sisters holding the relative rank of lieutenant. Canada thus became the first country to accord relative military rank to women; Australia was second at the outbreak of World War I and the U.S.A. followed after World War I. In 1906, Nursing Sisters Pope and Macdonald were appointed to the Permanent Army Medical Corps and were stationed at Halifax.

WORLD WAR I

Nursing Sister Macdonald became matron-in-chief of nurses of the Canadian Army Medical Corps at the beginning of World War I and achieved the relative rank of major. By the end of the conflict, more than 1,800 nurses were serving overseas with CMAC and Matron Macdonald had been succeeded by Edith C. Rayside. A total of 47 nurses had lost their lives serving with Canadian and allied forces, including 14 at the sinking of the Canadian hospital ship Llandovery Castle.

WORLD WAR II

More than 4,000 registered nurses saw active service during World War II, about 3,000 with the Royal Canadian Army Medical Corps, about 300 with the Royal Canadian Navy and about 450 with the Royal Canadian Air Force; after a request for assistance from South Africa for nurses to care for British soldiers from the Middle East, 300 Canadian nurses volunteered and served with the South African military services under Matron-in-chief Gladys J. Sharpe.

Matron-in-chief in Canada of World War II Army Medical Corps nurses from 1940 to 1944 was Elizabeth Lawrie Smellie, a Johns Hopkins nursing graduate who was on leave from her job as chief superintendent of the VON and became the first Canadian woman to achieve the rank of colonel; she also organized the
Canadian Women’s Army Corps. Matron-in-chief (overseas) was Emma F. Pense, succeeded in 1942 by Agnes C. Neill. Some 500 decorations were awarded to Canadian nurses during World War II. Two Canadian nursing sisters were prisoners of war in Hong Kong; one nursing sister lost her life as a result of enemy action.

Until mid-way through World War II, nurses held the relative rank of officers, but did not possess the official status of officers and equivalent power of command. In 1942, this was changed by privy council order. Nurses were granted commissions and put on an equal footing with all other commissioned officers. American and British nurses did not achieve official commissioned-officer status until after the end of World War II.

KOREAN WAR

Approximately 60 Canadian nurses served with the Canadian forces during the Korean War. Royal Canadian Air Force nursing sisters served as flight nurses caring for patients evacuated by air from the theater of war to Canada. Nursing sisters of the Royal Canadian Army Medical Corps served at the British Commonwealth Hospital at Kure, Japan, and with a field dressing station and a field surgical team in Korea.

RECENT DEVELOPMENTS

In 1959, the medical services of the navy, army and air force were integrated to become the Canadian Forces Medical Service. A nurse could still enter whichever branch of service she wished. The first matron-in-chief of the integrated service was Lieutenant Commander Mary Nesbitt. Currently about 500 nursing sisters serve on 40 military bases across the country and in Europe. Appointed matron-in-chief at the beginning of 1968 was Lieutenant Colonel M. Joan Fitzgerald.

In 1967, in response to representations by the CNA, the Department of National Defence took preliminary steps to make it possible and practical for male nurses to be commissioned in the Canadian armed forces. In early 1968, the first male nurses were commissioned.

A COMMUNITY OF INTERESTS

There are many organizations in Canada which devote time to nursing matters, and among them are three national groups on whose governing bodies the CNA, by tradition, is represented. One of these, the Victorian Order of Nurses, is devoted exclusively to nursing. But because of their general mandates, the Canadian Red Cross and the Order of St. John have also contributed to national nursing progress.

VICTORIAN ORDER OF NURSES

An important volunteer organization in the spread of professional nursing in pioneer Canada was the Victorian Order of Nurses, which is now the largest visiting nurse organization in the country and the only one to operate on a national basis. The primary function of the VON at this time is to provide skilled nursing
care on a visit basis to patients in their home, and to combine with this care, health teaching to the patient and family. It is available to everyone in the community for all types of illnesses, acute, chronic or convalescent and to mothers and babies. Under special circumstances other activities are undertaken.

The history of the VON dates back to the end of the 19th century, when immigrants were arriving by the shipload, many of them ill and many more becoming ill as they trekked west to homesteads in isolated Canadian regions. In 1897, when the Canadian National Council of Women held its annual meeting, two resolutions, one from the west and one from the east, requested visiting nurse services. The year 1897 was Queen Victoria's Diamond Jubilee, and when it was decided to form such a nursing association, the name chosen was The Victorian Order of Nurses for Canada.

Lady Aberdeen, wife of the Governor General, became the first patron of the new order, and traveled extensively to gain support for it. She included a trip to Boston to speak to Canadians living there and this led to a meeting with Charlotte Macleod, superintendent of the nearby Waltham Training Home for District Nurses. Miss Macleod, who had been advised during her studies in England and Scotland by Florence Nightingale, was from New Brunswick and more than half of the nurses in training at her school were Canadians. She was persuaded to become the first VON superintendent.

With the backing of many of Canada's leading citizens, the organization began to contribute greatly to the development of hospitals and nursing stations in many remote areas of Canada, particularly in the northwest where a visiting service was impractical. From 1898, the VON was instrumental in the formation of over 40 cottage hospitals. In time, these hospitals were taken over by local authorities and this phase of the VON's work ceased, the last hospital being handed over in 1924. Following this period, emphasis was placed on visiting nursing in rural areas and the first such district was organized around Lundbreck, Alberta, where the nurse covered great distances on horseback or by sleigh. With the coming of government-sponsored public health nursing organizations and municipal hospitals, the VON withdrew to more densely populated centers.

From its inception, the VON has offered a variety of services, adapting its program to the changing needs of communities and the development of health services. One recent, important development which has considerable impetus because of chronically crowded hospitals is the home care program, designed to permit early discharge of patients from hospitals. Associated with this program is a new housekeeping service, by which the VON employs non-nurses to undertake housekeeping duties where required. VON provides nursing and housekeeping services for most of the home care programs and administers some of them. Bursaries have been offered by the VON since the early 1920's, and currently a total of about 50 such awards are made each year at the post-basic diploma, baccalaureate and master's degree levels.
All VON nurses are registered and more than 65 per cent have additional public health nursing qualifications. More than one million visits are made each year by about 700 nurses in more than 100 branches in every province except Prince Edward Island. Current VON director-in-chief is Jean C. Leask, a graduate of the universities of Toronto and Chicago.

CANADIAN RED CROSS

The Canadian Red Cross Society has specific national and international responsibilities which include relief to sufferers from misfortune and victims of disaster, improvement of public health and expansion of the Red Cross Youth (formerly Junior Red Cross) programs.

A national voluntary health and welfare organization, one of its primary functions is to initiate and demonstrate — in consultation with other agencies and with statutory authorities — new health programs, and operate them until such time as other agencies are equipped to take them over. It is in this health program area that the closest community of interests exists between the nursing profession and the Red Cross.

Although its principles had been applied in Canada as early as 1885, and its first organization established in 1896, The Canadian Red Cross Society was not incorporated as an autonomous national body until 1909. Since 1919 it has been a member of the League of Red Cross Societies, an international federation of 108 national Red Cross, Red Crescent, Red Lion and Sun societies.

The roles of Canadian nurses and the Red Cross have been intertwined in all the wars of the 20th century in which Canada has participated. It was, however, in the years of critical health examination after World War I that the work of many civilian nurses became closely integrated with that of the Canadian Red Cross. Even before The Canadian Red Cross Society’s act of incorporation had been amended to permit it to carry out peacetime work, the CNATN had invited the Society to co-operate in a wide program to improve the country’s health services. The Red Cross responded over the next few years in the form of financial support to nurses and universities for higher education in nursing, and by the temporary support of public health nurses in the field, both directly and through the VON.

Since 1920, The Canadian Red Cross Society has been active in nursing education and institutional support, from the training of nursing housekeepers to the establishment of public health nursing courses in universities and to the granting of bursaries and loans ranging from awards to school girls entering basic courses to professional nurses working towards doctorates. In 1920, the Red Cross assisted financially in the development of chairs of public health nursing at the universities of British Columbia and McGill. It provided financial assistance to the universities of Dalhousie, Toronto and Western Ontario for the establishment of public health nursing diploma courses. Later, after World War II, the Canadian Red Cross financed the establishment of the Demonstration School of Nursing at Windsor, Ontario, which pioneered the independent diploma school of nursing in Canada in recent times.

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In 1919, the Red Cross began to train and maintain nurses for public health work in rural areas. A visible manifestation of this focus of effort was the Outpost Hospital and Nursing Station program launched in 1920. This program, designed to provide care in remote settlements, started with a handful of small stations and by 1950, there were 87 units functioning in remote areas throughout Canada. The introduction of the national hospital program in Canada has brought about a decline in the number of outpost hospitals since, when appropriate, the Red Cross prefers to hand over these units to self-reliant community groups.

As the hospital phase of activity declines, two other spheres of activity have increased in importance. The Red Cross Blood Transfusion program has become the largest volunteer health program conducted by any volunteer agency in Canada. In this program the professional nurse, employed by the Canadian Red Cross, co-operates with the volunteer. The organization’s modern emphasis on care in the home is also made evident by the fact that more than 800 professional nurses annually volunteer time to teach women basic nursing care in the home under professional supervision. In 1968 the national director of the Red Cross nursing service was Helen G. McArthur, a University of Alberta nursing graduate.

ORDER OF ST. JOHN

In the year 600, there was launched in Jerusalem for pilgrims a movement of charity and humanity which continues in many parts of the world today through the Most Venerable Order of the Hospital of St. John of Jerusalem. The eight-pointed cross of the Order was worn in Canada as early as the 17th century, but the Order did not appear as a formal organization in Canada until the early 1890’s. Today its presence is most readily visible in the uniform of more than 12,000 members of the St. John Ambulance Brigade whose work is familiar to all who have witnessed their quiet efficiency when injury occurs at sports contests or public gatherings. Equally effective, but less readily visible, is the work of the Order in many endeavors such as first aid, home nursing and child care where nursing skills form an essential element.

The activities of the Order and professional nursing are linked together in two broad areas, education and nursing service. A bursary fund provides awards annually to nurses for diploma, baccalaureate and post-graduate studies at the master’s level.

The scope of activities of the Order in the fields of first aid, home nursing and child care may be gauged from the fact that it provides instruction in these
areas to more than 300,000 Canadians annually. One of the early co-operative ventures between the CNA and the Order was in the 1930’s, when the CNA undertook to assist in the preparation of a Canadian edition of the St. John Home Nursing Manual that was previously published in England. With assistance from other nurses, this project was completed by Rae Chittick. The manual served until 1954 when a new manual was published: Home Nursing, compiled under the direction of the National Advisory Committee by Mary Acland, chief nursing officer of the Order. Other publications of the Order with overtones of nursing were What the Home Nursing Auxiliary Should Know About Civil Defense and Child Care in the Home. The former, published in 1951, was prepared by Mary Acland and Kay DeMarsh of the Red Cross; the latter was prepared by Mary Acland and published in 1964.

A more recent publication, Patient Care in the Home, was co-authored by M. Christine Livingston, former director-in-chief of the VON, and M. Pearl Stiver, former executive director of the CNA. Evelyn A. Pepper of the Department of National Health and Welfare prepared a section on care under emergency conditions. This book, like a number of its predecessors, emphasizes the continuing concern of the Order about patient care in the home.
V. Footnotes to History

Many interesting items relevant to nursing in Canada but apart from the central themes of the narrative were documented during the preparation of The Leaf and The Lamp. Some of this material is included in the next few pages.

CNA PROFESSIONAL MAGAZINES

The earliest articles about nursing appeared in ladies' magazines, many of them written by the early graduates from nursing schools. It was not until the nursing profession in Europe and America began to organize itself at the end of the 19th century that magazines specifically for nurses appeared. They were dedicated to communicating problems and objectives of the nursing profession to nurses on a national basis. The first such magazine of a national scope was The Nursing Mirror and Midwives Journal published in England in 1888. It was followed the same year by Nursing Record, which was bought by Mrs. Bedford Fenwick in 1893 and became the British Journal of Nursing. The American Journal of Nursing appeared in 1900 and The Canadian Nurse in 1905.

The need for a professional nurses' magazine became apparent in several parts of Canada at the beginning of the present century. In 1904, the newly formed Calgary Association of Graduate Nurses wrote to the Toronto Medical Society inquiring about the possibility of a nursing magazine. As a result of this inquiry, the alumnae association of Toronto General Hospital also discussed the matter of an alumnae journal and formed a committee to study the possibility. The Toronto alumnae president, Miss Lennox, was sympathetic to the idea, as she had spent some time in Alberta, and knew the need for such a magazine both in the cities and on the prairies.

In 1905, the publications committee of the Toronto General Hospital Alumnae Association sponsored the first quarterly issue of The Canadian Nurse and Hospital Review, which was actually owned by a business firm, the Commercial Press. The part-time editor for the first six years was Dr. Helen MacMurchy, a prominent physician and a strong supporter of nursing. In her first editorial, she said:

The Canadian Nurse will be devoted to the interests of the nursing profession in Canada. It is the hope of its founders that this magazine may aid in uniting and uplifting the profession, and in keeping alive the esprit de corps and desire to grow better and wiser, in work and in life, which should always remain to us as a daily ideal. For the protection of the public, and for the
improvement of the profession, The Canadian Nurse will advocate legislation to enable properly qualified nurses to be registered by law.

The first issue had 32 pages. The leading article was written by Mary Agnes Snively and one by Isabel Hampton Robb followed. In the minutes of the Toronto General Alumnae Association, it is recorded that $190 had been promised in advertising contracts. The journal committee hoped to secure $300 worth of advertising which would cover the expenses of publishing. It was further decided that the yearly subscription rate for the journal should be 50 cents. More than 1,300 subscribers were obtained in that first year of operation.

By 1906, the magazine was the official publication of several graduate nurse associations, but it remained essentially a regional publication with little circulation outside Ontario. In 1907, it became a monthly. Bella Crosby, a Toronto General graduate, who had been particularly active in international groups, became the second part-time editor in 1911.

In June 1916, the Canadian National Association of Trained Nurses bought the publication for $2,000 — with $500 down and the rest pledged by nurses. It was moved to Vancouver, and the new editor was Helen L. Randal, a graduate of the Royal Victoria Hospital, Montreal, and at that time secretary/registrar of the Registered Nurses' Association of British Columbia.

In 1924, shortly after the establishment of a national office for the CNA in Winnipeg, the editing and publishing of the publication was taken over by Jean Scantlon Wilson, a native of Quebec, a graduate from the Lady Stanley Institute, and a former superintendent of nurses at Moose Jaw General Hospital. It was during her tenure as executive secretary of the CNA and editor of The Canadian Nurse that the publication evolved into a national journal.

By 1932, the journal had become such a large and important operation that Ethel Incledon Johns was appointed the first full-time editor and business manager. Born in England and educated in Wales, Miss Johns was graduated from Winnipeg General Hospital in 1902, studied at Columbia University, and held nursing administrative posts in Manitoba and British Columbia, including one in Winnipeg during the 1919 strike. Subsequently, she served as a field director for the Rockefeller Foundation in Europe, assisting in the development of nursing in Rumania and Hungary. In 1929, she was appointed director of studies of the committee for nursing organization of the New York Hospital-Cornell Medical College Association. With Miss Johns' new appointment as The Canadian Nurse editor, the publication was again moved east to Montreal and by 1944, the year of her retirement, the journal circulation had reached 5,000.

Miss Johns was succeeded by Margaret E. Kerr, a graduate of Vancouver General Hospital, University of British Columbia and Columbia University, as editor and business manager. As the earlier editors had been, she was assisted by an editorial board with representatives from each province, which acted in an advisory capacity on policy, finance and business management. It also served as a liaison unit with the provinces.
Many years previously, in 1916, it had been the suggestion of Helen Randal that a subscription to the journal be a part of every nurse’s fee for her nursing organization. It was a long time in happening but, beginning with the New Brunswick association in 1950, all the provincial associations in turn voted to make mandatory a journal subscription fee in addition to the annual fee for membership in the provincial association.

As one association after another approved this subscription plan, which increased the circulation of the magazine, the realization that Canada has two principal language groups—English and French—came into sharper focus. Beginning in 1946, The Canadian Nurse provided some editorial material in the French language; but not enough to be really useful to the non-bilingual French reader. It was felt that the magazine’s responsibility in this area could be met adequately only by publication of a French edition but the major problem here was financial, the solution of which lay in the hands of the Association of Nurses of the Province of Quebec, with its large concentration of French members; its support by mandatory subscription by ANPQ members was necessary to provide the financial backing required to publish L’infirmière canadienne. In November 1958, that support was granted by a vote at the provincial general meeting. In June 1959, the first issue of the magazine in the French language was published, carrying translations of the English articles. It has now evolved from duplication of the English contents to a publication similar in content to the English edition, but specifically directed to the interests of French-speaking nurses.

In 1955, the first full-time assistant editor of The Canadian Nurse was appointed, and in 1958 Miss Kerr was appointed executive director as well as editor in recognition of the growing importance and function of the magazine. By 1965 the circulation of the magazine reached 75,000. Upon the retirement of Miss Kerr in 1965, the final responsibility for direction of the magazine became a function of the CNA executive director and the editorial board/advisor system was discontinued following the structural re-organization of the Association.

Virginia A. Lindabury, a graduate of Toronto General Hospital and the University of Western Ontario, succeeded Miss Kerr as editor of The Canadian Nurse in 1965, and Claire L. Bigué, a graduate of Ottawa General Hospital and Institut Marguerite d’Youville, Montreal, became the first full-time editor of L’infirmière canadienne. With the completion in 1966 of CNA House in Ottawa, the editorial, production and advertising staffs of the companion journals were moved there. At the beginning of 1968 the combined circulation of the two journals was over 86,000.

**CNATN-CNA FOUNDING MEMBERS**

The existing minute book of the CNATN from 1908 to 1918, available in the CNA library, lists 13 groups in attendance at the organizational meeting in October 1908 of the Provisional Society of The Canadian National Association of Trained Nurses, precursor to the Canadian Nurses’ Association:
The Canadian Society of Superintendents of Training Schools for Nurses
The Ontario Graduate Nurses' Association
Canadian Nurses' Association [of Montreal]
The Edmonton Graduates Nurses' Association
The Ottawa Graduate Nurses' Association
The Vancouver Graduate Nurses' Association
The Alumnae Association of the Montreal General Hospital
The Alumnae Association of the Toronto General Hospital
The Alumnae Association of the Hospital for Sick Children, Toronto
The Alumnae Association of the General Hospital, Galt
The Alumnae Association of the General and Marine Hospital, St. Catharines
The Alumnae Association of the Western Hospital, Toronto
The Calgary Graduate Nurses' Association

The CNATN minute book also lists four groups which could not attend the meeting but had signified their support:

Provincial Nurses' Association, Manitoba
The Riverdale Hospital Alumnae Association, Toronto
The Alumnae Association of St. Michael's Hospital, Toronto
The Kingston General Hospital Alumnae Association, Kingston

In the following month, November 1908, the groups listed above were recorded in The Canadian Nurse as being members of the CNATN. It also listed as members the Hamilton Graduate Nurses' Association and General and Marine Hospital Alumnae Association, Collingwood.

By 1911, at the first CNATN general meeting, 28 organizations were listed as affiliated.

**ICN OVERTURES**

Even though Canada had no formal representation in international organizations in the early 1900's, several Canadians were active in international meetings of women's groups. Here is a letter to Bella Crosby, later editor of The Canadian Nurse, which appeared in the June 1908 issue of the magazine:

*Dear Miss Crosby:*

*When are you going to have a National Council of Nurses of Canada? It is time, why not start, and come into affiliation with the International next year, 1909, when we hope to have a splendid meeting. Denmark, Holland and Finland have already applied for affiliation. Our Colonies and Dominions are behind in women's organizations — they are too parochial. The world is a very wee place, and too many narrow circles attempt to ignore that fact.*

*Yours very truly,*

*Ethel G. Fenwick*

*Honorary President, The International Council of Women*
After the organizational meeting in Ottawa, October 8, 1908, which brought into being the Provisional Society of The Canadian National Association of Trained Nurses, the following letter, self-explanatory in its enthusiasm and direction, was dispatched:

To the President of the National Council of Trained Nurses of Great Britain and Ireland.

My dear Mrs. Fenwick:

I know you will be very pleased when I tell you that we have organized our Provisional Society of The Canadian National Association of Trained Nurses, with myself as president and Miss Flora Madeline Shaw, of the General Hospital, Montreal, as secretary-treasurer. I am enclosing a copy of our constitution, which you will see has been borrowed for the time being from your constitution. It seemed to suit our needs very well.

Ottawa was the place of meeting, and October 8th the date on which this organization was accomplished. The convention of the superintendents of the Canadian Society of Training Schools for Nurses met in that city on October 8th and 9th, and the various societies represented in our National organization were invited to send delegates to this convention. Only one opinion was expressed, and that was that all were in favour of forming the national society. Eighteen societies are included in our national organization, and we are now in a position to make application for entrance into the International Council of Nurses; in fact, you are at liberty to regard this letter as an application, but the fee will be forwarded later.

I am so pleased to be able to tell you this piece of news that I have not taken time to have our constitution typewritten.

With kindest regards, and thanks for your many letters of assistance,

Yours faithfully,

Mary Agnes Snively

CNA HONORARY AWARDS

MARY AGNES SNIVELY MEDALS were presented from 1936 to 1944 to nurses who, in the opinion of the provincial associations, exemplified the lofty ideals and standards of service which characterized the life of Miss Snively.

Mabel F. Hersey 1936
Jean I. Gunn
Edith MacPherson Dickson
Jean E. Browne 1938
Jean S. Wilson
Elizabeth L. Smellie
E. Kathleen Russell 1940
Mother Louise Allard
Ethel I. Johns
Grace M. Fairley 1942
Eleanor McPhedran
E. Frances Upton
Marion Lindeburgh 1944
Helen L. Randal
Ruby M. Simpson

HONORARY MEMBERSHIPS were awarded by the CNA from 1958 to 1966 to give recognition to nurses residing inside or outside Canada who had made outstanding contributions to Canadian nursing, and to non-nurses for outstanding public service. Only one such membership had been awarded prior to 1958.

Mary Agnes Snively 1921
Mother Louise Allard 1958
Daisy C. Bridges (ICN)
Edith MacPherson Dickson
Kathleen W. Ellis
Florence H. M. Emory
Grace M. Fairley
Mabel F. Gray
Ethel I. Johns
Mrs. M. Louise (Meiklejohn) Lyman
Helen L. Randal
E. Kathleen Russell
Ruby M. Simpson
Elizabeth L. Smellie
Mrs. Jean E. (Browne) Thomson
Jean S. Wilson

Mother Marie Virginie Allaire 1960
Mme Louis de Gaspé Beaubien *
Ethel M. Cryderman
Marion F. Haliburton
Margaret E. MacKenzie
Anna J. R. Mair
Mrs. J. Cecil McDougall *
Elizabeth A. Russell
Isabel Maitland Stewart

Dr. G. Stewart Cameron * 1962
Mrs. Rex Eaton *
Nettie D. Fidler
M. Christine Livingston

* Non-nurses
<table>
<thead>
<tr>
<th>Name</th>
<th>Term</th>
<th>Position at time of office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary Agnes Snively</td>
<td>1908-12</td>
<td>Lady Superintendent of Nurses</td>
</tr>
<tr>
<td>Mary Ard. MacKenzie</td>
<td>1912-14</td>
<td>Chief Superintendent of Nurses; Assistant Professor</td>
</tr>
<tr>
<td>Mrs. Sharley P. (Wright) Bryce-Brown</td>
<td>1914-17</td>
<td>In charge of school of nursing</td>
</tr>
<tr>
<td>Jean I. Gunn</td>
<td>1917-20</td>
<td>Lady Superintendent of Nurses; Assistant Superintendent</td>
</tr>
<tr>
<td>Edith MacPherson Dickson</td>
<td>1920-22</td>
<td>Superintendent of Nurses; Director, Canadian Red Cross Junior</td>
</tr>
<tr>
<td>Jean E. Browne (Thomson)</td>
<td>1922-26</td>
<td>National Director; Editor, Canadian Red Cross Society, Toronto</td>
</tr>
<tr>
<td>Flora Madeline Shaw</td>
<td>1926-27</td>
<td>Director, School for Graduate Nurses</td>
</tr>
<tr>
<td>Mabel F. Gray (acting)</td>
<td>1927-28</td>
<td>Assistant Professor of Nursing, Dept. of Nursing and Health</td>
</tr>
<tr>
<td>Mabel F. Hersey</td>
<td>1928-30</td>
<td>Superintendent of Nurses; Director, School of Nursing</td>
</tr>
<tr>
<td>Florence H. M. Emory</td>
<td>1930-34</td>
<td>Assistant Director, School of Nursing</td>
</tr>
<tr>
<td>Ruby M. Simpson</td>
<td>1934-38</td>
<td>Director, Public Health Nursing Service</td>
</tr>
</tbody>
</table>

*Non-nurses*
<table>
<thead>
<tr>
<th>Name</th>
<th>Time Period</th>
<th>Position/Institution</th>
<th>Location/University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grace M. Fairley</td>
<td>1938-42</td>
<td>Director of Nursing; Principal, School of Nursing</td>
<td>Vancouver General Hospital</td>
</tr>
<tr>
<td>Marion Lindeburgh</td>
<td>1942-44</td>
<td>Director and Associate Professor, School for Graduate Nurses</td>
<td>McGill University, Montreal</td>
</tr>
<tr>
<td>Fanny C. Munroe</td>
<td>1944-46</td>
<td>Superintendent of Nurses; Director, School of Nursing</td>
<td>Royal Victoria Hospital, Montreal</td>
</tr>
<tr>
<td>Rae Chittick</td>
<td>1946-48</td>
<td>Associate Professor of Education</td>
<td>University of Alberta, Edmonton</td>
</tr>
<tr>
<td>Ethel M. Cryderman</td>
<td>1948-50</td>
<td>Director, Toronto Branch</td>
<td>Victorian Order of Nurses, Toronto</td>
</tr>
<tr>
<td>Helen G. McArthur</td>
<td>1950-54</td>
<td>National Director of Nursing Services</td>
<td>Canadian Red Cross Societies, Toronto</td>
</tr>
<tr>
<td>Gladys J. Sharpe</td>
<td>1954-56</td>
<td>Director of Nursing; Principal, School of Nursing</td>
<td>Toronto Western Hospital</td>
</tr>
<tr>
<td>Trenna G. Hunter</td>
<td>1956-58</td>
<td>Director, Public Health Nursing</td>
<td>Metropolitan Health Committee, Vancouver</td>
</tr>
<tr>
<td>Alice M. Girard</td>
<td>1958-60</td>
<td>Director of Nursing; Assistant Administrator</td>
<td>Saint-Luc Hospital, Montreal</td>
</tr>
<tr>
<td>Dr. Helen G. Carpenter</td>
<td>1960-62</td>
<td>Director, School of Nursing</td>
<td>University of Toronto</td>
</tr>
<tr>
<td>E. A. Electa MacLennan</td>
<td>1962-64</td>
<td>Director and Associate Professor, School of Nursing</td>
<td>Dalhousie University, Halifax</td>
</tr>
<tr>
<td>Mrs. A. Isobel MacLeod</td>
<td>1964-66</td>
<td>Director of Nursing; Principal, School of Nursing</td>
<td>Montreal General Hospital</td>
</tr>
<tr>
<td>Dr. Katherine E. MacLaggan (died February 6, 1967)</td>
<td>1966-67</td>
<td>Director, School of Nursing</td>
<td>University of New Brunswick, Fredericton</td>
</tr>
<tr>
<td>Sister Mary Felicitas</td>
<td>1967-</td>
<td>Director, School of Nursing</td>
<td>St. Mary's Hospital, Montreal</td>
</tr>
</tbody>
</table>
The title of the chief administrative officer employed by the CNA has changed over the years to reflect shifting responsibilities and increasing activity in the national office. The original title, established in 1923, was executive secretary; this was subsequently changed to general secretary in 1944, which could be combined with the treasury function to be called general secretary-treasurer. With expansion of activity in the CNA, the function was enlarged in 1962, and the position became that of executive director. By 1967 the CNA executive director function also included additional responsibilities as publisher of the two official journals of the Association and as secretary-treasurer of the Canadian Nurses’ Foundation.

Office holders have been:

<table>
<thead>
<tr>
<th>Name</th>
<th>Term</th>
<th>Graduate from</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jean S. Wilson</td>
<td>1923-43</td>
<td>Lady Stanley Institute</td>
</tr>
<tr>
<td>Kathleen W. Ellis</td>
<td>1943-44</td>
<td>Johns Hopkins Hospital; Columbia University</td>
</tr>
<tr>
<td>Gertrude M. Hall</td>
<td>1944-52</td>
<td>Winnipeg General Hospital</td>
</tr>
<tr>
<td>M. Pearl Stiver</td>
<td>1952-63</td>
<td>Toronto Western Hospital; Columbia University</td>
</tr>
<tr>
<td>Dr. Helen K. Mussallem</td>
<td>1963-</td>
<td>Vancouver General Hospital; McGill University; Columbia University</td>
</tr>
</tbody>
</table>

CNATN-CNA GENERAL MEETINGS

The first general meeting of the Canadian National Association of Trained Nurses was held in Niagara Falls, Ontario in 1911. With one exception during World War I, such meetings were held annually until 1922. Since that time, they have been held every second year.

<table>
<thead>
<tr>
<th>Year</th>
<th>Location</th>
<th>Date</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1911</td>
<td>Niagara Falls</td>
<td>May 22</td>
<td>1911</td>
</tr>
<tr>
<td>1912</td>
<td>Toronto</td>
<td>April 4</td>
<td>1912</td>
</tr>
<tr>
<td>1913</td>
<td>Kitchener</td>
<td>May 21</td>
<td>1913</td>
</tr>
<tr>
<td>1914</td>
<td>Halifax</td>
<td>July 10-11</td>
<td>1914</td>
</tr>
<tr>
<td>1916</td>
<td>Winnipeg</td>
<td>June 15-16</td>
<td>1916</td>
</tr>
<tr>
<td>1917</td>
<td>Montreal</td>
<td>June 12</td>
<td>1917</td>
</tr>
<tr>
<td>1918</td>
<td>Toronto</td>
<td>June 6-8</td>
<td>1918</td>
</tr>
<tr>
<td>1919</td>
<td>Vancouver</td>
<td>July 2-5</td>
<td>1919</td>
</tr>
<tr>
<td>1920</td>
<td>Fort Arthur-Fort William</td>
<td>July 7-10</td>
<td>1920</td>
</tr>
<tr>
<td>1921</td>
<td>Quebec City</td>
<td>June 1-4</td>
<td>1921</td>
</tr>
<tr>
<td>1922</td>
<td>Edmonton</td>
<td>June 19-22</td>
<td>1922</td>
</tr>
</tbody>
</table>
WHILE ON ACTIVE SERVICE

WORLD WAR I: A total of 47 Canadian nurses lost their lives during World War I.

Serving with the Canadian Army Medical Corps Nursing Service:

Baker, Miriam E.
Baldwin, Dorothy M. Y.
Campbell, Christina
Dagg, Ainslie St. C.
Davis, Lena A.
Douglas, Carola J.
Dussault, Alexina
Follette, Minnie A.
Forneri, Agnes F.
Fortesque, Margaret J.
Fraser, Margaret M.
Gallagher, Minnie K.
Garbutt, Sarah E.
Green, Matilda E.
Hennan, Victoria B.
Jaggard, Jessie B.
Jenner, Lenna M.
Kealy, Ida L.
King, Jessie N.
Lowe, Margaret
MacDonald, Katherine M.
MacPherson, Agnes
McDiarmid, Jessie M.
McIntosh, Rebecca
McKay, Evelyn V.
McKenzie, Mary A.
McLean, Rena
Mellett, Henrietta
Murro, M. Frances E.
Pringle, Eden L.
Ross, Ada J.
Sampson, Mae B.
Sare, Gladys I.
Sparks, Etta
Stamers, Anna I.  
Templeman, Jean  
Tupper, Addie A.  

Wake, Gladys M. M.  
Whitely, Anna E.  

**With the Imperial Army Nursing Service:**  
Hannaford, Ida D.  

**With the United States Army Nurse Corps:**  
Graham, Florence B.  
Overend, Marion L.  
Symmes, Kathleen E.  

Nicol, Christina  
Walker, Anna A.  
Welsh, Anne K.  
Whiteside, Lydia V.  

WORLD WAR II: Between 1939 and 1945, a total of 13 Canadian nurses lost their lives overseas while on active duty with Canadian forces.

**As a result of enemy action:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Branch</th>
<th>Home</th>
<th>Graduate from</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wilkie, Agnes</td>
<td>R.C.N.</td>
<td>Carman, Man.</td>
<td>Misericordia General Hospital, Winnipeg</td>
</tr>
</tbody>
</table>

**As a result of accidents:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Branch</th>
<th>Home</th>
<th>Graduate from</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bell, Marion E.</td>
<td>Army</td>
<td>Toronto, Ont.</td>
<td>St. Michael's Hospital, Toronto</td>
</tr>
<tr>
<td>MacDonald, Vera C.</td>
<td>Army</td>
<td>Glace Bay, N.S.</td>
<td>Halifax Medical Infirmary</td>
</tr>
<tr>
<td>McLaren, Mary S.</td>
<td>Army</td>
<td>Todmorden, Ont.</td>
<td>University of Toronto</td>
</tr>
<tr>
<td>Peters, Nora H.</td>
<td>Army</td>
<td>Cluny, Alta.</td>
<td>Calgary General Hospital</td>
</tr>
<tr>
<td>Westgate, Marion M.</td>
<td>R.C.A.F.</td>
<td>Regina, Sask.</td>
<td>Royal Victoria Hospital, Montreal</td>
</tr>
</tbody>
</table>

**Died overseas:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Branch</th>
<th>Home</th>
<th>Graduate from</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashley, Ruth Louise</td>
<td>Army</td>
<td>Saskatoon, Sask.</td>
<td>Saskatoon City Hospital</td>
</tr>
<tr>
<td>Cooper, Frances</td>
<td>Army</td>
<td>Halifax, N.S.</td>
<td>Vancouver General Hospital</td>
</tr>
<tr>
<td>Fitzgerald, Gladys H.</td>
<td>Army</td>
<td>Belleville, Ont.</td>
<td>Not known</td>
</tr>
<tr>
<td>Gannon, Frances</td>
<td>Army</td>
<td>Camrose, Alta.</td>
<td>St. Paul's Hospital, Saskatoon</td>
</tr>
<tr>
<td>McLeod, Jessie Margaret</td>
<td>R.C.A.F.</td>
<td>Halifax, N.S.</td>
<td>Victoria General Hospital</td>
</tr>
<tr>
<td>Polgreen, Frances</td>
<td>Army</td>
<td>Saltcoats, Sask.</td>
<td>St. Boniface Hospital</td>
</tr>
<tr>
<td>Spafford, Frances</td>
<td>Army</td>
<td>Winnipeg, Man.</td>
<td>Winnipeg General Hospital</td>
</tr>
<tr>
<td>Winnifred</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
VI. Milestones to the Present

The following listing is not intended to be a complete record of events of either the CNA or nursing in Canada. Rather, it is an effort to bring the essential patterns of Canadian nursing into chronological focus. Milestones makes only brief mention of some of the major events, studies and recommendations which have shaped the course of the CNA and the profession in Canada over the past 60 years. Some of these are discussed at more length in other parts of this text; some references are also made to events which took place outside the jurisdiction of the CNA but became pertinent to it.

1905 • Publication of *The Canadian Nurse* began, under the sponsorship of the alumnae association of the Toronto General Hospital. Editor was Dr. Helen MacMurchy.

1907 • The Canadian Society of Superintendents of Training Schools for Nurses was formed. Its first president was Mary Agnes Snively.

• Louise C. Brent, superintendent of the Hospital for Sick Children, Toronto, was elected president of the Canadian Hospital Association.

• The first two volumes of the first major history of nursing in America, by M. Adelaide Nutting and Lavinia L. Dock, were published.

• One of the first major standard texts in nursing schools in America, *Practical Nursing* was published. Its two authors, Anna C. Maxwell and Amy E. Pope, were both connected with Canada. Miss Maxwell, a graduate of Boston City Hospital, was the second nurse to attempt to establish a training school at the Montreal General Hospital; subsequently she was superintendent of Presbyterian Hospital, New York, for 29 years. A native of Quebec City and a Presbyterian Hospital graduate, Miss Pope wrote several texts on nursing and in 1902 had established the first lay training school for nurses at San Juan, Puerto Rico.

1908 • The Canadian National Association of Trained Nurses was formed by a group of alumnae, local and provincial associations. The first Canadian national organization for nurses, it was the precursor to the Canadian Nurses' Association. Its first president was Mary Agnes Snively.

1909 • CNATN was accepted as a member of the International Council of Nurses.

1910 • With the incorporation of the Graduate Nurses' Association of Nova Scotia, the first nursing legislation in Canada was passed. It provided for a
form of voluntary registration for graduate nurses. There was an examination and a board of examiners and any nurse not a graduate could register by passing the examination.

1913 • With the passage of an act incorporating the Manitoba Association of Graduate Nurses, Manitoba became the first province to obtain a registration act. Less than comprehensive, it did make stipulations for nursing school standards, registration and discipline for practicing nurses.

1914 • All provinces in Canada except Prince Edward Island had formed a provincial association.

- The report of a special committee on nurse education was presented to the CNATN’s fourth general meeting. Among the members of the committee was Sir Robert A. Falconer, president of the University of Toronto. Included in the committee’s recommendations were: “...Establish nurse training schools or colleges in connection with the educational system of each province, the raison d’être of which will be the education of the nurse, not as it is under the present system, the lessening of the cost of nursing in the hospitals. These schools should be separate in organization from the hospitals. The hospitals will be used to supply the practical training... This committee would recommend that a committee be appointed in each province to work out a scheme along these lines in connection with the educational system of the province.” Convenor of the committee was Mary Ardochrone MacKenzie, chief superintendent of the VON, who was a graduate in arts from the University of Toronto and in nursing from Massachusetts General Hospital. She later became superintendent of nursing at University of California Hospital, San Francisco, and then instructor in public health nursing at the University of British Columbia.

1916 • The Canadian Nurse was purchased by the CNATN and established as the official organ of the Association.

- Grace M. Fairley, superintendent of nurses, Alexandra Hospital, Montreal, was elected vice-president of the American Hospital Association.

1917 • The first organized system of student government in a school of nursing in Canada was established at the Toronto General Hospital.

- The Canadian Society of Superintendents of Training Schools for Nurses changed its name to the Canadian Association of Nursing Education.

1919 • University of British Columbia offered the first baccalaureate degree course in nursing in the British Empire.

1920 • Dalhousie University offered the first course in public health nursing in Canada for graduate nurses. McGill University offered the first course in teaching and supervision for graduate nurses.
1920-1924 • The CNATN developed three main sections of operation, and nurses participated in the section in which they were employed. These sections were: Public Health Nursing (formed 1920); Private Duty (1921); Nursing Education (1924—formed following the merger of CANE with CNATN). Sections with similar functions were developed in the provincial associations so that their efforts could be co-ordinated with those of the national association.

1921 • A major text, Principles of Nursing, was published. The author, Bertha Harmer, was a graduate from Toronto General Hospital and Columbia University. She held several positions in the U.S., including that of assistant professor at the Yale School of Nursing, before returning to Canada to become director of the School for Graduate Nurses, McGill University.

1922 • All nine provinces had some form of nursing registration legislation.
- The CNATN general meeting decided to open a national office and employ an executive secretary. The following year, Jean Scantlion Wilson, a native of Quebec and a graduate of Lady Stanley Institute, Ottawa, opened the first CNATN office at Winnipeg.

1924 • The CNATN changed its name to the Canadian Nurses’ Association.
- Sisters Fafard and Duckett of the Grey Nuns organized at the University of Montreal the first French-language course in nursing education and ward administration for graduate nurses. The following year, the first French-language public health nursing course in Canada was instituted at U of M, with Edith B. Hurley as director of the program. The first professor of prenatal hygiene and public health nursing was Alice Ahern, a native of Quebec City, who was a graduate from St. Mary’s Hospital, Brooklyn, had studied at Columbia and Fordham universities, and was assistant superintendent of nursing for Canada with the Metropolitan Life Insurance Company.
- Jean I. Gunn, superintendent of nurses, Toronto General Hospital, was elected second vice-president of the ICN, a post she held until 1933. The same year she was awarded a Rockefeller Foundation grant for study in Europe. In 1937 she was elected first vice-president of the ICN, holding this office until her death in 1941.

1926 • A “Report on Nursing Service” was submitted by the CNA upon the request of the federal Department of Health on behalf of its Inter-departmental Committee on Professionally Trained People. This report contained statistical data; statement of issues and trends in nursing; the increasing difficulties of recruitment and the large number of drop-outs; the need to reduce wastage and conserve nurse power.

1927 • A national enrollment plan was developed by the CNA and the Canadian Red Cross which envisaged the enrollment of all registered nurses who
could be ready for emergency service in case of war or disaster. This plan was operated by a joint committee of the two organizations on an intermittent basis and with varying degrees of effectiveness until just before the end of World War II.

- Following a resolution at the CNA general meeting from the Alberta provincial association, the CNA entered into a joint sponsorship with the Canadian Medical Association of a survey of nursing education in Canada. (This was initiated shortly after a similar project was started in the U.S. under the aegis of the National League of Nursing Education and the American Medical Association.) The CNA-CMA committee was chaired by Dr. G. Stewart Cameron. CNA members on the study group were E. Kathleen Russell, director, department of nursing, University of Toronto; Jean I. Gunn, superintendent of nurses, Toronto General Hospital; Jean E. Browne, national director, Canadian Junior Red Cross. In 1929, Dr. G. M. Weir, professor of education and head of the department of education at the University of British Columbia, was appointed director of the survey. Educational, economic and sociological factors were studied.

1929 • ICN quadrennial congress was held in Montreal. More than 6,000 nurses from about 20 countries attended, together with observers from more than ten others. Over 3,000 came from the U.S. and about 2,900 from Canada. President of the CNA, the host organization, was Mabel F. Hersey, superintendent of nurses, Royal Victoria Hospital, Montreal.

1930 • The CNA became a federation of the nine provincial associations, a move which had the effect of eliminating duplicate memberships, thereby making possible the first calculation of individual CNA membership. In 1930, there were about 8,000 members of the CNA; the fee was raised from 50 to 75 cents per member.

1932 • The Weir Report, entitled *Survey of Nursing Education in Canada*, was published by the CNA. Among the major recommendations was one suggesting that schools of nursing should be incorporated into the general educational system of the country and be subsidized by government funds.

- CNA national office was moved from Winnipeg to Montreal. Ethel I. Johns was appointed the first full-time editor and business manager of *The Canadian Nurse*.

1933 • Florence H. M. Emory was appointed chairman of the ICN membership committee, a post she was to hold for 20 years. Miss Emory, professor of public health nursing at the University of Toronto, published a book entitled *Public Health Nursing in Canada*.

- First basic baccalaureate degree course in nursing under complete control of a university was initiated at the University of Toronto.
1934 • The Canadian Florence Nightingale Memorial Committee was formed by the CNA, the same year that the Florence Nightingale International Foundation was officially inaugurated to establish and maintain a trust fund for nursing education. In 1936, E. Kathleen Russell was invited by the Foundation to be chairman of a group of four experts to study the facilities in London for advanced nursing education and make suggestions for the future educational policy of the Foundation. During World War II, the Foundation was inactive and in 1957 became the Florence Nightingale Education Division of the ICN. Activities of the Canadian committee had lapsed previously.

- Efforts to obtain dominion registration for nurses, begun as early as 1910, were re-endorsed at the general meeting of the CNA in 1934.

- The first French-language program in Canada leading to a baccalaureate degree in nursing was started at Institut Marguerite d'Youville, Montreal.

1936 • A Proposed Curriculum for Schools of Nursing in Canada was published by the CNA. It was written by Marion Lindeburgh, a graduate of St. Luke's Hospital, New York, and Columbia University, and then director of the School for Graduate Nurses, McGill University. This proposed curriculum arose from the Weir Report recommendations published in 1932, and in that year the CNA had established a national curriculum committee, chaired by Miss Lindeburgh.

1937 • Effie J. Taylor was elected president of the ICN. Miss Taylor, a native of Hamilton, Ontario, a graduate of Wesleyan Ladies College, Hamilton; Johns Hopkins Hospital, and Columbia University, was dean of the Yale University school of nursing and had been president of the National League of Nursing Education.

1938 • Jean I. Gunn was appointed chairman of the ICN committee on constitution and bylaws.

- The CNA submitted a brief to the Royal Commission on Dominion-Provincial Relations.

- A CNA committee was formed to proceed with plans to secure eight-hour duty for student and graduate nurses on both day and night duty. It recommended that hours of duty be limited to 96 hours per fortnight with one day off each week, or the equivalent each fortnight.

1939 • Edna Moore of Ontario became chairman of the ICN public health nursing committee.

1940 • A committee chaired by Marion Lindeburgh presented to the 1940 CNA biennial meeting a supplement to the Proposed Curriculum. Entitled Improvement of Nursing Education in the Clinical Field, it was prepared
as a guide to administrative, supervisory and teaching responsibilities that were relative to students on the wards.

- The severe shortage of nurses during World War II caused the CNA to search for new sources of nursing personnel and to recommend that the provinces support the development of courses for nursing assistants. The CNA produced its first *Curriculum Guide for Nursing Assistants*.

- It was reported at the June biennial meeting that there were 16,738 members of the CNA.

1941 • Grace M. Fairley was appointed third vice-president of the ICN to replace Jean Gunn, and retained this post until 1953.

• The first joint conference of the CNA executive committee and the directors of Canadian university schools of nursing was held.

1942 • As part of a program to alleviate the wartime shortage of nurses, the federal government provided funds, to be administered by the CNA, for nursing education. In 1942, the grant was $115,000 and this was increased in 1943 to $250,000 and was continued until the end of the war. The grants covered many phases of nursing education costs, including recruitment of student nurses, administration of the special wartime program, grants to schools of nursing, and a considerable number of bursaries for all levels of nursing students.

• Kathleen W. Ellis was appointed Emergency Nursing Advisor to the CNA. Suzanne Giroux was appointed French Associate to the Emergency Nursing Advisor.

1943 • Under a compulsory registration procedure conducted by the National Selective Service, all graduate nurses, active or inactive, married or single, were required to register with the Selective Service. The only exceptions were those graduate nurses serving in the armed forces.

• The CNA co-operated with National Selective Service and the Canadian Medical Procurement and Assignment Board in a survey of nursing service in Canada during the National Health Survey conducted in March 1943. This study revealed that there was an acute shortage of general duty nurses; private duty nursing still offered ample employment, shorter hours and higher remuneration. Among the conclusions reached by the study group was one stating that, to alleviate the shortage of nurses, and to attract the quality of student desired, it would be necessary to provide salaries and working conditions comparable to those prevailing in other occupations requiring equivalent preparation.

• The CNA’s first committee on labor relations was formed in November 1943, under the chairmanship of Esther M. Beith, director of the Child Health Association, Montreal. The CNA committee was established in response to the expressed need of some of the provincial associations,
including British Columbia, for a national policy statement on nurse-trade union relationships. This first CNA step into the labor relations field came at a time when Canada was formalizing and legislating collective bargaining procedures. The new CNA committee made its first report to the general CNA membership at the 1944 biennial meeting.

1944 • Public Health Nursing Section of the CNA recommended minimum and maximum salary levels for staff and supervisory public health nurses. The recommendations also covered vacations with pay, sick leave and pensions.

- Membership fee in the CNA was raised to $1.00 per member.

1945 • Membership at December 1945 had passed 23,000.

1946 • A Joint Committee, Canadian Hospital Council and Canadian Nurses' Association, was formed to consider the acute shortage of hospital personnel in comparison to hospital expansion. This committee grew to include representatives from the Canadian Medical Association, the Department of National Health and Welfare, and the Department of Veterans Affairs. Later it became known as the Joint Committee on Nursing. Gertrude M. Hall, general secretary of the CNA, became the first secretary of the group.

- At the request of the Department of National Health and Welfare, for the Inter-departmental Committee on Professionally Trained People, the CNA presented a submission entitled “Nursing Service in Canada”, which was prepared by Ethel I. Johns. It was part of a national survey undertaken by the Department of Labour to assemble information regarding future employment opportunities for professionally trained people in Canada.

- The CNA, in co-operation with The Canadian Red Cross Society and the Ontario Department of Health, established the Metropolitan Demonstration School of Nursing in Windsor, Ontario — a two-year nursing education program independent of any hospital. Its director was Nettie D. Fidler, nursing faculty member at the University of Toronto. Chief objectives of the program were to establish the idea of a nursing school as an educational institution and to demonstrate that a skilled clinical nurse could be prepared in two years, if the school controlled the student's time. An evaluation of the project by Dr. A. R. Lord of the Department of Education, University of British Columbia, was published in 1952.

1947 • Three Centuries of Canadian Nursing was published. Sponsored by the CNA, it was written by John Murray Gibbon in collaboration with Mary S. Mathewson, who was then director of nursing at the Montreal General Hospital and had been assistant director of the School for Graduate Nurses, McGill University.

- The Canadian Nurses' Association was incorporated under the Statutes of Canada. By the statute, the CNA was constituted as a federation of the provincial registered nurses' associations, to act for and under the authority
of these organizations, on nursing matters at the national and international levels. Incorporators were Rae Chittick, Sister Delia Clermont, Sister Columkille, Ethel M. Cryderman, Eileen C. Flanagan, Agnes J. Macleod, Evelyn Mallory, Fanny C. Munroe, Lillian E. Pettigrew and Sister St. Gertrude.

1948 • A standing committee on public relations was formed by the CNA.

1950 • Membership in the CNA had passed 30,000.
   • The New Brunswick provincial nurses' association became the first to collect a subscription fee for *The Canadian Nurse* along with the membership fee. All other provincial associations eventually followed this course.

1951 • A structure study of the CNA was undertaken by Dr. Pauline Jewett. As a result of this study, in 1954, the number of CNA national committees was reduced from 11 to 5, and the national office staff and function enlarged. The five standing committees established under the new organizational system were nursing service, nursing education, public relations, legislation and by-laws, and finance. A similar structure was adopted by provincial associations.

1952 • CNA membership fee was raised to $2.00.

1953 • The CNA presented to the Minister of National Health and Welfare a submission entitled "Implementation of the Recommendations of Major Concern to Nursing as Contained in the Provincial Health Survey Reports".
   • A "Study of the Functions and Activities of Head Nurses in a General Hospital" was carried out by the Research Division of the Department of National Health and Welfare at the request of the CNA. It endeavored to find ways of conserving the time of the head nurse in the best interests of patient care, and provided factual data for use in analyzing the duties of head nurses and the proper assignment of duties.

1954 • Lyle Creelman, a native of Nova Scotia, and a graduate from University of British Columbia and Columbia University, was appointed chief of the nursing division of the World Health Organization.
   • A firm of public relations consultants was retained to assist the CNA in the planning and execution of a long-term public relations program.
   • National office of the CNA was moved from Montreal to Ottawa. Offices of *The Canadian Nurse* remained in Montreal.

1955 • ICN code of ethics was adopted as the CNA code of ethics.
   • CNA became an associate member of the Canadian Hospital Association. In 1958, the CNA became an associate member of the Canadian Medical Association.
• Sister M. Denise Lefebvre, s.g.m., became the first Canadian nurse to earn a doctoral degree. Awarded a D.Paed. by the University of Montreal, she is a graduate from the Grey Nuns’ school of nursing in St. Boniface, Manitoba; University of Montreal; University of St. Louis, Mo., and Catholic University of America. Her dissertation was entitled “Technique d’évaluation des écoles infirmières”. She was co-author in 1947 of Le soin des malades: principes et techniques, the third edition of which was published in 1963.

• Membership in December 1955 passed 41,000.

1956 • Sister Denise Lefebvre, director, Institut Marguerite d’Youville, Montreal, was appointed chairman of a special CNA committee to plan a pilot project that would recommend ways of evaluating and accrediting schools of nursing on a national, voluntary basis, and of determining their readiness for accreditation. The impetus for this movement came originally from the Canadian Conference of Catholic Schools of Nursing.

• The CNA presented the statement entitled “Nurses, Their Education and Their Role in Health Programs” to the WHO to assist in preparing for the technical discussions of the ninth general assembly of WHO.

• CNA presented a brief to the Royal Commission on Canada’s Economic Future. It contained statistical data which showed that between the publication of the Weir Report in 1932 and 1956:
  a. The number of registered nurses had trebled.
  b. The number of public health nurses had almost trebled.
  c. The number of hospital beds had almost doubled.
  d. The proportion of private duty nurses had declined considerably while the number of nurses employed in hospitals was ten times as great as in 1932.

1957 • The first Canadian Conference on Nursing was sponsored by the CNA to focus attention on the nursing situation in Canada and to provide the organized profession with outside points of view on nursing matters. It was attended, by over 100 people including representatives from the CMA, CHA, government departments and interested members of the public.

Among the recommendations which emerged from this conference were: preparation of the nurse should be an educational experience; research projects should be undertaken by the CNA to provide factual data for assessment of nursing service, types of personnel required, and their functions and education; past studies of nursing should be recorded by the CNA; the CNA should investigate methods of expanding recruitments of nurses for advanced study; more attention should be given to the provision of nursing care in the home as a means of achieving more effective use of hospital and nursing resources.
Under the auspices of the CNA, a pilot project for the evaluation of schools of nursing in Canada was begun, with Helen K. Mussallem as director. The purpose of the study was to determine the readiness of Canadian schools of nursing for a program of national voluntary accreditation. The CNA believed that national accreditation, based on standards set by the whole profession, would provide the key to improved nursing education across the country and would keep nursing abreast of scientific and social changes. While provincial approval would continue to be compulsory, i.e., a school could not operate without it, national accreditation would be voluntary.

The conclusion reached by this study was that Canadian schools taken as a whole would need help in upgrading their programs before they would be ready for national accreditation. The report of this project, published in 1960, made four recommendations, three of which were implemented the same year. These were that the CNA undertake: a study of nursing education in Canada, a national school improvement program, and a national evaluation of nursing service programs.

Queen Elizabeth II became the first Royal Patron of the Canadian Nurses' Association.

1958 • CNA was responsible for securing the first Canadian postage stamp on health.
• CNA celebrated its 50th anniversary.
• CNA retirement plan was adopted, making available to privately employed nurses a portable pension plan; and an employer-employee plan to employers of CNA members.
• Alice M. Girard became the first French-Canadian president of the CNA. She was graduated from St. Vincent de Paul Hospital, Sherbrooke; Catholic University of America and Columbia University.
• Membership in the CNA reached 43,000.
• Arising from the "Study of the Functions and Activities of Head Nurses in a General Hospital" that was carried out earlier, the nursing service committee of the CNA, under the chairmanship of Sister Mary Felicitas, prepared a Manual for Head Nurses in Hospitals, which was published in 1960.
• F. Lillian Campion was appointed chairman of the International Labor Organization's Committee on Conditions of Work and Employment of Nurses. Miss Campion was at that time CNA Nursing Secretary.

1959 • The French-language journal of the CNA, L'infirmière canadienne, began publication.
• The first master's degree program in nursing in Canada was established at the University of Western Ontario.

1960 • The director of special studies for the CNA was appointed as the CNA liaison member to the Canadian Conference of University Schools of
Nursing (CCUSN). This marked one of the first major moves to link the CNA with progress in higher education for nurses and to establish close working relationships with the university schools of nursing.

- Membership in the CNA passed 59,000.
- CNA published *Spotlight on Nursing Education, The Report of the Pilot Project for the Evaluation of Schools of Nursing in Canada*.

1961

- Membership fee in the CNA was raised to $4.00. Membership 61,000.
- In co-operation with the Canadian Hospital Association, the CNA sponsored an extension course in nursing unit administration in Toronto. Financial support was received from W. K. Kellogg Foundation during the first six years. By 1963, a similar course was arranged in the French language at the University of Montreal. The courses were to assist head nurses and assistant head nurses unable to attend a university graduate school to up-grade their skills in the administration of nursing service units in hospitals. The CNA and CHA maintain equal permanent representation on the Joint Committee, Extension Course in Nursing Unit Administration.
- Lillian E. Pettigrew was appointed chairman of the ICN committee on constitution and by-laws; Alice M. Girard was appointed chairman of the ICN nursing service committee.

1962

- CNA brief to the Royal Commission on Health Services made 25 recommendations for the improvement of nursing service within the health services of Canada. A member of the commission was Alice M. Girard, immediate past-president of the CNA.
- The University of Montreal became the first university in Canada to establish a faculty of nursing. Alice M. Girard was appointed the first dean.
- The Canadian Nurses' Foundation was established to provide scholarships, bursaries and fellowships for post-graduate study in nursing. Provision was made in 1966 to include assistance for study at the baccalaureate level.
- The first French-language basic integrated degree program in the world was initiated at Institut Marguerite d'Youville, Montreal.
- Canadian Joint Committee on Nursing changed its name to the Liaison Committee, CNA, CMA, CHA. The CNA has equal joint permanent representation with the Canadian Medical Association and Canadian Hospital Association on this committee.
- A study of CNA administration and organization was undertaken by a firm of management consultants. In 1964, the report of the management consultants that was submitted to the executive committee recommended changes in organizational structure which led in 1966 to the reduction of standing committees from five to three and to the expansion of head office research and advisory functions.
1963 • Executive director of the CNA, Dr. Helen K. Mussallem, was appointed chairman of the First Scientific Group on Research in Nursing, WHO, Geneva.

• CNA briefs were presented to: Special Senate Committee on Aging; Royal Commission on Bilingualism and Biculturalism; Canadian Conference on Mental Retardation.

1964 • The CNA library evolved into a national library service, including a repository collection of Canadian nursing studies, and an archives section.

• Executive director of the CNA, Dr. Helen K. Mussallem, was appointed by WHO as chairman of the Expert Study Committee to advise on the program for the International School of Advanced Nursing Education, University of Edinburgh. In April of that year, Dr. Mussallem also conducted under the auspices of WHO, a survey on nursing and nursing education in the Lebanon. In July and August she was a WHO short-term consultant to assist in developing an evaluation of schools of nursing in 13 former British Caribbean territories. This was patterned after the CNA’s Pilot Project for the Evaluation of Schools of Nursing in Canada.

• The CNA established a standing committee on social and economic welfare.

• The earliest extant hospital in Canada, Hôtel Dieu, Quebec City, celebrated its 325th anniversary.

• CNA intensively studied recommendations contained in the report of the Royal Commission on Health Services with a view to establishing its own position and course of action.

• Ryerson Polytechnical Institute, Toronto, initiated an experimental program to prepare diploma nurses within the general post-secondary educational system. In 1966, under the auspices of the RNAO, F. Moyra Allen, associate professor at McGill University’s School for Graduate Nurses, began a study of the project.

1965 • Alice M. Girard was elected president of the ICN, the first nurse in Canada to hold the position.

• Construction began of CNA House, Ottawa.

• CNA executive director, Dr. Helen K. Mussallem, was appointed a member of the Canadian delegation to the Commonwealth Medical Conference, Edinburgh.

• Sister Annette Dion, s.g.m., a graduate from the University of St. Louis, and Sister Lucille Ouellette, a graduate from Institut Marguerite d’Youville, were honored by the Lebanese government for technical assistance in connection with hospitals and nursing schools in that country.

• A study undertaken by Dr. Helen K. Mussallem for the Royal Commission on Health Services, Nursing Education in Canada, was published. It con-
tained results of a survey of educational programs in 170 schools of nursing, 16 university schools of nursing and 70 provincially approved nursing assistant programs.

- Following an appointment as professor of nursing at the University of Ghana, Rae Chittick was appointed visiting professor of nursing, advanced nursing education, University of the West Indies, Jamaica.
- Full-time editors were appointed for both the French and English editions of the CNA journals. Combined circulation had climbed to more than 75,000. Final responsibility for the management and production of the journals became a function of the CNA executive director.
- Using computerized data processing procedures, the first national inventory of nurses registered in Canada was undertaken by the CNA.
- In December 1965, the membership of the CNA reached 78,312.

1966
- A Royal Commission on Health Services study by Dr. R. A. H. Robson was published, entitled *Sociological Factors Affecting Recruitment into the Nursing Profession*.
- The entire CNA operation was centralized in the new CNA House in Ottawa on April 1, 1966.
- *Vigil*, a film on nursing undertaken by the CNA as a centennial project in recognition of Canada's 100 years of nationhood, was completed, and distribution began in 1967.
- Three major studies that had been initiated in 1960 following acceptance of the Pilot Project were published in English and French:
  a. The uncompleted papers of the late Dr. Kaspar D. Naegle, prepared during his study on nursing education in Canada — under the title *A Course for the Future*.
- First students were graduated from Quo Vadis School, Toronto, now affiliated with Queensway General Hospital. This school was founded in 1964 for women between the ages of 30 and 50, and provides a two-year program on a 9-5, five-day week basis.
- A professional consultant on labor relations was retained by the CNA to advise on legal and other aspects of collective bargaining.
- In 1966, associate membership in the CNA was abolished, leaving one type of membership with a $10.00 annual fee. Included for the first time in the
total membership fee was the CNA's professional monthly magazine in the desired language. Membership statistics after December 1967 adopt the new base excluding associate members.

- Saskatchewan became the first province in Canada to transfer authority for hospital schools of nursing from the Department of Public Health to the Department of Education. Sister Thérèse Castonguay, a native of Quebec and a graduate from St. Boniface Hospital, Institut Marguerite d'Youville and Catholic University of America, became the first superintendent of nursing education within the Department of Education. The first class of students under the new system was admitted in September 1967.

- CNA adopted as its official code of ethics, the ICN code as revised in 1965.

- CNA re-affirmed the principle of national voluntary accreditation of schools of nursing.

- Executive director of the CNA, Dr. Helen K. Mussallem, was appointed by WHO as senior consultant to the First Travelling Seminar on Nursing in the U.S.S.R. Purpose of the seminar was to provide the opportunity for nurses from 23 countries (six WHO regions) to learn about health programs in the Soviet Union.

- Changes in the by-laws of the CNA reduced standing committees to three: Nursing Education, Nursing Service and Social and Economic Welfare. With a change in composition, the CNA Executive Committee became the CNA Board of Directors; the Sub-committee of the Executive Committee became the Executive Committee.

- Dr. Helen K. Mussallem became the first Canadian to be presented with the Award for Distinguished Achievement in Nursing Research and Scholarship by the Nursing Education Alumni Association, Teachers College, Columbia University.

- A news section was incorporated into the Association’s journals by which current nursing news could reach more than 86,000 subscribers each month.

- CNA appointed an ad hoc committee to study the possibility of having national testing examinations and a national testing service located at national headquarters.

- Membership in the CNA in December 1966 stood at 79,312.

1967 • Claire Gagnon was elected a regional vice-president for North America of the Committee of Catholic Nurses and Medico-Social Workers (CICIAMS). Miss Gagnon, a graduate of Hôtel Dieu, Sherbrooke, and the universities of Bathurst, Montreal and Columbia, was also in 1967 appointed director of the newly-established School of Hospital Science at Laval University.

- CNA president, Dr. Katherine E. MacLaggan, died during her term of office in February 1967. Later in the year, Dr. MacLaggan received posthumously
the Award for Distinguished Achievement in Nursing Education from the Nursing Education Alumni Association, Teachers College, Columbia University, New York.

- Sister Mary Felicitas was the first religious sister to become president of the CNA. She is a graduate of Providence Hospital, Moose Jaw, Saskatchewan; University of Ottawa and Catholic University of America.

- As a result of the amalgamation of Institut Marguerite d'Youville with the University of Montreal, the U of M became the first university in the world to offer both undergraduate and graduate degrees in nursing in the French language.

- From April to October, CNA participated in Expo 67 by staffing, in the Man and His Health theme pavilion, a demonstration booth on monitoring equipment for a nurses' station in an intensive care unit. CNA co-ordinator with the World's Fair for this project was Rita J. Lussier.

- CNA board of directors endorsed *A Statement of Functions and Qualifications for the Practice of Public Health Nursing in Canada*, published by the Canadian Public Health Association. The CNA director of research and advisory services, Mrs. Lois Graham-Cumming, was CNA representative on the advisory committee to the CPHA project director.

- *L'Homme Sain ou Malade* was written and published by Rollande Gagné, a graduate from Notre Dame Hospital, University of Montreal and a law student at McGill University.

- CNA House officially opened by His Excellency Roland C. Michener, Governor General of Canada.

- CNA undertook to develop a Canadian testing service for use by the provincial associations for registration or licensing of graduate nurses. This national service will succeed the tests produced in the U.S. by the National League for Nursing.

- CNA, CMA and CHA sponsored the first Canadian conference on Hospital-Medical Staff Relations.

- CNA completed a brief to the Royal Commission on the Status of Women.

1968

- CNA presented a brief to the Task Force on Labour Relations, a group set up at the request of the Privy Council in 1967 to examine industrial relations and make recommendations to the federal government concerning public policy and labor legislation.

- Publication by the CNA of the first annual edition of *Countdown: Canadian Nursing Statistics*, from material collected by the research unit of the CNA. Such material had previously been available only as separate, internally printed sets of tables.
• Liaison Committee, CNA, CMA, CHA changed its name to Joint Committee of the Canadian Hospital Association, Canadian Medical Association and Canadian Nurses’ Association.

• Publication by the CNA of The Leaf and The Lamp, a contemporary and historical overview of the Association during its first 60 years.

1969 • ICN quadrennial congress was scheduled for June 1969 in Montreal. More than 12,000 professional nurses from 63 member countries were expected to attend. In March 1968, Lieutenant Colonel Harriet J. T. Sloan joined national office as CNA co-ordinator for the event.

1970 • CNA 35th biennial meeting scheduled for June 1970 in Fredericton.
CNA OBJECTIVES

The spirit of the official objectives of the Canadian nursing profession has changed little since the original constitution was adopted in 1908. The 1947 Act of Incorporation of the Canadian Nurses' Association was revised in 1966, and the objectives were re-worded at that time to better reflect the fact that the CNA is a national entity which derives its strength and direction from the ten provincial associations. The CNA constitution states:

The object of the Association shall be to promote the best interests of the members of the nursing profession and the public generally, and in particular:

a. to formulate policies in the fields of nursing service, nursing education and employment relations, for the purpose of advising the provincial associations with regard to the maintenance and improvement of the ethical and professional standards of nursing education and nursing service, and the economic standards of nursing employment;

and

b. to provide effective media for the exchange of information within the Association and with other organizations.
Provincial Registered Nurses' Associations

NEWFOUNDLAND
Association of Registered Nurses of Newfoundland
95 Le Marchand Road
St. John's, Nfld.

NOVA SCOTIA
Registered Nurses' Association of Nova Scotia
6035 Coburg Road
Halifax, N.S.

PRINCE EDWARD ISLAND
Association of Nurses of Prince Edward Island
188 Prince Street
Charlottetown, P.E.I.

NEW BRUNSWICK
New Brunswick Association of Registered Nurses
231 Saunders Street
Fredericton, N.B.

QUEBEC
The Association of Nurses of the Province of Quebec
4200 Dorchester Blvd. West
Montreal 6, P.Q.

ONTARIO
Registered Nurses' Association of Ontario
33 Price Street
Toronto 5, Ont.

MANITOBA
Manitoba Association of Registered Nurses
647 Broadway Avenue
Winnipeg 1, Man.

SASKATCHEWAN
Saskatchewan Registered Nurses' Association
2066 Retallack Street
Regina, Sask.
ALBERTA
Alberta Association of Registered Nurses
10256 - 112 Street
Edmonton, Alta.

BRITISH COLUMBIA
Registered Nurses' Association of British Columbia
2130 West 12th Avenue
Vancouver 9, B.C.
Acknowledgements

When the project of compiling *The Leaf and The Lamp* was initiated by the CNA, it was recognized that such a large research and editorial undertaking was beyond the facilities of the Association's national office. Outside help was required for organization, research, writing and editing. Accordingly, the Montreal public relations consulting organization Forster, McGuire and Company, Limited was retained to compile the publication under the supervision and with the co-operation of national office staff members. The CNA acknowledges the efforts of B. J. McGuire and Susan F. Pilson, whose organization and treatment of the subject were approved by the CNA Board of Directors.

Wherever time and accessibility permitted, primary evidence was used, and this explains why some of the facts appearing here have not appeared before in recent CNA publications and others differ from what was published previously. The editors freely acknowledge, however, that they have leaned heavily on the work of earlier historians and writers.

Sincere thanks is extended to the many people who provided assistance and information, including personnel at the School for Graduate Nurses, McGill University, who kindly made available unpublished material from the files of Mary S. Mathewson.
References

In addition to many CNA publications and documents prepared over the past 60 years, these were among the texts consulted during the preparation of The Leaf and The Lamp:


Weir, G. M. *Survey of Nursing Education in Canada.* Toronto: University of Toronto Press, 1932.