Vol. 13, No 1, March 2002

Actualités

March 8, 2002

JOURNAL OF THE FIIQ

Summary

On the cover page
Photo : Rainville photographe
International Women's Day
March 8, 2002,
CHUQ, CHUL pavilion

The Journal Committee sometimes receives comments regarding articles published in *FIIQ Actualités*. We read them with great interest and try, in as far as possible, to respond or follow up on them. We invite you once again to send us your comments, questions or suggestions of articles by e-mail to: info@fiiq.qc.ca.

In this issue of *FIIQ Actualités*, you will find that the centrefold presents the Federation's opinion on the progress report of the ministerial task force on the health and human relations professions (the Bernier Report). This special report, prepared by the Communication-Information Service, should help you to gain a better grasp of some of the main issues at stake in the modernization of the professional system.

Good reading!
Journal Committee

FIIQ Actualités

Vol. 13, No 1, March 2002

FIIQ Actualités, the journal of the *Fédération des infirmières et infirmiers du Québec* (FIIQ), is published three times a year and has a distribution of 45,000 copies.

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ISSN : 1203-9837

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Urgent action required…

Last February, we publicly urged the employers and the government for speedy implementation of solutions to alleviate the burden that weighs heavily on nurses, who are currently in an untenable situation. In many hospitals, especially in Montreal and elsewhere, nurses' refusals to work under conditions hazardous to themselves and patients have multiplied. We know that nurses are exhausted, discouraged and fed up.

For acceptable working conditions

Hospital closures, a shift to ambulatory care that has gone off track, insufficient home care services, constant budget cuts and, finally, the infamous anti-deficit law have all contributed to undue pressure on the delivery of health care in Quebec and have disastrous consequences for the working conditions of nurses and other health-care workers. Nearly all the stakeholders agree that the health-care network is currently under-funded. Why maintain the anti-deficit law, a law that translates into new budget cuts, staff reductions and inevitably work overloads? The employers are still managing patient care delivery through nurses' overtime. This situation is only increasing the nursing shortage. We want solutions. This is an emergency!

No matter what some employers claim, we now that the regular teams have not been stabilized in many of institutions of the network. Furthermore, following the tabling of the *Report on Nursing Workforce Planning*, to which the FIIQ greatly contributed, a review of the organization of work, associated with several measures to attract and retain the nursing workforce, must be conducted. On the one hand, all parties addressed in this report must accelerate the application of the proposed solutions and the ministry must invest the necessary funds. On the other hand, even if this is not the solution preferred by the FIIQ, hospital administrators ultimately will have to consider the possibility of closing beds temporarily. It is essential to break the vicious circle of overtime, which leads to burnout and absenteeism, accentuating the nursing shortage. The FIIQ will continue to call on the ministers of Health and Social Services for permanent measures to resolve the situation of nurses and emergency rooms.

To work in dignity

Barely two weeks ago, union, feminist, student and community organizations celebrated March 8, International Women's Day. Under the theme *"Countering violence against women: together for a peaceful environment."* The *Intersyndicale des femmes* marked this day by putting special emphasis on violence in the workplace. Also during this day, the FIIQ launched a wide-ranging campaign intended to implement a policy against violence in every health-care institution in Quebec. Since 1992, we have always maintained that to work in dignity, our work environments had to be free of violence. But perhaps it is also useful to point out that to work in dignity, our work must be recognized at its fair value. Although, in a recent survey published in our daily newspapers, the public ranked nurses second among the professionals they trust the most, nurses are still working under extremely difficult conditions.

Compelling nurses to work overtime through emotional blackmail or threats of reprisals is also a form of violence against them. When nurses refuse to begin their work day because there aren't enough of them on shift, they are not only demanding better working conditions; above all, they are seeking to ensure that their patients receive quality care.

Jennie Skene,
President

International Women's Day

March 8, 2002

In 1791, after the French Revolution, Olympe de Gouges wrote:

"Woman is born free and lives equal to man in her rights. Social distinctions can be based only on the common utility."

"The purpose of any political association is the conservation of the natural and imprescriptible rights of woman and man; these rights are liberty, property, security, and especially resistance to oppression."

At the beginning of the 20th century, a vast social movement developed around the world, in Africa, Asia, America and Europe.

In 1903, in Egypt, women fought against the hijab, the exclusion of women and polygamy. Before the First World War, there were 15 feminist journals in this country.

In 1904, in China, intellectuals opened the first girls schools and demanded that women have the right to vote.

In 1904, in Japan, after the victory in the war against Russia, Japanese women who had taken part in the anti-war movement were ahead of the women's liberation movement.

In 1905, in Russia, after the revolution, a vast women's movement developed in which Alexandra Kolontaï played a very important role.

During the same period, in South Africa, in the anti-colonial struggles, there are references to the women's revolt. In India, British Guiana and South America we speak of the war of women.

In 1906, in Iran, Iranian women participated in the constitutional revolution and demanded the right to vote for women and the creation of schools for girls.

In the same years, in Germany, Rosa Luxemburg and Clara Zetkin were leaders of the Social-Democratic movement.

In 1908, during the strike in the needle trades in New York, women workers demanded the eight-hour workday and better working conditions. As a matter of fact, this American clothing workers' struggle is at the origin of International Women's Day.

In 2000, women all over the world marched and mobilized around to struggle against poverty and violence. Nurses were among those who shouted high and loud: *The power of women's solidarity: changing the world.* But we must not forget that, although there have been major gains after 200 years, we must continue this long march for the defence of the same rights.

Vigi Santé Ltée, (CHSLD Dollard-des-Ormeaux)

CLSC-CHSLD, MRC Denis Riverin, Ste-Anne des Monts

CHUQ, CHUL pavilion

CHUM, Hôpital Notre-Dame

Today, on March 8, 2002, in the wake of the *World March*, women continue to denounce violence and to struggle to eliminate it. Thus, the *Intersyndicale des femmes*, to which the Federation belongs, proposed that we mobilize around the theme: *Countering violence against women: together for a peaceful environment.* The Federation, for its part, took advantage of *International Women's Day* to launch a vast operation in view of implementing a general policy to counter violence in health-care institutions. Nurses celebrated March 8 with the slogan: *To work in dignity, taking action.* Once again this year, IWD was an opportunity to discuss, exchange, celebrate and mobilize… Nurses want to work in dignity… and, it is important to continually keep in mind that the movement of solidarity that has developed among women around the world cannot backtrack. The clocks cannot be turned back…

Élahé Machouf, nurse,
Journal committee

CLSC-CHSLD/Ste-Foy/Sillery/Laurentien

To Work in Dignity

Taking Action

Poem originally read in French at the Pierrefonds rally for the *World March of Women* and translated by the FIIQ:

"To march with steady strides
And take ourselves farther,
From an idea come the words
That will lead us higher.
Drive from your path
All pitfalls and doubts,
Keep only the best.
Together – no more fear.
Building the present,
Ensuring the future,
Going beyond borders,
Each day a challenge
Where women and men
Have grown in love
By strength and spirit
Daring to leave the shadows.
Open your eyes to the world
To unite our efforts.
A flower of hope
For women round the world.
We have grown stronger.
Let's write our own story
And pass on this hope
To the women of tomorrow."

Denise,
de Repentigny

Occupational injury: temporary assignment

When a nurse suffers an occupational injury, the employer can, providing he obtains the authorization of the attending physician, temporarily assign her to a job until she becomes capable of performing the duties of her job or, if necessary, another suitable employment. The employer can then pay her the salary and benefits attached to the job she occupied when her occupational injury occurred.[1]

Regarding overtime

In the difficult context currently prevailing in the health-care network, a large number of nurses are called upon to work overtime. What effect will these overtime hours have, on the one hand, on the calculation of the income replacement indemnity (IRI) set by the *Commission de la santé et de la sécurité du travail (CSST)* and, on the other hand, on the salary and benefits to be paid by the employer during a temporary assignment?

A nurse who performs the duties of a full-time or part-time position, at the time her occupational injury occurs, will be entitled to receive, during her period of absence from work, an IRI based on the gross annual income generated by such a position.

In the case that she worked overtime in the 12 months preceding her injury, she will then be able to show the CSST that she drew a higher gross income than the one strictly related to her position and, consequently, will receive a higher IRI. If the total gross annual income thus calculated is higher than the maximum annual insurable earnings established by law, that is $52,500 for the year 2002, the employer will then have to pay the difference in accordance with the provisions of the collective agreement.[2]

In the case of a temporary assignment, overtime hours constitute an employment–related benefit as defined in Section 180 of the AIAOD.

Courts clearly established that a worker must be compensated for overtime that is planned and agreed to before a temporary assignment. Consequently, if this worker is capable of proving that she would probably have worked overtime hours if she did not have this occupational injury, the employer will then have to pay her, in addition to her salary and the other benefits related to her position, a specific benefit corresponding to the percentage of overtime hours effectively worked during the 12 months preceding the occurrence of her injury.

This probability can be confirmed, among other things, by the maintenance of the volume of overtime hours offered by the employer after the injury. If your are in this situation and your employer refuses to pay you such a benefit, you must within 30 days after the knowledge of the fact:

- either lodge a complaint before the CSST by virtue of Section 32 of the AIAOD;
- or file a grievance with your employer by virtue of the collective agreement.

It is not possible to use both of these recourses at a time, a choice must be made at the very start. For help in doing this, it is always preferable to consult your local union.

Hélène Caron, consultant
Occupational Health and Safety Sector

Temporary work assignment

Section 179. The employer of a worker who has suffered an employment injury may temporarily assign work to him until he is again able to carry on his employment or until he becomes able to carry on a suitable employment, even if his injury has not consolidated, if the physician in charge of the worker believes that :

1. the worker is reasonably fit to perform the work;
2. the work, despite the worker's injury, does not endanger his health, safety or physical well-being; and
3. the work is beneficial to the worker's rehabilitation.

If the worker disagrees with the physician, he may avail himself of the procedure provided in sections 37 to 37.3 of the Act respecting Occupational Health and Safety, and in that case is not bound to do the work assigned him by his employer until the report of the physician has been confirmed by a final decision.

Section 180. The employer shall pay the worker who performs the work he temporarily assigns to him the salary or wages and benefits attached to the employment he held when his employment injury appeared and to which he would have been entitled if he had continued to carry on that employment.

1. Sections 179 and 180 of the *Act respecting industrial accidents and occupational diseases (*AIAOD).
2. In the case of an occupational injury, the employee receives from her employer 90% of her net salary (clause 23.19c of the FIIQ collective agreement). The net salary is understood to mean the gross salary minus the Federal and provincial income taxes, and contributions to the QPP pension plan and the employment insurance plan.

From overseas... to Quebec

In May 2000, on account of the shortage of nurses, the Quebec government, jointly with the *Ordre des infirmiers et infirmières du Québec*, launched a programme for recruitment overseas. Almost two year later, *FIIQ Actualités* wanted to know the opinion of some of these new co-workers. Jean-Sébastien Guitter and Annie Meslay shared some comments on their experience here. Both come from France and work for the *Institut universitaire gériatrique, Alfred-Desrochers* pavilion in Montreal. In France, Jean-Sébastien worked in oncology and Annie in long-term care.

Arriving on Quebec soil

As soon as they got off the airplane, there was someone waiting for the group of newcomers to direct them to their new workplace, either in Quebec City or in Montreal. This was greatly appreciated by everyone. Jean-Sébastien regretted the fact that they received no help to find an apartment. However, in Quebec City, the newcomers were provided with a place to stay until they found an apartment.

In general, Jean-Sébastien and Annie consider that the special conditions proposed for the recruitment of French nurses were respected. However, they were not told that they would have to pay $260 for their right to practice and that they would have to work mainly on the night shift and only exceptionally on the day shift.

Working as a nurse

Both consider that, here in Quebec, nursing care is well organized: ***"in a work team, each person has a well-defined role, each person knows what she has to do"***. Which facilitates the coordination of the work teams. Moreover, Jean-Sébastien and Annie consider that the legal framework for nursing practice is very specific, and even strict: ***"this can sometimes restrain the possibility of taking personal initiatives or being autonomous in one's work."***

Union life in Quebec and union life in France are worlds apart. In France, in the field of health, as in all other fields for that matter, unionization is not compulsory. Negotiations are conducted locally; they are therefore directly related to nurses' workplaces: general hospitals, residential centres, etc. Split shifts are common and breaks and meal periods are not as clearly defined as they are here. It even happens in some workplaces that nurses work nine consecutive hours without stopping to eat. However, such schedules allow them to accumulate these meal periods or breaks to reduce their work week.

Note that in France, there is no such thing as overtime. Thus, if a nurse works more than the number of hours stipulated in her schedule, she can only take the time back if another nurse is available to replace her. If this is not possible, she simply loses the time she accumulated. Overall, both consider that ***"the working conditions are better here than in France, even if the environment is totally different."***

As for the difficult situation that prevails in the health-care network: overcrowded emergencies, long waiting lists, etc, both consider that this situation could at least be alleviated ***"if there was a significant increase in home-care services"*** In France, it is common practice, both for nurses and doctors, to go to a person's home to deliver care.

Annie and Jean-Sébastien consider that their experience in Quebec is positive. Not only are they both pleased with their stay here, but they like the way Quebec nurses deliver care. ***"Care is personalized, respectful, and the approach is de-medicalized and very professional."***

FIIQ Actualités would like to thank, in particular, Annie and Jean-Sébastien for their testimony, and all nurses who came from overseas who came to lend a hand to Quebec nurses in the difficult context of the nursing shortage.

Noëlla Savard, nurse
Journal Committee

Have you heard about the RIIR ?

The ***Regroupement des infirmières et infirmiers retraité-e-s***, the RIIR, is a province-wide organization of retired nurses. It represents over 4000 members in ten zones, defined on a regional basis. Among others, it has the following objectives:

- to give retired nurses a collective voice;
- to provide counselling services and insurance services for retired nurses;
- to take part in nurses' demands with regard to retirement;
- to establish relations with other associations of retirees;
- to promote the defence of the rights of retirees;
- to take part in large public debates.

Following the period of massive retirements, the RIIR saw the number of its members increase significantly. In addition to the arrival of these new members, the modification of its structures, that is regional representations on the board of directors, and at the general assembly and Convention, all increased the public visibility of the RIIR and contributed to make it a dynamic organization present throughout Quebec.

In order to establish links with other associations and thus increase its power of influence and decision with regard to the defence of retirees, the RIIR participates in meetings with representatives of various associations in the public and parapublic sectors. Together, we demand recognition and that indexation be restored to protect the purchasing power of current and future retirees.

The RIIR also joined the *Alliance des associations de retraité-e-s* which represents 47 associations of retirees benefiting from a pension plan. Representing over 110,000 members, its objective is to defend the rights of members regarding their pension plans, that is to say :

- to consolidate strategic alliances to intervene with public decision-makers in view of influencing decisions or changing legislation that has a negative effect on income retirement;
- pursue strategic alliances to promote the laws affecting the struggle against poverty.

Who can be a member of the RIIR?

- Nurses who were practising their profession in Quebec at the time of retirement: unionized employees, management personnel or others;
- Persons employed by the FIIQ or its affiliated unions at the time of retirement.

During their active professional life, retired nurses waged battles for the recognition of their work and profession, the defence and improvement of their working and living conditions. Today, as retired nurses, they will continue to be active and involved in decisions, not only on questions that affect retirees and elders, but in major social issues. If you are close to retirement, do not hesitate to communicate with us. The more retirees join the RIIR, the stronger and the more dynamic the RIIR will be.

Gisèle Goulet,
President of the RIIR

RIIR
Regroupement des Infirmières et Infirmiers Retraitées

Founded:	in 1992, by the FIIQ
Membership:	4000 members
Head office:	1170, boulevard Lebourgneuf, bureau 405, Quebec City, Qc G2K 2E3
Telephone:	(418) 626-0861 or 1-800-639-9519
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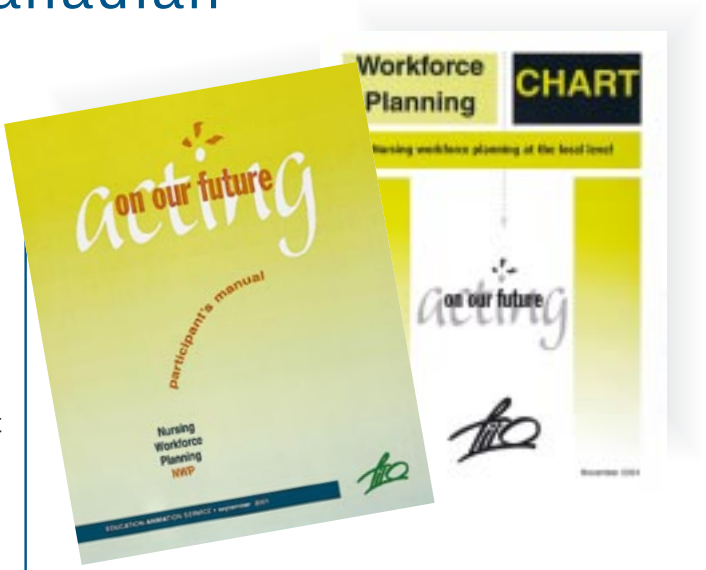
Meeting with our Canadian counterparts

For several years now, representatives of all Canadian nurses' unions, under the banner of the Canadian Federation of Nurses' Unions (CFNU), have been meeting twice a year to exchange on issues that concern nurses, and on the policies and decisions of their respective governments. The last meeting was held in Ottawa on February 11, 12, 13 and 14.



From East to West, nurses are confronted with the same situations: serious problems of nursing shortage, difficulty attracting new nurses, the rising trend to privatization, increasingly difficult negotiations, moderate recognition of advanced nursing practice and a quasi-absence of workforce planning.

Our colleagues in British Columbia suffered attacks by their government very similar to the ones we experienced here in Quebec in the past years. Indeed, the government slashed health services and public services, resulting in the layoff of thousands of public sector workers. Moreover, nurses and other employees suffered the dreadful consequences of repressive anti-labour legislation imposed by their government: unilateral modification of their working conditions. Thus, the nurses of British Columbia, who waged a harsh battle last spring for the renewal of their collective agreement by walking out, have had their working conditions imposed by decree by the new liberal government.

Despite the shortage of nurses, certain provincial governments do not hesitate to begin negotiations by presenting offers with significant setbacks. Thus, the government of Manitoba presented offers which contained major setbacks on 29 points. In fact, the situation is difficult everywhere.

In Ontario, however, nurses succeeded in winning a signed collective agreement and their salary now ranks first in Canada. Nurses in Nova Scotia had their salary at the fifth and last echelon raised to $27.52 an hour. In the weeks and months to come, we should keep an eye out to see what will happen in Newfoundland, Alberta and Saskatchewan where negotiations are on the agenda.

In a fair number of Canadian provinces, a workforce planning process is currently under way. Since we have the custom of sharing our training and mobilization material, we presented and handed to our counterparts in the other provinces the material drawn up by the Federation to support this vast operation: content of the training session, chart on nursing workforce planning.

At this meeting, we saw that the substitution of nurses by other categories of workers is not a practice exclusive to Quebec. Once again, it is in British Columbia that this practice is used in the most unacceptable way. Indeed, in one region, all the nurses of certain centres were laid off and replaced by nursing assistants. The government made this decision with only one objective in mind: cutting back costs. This is always a very touchy question since some Canadian nurses' unions have nursing assistants in their ranks, yet the complementary nature of the roles of nurses and nursing assistants is not brought into question… However, there is a difference between complementing and substituting …

Privatization was another subject of concern. This forever growing threat is very real when we see a government like that of Alberta open the door to this possibility by interpreting the principles that are the pillars of our health-care system very liberally. In several other provinces, nurses' unions voted funds, some even voted a special assessment to publicize the reality of the health-care system and make known the key role that nurses play.

As a matter of fact, the majority of nurses' unions presented a brief to the Romanow Commission. All unions reiterated their disapproval of the privatization of the health-care network and all expressed scepticism regarding the outcome of this commission.

The question of advanced nursing practice as well as that of nurse practitioners were also on the agenda. No province has the same criteria for the nurse practitioner diploma. Indeed, in one province, for example, experience acquired as a nurse is recognized and the Baccalaureate is not required in order to register; in another province, it is a pre-graduate programme. In Ontario, for example, out of 400 nurse practitioners, only 200 practise as nurse practitioners and, moreover, the majority work in outlying regions. Feeling threatened, medical circles are rather opposed to this practice. … So, what's new?

Thus, from East to West, nurses have to face up to many similar situations. More than ever before, we see that globalization and neo-liberalism have direct effects on the struggles we will wage. The struggle against privatization, the struggle for the improvement of working conditions, the struggle for the recognition of nurses' work and profession, the struggle for conditions that make it possible to ensure the quality of care and services to the population. Our next meeting is scheduled to be held next fall.

Michèle Boisclair,
3rd Vice-President,
in charge of the Journal Committee

Group insurance
Why are costs going up?

Since the coming into effect of the new rating schedule of the group insurance contract, on January 1, the FIIQ received a number of comments questioning this increase or proposing ways of reducing it.

Why this increase?

The increased rating of group insurance is directly related to the cost of premiums for the drug, and long-term disability benefits. Concerning drugs, the situation is out of control not only in Quebec, but also at the national and even international level on account of government policies and the trend in the pharmaceutical industry to develop new drugs that are more and more expensive. This means more profits for the pharmaceutical industry and higher costs for users.

Moreover, we all know that the nursing shortage and the deterioration of working conditions have had an important impact on the insurance plans. Indeed, nurses increasingly call upon professional services on account of the physical and psychological disorders caused by a stressful and exhausting work environment. The growing number of nurses on long-term disability is not unrelated to this work environment, resulting in a marked increase of the cost of this benefit.

Can costs be reduced?

Certain nurses suggested that we call for tenders in the hope of obtaining better rating from a new insurer in Quebec or even outside of Quebec. Remember that at the time of the last call for tenders, the Federation extended the call for tenders to insurers outside of Quebec. Only one company outside Quebec presented a tender, which turned out to be the highest bid. Quebec insurers, who are more familiar with the situation of public sector workers, were, for their part, more competitive. A call for tenders may seem attractive in the short term but, in practice, in the middle term, the rates are readjusted to reflect the true rating. Thus, in the current context, it would be difficult to consider a call for tenders.

Another solution was proposed: the possibility of cancelling certain benefits, like for example dental care. If such was the case, would the group insurance contract still meet the needs expressed by members?

It is with this question in mind that the Federation decided to conduct a survey to analyse the insurance needs of nurses. The survey will be conducted among 5,000 members. The objective is to review the structure of the group insurance contract in order to assess various cost-reducing options. This process will allow us to offer, for the next contract renewal, a group insurance plan that integrates the results of this survey and that continues to respond to nurses' needs.

Aline Michaud, consultant,
Social Security Sector

The Quebec smart health card

A MAJOR DIVERSION

On December 19, 2001, the Minister of State for Health and Social Services at the time, Rémy Trudel, tabled a draft bill at the National Assembly on the Quebec health card. The public consultations held under the responsibility of the new Minister, Mr. Legault, began on February 19, 2002, before the Social Affairs Committee. On February 8, the FIIQ tabled its brief with this Committee, which will be heard on March 28.

WHY SUCH A CARD?

Replacing the current Medicare card with its sunburst design, which has been in use for over 30 years, the new health card, according to the government, should support and improve the delivery of health and social services in Quebec.

Composition and functioning of the health card

According to the project, each Quebecer would have a personal smart card. It would allow online identification and verification of eligibility for insured health-care and service programs. The health card would retain its current form, but would contain a microchip and a personal identification number (PIN) known only to its holder.

The microchip would contain only identification data. No clinical information would be included. The data would be centralized at the *Régie de l'assurance maladie du Québec (RAMQ)*.

This health card, in fact, would be a key which would open the door to information identifying its owner. With the user's consent, this key could open another door leading to the health information summary. However, this door would have a different lock, and a second key would be required to use it. This key, the qualification card, would be held by the health-care practitioner.

The qualification card, also a smart card, would allow the health and social service practitioners prescribed by law to access the health information summary. Depending on the access rights and with the user's consent, the practitioner could consult and record any relevant new information permitted by law. An electronic signature would identify the person who records new information.

The FIIQ is favourable to the idea of a «shareable patient file». This is not at all what the RAMQ's project involves. In the draft bill on the Quebec health card, the clinical objectives appear to be secondary to the RAMQ's administrative objectives. The technological possibilities of the microchip card, if implemented, would allow the introduction of mechanisms for co-insurance and de-insurance of services or management of private health-care services. Even though the RAMQ is making reassuring noises on these issues, technology makes this contingency possible. What are the longer-term objectives? Are the practitioners and the insured any better informed?

The centralized information summary at the RAMQ would not replace the patient's file but would be superimposed on it. The draft bill would thus create a parallel legal system. Will physicians want to trust it?

There have been pilot projects, first in Rimouski, then in Laval and other localities, but most of them differ profoundly from the current project. No summary assessment of these experiments has been published. Why are the RAMQ and the government in such a rush to get this bill adopted?

It is also anticipated that the government could determine, on the one hand, what category of person is a health and social service practitioner who would have access to this database and, on the other hand, what category of person is a practitioner. This would be a very wide regulatory opening for claims.

Given that the identification and authentication objectives are not limited exclusively to the health and social services sector and given that the card could be used for other purposes than those initially foreseen, the debate on the citizen ID card is now on the table. It should be considered and clearly stated to the public. Major societal issues are at stake and, in a free and democratic society, they should prevail over economic development objectives. To consult the brief tabled by the FIIQ, please visit our website at www.fiiq.qc.ca.

Yves Tremblay, nurse
Journal Committee

Internship in Guatemala

In July 2001, within the context of a two-week internship organized by CISO, a group of 12 Quebec union activists, two of us nurses from the FIIQ, went to Guatemala with the following goals:

- get to know the organizations that play a major role in social struggles in Guatemala;
- learn about the effects of implementation of free trade zones and the impact of globalization in that country;
- prepare the ground to build active solidarity between Quebec and Guatemala.

Guatemala is barely getting back on its feet after 30 years of civil war. Despite struggles to improve living conditions, social and economic conditions are steadily deteriorating: corruption of the judicial system, criminalization of union action, intimidation, harassment, repression, violation of human and union rights, impoverishment of the population, privatization, deregulation, government disengagement. The healthcare system is in a deplorable state and the government is letting the situation deteriorate. The country is in the grips of serious problems of malaria, dengue fever, typhoid, cholera and tuberculosis. No government action is planned to counter the AIDS pandemic and healthcare workers who are contaminated at work receive no compensation or treatment.

Our respondent in Guatemala was Edwin Ortéga, Secretary General of the UASP (United Union and Popular Action). Thanks to his efforts, the interns met with union leaders, activists, workers and representatives of groups defending human rights.

Let's look at what the situation in Guatemala means in the daily lives of a few people we met.

Moria goes to work every day at the office of her Mutual Support Group, or GAM, where the walls are papered with photos of people who have disappeared. About 45,000 people have disappeared in Guatemala, as many as in all the rest of Latin America combined. Since its

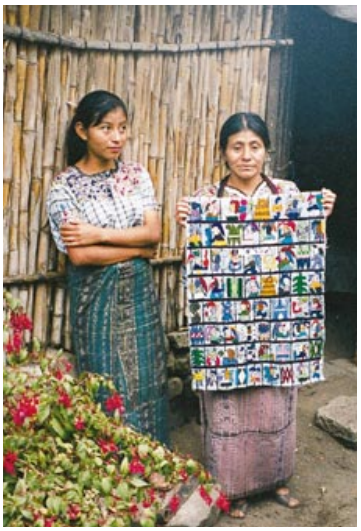
founding in 1984, 28 members of the GAM have disappeared and 60 have been murdered, including the woman who founded the organization …

Térésa packs bananas for the Del Monte company. She now has to work 12 hours a day to earn what she obtained in 8 hours before the company started experimenting with performance-based pay. She is exhausted and doesn't dare to complain for fear of losing her job. Three years ago, after demonstrations against mass layoffs, a militia group invaded the union office, held its leaders hostage and threatened them with death. They were compelled to resign.

Anastasia is involved in the struggle to defend Mayan rights as part of a peasant organization. Despite difficult bus transportation conditions and long hours on the road and walking, she travels the district with her infant to encourage women to demand their rights and offer them ways to help escape their misery.

Edwin gave political education workshops in guerrilla camps during the war. He is now Secretary of the U.A.S.P. He works relentlessly, and without pay, to rebuild the union and popular movement weakened by war, repression and now globalization. The corporations and the State have made union action a criminal offence and constantly engage in pressure and intimidation, including harassment and bomb threats. In this corrupt system, from 1980 to 1990, over 90 union members were murdered.

Maria and her children sell costume jewellery and fabrics in the central park in Antigua. The children solicit the tourists with pleading dark eyes: this earns the family a meagre livelihood. They walk 8 kilometres a day to the city. When evening comes, the children have to make the jewellery and the mother has to weave. Maria knows that her children should go to school. But like many indigenous families, she can't afford to do without the income from her children's labour.



These extraordinary people are admirable for their perseverance and determination to survive and fight to change the country's living conditions. Unfortunately, the media rarely talk about Guatemala. We are now sensitive to the problems these people are facing. Among other things, the internship in Guatemala really made us aware of the perverse effects of globalization.

Mireille Surra-Bournet, nurse
Claudine Bisson, nurse

From Porto Alegre

The World Social Forum (WSF) was the meeting of several thousands of people, of all races and cultures, from the four corners of the planet, working each in their own way to change the profound nature of the "market globalization" of the world.

I was present at this 2nd forum held from January 31 to February 5 in Porto Alegre in Brazil. Last year, 15,000 people hadattended. This year, over 50,000 people came to this event and took part in training workshops or discussion forums on a multitude of different subjects.

Why was the WSF held in Porto Alegre for a second time? The rulers of this State have chosen a very special political structure some ten years ago: the participatory budget. Thus, all decisions regarding investments, regardless of their nature, are discussed and decided upon by all citizens. Since this is a fundamental demand with regard to the negotiations around the *Free Trade Area of the Americas* (FTAA), the choice of Porto Alegre could not be more meaningful.

The scope of this annual meeting must be seen as a fantastic expression of union, labour, peasant, social and cultural solidarity on issues as diverse as biological culture, health, education, civil liberties and the right to decent living conditions. In all, 700 workshops where people analyzed the world as we know it of course, but also the world as it could and should be in order to reduce the gap created by the "privatization of the world", a result of the fact that decisions are made by the wealthy few.

To launch the World Social Forum: a flamboyant march, calm, with the flags of each country and membership group.

The Forum expected 5,000 young people, but 17,000 came to express their desire to participate in creating original alternatives. Their creativity and their enthusiasm were echoed by the groups present, but they also question our capacity to reorient the positions of current governments. There is undoubtedly a long way to go. Only those who choose to speak up have any chance at all of countering the daily effects of all-out commodification and we are among those who speak up.

Women have also chosen to speak up. This year they represented 43% of the delegation and their demands for an egalitarian, supportive, democratic and peaceful world are very clear. Moreover, women want to have abuse against children recognized by world legislation as a crime against humanity. Peace will be impossible as long as violence against women and children continues to be tolerated.

The World Social Forum has been an opportunity for the *Fédération des infirmières et infirmiers du Québec*, by way of its representative, to meet thousand of concerned activists, united for the redistribution of wealth, for a world where fundamental rights are respected… With its wide range of cultures, as well as the clear positions expressed at all forums where it was invited, the Federation continued to seek alternatives for its members as unionized workers, women and mothers. We continue to uphold that a process of change for a different world cannot happen without us, that our needs and rights must be heard and that, for this reason, our vigilance must be unfailing.

Chantal Boivin,
Secretary on the
Executive Committee
in charge of Solidarity Work

RREGOP
Buying back years

In the last issue of the *FIIQ Actualités*, in December 2001, we reported that an agreement had been reached between the government and the FIIQ, FTQ, SFPQ, CSN and CSQ concerning the buyback of years of service. This agreement establishes a new rating method that is clearly more advantageous for the buyback of leaves of absence without pay and service as a casual employee. This new rating method was also extensively explained in the last issue of *FIIQ Actualités*.

On account of legislative procedures, this new rating method will only officially come into effect after the adoption of the modifications to the RREGOP Act by the National Assembly, that is normally in spring of 2002. However, the agreement stipulates that the new rating method will apply retroactively to the proposals for buyback agreed since June 1, 2001. Since June 2001, CARRA has stopped processing most applications for buybacks. This is why many nurses have not received a response to their requests.

What happens in the case of requests made before June 1, 2001 or after June 1, 2001 for which the CARRA has not yet issued a proposal?

You will receive a proposal for buyback based on the new rating method, but it will be conditional to the adoption by the National Assembly of the modifications to the RREGOP Act. As soon as they are adopted, the CARRA will communicate with you to confirm your right to the buyback requested.

You have accepted or refused a proposal for buyback on or after June 1, 2001 which you believe was calculated according to the old rating method?

These situations are RARE, though possible. However, you can check the calculations yourself. Indeed, the new rating method is based on a percentage of your salary at the time of your buyback. This percentage varies according to your age, the type of buyback and the year bought back. For more details, consult the table published on pages 10 and 11 of *FIIQ Actualité*s in December 2001. This will enable you to calculate the approximate cost of the buyback.

Rates applicable for a leave without pay

	39 years or less	40 – 47 years	48 – 54 years	55 years or over
Year CPI* (before July 1982)	10.5%	13.5%	17%	21%
Year CPI – 3%** (July 1982 to January 2000)	8.5%	11%	14%	17%
Year CPI – 3%*** minimum 50% (since January 2000)	9%	11.5%	14.5%	18%

Rates applicable for a leave of absence following a maternity, paternity or adoption leave as of January 1, 1991 and period of casual service from July 1, 1982 to December 31, 1986

	39 years or less	40 – 47 years	48 – 54 years	55 years or over
Year CPI* (before July 1982)	5.25%	6.75%	8.5%	10.5%
Year CPI – 3%** (July 1982 to January 2000)	4.25%	5.5%	7%	8.5%
Year CPI – 3%*** minimum 50% (since January 2000)	4.5%	5.75%	7.25%	9%

Rates applicable for a period of occasional service From July 1, 1973 to June 30, 1982

	39 years or less	40 – 47 years	48 – 54 years	55 years or over
Year CPI*	4.37%	5.62%	7.08%	8.75%

* CPI: consumer price index. Year with full indexation to the cost of living.
** Year with a reduction of the cost-of-living adjustment.
*** Year with a reduction of the cost-of-living adjustment, but never less than 50% of the indexation.

If you accepted the buyback proposal, the CARRA will make the correction and you will receive a reimbursement for overpayment.

If you refused the buyback proposal, the CARRA will issue a new proposal based on the new rating method.

In both of these situations, it is wise to communicate with the CARRA

In closing, remember that the new rating method does not concern the buyback of years of service prior to RREGOP (bought back as pension credits) which already benefits from highly advantageous rating. Although the modifications to the RREGOP Act is scheduled to be passed in the spring, it is nevertheless important to present your application for buyback. The age at the time of the buyback and the salary determine the cost of the years to be bought back; if you wait, it may cost more.

Line Lanseigne, consultant
Social Security Sector

Business lunch... and community toasts

Cap-Monde, which represents community groups, union organizations and student associations, gave a press conference on February 8 at the *Accueil Bonneau* and invited journalists to have a community toast while the finance ministers of the richest countries of the world (the G7) were meeting in Ottawa and preparing for the business lunch. Cap-Monde wanted to voice its opposition to the impoverishing policies of the G7 and put a few questions to the Finance ministers of the G7.

The spokespersons for Cap-monde, Mrs. Jennie Skene, President of the *Fédération des infirmières et infirmiers du Québec*, Mrs. Manon Massé, coordinator for the *Fédération des femmes du Québec,* Madam Lorraine Théberge, representing the *Canadian Religious Conference (Quebec section),* Mr. Pierre Henrichon, representing *ATTAC-Québec* and Mr. Jocelyn Huot, representing the *Fédération étudiante collégiale du Québec*, each in turn criticized this economic development model.

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FÉDÉRATION DES INFIRMIÈRES
ET INFIRMIERS DU QUÉBEC

Official Statement

A formal Commitment

Management makes a commitment to protect its personnel. This can only be done with transparent management strategies based on trust and consideration. In this, the union is an unavoidable partner. It has the duty to ensure that the work environment is sensitive and supportive. Employees, for their part, make a commitment to break the silence and to develop solidarity in order to work in dignity.

Management makes a formal commitment to promote zero tolerance. This commitment is based on the following principles:

- **unequivocal condemnation of violence in all its forms;**
- **recognition that women make up the majority of personnel and that they can be the target of specific violence;**
- **setting up of a general policy aimed at conflict prevention and resolution;**
- **commitment to having services respect the general policy;**
- **provision of support to victims of aggression;**
- **encouragement of personnel to become involved in the creation of a violence-free environment with adequate information and appropriate training;**
- **call on clients' responsibility to show respect and dignity for personnel in a spirit of reciprocity.**

Taking Action

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SPECIAL REPORT

REGULATION OF PROFESSIONS: major changes

In June 2001, the FIIQ was invited by the ministerial Task Force, the Bernier Group, to make known its views concerning a possible modernization of this sector's professional organization. The Task Force on health and human relations professions tabled its report in November 2001. In December 2001, the FIIQ was again invited to present its comments regarding this report. Here is the FIIQ's response to this invitation.

The model proposed by the Bernier Task Force includes certain positive elements. It is not only uniform for all health and human relations professions but is also easier for the general public to understand. Among other matters, it raises the importance of public protection, professional autonomy and training. It also suggests a way of defining the field of practice of health and human relations professionals which represents a major change from what exists in the current legislation. However, it contains some contradictions. For example, while focusing on professional autonomy, it introduces the concept of supervision, or while advocating public protection, it neglects to consider the basic training delivered to professionals.

Obsessed by the introduction of flexibility in the professional system, it can be asked, upon reading the activities reserved for the different groups of professionals, whether the Task Force has gone to the other extreme. In fact, the explicit overlaps between the fields of practice of the different groups of professionals are numerous and significant. Interdisciplinarity must not become a justification for prejudice to the specific professional identity of each profession. In this sense, even though the proposal of the field of practices and activities reserved for nurses recognizes and expands their current practice, some activities reserved for nursing assistants, for which they have not received training, contradict the specific professional identity of nurses.

THE FIELD OF PRACTICE AND RESERVED ACTIVITIES: the same approach

For each profession concerned by the progress report, the field of practice includes an initial general statement based on the ultimate purpose of the profession practised by a group of professionals and a second identical statement shared by all health and human relations professions.

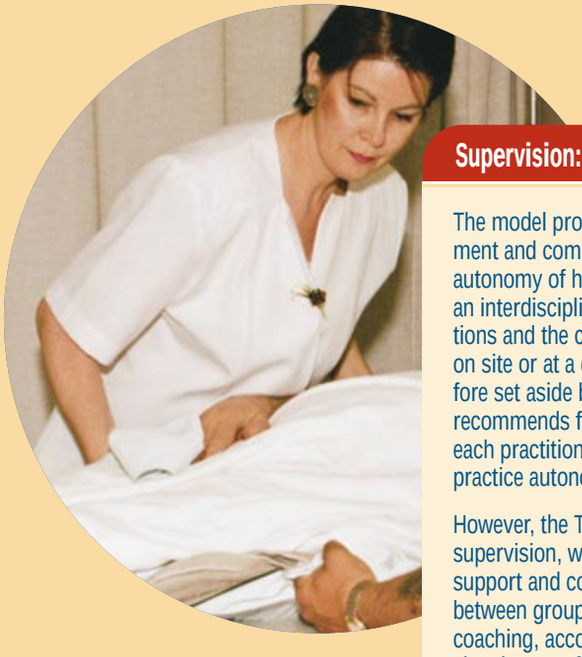
THE FIRST FIELD OF PRACTICE STATEMENT focuses on the professional designation, that is, the recognized main title (e.g.: nursing practice) and the objectives or ultimate purpose of the professional practice (e.g.: evaluate the person's state of health, ensure that the nursing care and treatment plan is fulfilled, etc.). It specifies the general areas of practice, their main component activities, the main goods or services provided or delivered by the professional, the conditions of practice, the places or environments, and finally, the methods or techniques used.

THE SECOND STATEMENT, identical for all health and human relations professions, focuses on health promotion, and disease and accident prevention. The report calls for all health and human relations professions to share this responsibility.

A series of reserved activities, distinct for each group of professionals, is associated with this two-statement description of the field of practice. However, an activity of the same nature, such as taking samples, can be found in the series of activities reserved for more than one group of professionals. This choice creates explicit overlaps of acts between the different groups.

These proposed descriptions of the field of practice and reserved activities, if they are adopted, would dispose of Sections 36 and 37 of the Nurses Act and the delegated acts regulations currently in force.

FÉDÉRATION DES INFIRMIÈRES ET INFIRMIERS DU QUÉBEC



Supervision: a concept to be eliminated

The model proposed by Bernier is based on the empowerment and competence of professionals. It relies on the autonomy of health and human relations professionals in an interdisciplinary context. The delegated acts regulations and the concept of immediate monitoring, whether on site or at a distance, which is attached to it, are therefore set aside by the proposed new model. The Task Force recommends favouring the professional responsibility of each practitioner who proves that she has the capacity to practice autonomously.

However, the Task Force puts forward the concept of supervision, which is defined as a form of professional support and coaching practiced between professionals or between groups of professionals. This supervision or coaching, according to Bernier, would allow some professionals to perform activities which they could not perform in complete autonomy, because of the need for a guide or a resource person to whom to refer.

This concept of supervision is in contradiction with the full autonomy of each professional and is cause for confusion, to say the least. Thus, for the FIIQ, each group of professionals which is assigned a reserved activity should be able to exercise it in complete autonomy, without conditions of monitoring or supervision

Training: a key factor

The report specifies that assuring the quality of acts involves requirements. The FIIQ agrees, and in this sense reaffirms the importance of good basic training to prepare professionals to practice their profession. The Task Force considered that the training delivered to nurses was adequate.

In the wake of the proposed reform, the Bernier Task Force attaches great importance to protecting the public, and this is totally justified. In a context where a growing number of seniors and people with reduced capacity are kept at home or housed in supervised environments to defer hospitalization as long as possible, the use of non-professional resources is proposed to perform certain acts, said to involve little risk of prejudice to the health and safety of individuals, without thereby compromising the quality of the acts performed.

The FIIQ agrees with this assessment. However, the FIIQ also believes that continuing education and updating or professional improvement activities must not be substituted for or likened to basic training. Continuing education cannot and must not compensate, alleviate or substitute in any way for the shortcomings or absence of training in certain aspects of the basic training program delivered to future professionals or practitioners.

Even though we can understand the role that non-professionals may play with these persons, the FIIQ believes that public protection cannot be assured unless a minimum of training has been given to these so-called non-professional resources. We must not lose sight of the fact that the acts these resources will be asked to verify or perform in place of the elderly person or individual with reduced capacity have been the object, at one time or another, of training delivered by a professional to the person who requires this care. For example, when she was still autonomous, a diabetic normally received training from a nurse to find out how to test her blood sugar and therefore self-administer the required insulin dose. It is therefore unthinkable not to provide for training with content that qualifies non-professionals to perform such acts.

It is also essential to avoid falling into the trap of trivializing these acts. They represent care which, if not provided correctly, can have serious consequences for a person's health. Finally, the ability to perform an act must be differentiated from the ability to understand the scope and consequences of the care provided.

Determination of local conditions: a process to be avoided

The FIIQ is opposed to this Task Force proposal. For the FIIQ, the process of delegation of acts should be carried out by way of the professional orders concerned, and take the form of a regulation applicable throughout Quebec. It is essential to avoid reproducing previous experiences where the conditions of practice adopted locally were different from one environment to another, creating major disparities between professionals of the same group and resulting in tensions between the different groups of professionals. The Task Force recognizes the existence of this type of problem and is seeking to put an end to it.

The Bernier task force's report points out that delegation of acts is an obsolete mechanism, even described as a failure. In their opinion, the current delegated acts mechanism gives rise to confusion, major disparities between regions, care environments and professionals, dissatisfaction and interprofessional tension. According to the ministerial task force, delegation of acts should encourage multidisciplinarity instead of hindering it. It also noted the existence of numerous inconsistencies in the delegation of medical and nursing acts. The ministerial task force suggests that professional orders define the acts that can be shared and the conditions that are required, and that institutions determine the conditions for application in order to ensure user safety.

Pilot projects: an absurd exercise

In the FIIQ's opinion, the Task Force, after one year of research and analysis, has all the necessary information to propose a new legal and regulatory framework. Relying on pilot projects to fine-tune the changes in professional practice is absurd, considering the overall vision and cohesion necessary for the changes introduced in the professional practice of the different groups of health and human resources professionals.

To ensure the evolution of the proposed legislative and regulatory framework, the ministerial Task Force suggests experimentation through pilot projects.

The field of practice and activities reserved for nurses: a recognition of their expertise and practice

Regarding reserved activities, the FIIQ welcomes the Bernier Task Force's proposal, which recommends reserving to nurses those activities which include all acts already delegated by the current legislation and regulations, including those delegated to them under the Regulation respecting the Acts contemplated in Section 31 of the Medical Act, which may be performed by professionals other than physicians. The Task Force thus recognizes the nurses' contribution to the performance of care activities it has deemed it necessary to reserve for them, because these activities involve a major risk factor.

Thus, the type of activities reserved for nurses involves several characteristics. The risks of harm analysis grid used by the Task Force has the effect of reserving for nurses activities recognized as invasive and complex, with a high degree of technical content, involving the use of drugs and likely to cause damage. For the FIIQ, this choice corresponds and is directly related to the basic training of nurses, their competencies, and the experience and expertise they have acquired and developed in the care environments over the past twenty-odd years.

Regarding the Task Force's proposal concerning the activities reserved for nurses, the FIIQ suggests certain changes. For the reserved activity which reads "Initiating emergency and front-line diagnostic and therapeutic measures, according to a prescription," the FIIQ proposes to incorporate what is commonly known as the second-line level. In fact, nurses work in certain specialized "second-line" clinics. We are thinking here of high-risk pregnancy, diabetes or chronic obstructive lung disease (COLD) clinics. These nurses must be able to initiate diagnostic and therapeutic measures, and some are already called upon to do so. A second amendment is also proposed to cover operationalization by nurses of immunization protocols formulated by the Ministère de la Santé des Services sociaux. This new reserved activity would thus grant recognition to an already existing practice.

The FIIQ therefore believes that, in general, the wording proposed to describe the activities reserved for nurses considers their work reality and current practice.

In its final report, the Bernier Task Force defines nursing practice as follows: nursing practice consists of evaluating the person's state of health, determining and ensuring the accomplishment of the nursing care and treatment plan, providing nursing and medical care and treatment for the purpose of maintaining and restoring health, and preventing disease, and providing palliative care. Information, promotion of health and prevention of disease and accidents are also part of the practice of the profession with individuals, families and communities. This statement recognizes:

- The nurse's competence to evaluate the state of the person's health.
- The nurse's competence in deciding, preparing and producing the nursing care and treatment plan. The accomplishment of the care plan underlies the coordination of the care episode, which can be assumed by the nurse.
- The concept of nursing treatment, which confirms the nurse's autonomy in making decisions regarding treatment.

SPECIAL REPORT

Nurses in advanced practice: the importance of recognition

The Task Force's recommendations therefore call for the recognition of two types of advanced practice nurses: nurses in a medical specialty and nurses in primary health-care in remote regions.

Even though it is in agreement with the recognition of these two types of advanced practice for Quebec nurses, the FIIQ, as already mentioned, deplores the absence of recognition of the nurses' right to engage in advanced practice in primary health care throughout Quebec. The FIIQ therefore considers that advanced practice for front-line nurses should be recognized as soon as possible, throughout Quebec.

Relations between nurses and nursing assistants: activities to be circumscribed

The Task Force proposes that the list of activities reserved for nursing assistants include the following: «*administer drugs and other substances when a prescription exists to this effect, including, under the supervision of a nurse or a physician, intravenous from a peripheral site*». This statement would also cover the administration of vaccines.

The FIIQ is in total disagreement with this addition to the list of activities reserved to nursing assistants. On the one hand, in a context where the autonomy of each professional is necessary and desirable, there can be no question of replacing the concept of monitoring that currently exists in the delegated acts regulation with the concept of supervision, which is ambiguous and undesirable. On the other hand, public protection requires that each professional not only be capable of performing the activities reserved to her on the technical level, but also that she understand their scope and effects, and especially that she know all the possible complications.

According to the FIIQ, the basic training delivered to health professionals must not only meet the necessary requirements of public protection, but must also allow them to occupy their field of practice fully and adequately. In our opinion, the basic training delivered to nursing assistants does not prepare them to assume intravenous administration of drugs or other substances. The FIIQ therefore reiterates its firm objection to these additions to the activities reserved for nursing assistants.

Relations between nurses and inhalation therapists: activities to be circumscribed

In the proposal put forward by the Task Force concerning the inhalation therapists' field of practice, *"cardiorespiratory evaluation"* is mentioned.

The FIIQ questions how this should be interpreted. We should remember that a good many nurses work with patients in critical care units: intensive care, cardiology, intermediate or coronary care, etc. We should also remember that in these units, nurses autonomously assume all of the care required by the patient's status. To avoid any confusion in these care units, the FIIQ suggests changing the wording of the field of practice to exclude the cardiac system.

Although, on the whole, the FIIQ responds favourably to the report of the Task Force on health and human relations professions, the changes it proposes and the reservations it has expressed must be taken into account in order for this project to be acceptable for nurses and to guarantee the public the protection to which it is entitled.

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This special report was produced thanks to the cooperation of the Task and Organization of Care Sector and the Communication-Information Service.