

ties that bind:

the evolution of education
for professional nursing in
Canada from the 17th to the
21st Century



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This Project was undertaken by CASN National Office Staff to mark the occasion of the 70th Anniversary of the Canadian Association of Schools of Nursing.

Authors: Cynthia Baker, RN, PhD, Elise Guest, MA, Leah Jorgenson, MA, Kristine Crosby, MA, and Joni Boyd, RN, MEd

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Preface

Dear Reader,

The Canadian Association of Schools of Nursing is pleased to provide you with a copy of this booklet on the history of nursing education in Canada. Written to celebrate the organization's 70th Anniversary, it provides a synthesis of information based on archival CASN documents and secondary sources.

This booklet takes you through the historic, political and social events that influenced the health care system and education of Registered Nurses in Canada that led to the development and evolution of the Canadian Association of Schools of Nursing. It highlights the influence of gender, religion, class and ethnicity on nursing education in Canada. Finally, it honours the significant contributions that nurse educators and nursing students have made to the health of the citizens of this country over the years.

On behalf of the CASN Board of Directors, I sincerely hope that you will enjoy and treasure this brief account of our past.

Sincerely yours,

A handwritten signature in cursive script, reading "Clémence Dallaire".

Clémence Dallaire
CASN President
November, 2012

Introduction

As part of the activities marking its 70th Anniversary, the Canadian Association of Schools of Nurses (CASN) has developed a history of nursing education in Canada. This document honours the significant contributions nurse educators and nursing students have made to the health of the citizens of this country beginning in the very early settlements of Québec in the 17th century. Based on secondary sources and archival CASN documents, our story starts with the hospitallers, the nursing religious orders that arrived in Québec in 1639, and continues through four centuries, concluding with the history of CASN since its creation in 1942. The evolution of nursing education in Canada is discussed within the broader context of a changing political landscape and health care system.

The history of nursing education in Canada is a story laced with the effects of gender, religion, class, and ethnicity; it is also a story about silencing and dismissive non-recognition. What emerges, however, is the powerful impact that nursing education has had on the quality of health care from the inception of this country. The overall direction of the evolution of nursing education in Canada is one of significant progress. This progress, however, has been fraught with major obstacles that have occurred with cyclical regularity. The emerging themes include the need for educated nurses to improve patient outcomes overriding competing forces blocking their education. New or reformed model of nursing education were created, followed by the subversion or erosion of this by external forces, and a subsequent decline in standards. Then, the need for better-educated nurses to ensure adequate patient outcomes re-emerges.

Nursing Education from the 16th to the 21st Century

Religious Beginnings

When asked to consider the birth of health care in Canada, Canadians often think of Saskatchewan Premier Tommy Douglas, and the efforts of his provincial Cooperative Commonwealth Federation government of the 1960s. Canada's current national health care system undoubtedly arose from this movement in the West of Canada, which resulted in the Canadian federal government legislating the Medical Care Act in 1967 and providing public insurance for physician services (Fierlbeck, 2011). Our health care system, however, has its roots in an earlier network of health care services that were founded and administered by trained nurses.

To understand the beginnings of health care in Canada, one should look first to Marie Rollet Hubou. The wife of Louis Hébert, a surgeon/apothecary, she came to the newly founded colony of New France in 1617. When Hébert died in January 1627, Marie remained in Québec and remarried. She then began visiting and caring for her sick neighbours using knowledge that she had acquired from her first husband (Gibbon, 1947). The need for nursing services in the settlement was enormous.

Trained nurses, members of female religious nursing orders, soon began arriving from France. Between 1632 and 1683, the annual publication of *Jesuit Relations*, a series providing missionary reports on the new world, inspired courtiers and philanthropists in France, motivating the migration of nursing orders to the colonies to care for the settlers (Gibbon, 1947). These nurses played a critical role in supplementing a tradition started by Marie Rollet, of untrained nurses providing care in the community, with new institutions where the sick could acquire care. The Order of Nursing Sisters from Dieppe, the first trained nurses to come to this country, arrived in 1639 and founded Québec's Hôtel-Dieu in the same year. Three years later, Jeanne Mance, a lay nurse from France established the Montréal Hotel-Dieu. These institutions proved to be precursors of a widespread network of Catholic hospitals across Canada founded and run by female religious nursing orders (Violette, 2005).

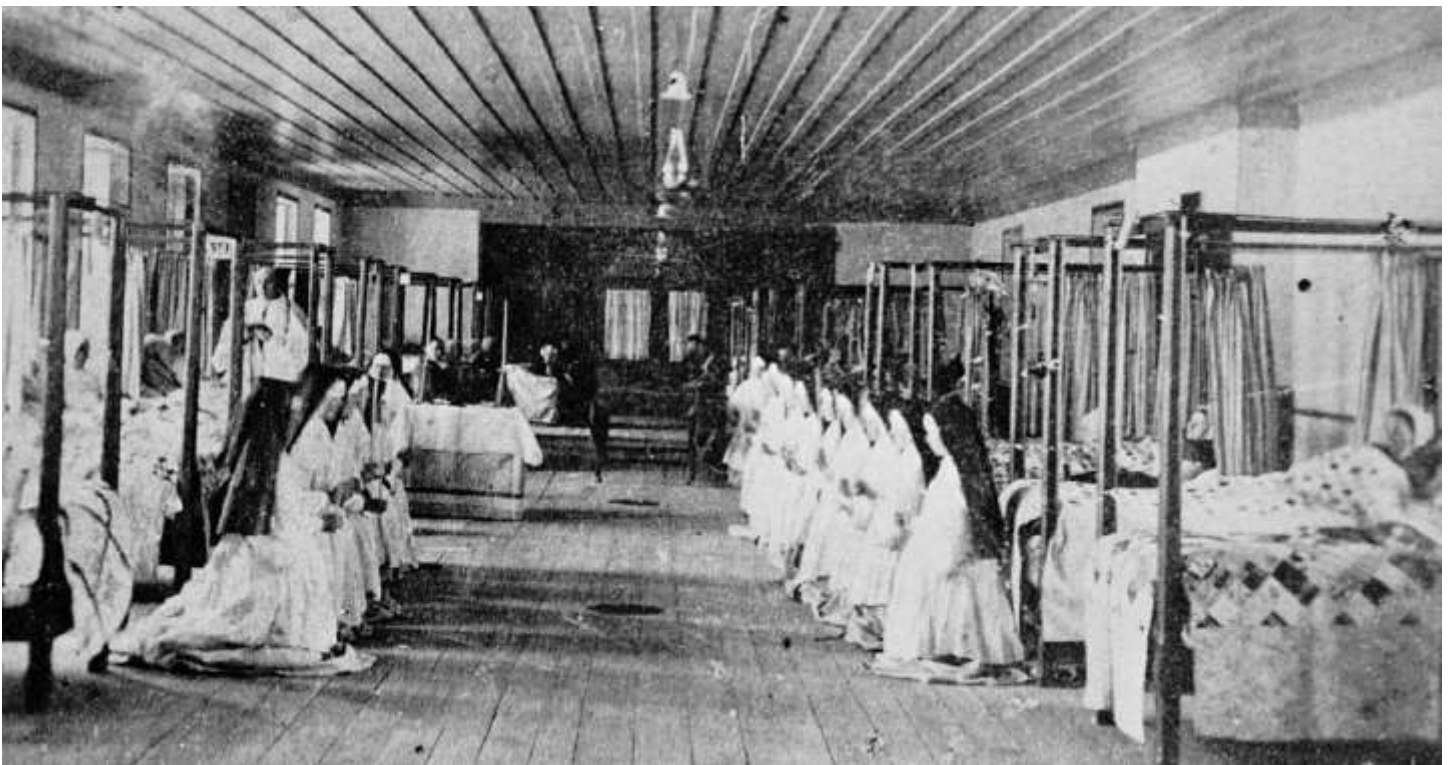
Hôtel-Dieu institutions, were religious houses, run by religious orders. Religious orders provided health care based on the Christian virtue of charity; their members received educational training as nurses



[Photograph of Hotel Dieu, Quebec.] Peter Winkworth Collection of Canadiana (Acc. No. R9266-97), Library and Archives Canada, Ottawa, Ontario.

within the order, which also employed physicians to provide medical treatments (Violette, 2005). That they survived and grew in the succeeding centuries is something of an historical anomaly. North America in the 17th and 18th centuries can only be characterized as colonial; the English established a foot-hold with the Thirteen American Colonies (from New York to Georgia), and the French settled along what is now the St. Lawrence Seaway. A contested situation, it ended with a defeat of the French, who were forced to sign over their colony in North America to England as part of the 1763 peace settlement. As a condition of the treaty, England guaranteed the French colonists the right to retain their religion, which was achieved with the *Québec Act* (1774). For the first time in a British holding, the Catholic Church was allowed to retain its authority, and Catholic religious orders were free to deliver services to their communities. Pauline Paul, a nurse historian who has documented the significant role nursing sisters played in developing health care in Western Canada, notes that the 1774 Act not only protected an important piece of French-Canadian culture, but secured a major component of the emerging health care services in the early history of this country (Paul, 2005).

The Grey Nuns who first arrived in Québec in 1737 were among the Orders to benefit from this legislated protection of religion. Under the direction of Marie-Marguerite d'Youville, they founded a poor house, and a year later took over the management of Montréal's Hôpital Général (Hanrahan & Pedersen, n.d.). The number of institutions established and run by the Grey Nuns continued to grow throughout the 19th century both in and outside of Québec. In 1844, Bishop Provencher recruited a group of Grey Nuns to voyage to Western Canada. They arrived by canoe bringing much-needed health care to the frontier community of Red River (Paul, 2005). The following year, the Grey Nuns established a hospital in Bytown (now Ottawa) (Gibbon, 1947). Continuing in their tradition of providing care to communities in need, the Order of Grey Nuns returned to the Red River Colony where they established another hospital in 1855, followed by one in Lac Ste-Anne (near Fort Edmonton) in 1859.



[Photograph of L'Hôtel Dieu 1877. Salle des femmes malades.] (C-022763), Library and Archives Canada, Ottawa, Ontario.

Rise of the Lay Hospital

While the Grey Nuns were taking advantage of the religious freedoms granted under the *Québec Act* in the 19th century to build health care across the country, lay hospitals were being established for the poor, soldiers, sailors, and new immigrants (McPherson, 2005). The Montréal General Hospital opened in 1821 (and should not be confused with the earlier hospital run by the Grey Nuns of the same name); the Toronto General Hospital had its roots in a military hospital set up in 1812 which led to the establishment of the York General Hospital in 1829; in Halifax, the Victoria General was founded in 1844 and began operations in 1867; Hamilton received a grant for a General Hospital from the Government of Upper Canada in 1850 and located it into a three-story brick building in 1855; the Protestants in Ottawa supported the establishment of the County of Carleton General Protestant Hospital (later to become the Ottawa Civic) in 1852; Winnipeg, the first in the Prairies to establish a lay hospital, opened the Public General Hospital in 1872 (Gibbon, 1947). This hospital movement continued to grow and by 1929 there were 954 hospitals in Canada: Of these, there were 481 public general hospitals, 42 mental hospitals, 31 tuberculosis sanatoria, 33 for incurables, and 269 private hospitals (Canadian Museum of Civilization, 2010). In marked contrast with the hospitals founded by the religious orders, lay hospitals were to be staffed by student nurses and run by physicians.

Initially, epidemics played an important role in the establishment of lay hospitals. As migrants flooded into Canadian ports, many arrived with contagious diseases such as typhoid and cholera. In order to protect the resident population, public officials organized quarantine hospitals, such as the Immigrant Hospital in Québec City (f. 1824) and the Marine and Immigrant Hospital, also in Québec City (f. 1830) (Gibbon, 1947). The key forces driving the growth of lay hospitals in the later part of the century, however, were advancements in medical science and the professionalization of physicians (Violette, 2005).

Despite efforts to look after the sick in the first lay hospitals, untrained attendants provided nursing care. As a result, the level of care was low and the conditions were rank. Those immigrants arriving with contagious diseases often saw no more of their new country than their journey from the ships they came on to the hospital where they died. As the 19th century progressed, medical treatment in hospitals became safer and more effective with the gradual introduction of asepsis and anesthetics from 1848 onward. By the 1880s hospitals had begun to serve the middle and upper classes laying the foundation for the two-tiered, hospital based system of care that characterized the health care system until the introduction of National health care in 1969 (Canadian Museum of Civilization, 2010).

Secularization of Nursing Education

The nursing religious orders had a well-developed system of nursing education (Violette, 2005) but it was only for religious recruits in the order. Lay hospitals run by physicians introduced a new secular model of education for lay nurses. In 1874, Dr. Theophilus Mack initiated this, establishing the first hospital training school in Canada in St. Catharines Ontario, with the assistance of two nurses trained under Florence Nightingale. Convinced that respectable, young women educated to be nurses were needed to improve outcomes in the public hospitals and alter the public's deep-seated prejudice against going to them, he wrote in his first annual report in 1875: "all the most brilliant achievements of modern surgery are dependent to a great extent upon careful and intelligent nursing. Incompetency on the part of a nurse renders nugatory the best efforts of the doctor in the most critical moments, and has frequently resulted in loss of life" (cited in Gibbon, 1947, p. 145). McPherson (1996), an historian who has studied the history of nursing in Canada, described this as a reflection of a much wider international movement involving "the ascent of medical control", and "the evolution of hospitals from charitable and custodial institutions to socially respectable and therapeutic ones" (p. 6), both of which required a more highly skilled nursing workforce.

The secular hospital training model introduced in Canada by Dr. Mack and the religious training model of the nursing sisters had their roots in Western Europe. Historically, European religious orders provided



[Photograph of staff and first graduating class of the Mack Training School for Nurses, 1878.] Canadian Nurse Association (MIKAN 3604067), Library and Archives Canada, Ottawa, Ontario.

nursing services and nursing education, and this continued following the reformation in Catholic countries such as France. Thus, the first nursing nuns (hospitallers) in Québec brought this tradition with them. Prayer and religious rituals were always an important component of their education as nurses, but it involved more, including pharmacology, hygiene, wound dressing, and making and administering medications. These nursing nuns learned first by observation, then through supervised caregiving at the bedside, and finally by an apprenticeship with a pharmacist (Violette, 2005). Medical treatment in their hospitals was provided by physicians who “had authority over medical decisions but carried out their work under the administrative supervision of the head hospitaller” (Violette, 2005, p. 61).

Following the Reformation in Europe, monasteries and convents declined in Protestant European countries, and their hospitals closed. Indeed, 1500 to 1860 A.D. has been called the “dark period of nursing” for this reason (Jamieson, Sewall & Suhrie, 1968, p.148; Mellish, 1984, p. 54). Nothing was done to replace the nursing services the nuns and monks had delivered, nor the nursing knowledge they had developed, and the lay hospitals of the period were unsanitary, overcrowded, and a source for epidemic outbreaks (Mellish, 1984; Jamieson, Sewall & Subrie, 1968). It was in this context that Florence Nightingale established her celebrated model of nursing education, outside the control of a religious group, thus beginning the secularization of nursing education (Jamieson, Sewall, & Suhrie, 1969).

Interestingly, the two nursing traditions brought to Canada from Europe, intersected with one another through Nightingale herself. Persistent in her pursuit of a nursing career, Nightingale looked for opportunities that would allow her to learn about nursing. As a result, she studied in Rome with a community of nuns, in Alexandria with the Sisters of Charity of St. Vincent de Paul, and in Greece at a school

and orphanage run by American missionaries (McPherson, 2005). Sioban Nelson, a nurse historian who studied nursing in religious orders internationally in the nineteenth century, indicates that Nightingale borrowed from Irish Catholic orders in the Crimea (Nelson, 2001). Thus, her perspectives on nursing and nursing education were influenced by the knowledge the religious orders had developed. In describing what she considered to be vital in a nurses' education Nightingale notes:

...what strikes one most with many women, who call themselves nurses, is that they have not learnt this A B C of a nurse's education. The A of a nurse ought to be to know what a sick human being is. The B, to know how to behave to a sick human being. The C, to know that her patient is a sick human being and not an animal" (Nightingale, 1860, p.128).

In her *Notes on Nursing* (Nightingale, 1860) we see the "B" of nursing education:

It (nursing) has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper choosing and giving of diet – all at the least expense of vital power to the patient (p.15).

As her popularity grew during her service in the Crimea, supporters in England set up the "Nightingale Fund" in 1855 in recognition of her work (McPherson, 2005). The Fund amounted to £50,000 (Jamieson, E., Sewall, M. & Suhrie, E., 1968, p.149), and was used to establish a nursing school at St. Thomas's Hospital in London (Bates, Dodd, & Rousseau, 2005). There were three main goals of the Nightingale School: 1) to train 'matrons' who could organize hospitals and train others; 2) to train hospital nurses who could supervise the untrained nurses; and 3) to train district nurses to care for the sick poor in the community.



[Photograph of Florence Ward (St Thomas' Hospital).] (Object number 0060), Florence Nightingale Museum, London, United Kingdom.

Nightingale had a strict code of conduct in her school that served to increase the respectability of nurses, and as a result, the school soon began to attract women from the upper- and middle- classes (Mellish, 1984). Dr. Mack's program of education incorporated this ethic for the same reasons. Strict regulations were set out in the by-laws, the first of which reads:

The nurses in the daily discharge of their duties must observe the strictest secrecy, and carefully avoid 'gossip', their demeanour should be kind and respectful on all occasions, and when on duty at private houses, they are expected, in addition to taking the complete charge of their patients, to avoid giving unnecessary trouble, to wait upon themselves, and to pay the closest attention to the preparation of ailments for the sick, as well as to cheerfully assist in many matters not strictly within their duty – to faithfully carry out the physician's directions, and in the event of emergencies, to report any instance when the execution of his orders have been exceeded or omitted. To evince no bias to any favourite medical practitioner. To attend scrupulously to the special duties to the patient with the gentleness and exactitude taught by their superiors, and never to interfere with or criticize treatment (as cited in Gibbon, 1947, p144).

The new hospital training school model spread rapidly and dominated nursing education for almost a century. Dr. Mack stressed the educational component of the model when setting it up, stating in his first annual report on the school in 1875 that:

E]very possible opportunity is seized to impart instruction of a practical nature in the art of nursing, while teaching will be given in chemistry, sanitary science, popular physiology and anatomy, hygiene and all such branches of the healing art as a nurse ought to be familiarized with (cited in Gibbon, 1947, p. 145).

The model, however, was an apprenticeship one, and nursing students quickly became the workforce of the rapidly burgeoning system of hospitals and hospital-based health care in Canada. In 1887 the Winnipeg General School of Nursing was founded, followed by Halifax's Victoria General School of Nursing in 1890 and St. Michael's Hospital School in 1892 in Toronto. From there, hospital schools grew exponentially and by 1909 there were 70 hospital schools, and over 200 by the 1920's (McPherson, 2005).

While the initial impetus for educating nurses in secular hospital training schools was to improve patient outcomes, the economic benefits quickly superseded the original purpose. Except for a very small number of supervisors and instructors, the students provided the nursing services in hospitals. From their inception, hospital training schools kept this young, female workforce of nursing students under tight control, and in contrast with the hospitallers of the religious orders, they and their instructors stood in very much of a subservient position to the increasingly dominant physicians.

Hospital schools generally followed a familiar pattern in the development of their students. Each new incoming class had a three-month probationary trial period; if they made it through three months of training, they moved through the system as juniors, then intermediates, then seniors. As seniors, student nurses took on more responsibility as ward supervisors or moved into specialty care. A good deal of ritual and symbolic markers came to be woven into the three years: students would receive a cap in a capping ceremony if they survived probation: markers on their uniform or cap would signify whether they were junior, intermediate or senior students, and on graduation they would receive a distinctive pin from the hospital representing where they had been trained. Upon obtaining their diploma after completing the two or three year training program, few continued to work in hospitals until the 1940s, when the war and technology increased the

need for staff nurses (McPherson, 2005). Employment for graduates came as private duty or outpost nurses in Canada's frontier settlements. Not surprisingly, many married leaving nursing altogether on completing the program, as the admission criteria included being an unmarried or widowed female between ages 18 and 35 years of age. In fact, McPherson (2005) found that hospitals used entrance requirements to their training programs to define nursing within their institutions as a respectable occupation, differing from domestic service, for young, single, White women. Thus, applicants were required to enter with a grade 9 education (which soon increased to grade 11 or 12), speak English or French fluently, ruling out many immigrants, and until the 1940's, no African Canadian or First Nations women meeting the other criteria were admissible in these schools (McPherson, 2005).

Although religious nursing orders continued to found and administer hospitals, as well as train nursing sisters, by the end of the 19th century their hospitals began establishing similar training schools for lay nurses. This reflected a shift in the power relations between the sisters and physicians in the Catholic hospitals. Thus, in 1901, l'École Jeanne Mance of the Hotel Dieu in Montréal accepted lay students and the trend continued (Mansell & Dodd, 2005). Historians suggest that religious orders adopted the nursing education model inspired by the work of Nightingale, but adapted it to incorporate their holistic vision of the body and soul (Mansell & Dodd, 2005).



[Photograph of two nurses from the John H. Stratford Hospital Training School for Nurses (later re-named the Brantford General Hospital School for Nurses) in their student nurse uniforms.] Canadian Nurses Association (MIKAN 3604066), Library and Archives Canada, Ottawa, Ontario.

National and Provincial Responsibilities

The political landscape changed just as the two-tiered hospital based system staffed by nursing students began to emerge. The passing of the *British North America Act* (BNA Act) in 1867 created the Dominion of Canada and clearly identified the responsibilities of the federal and provincial governments in relation to health care and education. As per clause 91.11 (under section VI – *Distribution of Legislative Powers*), the Parliament of Canada is responsible for “all matters” concerning “quarantine and the establishment and maintenance of marine hospitals.” Clearly, the immigrant-led epidemics were still fresh in the minds of Parliamentarians. Conversely, in the section that speaks to the executive powers of the provincial legislatures, the provinces were given responsibility for “the establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the province, other than marine hospitals” (7), “municipal institutions in the province” (8) and “direct taxation within the province in order to the raising of a revenue for provincial purposes” (2) (Government of Canada, 1982). This legislation, which has guided federal and provincial government relations in health care delivery and services since its passing, placed hospitals and the nurses training schools under provincial legislation.

Professional Education for Nurses

The explosion in the number of hospital training schools led to concerns among nursing leaders at the profession's lack of control over nursing education (Kirkwood, 2005). None of the hospital schools had independent funding like the Nightingale St. Thomas Hospital school in England, and the instructors were "dependent on the legal, administrative, and financial authority of the institution" (McPherson, 2005, p.77). There were also serious concerns that the exponential growth of hospital schools had resulted in a decline in



[Photograph of a group of Nursing graduates, Lady Stanley Institute for Trained Nurses of the County of Carleton General Protestant Hospital, Ottawa, Ont., 30 May 1913.] Lady Stanley Institute Nurses Alumnae Association fonds [textual record, graphic material] (R2822-0-4-E), Library and Archives Canada, Ottawa, Ontario.

admission standards, a lack of appropriate educational facilities, and a lack of prepared instructors (Bramadat & Chalmers, 1989).

Nursing leaders began to look to universities to affiliate or incorporate nursing education programs. In 1905, the Graduate Nurses' Association of Ontario submitted a memorandum to the University of Toronto requesting that the university offer a course of training and education for nurses. This was the first documented evidence of efforts to establish university education for nurses in Canada (Ross-Kerr, 2011). It was unsuccessful, but calls for university education for nurses continued from nursing leaders and some physicians.

The landmark Flexner Report in the United States published in 1910 on medical education had an influence on this interest in university education programs for nurses in Canada. Commissioned by the Carnegie Foundation to assess the quality of medical education, it led to major reforms in medical education in the United States and in Canada. Schools that were operating for profit were closed, and universities became responsible for the education of physicians. This provided a model for reforms in nursing education and intensified calls for the separation of service from education (Paul & Ross-Kerr, 2011).

Two key social reform issues of the day, scientific management and public health, also influenced the interest in university education for nurses. Dr. Malcolm MacEachern, superintendent of the Vancouver General Hospital, and Dr. Henry Esson Young, the provincial medical officer of health, promoted university education for nurses believing that this was necessary if hospital and community health reforms were to be carried out competently and cost effectively (Kirkwood, 2005). This initiative led to the establishment of a five

year baccalaureate degree program for nurses at the University of British Columbia (UBC) in 1919, under the direction of Ethel Johns. It was the first in Canada, and indeed in the British Empire (Davidson Dick & Cragg, 2003).

Another initiative contributing to university education for nurses came from the Red Cross Society in 1920 as a result of lobbying by Jean Gunn, the president of CNA and superintendent of the Toronto General Hospital (Kirkwood & Bouchard, 1992). It funded postgraduate programs in public health nursing at the University of Toronto, McGill University, University of British Columbia, University of Alberta and Dalhousie University. These courses for hospital trained nurses led to a certificate in public health, and when the funding ended in 1923, only Dalhousie University closed its program. In 1925 the Université de Montréal also established a certificate course for public health nurses with funding from the Metropolitan Life Insurance Company, the City of Montreal, and the Anti-tuberculosis and General Health League (Kirkwood & Bouchard, 1992). Degree programs were also established in the twenties. In 1924 the University of Western Ontario established a degree program, followed by the University of Alberta in 1925. The Université de Montréal began offering courses for nurses in 1923 in response to requests by the Grey Nuns, and in 1934, the Grey Nuns funded the Institut Marguerite d'Youville as an affiliated school to the Université de Montréal.

Lynn Kirkwood, a nurse historian, has emphasized that despite the growth in programs, university education at this time was seen as “a means of providing a small group of nurses who would become teachers, supervisors, and public health nurses with the leadership skills to reform nursing” rather than the educational path for all nurses (Kirkwood, 2005, p. 190).

The model of baccalaureate university nursing education introduced in the 1920s was referred to as the “sandwich” or “non-integrated” model. The first and last years were undertaken in the university and the intervening years were spent in a hospital school. A criticism of this model was that the university had no authority over the student, nor control over the nursing courses in the years between the first and last, and were unable to ensure that what students learned in the university was being integrated into courses and clinical experiences in years two, three, and four (Davidson Dick & Cragg, 2003).

In 1942, Kathleen Russell started the first ‘integrated’ nursing program at the University of Toronto. She had developed and implemented it a decade earlier with Rockefeller Foundation funding as an independent diploma program that would meet the criteria for a university degree. After ten years of delivering the program, convinced that it did indeed meet all the academic standards and requirements of the university, she successfully applied for degree status. In contrast with the sandwich model, the university



[Photograph of “The Comforter, Red Cross Nurse”.] War Records Survey Posters [graphic material] (R1185-67-0-E, Acc. No. 1983-28-2515), Library and Archives Canada, Ottawa, Ontario.

was responsible for what students were taught in the hospital clinical courses in the integrated program (Davidson Dick & Cragg, 2003).

Kirkwood (2005) describes rampant and overt prejudice about female intellectual inferiority in the university milieu faced by nursing students and faculty during this period. At McGill University, for example, she notes that they were introduced to scholars such as Stephen Leacock who “decried women’s ability to do even elementary science” (p. 192). Kathleen Russell outlined her pragmatic and strategic approach in face of this prejudice in the *Canadian Nurse* in 1928: “The nursing school of Canada must accommodate itself to the Canadian university if it wants to work with it....At present, I must repeat once more, we must know our university and *use it as it is*” (as cited by Kirkwood, 2005, p.192).

Despite barriers, the push for university education continued to grow. At the beginning of the 1940s there were five university degree programs and two university diploma programs, and by the end of the decade, five more universities had baccalaureate programs in place. The nursing shortage that emerged from the demands of the Second World War and the increasing medical technology stimulated philanthropic organizations to provide some funding for university nursing programs in Canada. The W.K. Kellogg Foundation gave scholarships and loans to students attending McGill University, Université de Montréal, University of Toronto, University of Western Ontario and Université Laval (Kirkwood & Bouchard, 1992). Enrollment in university schools however remained small. In 1962 only 148 students graduated from basic baccalaureate programs, whereas 6,000 graduated from three year diploma programs (McPherson, 1996).

Call for Nursing Education Reform

The concerns with the hospital training schools in the first decades of the twentieth century led the Canadian Medical Association (CMA) and the Canadian Nurses Association (CNA) to collaborate in conducting research on the schools of nursing in 1927. Dr. George Weir from the University of British Columbia was commissioned to undertake a survey of nursing education in Canada (Ross-Kerr & Wood, 2011).

The study was extensive, as data was collected from 145 training schools across Canada for the report. Weir administered over 2,200 intelligence tests to student-nurses, and received completed questionnaires from over 2,300 doctors (Weir, 1932). Recommendations in his report for nursing education and the nursing profession included: 1) that university training schools award degrees instead of diplomas where nursing courses were well established; 2) that entry standards be increased; that approved hospitals hosting training schools have at least 75 beds and an average of 50 patients per day; and, 3) that schools of nursing be brought into the general education system and be funded on the same principles as other schools (Weir, 1932).

In contrast with the Flexner report in the United States which had had a significant impact on medical education, the follow up on the Weir recommendations for nursing education was limited. The smallest nursing schools were closed (Pringle, Green & Johnson, 2004), and the Canadian Nurses Association struck a National Curriculum Committee that published common standards of education in 1936 (Kirkwood, 2005). Unfortunately, the Weir report provoked outrage among francophone nurses in Québec. Weir spoke no French, the only Québécois on his committee was an anglophone from the Montréal General Hospital, and francophone students were not included in the survey. Nonetheless, he came to a conclusion without any data to support it that “the ecclesiastical tradition, however, laudable in the abstract, has exerted, and is exerting a somewhat prejudicial influence on the evolution of Canadian nursing” (as cited in Mansell & Dodd, 2005, p.209). In reaction to the report, Mother Virginie Allaire of the Grey Nuns in Montréal led the congregations in creating the *Conférence des hôpitaux catholiques de la province de Québec* with a view to promoting the progress of the hospitals in the spirit of Christian charity (Mansell & Dodd, 2005).

Birth of National Health Care

With the passing of the BNA Act, the new government of Canada created the Department of Agriculture with a mandate to oversee the health of Canadians (Chenier, 2002). In 1919 it founded the Federal Department of Health to take on the responsibilities related to health and health care. Debate, discussion, and reports about the direction of health care, the education of physicians, and the education of nurse began to occur at a national level. During and following the Second World War, the federal government began seeing health as an area in which they should be more involved and provided capital grants for hospital construction to expand the size and scope of their services. In 1948 the Federal Hospital Grant Program provided institutions with funding for education and capital costs (McPherson, 1996).

The post Second World War years saw both an expansion of hospitals and a growth of nursing positions in the hospitals driven by government grants, economic growth, and new medical technologies (McPherson, 1996; Toman, 2005). Increasingly, in the mid twentieth century, Cynthia Toman, a nurse historian, notes that medical technology was becoming too expensive and complex for the individual physician to own or use independently. Hospitals became the principle location for this technology and nurses' skill "enabled its proliferation" (Toman, 2005, p. 97). In this way, physicians would introduce a technology, initially be responsible for using it, but would then train graduate nurses and delegate the procedures to them. In addition, many of the new medical interventions for which they maintained responsibilities, required the assistance of skilled nurses to perform (McPherson, 1996). Medical advances were becoming increasingly "contingent on the availability of reliable skilled nurses" (Toman, 2005, p. 101) and staff nurse positions began to increase in the hospitals from the beginning of the Second World War onward. In 1951 the Canadian census listed 35,138 graduate nurses as employed, and by 1961 this had risen to 61,699 (McPherson, 1996). Most nurses were working as general duty nurses or supervisors in the hospitals. In 1962, McPherson (1996) reports that 11% worked in public health or industrial nursing, and only 9% in private care. Between 1939 and 1946 the number of nursing graduates increased by 45%; and between 1951 and 1961 it increased by 50%. As the demand for nurses increased, racial and ethnic barriers to admission into nursing schools began to erode.



[Photograph of a nurse instructing students at the University of Alberta Hospital.] University of Alberta Photography Department, Medical Services Branch Photographs [graphic material] (R227-208-8-E), Library and Archives Canada, Ottawa, Ontario.

Canada's National Health Care System was established in this period of hospital expansion although the push towards it had begun much earlier in Saskatchewan. In 1916, the Saskatchewan provincial legislature passed the *Union Hospital Act*, which merged municipalities, towns, villages, etc., into hospital districts responsible for the maintenance of local medical resources. In 1917, the *Act* was altered to allow municipalities to pre-pay a set amount to their hospitals to secure care for poor patients. Two years later, the Saskatchewan legislature passed a law allowing municipalities to pay physicians to come and/or to remain in their districts. Both pieces of legislation underwent regular amendments to allow for expansion until 1939 when the provincial government passed the *Municipal and Medical Hospital Services Act*, which empowered municipalities to tax residents for medical services and to use the funds to pay physicians for their services. By 1962, the Saskatchewan legislature had passed a law bringing the Saskatchewan Medical Care program into effect (Hall, 1964).

The Government of Canada was not far behind the province of Saskatchewan in developing a national program for Medicare; in 1957, the federal government passed the *Hospital Insurance and Diagnostic Services Act*, which established a 50/50 cost-sharing scheme with the provinces for medical expenses (Fierlbeck, 2011). It set up a Royal Commission of Health Services, under the direction of Emmett Hall. The results led to 200 recommendations and a call for a "comprehensive universal Health Services Programme [sic]" for all Canadians (Hall, 1964). The *Medical Care Act* in 1966 nationalized a program of public insurance covering the cost of all physician services (Fierlbeck, 2011). Though not every province bought into the plan immediately, by 1971, all Canadians were enjoying the benefits of the *Act* (Chenier, 2002). The *Medical Care Act* support of hospital based care bolstered the technology based expansion of hospitals and the growth of nursing positions.

Demise of the Hospital Training School

The Hall Commission report included an examination of a wide range of health services, among which was nursing. It identified an urgent need to restructure nursing education and recommended radical changes, most of which were soon implemented. Written more than 30 years after Weir's report, the Commission echoed Weir in stating: "in light of our knowledge of and established practice in the education of all other



[Photograph of a nurse observing as a nurse in training tends to a patient's arm at the School of Nursing at Sherbrooke Hospital.] Gerry Lemay, Medical Services Branch Photographs [graphic material] (R227-208-8-E), Library and Archives Canada, Ottawa, Ontario.

professions, the apprenticeship-type system by which the majority of nurses are now solely trained clearly requires re-examination” (Hall, 1965, p.63). The report identified a serious shortage of qualified instructors with 75% in hospital schools and 56% in university schools lacking even minimum qualifications. The Commission also called for a complete separation of nursing education from the hospital nursing service, and a shift in control of education from the hospital to the Director of the School of Nursing (Hall, 1965). Moreover, the Commission Report argued that education for nurses should be organized and financed like other forms of professional education.

The Hall Commission also recommended that there be two categories of nursing educational programs. Approximately 25% of nursing students were to be educated in a four or five year university program for administrative, instructor, and supervisory positions, whereas 75% were to be educated as bedside nurses in a new type of two year diploma program. An urgent need for the university schools to prepare instructors was identified and in order for this to be feasible, it was further recommended that ten additional university schools of nursing be established (Hall, 1965).

The Commission reported that six of the 14 existing university schools of nursing were offering an integrated program in which the university was responsible for the student’s learning experiences throughout the program, whereas eight involved two years of study at the university and three in the hospital. It recommended that university programs be integrated and that at least one university in each of Canada’s four main regions also develop a Master’s degree in nursing, one of which should be in French.

The report was successful in spurring the separation of nursing education from service. Beginning in the 1960s, community colleges were being founded, and following the Quiet Revolution in Québec, Collèges d’enseignement Général et Professionnels (CEGEPS) were created. Nursing education in Québec, Ontario and Saskatchewan began to move out of hospitals. In 1967 the Ontario government called for 20 colleges of applied arts and technology to be created, in 1969 Humber College was the first of which to offer a nursing program. By 1974 seven hospital schools in Alberta had moved into colleges, although seven still remained (Paul & Ross-Kerr, 2011). New university schools of nursing were opened across the country as a result of the commission (Memorial University, Université de Moncton, Université Laval, Laurentian University, Lakehead University, University of Saskatchewan, and the University of Calgary), and four years after the report, 97% of the admissions to university schools were into integrated programs (Paul & Ross-Kerr, 2011).

Although most nursing schools moved out of hospitals, some in Alberta, British Columbia, Manitoba and Nova Scotia remained in hospitals into the 1990s.¹ Moreover, there was opposition to the demise of the apprenticeship system from some employers who felt that nursing graduates were inadequately prepared for the ‘real world’ (Davidson Dick & Cragg, 2003). For the next couple of decades there were frequent calls for new nurses who could “hit the ground running” and the phrase “reality shock” was coined in the 1970s and continues to be discussed today (Davidson Dick & Cragg, 2003).

Although the Hall Commission considered the three year program was unnecessarily long because too much time was spent on service, a great deal of supervised learning was in fact happening during the service component in the later years of the hospital model. Educators quickly recognized a need for more practice experience and particularly, supervised integrative practice experience towards the end of the program. Subsequently, the two year diploma programs were lengthened in many schools by three, six months or a year to provide a preceptorship or internship at the end of the program. University schools also began incorporating preceptorships into their programs. Moreover, as the complexity of the nursing role continued to increase, there were growing concerns that nurses needed greater depth in their education than the diploma programs could offer.

¹ Some of the last hospital schools of nursing to close were the Foothills Hospital School of Nursing (Albert, 1995), and the Victoria General Hospital (Nova Scotia, 1995), and the Vancouver City Hospital Training School for Nurses (British Columbia, 1998).

Entry-to-Practice

The level of education needed for entry-to-practice became a major topic of debate in the closing years of the 1970s and the beginning of the 1980s among nursing organizations, regulators, educators, governments, and community colleges. As noted earlier, caregiving in the hospital setting was becoming more and more complex with the increasing acuity of patients, a proliferation of various types of intensive care units, and an expansion of nursing roles in the community. Although controversial, there was a growing belief among nursing leaders that university education was the most effective way to prepare nurses for the diverse roles and changing demands of the health care system.

The nursing workforce had been increasing over four decades and the numbers of students and institutions that would be affected by this was high: In contrast with earlier debates about nursing education, it was the provincial governments who were concerned at possible cost increases, and the colleges who did not want to lose what was often their largest program, rather than physicians and employers, who were involved in this issue when education moved out of the hospitals.

The first statement of the baccalaureate as the entry-to-practice did not come from a national organization, instead it was published by The Alberta Task Force on Nursing Education (Wood, 2011). Although the government of Alberta subsequently rejected the Task Force's position, discussion of the document continued and gained momentum. The Alberta Association of Registered Nurses endorsed it in 1976 (Wood, 2011), and four years later, at the 1980 biennial convention of CNA in Vancouver, delegates debated and approved a resolution to develop a position statement on the minimal educational requirements for entry-to-practice. In 1982, the CNA Board unanimously adopted a resolution that university preparation be the requirement for entry-to-practice by the year 2000, and set up a task force to develop strategies to reach this goal (Wood, 2011). In the same year, CNA published the first in its series of *Entry-to-Practice Newsletters*, outlining the organization's position that baccalaureate preparation for nursing be the national standard by 2000. Although heavily debated, by 1984 seven provincial associations had voted in support of this decision, and in 1989 all except Québec had endorsed it (Ross-Kerr, 2011). In 2011, l'Ordre des infirmières et infirmiers du Québec took a position in favour of the degree as entry-to-practice.



[Photograph of nurses-in-training working in the library at the Winnipeg General Hospital's School of Nursing.] Canadian Nurses Association, Photographs [graphic material] (R4440-16-3-E), Library and Archives Canada, Ottawa, Ontario.

All the provincial professional associations had signed on by 1989 with differing implementation dates except for Québec. Implementing processes were moving forward throughout the nineties when an acute global shortage of nurses emerged presenting a new challenge, and one that brought physicians and employers into the fray. In January 2000, the Saskatchewan provincial government, decided to accept diplomas again as the minimum entry-to-practice standard as a result of the acute need for more graduates. In a significant move of nursing leadership, however, the provincial nursing student association rejected the plan and was vocal in their protests. By March, public pressure and attention had become so great that the provincial government reversed its position, and returned to the baccalaureate degree as the entry-to-practice requirement (Davidson Dick & Cragg, 2003). In the early 2000s the Governments of Alberta and Manitoba also re-opened up seats for diploma students to address the shortage of nurses.

Colleges and universities began to work together to establish collaborative partnerships to offer the baccalaureate degree in joint programs well before the entry-to-practice implementation dates. Planning began, for example, in 1985 in Alberta between the University of Alberta and Red Deer College, resulting in the implementation of a collaborative model for a four-year baccalaureate program that was later extended to include other schools (Wood, 2011). In British Columbia, the University of Victoria and college partners also began to work together and develop a joint collaborative degree program early in the move to the



[Photograph of nurses looking at skeleton.] Rosemary Gilliat Eaton, Western Canada [graphic material, textual record] (R12438-1-2-E), Library and Archives Canada, Ottawa, Ontario.

baccalaureate degree, and collaborations continued to grow throughout the Western provinces. In Newfoundland, all college schools were collaborating with Memorial University in the early nineties, and Dalhousie University began partnerships with two institutions that had offered diploma programs in 1995. The College of Nurses of Ontario adopted the degree as the educational requirement for entry to practice in 1998 with 2005 set as the effective date, and this decision was endorsed by the provincial cabinet in 2000. All 22 colleges in Ontario began developing collaborative programs in partnership with universities to meet the new 2005 requirement. Colleges in the territories also established collaborative partnerships with degree granting universities in the South. Aurora College, for example, in the Northwest Territories, is in partnership with the University of Victoria. Although the degree was not the entry to practice requirement in Québec, the government mandated all 42 CEGEPs offering diploma programs, and universities offering nursing degrees (9) to work together to plan a five year program in nursing. The DEC-Bac was, therefore, created allowing students to do two years at the CEGEP and three at the University (Wood, 2011). In New Brunswick, no collaborations were established as the diploma schools of nursing were closed in 1989 and incorporated into the two universities in the province. Similarly in 1988, Prince Edward Island phased out the diploma program entirely in favour of a university degree program.

As a result of the changes to the entry-to-practice requirements, there has been significant growth in the number of baccalaureate nursing programs offered in Canada. In 1983 there were 28 university schools of nursing offering baccalaureate nursing programs in Canada (Ellerton & Downe-Wamboldt, 1984), and as of 2010, there were 91 (CASN, 2010).

Graduate Education

While university education in the 1940s and 1950s was focused on the baccalaureate degree, there was recognition among nurse educators of a need for Canadian graduate programs in nursing. Because Canadians nurses had to leave the country for graduate studies in their field, few nurses in Canada were adequately prepared for leadership and teaching positions (Wood & Ross-Kerr, 2011). The University of Western Ontario started Canada's first Master's program in nursing in 1959 with funding from the W.K. Kellogg Foundation. This program was a thesis-based program in response to the need for with a focus on research in nursing (Wood & Ross-Kerr, 2011). McGill University soon followed in 1961, also with funding from the W.K. Kellogg Foundation, who awarded it because graduate nursing programs in Canadian universities were greatly needed. The Université de Montréal established a program in 1966 and was the first to offer a Master's program in a clinical content area. The University of British Columbia started its Master's program in 1968, and in 1975 three more schools established Masters' programs: University of Toronto, University of Alberta, and Dalhousie University.

Enrollment in Master's programs has increased significantly since they were first introduced. In 1965-1966 total enrollment in all programs was 37; by the 2006-2007 academic year, almost 3,000 students were enrolled in Master's programs (Wood & Ross-Kerr, 2011). As of 2012, 32 universities offer a Master of Nursing or a Master of Science in Nursing in Canada, and there is a growing number of areas of specialization including clinical nurse specialists, nurse practitioner preparation, teaching/education, leadership, gerontology, Aboriginal health, policy, cardiology, mental health, and community/public health (CASN, 2012).

The nurse practitioner (NP) role was first introduced in Canada in the 1960s-1970s. Key factors that have been identified for this include: "1) the introduction of universal publicly funded medical insurance, 2) the perceived physician shortage, 3) the increased emphasis on primary healthcare and 4) the trend towards increased medical specialization" (Kassalainen et.al., 2010, p.39). There has been diversity in

educational preparation for this advanced practice role with program length varying from several months to two years and program level ranging from post-diploma certificates to post-Master's degrees. In the last decade, with regulation and entry-to-practice exam requirements now in place, there is greater consistency, as well as a move to Master's preparation. The majority of programs are now at the Master's level (CASN, 2012).

An important factor in the development and increase of NP programs was the introduction of a one-year program certifying nurses as Primary Health Care nurse practitioners. It was implemented early in the 21st century by a consortium of ten universities with funding from the Ontario government. The Ontario universities in the Consortium have now incorporated the program into their individual Master's program and the nurse practitioner courses have been upgraded to a Master's level.

The need for doctoral programs in nursing was first discussed in Canada in 1975 at the Fourth National Nursing Research Conference in Edmonton, Alberta (Wood & Ross-Kerr, 2005). This need continued to grow as baccalaureate programs and advanced practice roles increased. It was not until January 1, 1991, that the University of Alberta started Canada's first doctoral program in nursing. It was closely followed by University of British Columbia in September of 1991. Two more programs were established in 1993, one at the University of Toronto, and the other, a joint program between McGill University and the Université de Montréal which has since become two separate and independent programs. Doctoral programs continued to increase slowly but steadily and in 2011 numbered 16 (CNA & CASN, 2012). Enrollments have grown from 62 in 1996 to 480 students in 2011. While Canadian nursing doctoral programs have different objectives, they share a focus on providing a research-intensive program and on offering a small number of core courses (Wood & Ross-Kerr, 2011a).



[Photograph of a German, a British, and a French nurse working alongside a Canadian nurse at l'Hôtel-Dieu in Kingston, Ontario.] Government of Canada (Acc. No. 1972-047), Library and Archives Canada, Ottawa, Ontario.

A National Organization for Nursing Education in Canada

The Canadian Association of Schools of Nursing first entered into the history of nursing education in Canada at the beginning of the Second World War as the demand for staff nurses was rising dramatically, and the competencies they required were becoming more complex. The need for standards, professional control over standards, and appropriate educational preparation for nurses have been the driving forces of the organization since its first meeting in 1942.

Creation and Context

At the 1923 annual meeting of the Canadian Nurses Association (CNA), Ethel Johns, the founding Director of the University of British Columbia's nursing program, raised the question of establishing an organization of the fledgling university programs. She argued that nurse educators needed to join forces to promote university education for nurses and to increase their limited authority within the university milieu (Kirkwood & Bouchard, 1992). No plans, however, were made at that time for educators to meet or to follow up on this.

Almost a decade later, in 1932, as a number of university degree programs were being conceived or introduced, the Executive Committee of the CNA, recognizing the need to place nursing on an equal footing with the other professions in the academic environment, passed a resolution urging "all University Schools and Departments of Nursing to standardize the requirements for admissions to the same level as those of all other faculties and departments" (CAUSN, *Chronological Outline of the Development of the CCUSN*, ca. 1969). It was the acute nursing shortage and pressing need for more nurses at the beginning of the Second World War however, that brought university educators together for the first time to a meeting on education. Arranged by Grace Fairley, the President of CNA at the time and also an educator at University of British Columbia, fourteen educators from eight university schools or departments conferred with the



[Photograph of student nurses being shown how to make up a bed at the Medicine Hat Regional Hospital.] Canadian Nurses Association, Photographs [graphic material] (R4440-16-3-E), Library and Archives Canada, Ottawa, Ontario.

Executive Committee of CNA at McGill University in September of 1941 (Kirkwood & Bouchard, 1992). Although there were differences of opinion on the matter among them, the educators agreed to meet again as a separate group rather than a Committee within CNA (CNA, 1941).

It was on June 20, 1942, at the Windsor Hotel in Montreal, that this group of representatives from university schools of nursing first met for three days on their own, as the Provisional Council of University Schools and Departments of Nursing (PCUSDN). Kathleen Russell from the University of Toronto, who had introduced the first integrated university program, chaired the meeting, and representatives of eleven university Schools of Nursing were there: Universities of Alberta, British Columbia, Ottawa, Saskatchewan, Toronto, Western Ontario; the Institut Marguerite d'Youville, McGill University, and Université de Montréal. Université Laval and St. Francis Xavier attended as observers as their programs had not yet started (Kirkwood & Bouchard, 1992). Kathleen Ellis of Saskatchewan was elected president, Reverend Mother Allaire, who had led the francophone protest against the Weir Report, was elected the vice-president, and Mary Mathewson of McGill the secretary/treasurer. After three days of meetings, it was agreed that the objectives of the Council were four-fold:

- a) To decide upon the form of a permanent association of university schools of nursing.
- b) To determine desirable standards for university schools of nursing represented by members of this Council.
- c) To strengthen the standards of existing university schools of nursing and to support the development of further university schools of nursing where desirable conditions exist.
- d) To strengthen the relationships between university schools of nursing in Canada and other countries. (PCUSDN, [Proceedings of PCUSDN meeting of June 20, 1942, Montreal], ca. 1942).

The representatives decided on a two dollar annual (individual) membership fee, established committees, and decided to look at developing standards for schools of nursing related to:

- a) General standards for university schools of nursing, including organization and administration, qualifications of faculty, entrance requirements, student records, etc.
- b) The organization and content of theory and practice in hospital and school of nursing courses, undergraduate and graduate.
- c) The organization and content of theory and practice of public health nursing courses. (PCUSDN, [Proceedings of PCUSDN meeting of June 20, 1942, Montreal], ca. 1942).

Interestingly, as Kirkwood and Bouchard (1992, p 11) note, “Nowhere in the minutes of the early meetings was there any discussion of what university schools of nursing might contribute to the training of nurses during the war”, the issue that had actually brought them together. What emerged instead were their concern with educational standards, and the need to promote university education for nursing.

Getting Established

After the initial June 1942 meeting, the Provisional Council did not meet again until after the war on July 1, 1946, in Toronto, Ontario. Following this meeting, members met once or twice a year, often in conjunction with CNA meetings, as many members were involved in both organizations (Kirkwood & Bouchard, 1992). However, the Provisional Council members continued to discuss whether they should be a group within CNA or an independent association. The argument for affiliation with CNA was to have a greater influence on education as part of a single, unified nursing voice; the argument for independence was greater freedom and flexibility to advocate for nursing education as a separate organization (Kirkwood & Bouchard, 1992). At the January 1949 meeting, members addressed the provisional status issue of their organization,

and in light of the prevailing desire to continue advocating on behalf of nursing education as a group, decided to become a permanent organization renaming it, the Council of University Schools and Departments of Nursing (CUSDN). (CUSDN, *Minutes – Council of University Schools and Departments of Nursing*, ca. 1949). Kathleen Russell, however, who had been instrumental in the foundation of CNA and was firmly committed to the unity position retained her membership in the Council but no longer actively participated in it as a result (Kirkwood & Bouchard, 1992).

This name was changed again in 1950 to the Canadian Conference of University Schools of Nursing (CAUSN, *Chronological Outline of the Development of the CCUSN*, ca. 1969) and, beginning in 1952, the organization experienced something of a resurgence. Its goals were updated in the 1950s following the ratification of the Constitution (ca. 1953). According to the Kirkwood and Bouchard (1992), the objectives which guided the Conference throughout the decade were:

- 1) To provide an organized body to speak for university nursing education in Canada and to facilitate the exchange of information and ideas regarding university nursing education with other countries;
- 2) To determine desirable standards for university schools of nursing in Canada;
- 3) To strengthen and support the development of nursing education in universities in Canada;
- 4) To strengthen relationships between universities schools of nursing in Canada; and
- 5) To support university schools of nursing in their efforts to strengthen relationships with other universities.

Over the next several years, the Conference was convened to discuss issues such as regionality, the authority of the Conference's constitution and by-laws, and its first public statement of priorities (Kirkwood & Bouchard, 1992). A major activity in this period, however, was standard development, the major goal for members from the outset of the organization. In 1957, members accepted a document titled, *Desirable General Standards for Canadian Schools of Nursing*, prepared by the Committee on Studies. The standards addressed the purpose of a university school, administrative issues, and human and material resources (faculty, students, facilities).



[Photograph of an anatomy class in progress.] Canada Department of Manpower and Immigration (MIKAN 4365901), Library and Archives Canada, Ottawa, Ontario.

Throughout the 1950s and 60s, the Conference met twice a year to discuss business, build the organization, and strengthen its voice. In 1967, it was finally accepted as an associate member of the Association of Universities and Colleges (AUCC). There were also discussions that year on a potential reorganization of the Conference. In May, the members decided on a Council of Deans and Directors of member institutions, and four regional associations consisting primarily of individual members (West, Ontario, Québec, Atlantic). Two regional members from each affiliate would sit on Council, and the Executive would be drawn from the Council membership. This reorganization introduced institutional rather than individual membership of Council, and the creation of regional affiliates (Kirkwood & Bouchard, 1992).

The structure planned in 1967 was implemented in 1969, and the new constitution was adopted in 1971 along with another name change, the Canadian Association of University Schools of Nursing (CAUSN). CAUSN opened a national secretariat in Ottawa under the direction of Eileen Mountain who had been a faculty member at the University of Western Ontario (Kirkwood & Bouchard, 1992, p. 21). She wrote in her first report to the Executive Committee:

I am convinced... that it is important for CAUSN to have a secretariat located here in Ottawa. CAUSN needs a voice at the national level and with the probable formation of a Canada Health Council it's just that much more important that CAUSN has a permanent office here in Ottawa." (Mountain, E., *Report to the Executive of CAUSN from Executive Secretary*, 1972).

Eileen Mountain began advocating for office space for the Association's national secretariat. Instead of the spare bedroom in her two-bedroom apartment, she presented CAUSN's Executive Committee the option of renting office space from the Association of University and Colleges of Canada (AUCC). Such a move would place many of AUCC's services (such as secretarial support) at the Association's disposal (Mountain, E., *Report of the Executive Secretary to the Executive Committee*, 1974). This was not achieved, however, until 1985; the solution in the intervening years was to remove files from the Executive Secretary's home and place them in storage at the University of Ottawa (CAUSN, *Minutes of CAUSN Executive Meeting, Calgary Inn – Calgary Sunday, October 6, 1974*, 1974).

During her six years in the position, Eileen Mountain was committed to developing a more professional operational status and structure. In 1972 and 1976, two events occurred which helped further this. The first was the publication of an information pamphlet on the activities and purpose of CAUSN in 1972. Mountain justified the need for this by informing the Executive Committee that a reporter who had written a recent article for the *Ottawa Citizen* on the expanding role of nursing and university training for nurses consulted neither the University of Ottawa School of Nursing, nor CAUSN. When asked why not, the reporter explained that she had never heard of CAUSN (CAUSN, *Report of Executive Secretary to CAUSN Council*, 1972). As a result, Eileen Mountain sought permission and funding for the publication of a brochure outlining what CAUSN does, its Executive, the composition of the Standing Committees, and providing a list of member schools (totaling 12, at the time) (CAUSN, *Information CAUSN Canadian Association of University Schools of Nursing*, ca. 1972). The second event, in 1976, was CAUSN's attainment of Registered Charitable Organization Status that offered tax benefits and therefore, reduced operational costs.² Operational stability continued to grow after Eileen Mountain's

² CAUSN incorporated as an association in 1979. (CAUSN, *CAUSN Council Meeting November 12, 1979*, 1979).

mandate and by 1984, the secretariat was in office space in downtown Ottawa, and the Executive Director position was made a full-time staff position. The logo was also introduced that year; three right-facing chevrons representing three levels of nursing education (Baccalaureate, Master's, and Doctoral), and laid out to show forward movement. In 1991 an administrative assistant position was also created (Bouchard, J., *Report of the Executive Director to the November 22, 1990 Council Meeting Ottawa Delta Hotel*, [ca. 1990]). 1991 was also the year that CAUSN went digital: as Jeannette Bouchard, the Executive Director at the time, gladly informed the Executive, that she had purchased a Compustar 286-12CPU system, and was making arrangements to secure an "E Mail" system for the Association. (Bouchard, J., *Executive Director's Report to Council June 5, 1991 Kingston Ontario*, [ca. 1991]).

Accreditation

Eileen Mountain's reference to the 'Health Council' in her 1972 report to the Executive Committee was an allusion to a larger trend emerging in the politics of health care at the time. Beginning in the 1970s, Health and Welfare Canada initiated a nation-wide consultation on the potential formation of a national accrediting agency for health care institutions and educational programs (LeClair, M., Unaddressed letter, April 21, 1972). Though findings of the consultation did not lead to a national accrediting body, it raised concerns among CAUSN members that nurses would lose control over criteria determination and the review process (Kirkwood & Bouchard, 1992). In 1972, CAUSN Council passed the following motion: "That CAUSN assume responsibility for the accrediting function for university schools of nursing and be recognized as an accrediting agency." It was noted in the minutes that this motion fit the goals of the Association (CAUSN, *CAUSN Council Meeting October 30, 31, 1972, 1972*).

The following year, Council members voted to strike an ad hoc committee to "promote activities on evaluation and development towards accreditation" (CAUSN, *Minutes of CAUSN Council Meeting McMaster University Health Sciences Centre October 1, 1973, 1973*). At the Council meeting the next year (1974), the ad hoc committee reported on its progress to date and was given the task of exploring the process for developing an accreditation program (Kirkwood & Bouchard, 1992).



[Photograph of a professional student nurse, intern, registered nurse, and Miss. G. Froese, a certified nursing aide.] Canada Department of Man-power and Immigration (MIKAN 4365918), Library and Archives Canada, Ottawa, Ontario.

Throughout the late 1970s, CAUSN looked for ways to develop and implement the accreditation program, including partnerships with CNA and the Canadian Nursing Foundation, and through external funding from the W.F. Kellogg Foundation. In 1981, the W.F. Kellogg Foundation denied funding on the grounds that the program would be of potential benefit to only 22 schools (CAUSN, *Minutes of CAUSN Council Meeting Inn of the Provinces, Ottawa, Ontario November 24-25/81, 1981*).

Despite the lack of external funding, the process of developing an accreditation program continued and, in 1983, Council voted to receive the document, *Accreditation: Criteria and Process for Baccalaureate Programs in Nursing*. It identified the criteria of relevance, accountability, relatedness and uniqueness as standards against which programs in nursing education should be evaluated (Committee on Accreditation, CAUSN, *Evaluation of the Accreditation Process: The First Five Years of Implementation 1986-1991, 1986*). CAUSN Council adopted a motion in 1984 to create the Board of Accreditation for Baccalaureate Programmes [sic] in Nursing in order to administer the program that had been developed the preceding year. Though the Board first met in 1985, it was not until 1986, following a meeting of Council, that the accreditation program was approved for use. In 1987, the program and process were implemented for the first time at the Université de Montréal, the first school to be granted CAUSN accreditation.

It was a long process, but members of CAUSN Council were committed to ensuring the development of a quality program. Since its initial implementation, the original program has undergone minor revisions in 1995 and 1999 and a major revision in 2005.

Incorporation of Accreditation and Approval Processes

As accreditation evolved, some jurisdictions chose to have voluntary accreditation for their schools. Others chose to use the accredited status of a nursing program as the basis for approval. The first to utilize the CASN Accreditation program to blend with their approval processes was the Association of Registered Nurses of Newfoundland and Labrador. Since 1997 they have used CASN accreditation process results as a key input to their approval process. The College of Nurses of Ontario began to utilize the CASN Accreditation Program as the process to achieve provincial regulatory approval in July 2001 and since 2008, the College of Registered Nurses of Nova Scotia (CRNNS) has continued to carry out a joint, integrated approval and accreditation process. The integration of approval of schools and accreditation now involves the majority of schools of nursing in Canada.

Entry-to-Practice

The organization had been promoting educational standards and university education since its first meeting in 1942. The original vision of the Charter members, however, did not include promoting the baccalaureate as the entry-to-practice requirement for all nurses (Kirkwood & Bouchard, 1992). By the second half of the 1970's, however, this emerged as a major priority for CAUSN, dominating attention throughout the eighties and nineties.

Baccalaureate education as the entry-to-practice requirement for nurses in Canada rose to the forefront of members' attention at the 1979 CAUSN Council meeting when members were informed that the Québec provincial government was exploring the matter of baccalaureate preparation for nurses. Council members voted to support a move to baccalaureate education in principal and to prepare a position statement on it (CAUSN, *CAUSN Council Meeting November 12, 1979*).

CAUSN followed up with a paper: *In Response to the Committee Established by the Ministry of Education to Study Nursing Programs in the Province of Québec* in 1979 ([CAUSN?], *CAUSN's Response to Entry to Practice Issue*) and published a statement of the CAUSN Western Region that included the

following two recommendations in view of the complex nature of professional nursing :

- 1) The minimum educational qualification for licensure and registration and entry into practice be the baccalaureate degree in nursing.
- 2) Provisions be made for the continuing registration or licensure of nurses without baccalaureate preparation who are registered or licensed at the date at which the baccalaureate is mandatory for registration or licensure, and entry into practice (Western Region C.A.U.S.N., *Position Paper on Preparation for Nursing Practice*, 1979).

At the 1980 Council meeting in June CAUSN adopted the following formal position statement on the issue: “The Canadian Association of University Schools of Nursing supports the basic premise that the entry level of preparation for nursing practice be the baccalaureate degree in nursing”. At the next Council meeting in 1980, the *Position Paper on Entry Level Preparation for Nursing Practice* was presented by the Committee on Baccalaureate Education and adopted (CAUSN, *Position Paper on Entry Level Preparation for Nursing Practice*, [ca. 1980]).

Recognizing the issue was highly controversial, the CAUSN Council began to develop strategies to advance its position (Kirkwood & Bouchard, 1992). At the June 1982 Council meeting, it was agreed that CAUSN should work with CNA to find effective means to implement CNA’s entry-to-practice initiative ([CAUSN, *Council Mtg. June/82*, [ca. 1982]) and at the November Council meeting, it adopted a motion to call a press conference to announce CAUSN’s entry-to-practice position. Members all decided to initiate a grass-roots campaign to inform all University rectors/presidents and appropriate provincial bodies of the CAUSN position and the reasons for this position (CASUN, *Minutes – CAUSN Council Meeting November 11-12, 1982 Hôtel Méridien, Montréal, Québec, 1982*).

In 1985 Council addressed two key issues that were being discussed in the debates around the country on the question: the quality of the numerous programs that would be required to meet demand, and the fate of the diploma-nurses. At the November 1985 Council meeting, two motions were passed; the first called for “extending generic programs,” while the second called for “primacy [to] be given to the development/expansion of baccalaureate programs for post-diploma nurses.” ([CASUN], [Untitled minutes of November 7 & 8, 1985 Council meeting], [ca. 1985]).



[Photography of a class demonstrating procedures on dummies in St. Boniface School of Nursing, 1949]. Canadian Nursing History Collection (Catalogue Number 2006-H0005.2), Museum of Civilization, Gatineau, Canada.

In the same year, CAUSN published *Entry to Practice: A Summary of Strategic Goals and Actions* with a view to assisting CNA in its advocacy role. It laid out CAUSN's strategy in moving the profession forward to the baccalaureate entry-to-practice standard. The strategy was designed to meet the following goals:

- 1) To increase enrollment in baccalaureate nursing programs in Canada;
- 2) To increase accessibility and flexibility of baccalaureate nursing education;
- 3) To promote collaboration in program planning, development and implementation;
- 4) To monitor and collect data to assist CAUSN members in program planning and development in relation to Entry to Practice;
- 5) To build political support for the for the position of Entry to Practice;
- 6) To promote development of a resource base to support the decision of Entry to Practice;
- 7) To promote an appropriate balance among basic, post-basic undergraduate, graduate, and continuing education nursing programing; and
- 8) To promote an appropriate balance of faculty activity among the education, research and professional service missions of the university (CAUSN, *Entry to Practice: A Summary of Strategic Goals and Actions*, 1985).

In 1986, a CAUSN Task Force on Entry to Practice developed a strategic plan to guide entry-to-practice advocacy (CAUSN, *A Strategic Plan for Entry to Practice – November, 1985*, 1985). The Association also held a one-day think tank on November 12, 1987, attended by 61 people. This resulted in a list of six actions for follow-up, related to widespread dissemination of the CAUSN position and the reasons for this position (CAUSN, *Report on CAUSN Think Tank on Entry to Practice*, 1988).

By 1991, with CNA's 2000 deadline less than a decade away, CAUSN provided testimony to the Commission of Inquiry on Canadian University Education, which addressed the demands of the current health care system, the need for university-prepared nurses and well educated faculty, and the effective role of the educated nurse in the health-care system (Gilchrist, *Submission to Commission of Inquiry on Canadian University Education*, 1991).

Graduate Education

Although the baccalaureate, entry-to-practice issue had galvanized a great deal of attention, the Council members recognized the increasing role graduate programs were playing in nursing education. Master's programs were growing in number and enrollments increasing and doctoral programs were being introduced. The organization initiated an ad hoc Working Group meeting on Graduate Studies, held the day prior to the November Council meeting in November 1997. The Group proposed to Council that this group be formalized as a committee to meet annually before Council. It would offer a forum for debate, dialogue, and exchange around graduate education, provide leadership for graduate education, and consensus building around issues, and advocate on selected issues. The structure would include a Chair, co-chair and secretary with two year terms to set agendas and maintain communication. The committee of the whole would include the heads of graduate studies and others developing graduate programs. The motion passed and the annual Forum has continued since with increasing attendance over the years reflecting the continued growth of graduate programs and their importance in nursing education.

CAUSN Becomes CASN

The new millennium brought a significant change to the organization. Collaborative college partners of Universities had begun to attend Council meeting as associate, non-voting members. They objected to this exclusion from any decision making and argued for full and equal membership. With the implementation of the degree-as-entry to practice, and collaborations developing across the country, there was a need to acknowledge the change in the delivery of baccalaureate education, reorganize, and restructure to accommodate the new reality in nursing education. Under the Presidency of Marianne Lamb, consultations, forums, strategic planning resulted in the development of a new organizational structure that included College partners collaborating in degree programs as institutional members.

In June 2002, Council met in Québec, and adopted a new governance structure. Although a Council of Deans and Directors was maintained, it elects the Board of Directors and Officers, and the Board of Directors oversees the Association and is the policy making body. The Board consists of 15 elected faculty of member schools and representing the four CASN regions, and one appointed community representative. The CASN Accreditation Bureau is a standing committee of the Board with 10 members, operates at arms-length from the Council and the Board, and is responsible for making accreditation decisions. In order to reflect the new membership composition, University was taken out of the Association's name and CAUSN became CASN, the Canadian Association of Schools of Nursing. Membership jumped from 32 to 91 in 2002 positioning the organization as the national voice of nursing education.

Conclusion

Nursing education has been a key factor in the quality of health care throughout Canada's history, and the quality of education for nurses has been a key focus for CASN throughout its considerably shorter history. The progress in educational standards has clearly been substantial since Dr. Mack first established his training school in 1875. History suggests, however, that this progress is always tenuous and subject to erosion or subversion by external forces. The overriding goal set by the Association's founding members for nurse educators to join together and present a strong voice in support of quality in nursing education continues to be as relevant in today's complex environment as it was in 1942.



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99 Fifth Ave, Suite 15
Ottawa Ontario K1S 5K4
www.casn.ca