Original article

Worldwide overview of critical care nursing organizations and their activities

G. Williams[1] RN, RM, Crit.Care Cert., B. Appl. Sc. (Adv. Nursing), Grad. Cert. PSM, MHA (UNSW), FCN (NSW), FRCNA, FACHSE, W. Chaboyer[2] RN, PhD, R. Thornsteindóttir[3] RN, CCN, BSc, P. Fulbrook[4], C. Shelton[5] RN, BAAN, MHSc, MSc(c), CNCC(C), D. Chan[6] RN, ICU Cert(ENB100), BScN(Hon), MN(Acute Care), ACLS Instructor(JIBC) & A. Wojner[7] PhD(c), MSN, RN, CCRN

1 Associate Professor of Nursing, Flinders University, South Australian and Northern Territory University, Northern Territory, Australia; Executive Director of Nursing Services, Alice Springs Hospital, Northern Territory; Immediate Past National President, Australian College of Critical Care Nurses

2 Senior Lecturer, Faculty of Nursing and Health, Griffith University – Gold Coast, PMB 50 Gold Coast Mail Centre, Bundall Queensland, Australia 9726

3 Chair, Icelandic Critical Care Nursing Association; Secretary of EfCCNa; Clinical Nurse, Intensive Care Unit, Landspítali University Hospital, Reykjavík, Iceland

4 Senior Lecturer in Research, Institute of Health & Community Studies, Bournemouth University UK; Treasurer, British Association of Critical Care Nurses; Treasurer, European Federation of Critical Care Nursing Associations

5 Clinical Nurse Specialist, Multi Organ Transplant Program, Toronto General Hospital, University Health Network, Toronto, Ontario, Canada

6 Nurse Specialist (ICU), Prince of Wales Hospital, Hong Kong; Visiting lecturer, Department of Nursing, The Chinese University of Hong Kong; PDC Chairman, Hong Kong Association of Critical Care Nurses

7 Assistant Research Professor, Department of Neurology, Medical School, University of Texas–Houston, Texas, USA; President, Health Outcomes Institute, The Woodlands, Texas, USA

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Correspondence address:
Associate Professor Ged Williams, Executive Director of Nursing Services, Alice Springs Hospital, PO Box 2234, Alice Springs, NT 0871, Australia
Tel.: +61-88951-7981
Fax: +61-88951-7556
E-mail: ged.williams@nt.gov.au

Abstract

While critical care has been a specialty within nursing for almost 50 years, with many countries having professional organizations representing these nurses, it is only recently that the formation of an international society has been considered. A three-phased study was planned: the aim of the first phase was to identify critical care organizations worldwide; the aim of the second was to describe the characteristics of these organizations, including their issues and activities; and the aim of the third was to plan for an international society, if international support was evident. In the first phase, contacts in 44 countries were identified using a number of strategies. In the second phase, 24 (55%) countries responded to a survey about their organizations. Common issues for critical care nurses were identified, including concerns over staffing levels, working conditions, educational programme standards and wages. Critical care nursing organizations were generally favourable towards the notion of establishing a World Federation of their respective societies. Some of the important issues that will need to be addressed in the lead up to the formation of such a federation are now being considered.

Introduction

Flexner's (1915) landmark identification of the traits possessed by professions began an era of inquiry into the organization of workers. For the next 50 or 60 years, researchers attempted to refine these traits by examining the 'true' professions of law, medicine and the clergy, and began comparing other groups of workers to these professions (Carr-Saunders & Wilson 1933; Greenwood 1957; Etzioni 1969). While nursing was previously labelled a 'semiprofession' (Etzioni 1969), concurrent with changes in conceptualizing the nature of professions (Larson 1977; Abbott 1988; Collins 1990; Larson 1990; Hugman 1991; Witz 1992) it has since achieved full professional status in many countries (Australian Institute of Health and Welfare 1998). Kimball's (1992) comprehensive historical analysis identified that expertise, service and associations were the three essences of a profession. This article focuses on this third essence, that of associations, which is also one of the 10 criteria that the International Council of Nursing (ICN) identified in 1992 as a requirement for an area of nursing to be considered a specialty. It documents the process by which an international association of specialist nurses in critical care is emerging.

Critical care nursing can be loosely defined as that specialty of nursing focused on the care and treatment of critically ill patients (CACCN 1996; BACCN 2001). This generally encompasses nurses working in intensive care units, whether generalized or specialized, in postanaesthetic recovery rooms, in emergency departments, in renal dialysis environments and even those who work with air-medical and retrieval teams. Around the world, many such nurses have developed professional organizations, associations and groups to provide support networks for the specialty and those nurses who identify with it. The more established associations trace their beginnings back to the 1960s and 1970s, some 10 years or more after the establishment of intensive care units (ICUs) in their respective countries (Hilberman 1975; Fairman 1992; Fairman & Lynaugh 1998; Daffurn & Wiles 2001). Whilst it is assumed that many of these associations of critical care nurses have well-defined roles and functions within their country, little documented literature exists that describes these associations and their functions from a global perspective. In fact, the authors of the present report were unable to locate a single reference or index of all known critical care nursing organizations. Without such a database, it is difficult to gain any perspective on the challenges and issues commonly faced by these specialist nurses.

Historically, critical care nursing organization (CCNO) leaders from around the globe have established forums at the 4-yearly World Congresses of Intensive Care. The need and value of a stronger international network of CCNOs has been discussed at these forums (See Appendix I). A small number of nursing organizations have attempted to use the World Federation of Intensive Care and Critical Care Medicine (WFICCCM) as a vehicle to establish a nursing network. In 1993, the WFICCCM established the first nursing position on the 15-member board of directors with the hope that this initiative might drive such a development. Since that time, only Australia and the United States have maintained nursing society membership with the WFICCCM, with CCNOs from Spain, Britain and Canada having short-lived membership. This article describes a three-phased process in the development of an international critical care organization. The aim of the first phase was to develop a register of all known CCNOs in the world. The purpose of the second phase was to understand the universal concerns and unique issues faced by critical care nurses around the world. The purpose of the final phase, which is currently underway, is to identify how respective organizations might develop, including their mission, goals, structure and processes such as communication and regional networks, if sufficient interest in international collaboration exists. This article describes the results of the first two phases.

Method

Phase I

The focus of Phase I, conducted from 1998 to 1999, was to identify as many CCNOs as possible and then

make contact with a reliable senior member in each organization. To accomplish this, the authors first formed a reference group and contacted as many colleagues in countries around the world to obtain their name, address and contact details. Second, a list of the names and addresses of all nurses who attended a World Summit Meeting of CCNOs at the 7th World Congress on ICU in Ottawa, August 1997, was obtained. The third step in this first phase involved contacting the International Council of Nurses (ICN) who agreed to send each of their 200 member organizations a letter from the research team informing them of the study. The letter asked them to make contact with either the CCNOs in their country or (if a CCNO did not exist) a senior and reliable critical care nurse. The letter from the research team was written in English and translated into French and Spanish, thus encompassing the three official languages of the ICN. The ICN also provided the principal author with contact details of all known CCNOs.

Table 1 Countries responding to the survey (Phase II)

The Americas	*Europe and Africa*	*Asia and the South Pacific*
Canada (1200)	Iceland (75)	Korea (2000)
USA (65 000)	Britain (3200)	Hong Kong (500)
Mexico (200)	Norway (1700)	Australia (2500)
	Belgium	Taiwan (NA)
	Italy 2500	New Zealand (130)
	India (NA)	Japan (1300)
	Turkey (300)	Philippines (350)
	Slovenia (300)	
	Greece (115)	
	Germany (850)	
	Denmark (2700)	
	Ireland (400)	
	France (225)	
	Finland (1456)	

The number of members in each society are shown in parenthesis after the name of the country.
NA, not available.

Phase II

Phase II, completed in 2000, was a survey of all known CCNOs. In countries where CCNOs did not exist, individual critical care nurses were surveyed using data from Phase I. A semistructured survey was sent, either by mail, facsimile or e-mail, to contacts in 44 countries (Table 1). Participants were told that the aims of the survey were to:

1 obtain an overview of their organization and its activities in their country,

2 identify the major issues and concerns for critical care nurses in their country,

3 determine their organization's interest in being part of an international communication network,

4 identify their organization's interest in supporting the establishment of an International Society of Critical Care Nursing Organizations, and

5 obtain their perspective on the mission of such a society.

The first part of the survey was demographic in nature, with questions about official organization contact details, number of members, etc. The second part of the survey asked respondents about the issues facing critical care nurses in their country. They were asked to rate the importance of 14 issues for their country on a 10-point scale (where 1 = not important and 10 = very important). A modified Delphi technique (Turoff 1975) with international critical care nursing experts was used to identify the issues. Respondents were then asked to expand on the three main issues facing critical care nurses in their country. The third section of the survey focused on services of their organization. Using the same Delphi technique, 15 services were identified, then questions were asked, focusing on the organization's provision of these services, with 'yes' and 'no' responses possible. Respondents were then asked to rate the importance of these services, irrespective of whether or not they were currently undertaken in their organization, on a 10-point scale (where 1 = not important and 10 = very important).

The final section of the survey gathered information on support for the development of an international critical care nursing society. Thus, respondents were asked whether their country/organization would participate in such a society, what they perceived the mission and functions of such a society should be and what financial support,

if any, their organization would be willing to contribute to the formation and ongoing operation of such a society.

The focus of Phase III, which is currently underway, is to develop such an international society. Paramount is identification of a sustainable framework that facilitates collaboration, communication and, importantly, the advancement of the specialty of critical care nursing, including practice, education and research. By reporting on the first two phases we hope to further this next phase.

Results

In total, 73 contacts from 44 countries were identified in Phase I of the study. These contacts were located in each continent and region of the world. For convenience, countries were divided into three geographical regions (Europe/Africa, the Americas and Asia/South Pacific; see Fig. 1). In Phase II, the 44 countries were sent the survey: 26 surveys were sent by e-mail; 10 by facsimile; and nine by post. A total of 24 countries responded, representing a response rate of 55%. Eighteen of the 24 surveys were returned by e-mail, six by facsimile and none by post. Table 1 identifies the responding countries and their description of membership size. Twelve countries reported having ≤ 1000 members, six reported having 1001–2500 members, two reported having 2501–5000 members, and one country – the United States – reported having 65 000 members. Two countries did not provide information on membership size because they did not have an organized society.

When asked to identify the issues that were currently important to them, almost every country identified inadequate staffing levels as being the most important issue for critical care (Table 2). Other important issues included working conditions, access to quality educational programmes

Americas	Euro-Africa			Asia/South Pacific	
Argentina	Austria	Finland	Netherlands	Australia	Papua New Guinea
Brazil	Belgium	France	Norway	China	Philippines
Canada	Bosnia	Germany	Slovenia	Hong Kong	Singapore
Costa Rica	Croatia	Greece	Spain	India	Taiwan
Mexico	Czech Republic	Hungry	South Africa	Indonesia	
Puerto Rica	Denmark	Iceland	Sweden	Japan	
USA	Britain	Ireland	Switzerland	Korea	
Uruguay	Estonia	Italy	Turkey	New Zealand	

Fig. 1 Critical care organizations/contacts identified (Phase I). Dark grey, countries with critical care nursing organizations (CCNOs); light grey, no CCNOs, but contacts known; white, no contacts at all.

Table 2 Mean responses for important issues* for critical care nurses

Issue	*Europe*	*Americas*	*Asia/South Pacific*	*World mean*
Staffing levels	8.91	10.00	9.67	9.24
Working conditions	8.64	10.00	8.83	8.86
Access to quality educational programmes	8.73	8.00	9.33	8.76
Wages	8.55	9.33	8.33	8.52
Formal practice guidelines/competencies	8.64	7.67	8.33	8.38
Work activities/roles	8.18	9.00	8.33	8.33
Teamwork	8.45	7.00	8.67	8.29
Extended/advanced practice	8.20	7.33	7.83	7.90
Relationships with doctors	7.91	7.00	8.00	7.76
Formal credentialling processes	7.40	7.67	7.83	7.60
Use of technologies	6.91	7.67	8.00	7.38
Facilities and equipment	6.82	7.00	7.83	7.24
Relationships with other nursing organizations	6.55	7.33	7.33	6.90
Relationship with other health groups	6.18	7.00	7.67	6.76

* Results are presented on a scale of 1 (not important) to 10 (very important).

Table 3 Services/activities provided* and the importance attached to each

Service or activity	*Provided*	*Europe*	*Americas*	*Asia/South Pacific*	*World mean*
Professional representation	17 (71%)	9.14	9.33	8.00	8.75
National conferences	19 (79%)	9.44	10.00	6.83	8.67
Standards for educational courses	13 (54%)	9.50	8.00	7.67	8.67
Practice standards/guidelines	16 (67%)	9.00	9.00	7.67	8.40
Workshops/education forums	18 (75%)	8.56	10.00	6.50	8.29
Credentialling process	12 (50%)	9.22	9.33	6.33	8.25
Journal	16 (67%)	8.30	8.50	7.00	7.93
Local conferences	17 (71%)	8.30	10.00	5.67	7.81
Newsletter	16 (67%)	8.29	7.00	7.17	7.73
Initiate, conduct or lead research studies	13 (54%)	8.70	8.50	6.33	7.58
Training/skill-acquisition course (e.g. Advanced life support)	13 (54%)	8.20	10.00	6.50	7.42
Study/education grants	9 (38%)	9.50	7.00	5.50	7.00
Industrial/union representation	6 (25%)	6.40	5.50	3.33	7.20
Website	15 (63%)	7.71	8.00	6.00	6.79
Research grants	7 (29%)	10.00	6.50	5.33	6.43

* Results are presented on a scale of 1 (not important) to 10 (very important).

and wages. Worldwide, on average, only two issues – relationships with other nursing organizations and relationships with other health groups – were rated with a value of < 7 on the 10-point scale.

Table 3 presents an overview of the types of services and support provided by CCNOs to their members. Of the 15 service or activity choices, seven were currently being provided by two-thirds of the

organizations. The respondents perceived professional representation, national conferences and standards for educational courses as the three most important activities that these professional organizations could provide for critical care nurses in their countries. Interestingly, the provision of funding grants, a website and industrial/union representation were ranked very low against the other options in this question.

Respondents were asked if their CCNO/country would like to participate in an International Society (Network) of CCNOs. All but two responded positively. The remaining two stated that they did not know and would need to discuss the issue further.

Respondents identified several activities they perceived that such a society could provide. These activities were then grouped into the categories of practice, education, research and professional. Practice activities included exchange of information, staff exchange programmes and benchmarking practices. Educational activities encompassed study tours and sharing educational programmes and ideas. The research-related activity identified was facilitating the conduct of international research. Professional activities comprised the bulk of the suggestions, and included gaining access to conference speakers, worldwide conferences, development of international standards and mutual inspiration.

Nineteen of the 24 respondents suggested English as the first language of choice for international communication, two selected French and three selected other languages. Of the five who did not select English as their first choice, all selected it as their second.

When asked the extent to which they could financially contribute to the administration and communication functions of an international society, one responded that no support could be provided and eight did not know. Fifteen indicated that they could provide up to $200 (US) per annum. In a separate question, respondents were asked if they could support a contribution of up to $750 (US) per annum; seven responded positively.

When asked what activities and services an international society of CCNOs might offer member organizations and critical care nurses internationally, most suggested a website, international conferences and study exchanges as being of most value; providing international education and research support, and a journal, were also seen as being of benefit (Table 4).

Table 4 Potential services/activities* for an international society

Service and activity	*Europe*	*Americas*	*Asia/South Pacific*	*World Mean*
Website	9.64	10.00	8.00	9.19
Co-ordinate/support international conferences	8.73	9.33	9.17	8.90
Co-ordinate/support international study exchanges	8.55	9.33	9.33	8.86
Provide international guidelines/principles relevant to critical care practice	8.36	10.00	9.00	8.74
Co-ordinate/support international education	8.64	8.67	8.83	8.67
Co-ordinate/support international research projects	8.45	8.33	8.83	8.57
Journal	8.55	7.67	9.17	8.52
Make representation to national and international bodies on issues of health and human society	8.27	9.33	8.67	8.43
Newsletter	7.45	7.67	7.67	7.48

* Results are presented on a scale of 1 (not important) to 10 (very important).

Discussion

This study was designed to identify CCNOs worldwide and to document their services in addition to their perceptions regarding the development of an international society. Whilst a variety of strategies were used to identify CCNOs, it is probable that some were missed. Furthermore, the fact that almost half of those identified did not complete the second phase – the survey – was disappointing. The reasons for this non-response could be varied, including lack of time/interest or a language barrier. It is possible that after learning about the potential for an international critical care society, a greater number of individuals and countries will make contact with the reference group.

It is interesting to note that the majority of the respondents described having organizations with $\leq$2500 members. Critical care units tend to have a high nurse-to-patient ratio. Two possible explanations for the relatively low membership numbers exist. First, we did not collect information on the numbers of critical care beds that each country had and it may be that some countries have relatively few beds and thus relatively few critical care nurses. Alternatively, it may also be that many critical care nurses do not join voluntary professional organizations. For example, Williams (2000) identified that there were $\approx$9610 intensive care nurses in Australia in 1997 and possibly double that number in critical care environments, yet the Australian College of Critical Care Nurses had fewer than 2500 members. Hence, many nurses did not join this professional organization.

The results suggest many strong similarities between CCNOs and critical care nurses in those countries who responded. Many of the responding countries are generally considered wealthier, with greater access to education and global communication tools, than those countries who did not respond. Additionally, English literacy was common in responding countries. Future studies will need to invest more time and resources into addressing the needs of countries where English literacy and e-mail technology are less common.

Respondents consistently identified several important issues that their organizations were dealing with. Staffing levels, working conditions and access to quality education were the three issues rated as of greatest importance. Whilst each of these issues have been documented previously (Friedman 1990; Chaboyer & Retsas 1996; Chaboyer et al. 1997; Williams 1997; Dracup & Bryan-Brown 1998), this survey had identified that they are common to over 20 different countries and therefore require more attention from the organizations representing the needs of these groups. With such widespread acknowledgement of these issues, it appears essential for nursing organizations to reconsider how these specialist nurses are prepared, how nursing services are organized and how nursing care is delivered.

The two most frequently provided services or activities were national conferences and workshops/educational forums, with $\geq$75% of respondents stating that their organizations were involved in these ventures. Thus, it appears that these countries have a national venue for disseminating new knowledge and emerging technologies, and it seems apparent that meetings and forums such as these reflect the preference for face-to-face interaction of nurses when learning and networking. However, what is not known is the proportion of critical care nurses who actually attend these sessions.

The final aspect of the survey focused on the development of an international society of CCNOs and received overwhelming support. In order for such a society to be formed, a governing body comprising representatives from member organizations would probably be required. Additionally, terms of reference or some form of a constitution would be needed to define its role and purpose in order to ensure that any activities undertaken were of value and meaningful to the member organizations. It is clear that the World Wide Web and e-mail have dramatically improved international communication and indeed contributed to the success of this study. Additionally, the 1999 formation of the European Federation of Critical Care Nursing Associations (EfCCNa) made the identification and communication with European countries more efficient than with countries in lesser-organized parts of the globe. These progressions may prove to be invalu-

able in the development of an international society of CCNOs.

The European experience in forming the EfCCNa suggests that 'regionalization' of the world into subgroups may help to progress international and multinational communication and collaboration. Similar world groups, such as the World Health Organization, the ICN, the WFSICCCM and some geo-political-economic clusters, use a regional structure to support a larger world structure. In the process of establishing a worldwide network of CCNOs, consideration to the formation of regional clusters should be given. In this report we have suggested three, somewhat arbitrary, regions based on time zone and proximity. Clearly, other combinations are possible and should be considered.

Bucher (1988) suggested that a 'natural history' framework could be used to assess the emergence and evolution of health care occupations and their specialties. She described three phases in this evolution: emergence; consolidation; and transformation. In addition to several indicators, the emergence phase includes the development of formal organizations. Bucher (1988) described the second phase as a process of consolidation. She suggested that organizations should formalize further with developments such as societies and trade organizations. Findings from this study suggest that CCNOs are currently in this consolidation phase, internationally and perhaps even regionally and nationally.

Based on these survey results, we have identified several arguments in favour of an international society. We believe that these points can be used to further this debate and identify the relative merits of pursuing such an organization. The results clearly identify support for such a global organization of CCNOs. Depending on the mission, aims and goals of such a society, it may also indirectly promote the professional development of smaller organizations. While the study did not determine what the philosophy (including its mission, aims and goals) might be, it did identify the activities that would be supported. These activities were readily categorized as practice, education, research and professional development; hence, these same categories could be the foundation for the work on the purpose of such an organization. Given the huge variation in memberships among CCNOs, and probably their relative wealth, it appears that proportional representation would result in an over-representation of English-speaking and 'Western' countries. It must also be recognized that, owing to wider economic issues faced by developing countries, some CCNOs may be very supportive of, and active in, such an international society, but be unable to financially contribute to it. A further challenge for such a global CCNO is an acknowledgement of the status of nursing in various countries and regions. Thus, the administrative structure, membership and funding of such an international organization must be dealt with in such a manner that is sensitive to wider economic and political issues.

Conclusion

The concept of living in a 'global village' has become a reality for critical care nurses and organizations. Ready access to the World Wide Web has made international communication, collaboration and co-operation a reality. This study has identified the issues faced by CCNOs and their activities around the world, and affirmed support for the establishment of a world society or federation of such organizations to enhance collaborative partnerships between CCNOs and their members internationally. To date, developing and non-English speaking countries have been poorly represented in this work. We hope that the establishment of a World Federation of CCNOs, however termed or structured, can form a common foundation and linkage to most countries and will provide support to critical care nurses and their associations around the world.

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Appendix I

History of formal international dialogue aimed at forming stronger international networks between critical care nurses and critical care nursing organizations (CCNOs)

1985: 4th World Congress, Tel Aviv. Australia first ask to be admitted to the WFSICCM.

1989: 5th World Congress, Kyoto. Australia and USA applications are accepted by the WFSICCM. Sarah Sandford (USA) and Lorraine Ferguson (Australia) ask for a nursing position on the board.

1993: 6th World Congress, Madrid. CCNOs from Australia, USA, Britain and Spain are formally admitted to the WFSICCM and a Nursing member (Belinda Atkinson, England) is appointed to the board. Madrid Declaration on the Preparation of Critical Care Nurses is announced and signed. CCNOs pledge to improve international communication, collaboration and expansion.

1994: AACN Global Connections Conference, Toronto. CCNOs meet during this conference, share visions and pledge to improve international communication, collaboration and expansion.

1997: 7th World Congress, Ottawa. CCNOs meet during this conference, share visions and pledge to improve international communication, collaboration and expansion.

2000: BACCN Global Connections Conference, Edinburgh. Ged Williams presents results of the world CCNOs survey and outlines possibilities for a World Federation of Critical Care Nursing Organizations.

AACN, American Association of Critical Care Nurses; BACCN, British Association of Critical Care Nurses; WFSICCM, World Federation of Intensive Care and Critical Care Medicine.