Linda Bridge & Barbara Charles

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LB: My name is Linda Bridge. I am currently a casual employee for the Chinook Health Region. I work casual as a bed utilization nurse and as an evening supervisor. I run my own business called Hopelessly Human Productions, which encompasses me doing workshops based on two books that I co-authored called *The Hopelessly Human Nurse*, which are books based on my experiences as a nurse as well as my business partner's experiences. In respect to self-care for nursing, the things that I wish somebody had told me when I was a junior nurse about how to look after my emotional health. That's where my business focuses on. My work as a union representative for our local began when my good friend Barb, who's sitting beside me here, and I were having a conversation at work one night. I was angry at the way the bargaining was going. I was angry that we asked for a whole loaf of bread when we only wanted one piece. I didn't understand it, and I was very upset with the process. Barb at the time was the treasurer for our union local. She said, "Then come to a meeting." I came to a meeting and ended up vice-president. The moral of that story was don't go to meetings. But, that was the beginning of a very in-depth learning curve for me, and over the next 14 to 15 years I stayed involved on our local executive, either as vice-president or president. I really did truly learn a lot over that time period, and I enjoyed every bit of it. One of the main reasons that I stayed so involved was Heather Smith. Heather was just a young lady at the time and was just elected president shortly after I got involved. I was so taken by her respectful mannerisms and her ability to orate that I was hooked. That was the beginning of a very lovely friendship. I really respect her to this day and what she's done for the nurse's union. … The local that I'm referring to is Local 120, which encompasses the Chinook Regional Hospital. At that time we started as the Municipal Hospital and changed our name to the Regional, and now we're changed back to Chinook. Over the years many different names. But, basically, it was the city hospital site that I was involved with. I started as vice-president, and I was vice-president for three years from '92 to '95. Then, from '95 to 2004, I was president of the local. That was my history.

BC: My name is Barb Charles. At this point in my nursing career of 32 years I'm working in occupational health. I used to be a supervisor at the hospital, but I have a very

bad back, so unfortunately I had to go out-of-scope. Now I'm part of management, and that ended my union career. I have been involved in UNA at the local level at Local 120 since 1977, actually '76. I started out as staff nursing and was involved in the birth of UNA. So, I've been involved since the very beginning. Over the years I've been treasurer, I have also been vice-president, and I was also president of the local. That is the span from '76 to 2007. I was also south district rep, which includes the whole region from Medicine Hat, from the Saskatchewan border to the BC border to the U.S., so one of the reps and involved in two rounds of negotiations. My real awakening to the union was not only the birth of UNA, but was in 1988 when we were involved in one of the most horrendous strikes that I've ever been involved in, our first illegal strike. Very difficult on all of us. You're always telling your children to obey the law, and here's Mom worried about whether she was going to be in jail or not the next day. That was my real awakening, and that's when I really became involved more in the union, and have, since 1988 to 2007, never stopped being involved. That's the history, and my local and union involvement.

Q: How has training of nurses changed?

BC: I came through a three-year nursing program, which was hospital-based, so we had no involvement in a university or college. It was a school of nursing we came through. When I joke and say I'm an apprentice nurse, it's because we were actually the workers of the hospital. As we went through our training, you actually became part of the nursing staff. By the time you're in your third year, you're probably in charge of the floor. That's how I came through nursing. What I've seen in nursing, of course we started off working, you had to work 13 shifts in a row to get a weekend off. There was no such thing as overtime. If you missed your break, you missed your break. Days off were few and far between. You would know your schedule one week or two weeks ahead of time. If you wanted to plan going to a wedding or anything, it just didn't happen, because you didn't know what you were going to be working. So, as we've come through and things that we've got, we've got overtime, we have scheduling 12 weeks in advance, stat holidays off, you get paid for your stats. It's amazing how it's changed. Maternity leave, pensions.

Married women never used to be able to belong to the pension plan, you could only be single. When we went through the last round of layoffs with nurses, this was out in the rural areas, and that would probably be about four years ago we were still laying off nurses. There were women that had no pensions, they had nothing. So, here these women are, they've got two or three years to go, and they're losing their positions, and they have no pensions on which to fall back on.

Q: What changes in training have you seen?

LB: I trained in a religious background school, Misericordia School of Nursing in Edmonton. I went into training as a 17-year-old young woman from a small town, very naïve and very uneducated to the ways of a city. Our training was very much like going to convent. There were all sorts of rules. It was very intense, the first year especially. We had weekly exams, and if you flunked, you were gone. They'd weed out quite a few people in the first year, and that was their intent. It was an interesting time, and I wouldn't trade it for the world, for the fact that we developed family relationships with each other. As friends and students together, we lived 20 girls to a floor. In my training, there was only 60 per class, so we became very close. We had our first deaths that we shared; we shared our first triumphs; we shared everything. We'd come home after a round on the wards and share with each other. It was a wonderful experience. Something that I know from people talking to me today that's missing in today's more educated world, where they're educating nurses, not training them. They're not living in residence; they're not sharing with each other. They come home after their first death now, and they sit in their car and cry alone. This is stories that I'm hearing. They don't have anybody else to talk to. I think it's probably one of the greatest things that we did have in our training time, was that ability to debrief with each other. I do appreciate that. It was an interesting time. We saw the first death, our first births, very many firsts when you come from a small town and no background in medical at all. You come into a busy hospital, and there's lots of firsts. Apart from that, I don't know; it was a great camaraderie, and there was also a sense within the building that we were like everybody else's children. Yet the nurses that were working wanted us to be the best we could be because we were carrying the name

of the school forward. There was a pride in our schools. There was a rivalry in the city of Edmonton, especially the Royal Alex and the Mis, all had a little rivalry. The U of course was separate again. We had football teams and baseball teams and hockey teams. We did the sports things against each other. But there was also a school pride thing, and the fact that you could mention which school of nursing you came from, and everybody would know the standard of nurse that you were. I got my first job based on that alone, over the phone. If you're a Mis grad, no problem, we'll hire you right now.

Q: Was there a problem getting jobs in those days?

LB: When I graduated, it opened up. When I went into training in 1976, there was a glut of nurses on the market. My father did not want me to go—he felt it was no point. At that time you couldn't get a job as a nurse, all over the country it was a struggle. But by the time I graduated, I could go anywhere I wanted. It had opened up within that three-year period. I had several job offers my first year out. There was no difficulty. Jobs wouldn't become tight again, that I noticed, until the '80s.

Q: Was it the same with you?

BC: I'm older than she is. I graduated in '76 from nursing, and it was very difficult to get a job. When Linda talks the schools of nursing and how you train, it's missing now. The people who taught us nursing were those women that worked on the floors, the nurses. They were our mentors, they were our teachers. I definitely find now everybody says, "These girls don't know anything." Nobody cares anymore what's happening to the nursing students. I find that it's missing. But it definitely is missing, I find. When I graduated in 1976, it was hard to get a job. There was nothing for nurses. When Linda talks about, when I trained—I trained here at the Galt School of Nursing, at the actual school. I say, "No, not the museum." They ask me that when I talk to the kids at the college about unionism. I say, "Definitely not at the museum." But, when they say, "Where did you graduate from?" and I say I came from the Galt School of Nursing—a three-year program nurse was taken anywhere in the world over anything else because of

the training we had. I definitely feel that made us superior. We spent two months in the OR: you scrubbed in with a doctor, you saw the autopsies, you did everything that was involved in it.

BC: Basically, right now what's happening is we're educating young women to become nurses. But, we're lacking in the apprenticeship training part of that program, in my view. They're getting prepared on the educational level, but they're not being prepared to physically walk into the job the day after graduation.

Q: But they still get a fairly sizeable practicum, don't they?

LB: No. For instance, in 1980 I worked a bit for the college. These kids I did pediatrics. Their whole training they had 18 shifts on pediatrics. I had six months. So, that's where it's changed, and it's even worse. They never, ever got to go into the OR. With these kids, if I knew there was a surgery going on, I try and get them up there. Otherwise they wouldn't see any of this stuff. How can you look after somebody who has their appendix removed if you don't know what it's like to have it removed in the first place? It's definitely missing, and I wish we could change it back.

BC: Right now, a young woman can be done her practicums in the hospitals at the end of her second year, go on back, do a full other year at university, and then in her last year of university take a practicum in public health, and then graduate and never step foot back in the hospital. Yet they're supposed to come out and be ready to work. It's very difficult on them.

LB: All of a sudden we're coming up with all these wonderful ways to apprenticeship them. I think it's not working in their favour. I think they're doing a wonderful job coming out of their education and sticking with it, but I believe that's one of the reasons we're losing so many young nurses—30 percent, they said. I think they said 30 percent of the nurses that graduate will walk away from nursing within five years.

Q: Are there other changes happening?

LB: Most of my writing in the last year or two has been about this. It's about my awakening to the fact that I didn't have to be a Florence Nightingale and still love my profession; I didn't have to give myself away. There's negatives about nursing, and one of them was—I don't know if it's because mainly we're a lot of females, and we have this way of giving ourselves away, not having our own boundaries and enough self-care issues. What we're seeing is burnt-out nurses, and nurses that just have compassion fatigue, all those things that are coming along these days. For me, when I did my retrospective writing, it was because I didn't have enough boundaries, and I had nobody that showed me them—that I could still love what I do, and have enough gumption and things about myself and self-respect to say no sometimes, and to look after myself. I think the young nurses are throwing away what we had, thinking that it's like a black or white, all or nothing. If they don't want to be like me, they have to this person that doesn't care, that can just do this for a couple of years and make money and walk away. I believe there is a middle ground where we can still do this for a lifelong career and be healthy.

BC: But, I also think they're missing, with the fact that you don't have this camaraderie on the floor, and you don't have everybody together; these girls come out by themselves. Here, you are by yourself with nobody there that you've lived with for the last three years, or that taught you for the last three years. You don't have a sense of belonging. I really think that has a lot to do with the feeling that they come out as a single person against this huge job that they have to do, with a sense that nobody's there to help them. I did try several times to get a mentoring program going, which we need. The year after I left the union, they created this mentoring program, but it's still not done. They go in and get to work for a year, but they're still not being mentored. They're not choosing the right mentors. I really have to say part of it is the educational system where it's a profession and you get this degree. They're taking away what nursing is.

LB: The focus is different, it's educated. I can research a paper, I can learn how to do this, but nobody's taught me how to put that all together.

BC: The biggest comment from some of the young staff that I've heard is they don't want to work as hard as we did. It's like, “I'm not working that hard. I'm not working like you did. I'm not going to be beaten up and broken by the time I'm 45.”

LB: Or, “I didn't go to university four years to wipe somebody's butt. I'm not going to do that. I went and got this education, I went to school the same length of time as an engineer—why shouldn't I make the same amount of money as him, and why am I doing the things that I have to do?” That's the concept, and it's really frightening to think that this is what we're doing to nursing.

BC: They're after lifestyle, though. I've heard the young people talk about lifestyle choices. They don't want to work weekends, they don't want to work nights. They just want to work part-time. Most of them don't want to work full-time; there are some that do, but a lot of them don't. They are doing what I'm doing now in my 50s; they're doing it in their 20s. They're choosing.

LB: I have to say the wages that we've negotiated over the years—when I came out, I made $600 a month; that's what I made as my wage. Even in 1988, I was still making less than the cashier at Safeway. People were actually leaving nursing to go do cash at the Safeway store. So, we negotiated these wages up where they're making a great amount of money, so they don't have to work full-time. They can make those choices.

Q: It's because of the union gains that some of these things are happening.

LB: Part of me, because I believe in self-care, I'm patting these girls on the back, saying go for it, good for you. You're making healthy choices because you can. You're choosing the payoff. I can make less money, have a family, have a good decent healthy lifestyle. I don't have to make $5,000 a month; I can settle for working part-time and bring home $2,000 a month, which is still more than full-time people in other jobs.

Q: But we've lost that sense of service and belonging.

LB: We did give that up. I think that was totally gone when we got rid of the diploma programs, where it was a family, and you belonged and were trained in a facility. There is no sense anymore of belonging to—there's a sense of belonging to a profession, a big group of nurses, but not to the service of nursing. The service of nursing, in fact, is a dirty word. They don't want you to talk about service; they're not servants to anyone, is kind of what I've been told.

BC: When I used to go talk to the kids at the college, they'd always have the union come and the professional association. I'd say to them, "When I started out in nursing, this is the way it was, and this is the way things were. But the union, what the union has done for you, is created all these things. It's given you all these things and it's something to be very proud of." I am still proud of what the union has done. Has it destroyed anything? No, I don't think so. I think what's happened is, I think it's the education part that has destroyed it, not the union. It's made life easier for them, but I'm still saying they don't have the feeling of belonging that we had.

Q: Why were those changes introduced?

BC: What happened was the provincial government decided that nursing no longer should be in the schools of nursing; it should become part of the education program. It came out of the hospital system into the education system. That's why you saw the change. What happened was the schools of nursing, it had to go into a college or university program, and the schools of nursing were closed. That's where the change came in. That happened in about 1974 or '75, just after I started. The government decided that schools of nursing could no longer teach nursing. I partly blame our professional association for doing that, I do. I think that they wanted to move us. They wanted to create us as professionals. An architect is a profession; a doctor is a profession. Nursing should be a profession, and to be a profession, you had to go through the university or a college program. That's when I started to see things change. The research that I've done is

they decided that we had to become a profession, and that's where you see the ending of this.

Q: Was there a change in the job description?

LB: Not until recently.

BC: What I did notice was that the minute we started having college and university prepared nurses instead of training program nurses, was that what the students were allowed to do changed. Students weren't allowed to work night shift. There was a difference because they wanted them to be educated, not trained. They weren't allowed to be used as staff, ever. All those kind of changes came about. I'm thinking that it came from our professional association, the charge to move it to a profession. But, I don't have the facts to say that for sure.

Q: Has the job changed significantly from the time you started?

BC: That's where they want to put us, but we haven't got there yet. The LPNs became stronger and stronger. When we had to make the whole *Health Professions Act*, when that came in, your scope of practices they had to get in. The LPNs were very quickly off the blocks, they got in their scope of practice with the government. CARNA, on the other hand, waited and waited, so we gradually lost a lot of our stuff that the LPNs were getting. They now could give IM injections; they could give narcotics; they could start IVs; they could do all the things that we used to do. Then they had to come up with a scope of practice for the RNs. You can suture; you can set bones; you can intubate. We could never intubate. A paramedic can intubate, but a nurse could never intubate. Now that's in our scope of practice, but nobody's allowed to do it yet. So, it's interesting because the hospitals have not evolved around our scope of practice. We have a lot more paperwork to do because they keep changing the charting system. I also blame a lot of the legal society for having to do all this charting—because somebody's going to sue you,

you've got to do all your writing; you've got to make sure everything's in place. I think that had a lot to do with it.

LB: The whole primary care is coming out—I don't know if you heard a lot in the news about that. Everything's been set in place so this stuff can fall in. There's the desire to have registered nurses be the head of these clinics and coordinate the patients coming through these clinics, and the physicians will see only the ones they need to. The nurse will see everybody, and put them to where they—triage them to a physio, to a pharmacist, to nutrition services, or to a physician. Case management. This is where the scope of practice for RNs was going, where the Canadian Nurses and CARNA and all the provincial associations have been pushing to have nurses get their masters, becoming more nurse practitioner types, move up the ladder and do more of these jobs. Their answer to the government was, "We can fill the void where you don't have enough physicians." The LPNs' answer was to the government, "We can fill the void where you don't have enough registered nurses." So, everybody's moving up a step. But, in the meantime, the hospital is in chaos because hospitals aren't part of this big plan. The hospital is just a building where they're still trying to do business as usual. It's slower to adapt to all these things. So, we have LPNs now that are trying to do what the nurses are doing, and nurses that haven't moved up the ladder because the physicians won't let go. So, everybody's kind of fighting each other.

Q: So your proportion of total staffing has now decreased?

LB: Not really, because the LPNs haven't increased enough. They haven't let them do their scope of practice enough to replace us. Where it has happened is in long-term care. Long-term care, the registered nurses have been let go. They've changed the name from nursing homes so they didn't have to be under the law. The only law in Alberta on the books said a nursing home must have 33 percent of their hours RN hours. So, they got rid of all the nursing homes; there's no such thing as a nursing home anymore. So, they don't have to have RNs.

BC: Designated assisted living now, it's called.

LB: They changed the wording so the law doesn't apply. So, they don't have to have registered nurses: they can have LPNs now in charge of those buildings, and they do. A lot of these places no longer even see a nurse. They have the LPNs and patient care aides and home care nurses. The only time they'll see an RN is when a home care nurse comes into that building as a recommendation.

BC: It was done under privatization. The nursing homes or the long-term care facilities went into talks about they got rid of the nursing home because they no longer wanted nursing. That's because they privatized all of your long-term care. All of your older people is all privatized; it's called designated assisted living, it's no longer called long-term care. It's all private. All your long-term care is private. Now within this region, Chinook happens to be one of the biggest pushers of this because they want to get rid of long-term care. We still have a few long-term care places. There's one in Taber; Fort Macleod, Crowsnest Pass still have long-term care. You'll see in town here we have one. Within two years, they plan on totally and utterly—long-term care will no longer exist within the hospital. It will now become private. A US company owns this private, and there will be no longer a registered nurse involved whatsoever. So, your LPNs will move for it. Hospitals, on the other hand, fall under the *Hospitals Act*. Interesting enough, all you need in the *Hospitals Act* is a registered nurse for the operating room. You actually don't need a registered nurse on an acute floor. It's quite an interesting thing to read. So, as you see things move along, the hospitals haven't moved yet, but it's coming.

LB: At one point there were only 4,000 LPNs in the province of Alberta, versus 20,000 registered nurses. There's no way this group could've taken over our jobs to that extent. The hospital setting, it's not going to happen. Slowly they're getting an increase in what they can do. The difference between a diploma nurse and an LPN is very minimal now. The new program of the LPNs is two years, the old diploma program for nurses was two years. There's not really much difference. I think it was a way to get around the union.

Our LPNs belong to AUPE, therefore they have a lesser contract compared to the registered nurses. So, they're going to get the same work for less money.

BC: UNA is very strong, so if we could get rid of UNA, we're going to do a better job.

Q: How have physicians' attitudes changed? How are nurses prepared to handle tough cases, such as people that are dying?

LB: Our physicians are coming out better prepared now. They're coming out a little bit more tolerant and not as egotistical as the physicians were in our day. You don't have to wear a mitt into the operating room to catch a blade. There used to be a very large hierarchical difference.

BC: I have to say, I still get off my chair for a physician. A physician came, you got off your chair; he had your chair. Honest to god, I still do it today.

LB: We have a group of physicians in this region still. When they come on, I treat them different. The young doctors come out now saying, “Please call me by my first name.” It's respectful to do so. The old physicians still are of the mindset that it's not respectful to do that. My thing is it's not about respect that way. If the patient's not comfortable to ask you a question, then you're not doing your job as a physician. If you keep this hierarchical thing there, sometimes it interferes with patient care. That's my own personal view of that. As far as being prepared, we talked about our training days with the debriefing we learned to do with each other and how we learned to share when we had bad things happen in our training time. That set a bit of a foreground in how to deal with difficult situations. I found myself over the years seeking out my coworkers to talk to when we had rough times, when things happened. But, over time it wasn't always as easy, and it wasn't supported. There was an attitude of “Suck it up, you can fall apart later.” The trouble was, later never came. How do you deal with a baby dying a SIDS death when they haven't dealt with the 29 other deaths that have happened over the years before, that you never got a chance to talk about. It was difficult. Barb and I both shared

the same job in the last few years when we both supervised for the hospital. One of our jobs there was to do the body viewings for all the outside guests. So, if the police brought in a body from a suicide, or from a homicide, or any kind of death outside the hospital, we would have to go with them and the families and do the body viewings. That meant that we would also have to deal with the family's emotional crisis as well. Both Barb and I had horrific weekends sometimes, with six or seven people dying out of one bad car accident. We would debrief each other; thank goodness for that. We're close friends still and do that for each other. I don't see that for some of the younger staff. It worries me. I don't know if they're getting taught about how to do self-care; I don't know if they're getting taught about debriefing. I don't know what they're getting in the program. When I do my talks that I do, I get the impression that they don't get anything much in their training programs about that. It's something I do talk about when I do my sessions with them.

BC: It used to be in our emergency department—both Linda and I have worked in emergency—so you'd have a child come in and die, or you'd have a horrible…I'll never forget the mother and daughter that were pushed into the train and both of them died. The woman that was shot by her husband. We had horrible things come in there. But, at that point in time, we all talked. We all debriefed with each other, everyone who worked. We'd talk and say, "Is everybody happy?" They don't do that anymore, and it's very sad. They'll have something in, and everybody says, "Okay let's get back to the other job; we're busy over here." One night, I had two families completely and utterly destroyed by a car accident. One was the father who lost his wife and children. It was the most horrible night I'd ever had. Interesting enough, debriefing, this big debriefing, let's do this. They were going to have it, and one of the girls didn't want it. So, here I am left with nothing. I have these families, I have a mother and father that wouldn't leave the morgue. They said, "I'm staying, I'm not going to leave my child." How do I get them out of there? It took me days to get over that. Finally, I started talking about it, and finally I started to feel better. But, they don't get it anymore, they don't have it. Thank god we had each other to talk to when we used to have those bad nights. It's unfortunate; I don't know what we can do. I think that's why they're so unhappy, a lot of them.

Q: Is maintaining emotional health a big part of it?

BC: Yes, I think that's a big part. Then I can go on, we talk and can get over it. Then I can go on to the next body, or the next accident, or the next tragedy. You go up to the floors and these girls are so unhappy. They say, “I'm too busy, I can't talk. I can't do this.” They don't sit and talk to each other, and I think it's destroying our profession. I really do. They're not the same.

LB: I was just going to share a story about another nurse. There was an older nurse in her 70s that approached me. I was selling my book somewhere. I didn't know she was a nurse, and I was talking to this other young nurse. She was an older woman; she picked up the book. She said, “When do the nightmares stop?” I'm like, “Excuse me?” She said, “When do the nightmares stop? I'm a retired nurse. I've been retired for 15 years, and I worked for 40 years in the operating room in the emergency department, and now I'm having nightmares.” She said, “I'm having to see a shrink.” She was quite distressed. I said, “Did you ever talk about your experiences while you were working?” She said she was having nightmares about blood and seeing old cases. I asked her if she'd ever talked to the other staff while she was working. She said, “No, you couldn't work there if you were too emotional and talked about your feelings too much.” She was right. So, as much as Barb and I talk about we debrief each other, it was something that we didn't talk about doing. We did it, but we did it on the sly. We did it sometimes over drinks, which sometimes wasn't the best case. We did it sometimes using a lot of black humour and not a lot of true feelings. But, we've known each other so long that we've gotten to the point where we can just say, “I'm not sleeping, I can't process this.” But in the beginning, we didn't.

BC: When we shared the job, we were both supervisors, so we had all the units that we looked after. I think part of our job, both Linda and I realized, is we go and say, “Talk to us, tell us what's going on. How's your day, what's going on?” I think it's because we knew that you had to do this. To this day, I have to say everybody misses us. “When are

you coming back? We want you back to do the job." I think that had a lot to do with it. We considered what they were going through and went there and said, "Tell me what's going on. How can we help you?" It's missing.

LB: I truly believe that if we want to maintain nursing as a profession viable for any length of time that we must support nurses emotionally. We must do it more formally than their backroom debriefing or in the bar after work, which leads to other social issues.

Q: How do male nurses handle things?

BC: That's a really good question, because we have more men now than we ever did. The first man in my training program started the year after I did, so he was a junior, and we only had one in my whole training program at the time. I do work with a lot of young men now. There's a lot of young men going into the profession. I don't know that we're dealing with their mental health at all. I don't think we're dealing well with the females' mental health, let alone our young men's. I think there's a lot of work to be done in our profession about that, and I think we're just barely scratching the surface. But I do know that the black humour hurt me a lot of years as much as it helped me to have people to talk to. Because we didn't know how to do it properly, we used a lot of black humour. I know that's not always so healthy. I have a lot of guilt over that because I was making fun of other people's misery. It's one of the reasons my family says, "No nurse talk here tonight."

BCB: With the young men, they become more crass. They get very flippant. It's interesting when you talk about the males, whether we are supporting them or not. It's true, I don't think we are. Unless you have some of them that can come out and say it. I think maybe that's why a lot of the guys are leaving nursing.

LB: They go to a different section of it. I know for me, it's like you have to dehumanize yourself to be there over and over and over again. That's the whole problem. That's what black humour is: it's dehumanizing other people as well. But, you can't dehumanize other

people if you don't dehumanize yourself first. That's what the profession sets you up to do, because how else do you carry on? You have to detach. You don't have to detach as much as I learned how to do, and I think that's the difference. There is a better balance in there.

BC: When Linda talks about the black humour it's really quite funny, because I can give you a perfect example of what black humour is. What do you do if somebody has an epileptic seizure in the bathtub? You throw in the laundry. See, that's what you do so you can get through, because oh my god one of these times, you have a guy who's having an epileptic seizure in the bathtub and here you are stuck. What do you do with this guy? Very frightening. So you create something to make fun of it. That's what we mean when we talk about black humour.

LB: Which is why when you go to the bar late at night after 11 o'clock shift anywhere near the hospital, if you really want to hear black humour, you just sit close to that group that comes in. Eventually the bartender kicks them out because they're too loud and too noisy and too gross. Everybody's going, “Ugh.”

Q: Have there been any surveys done to find out why people were leaving the profession?

BC: Not to my knowledge. The universities might, but I don't know.

Q: You were both around before UNA formed. Tell me about the organization that preceded the 1980 changeover, and why the change took place.

LB: I can tell you, because I was around at that period of time. What happened before was AARN, which is now CARNA, used to be your negotiating team. What you had was this team of nurses that negotiated. Their type of negotiating was the employer would send a case of wine and say, “Let's have good negotiations.” I'm telling you the truth. They never got anything better. We never, ever had a change. In 1977 when UNA started,

it was funny because the group of people that developed UNA took over an AARN meeting, got the whole policy changed, and took negotiations away from our professional association. That's how UNA began. They filibustered; they took it away, felt that our professional association should not be doing negotiations. So, in 1977 along comes UNA, the first round of negotiations. Guess what happened in 1977? We had our first strike. It wasn't the whole province: we had a rotating strike. So 1977 we had a strike; 1979 we had another one; 1980, '82, '81, we continuously had to do these every year until 1988. Actually it was before that, when Mr. Lougheed and Mr. Getty said, "You girls need to go back to work. Get back to work, this is silly." That was the first time we were ordered back to work in which we denied that we would not go back to work. But, the birth in 1988 did create quite a change because it was an illegal strike. The whole province went out. They ordered us back to work; they fined us; they did everything. We said, "Fine, do whatever you have to. We're staying out until we get this."

BC: The '88 strike was about working alone.

Q: What were some of the precipitating issues?

BC: My first memorable strike—because I happened to have graduated in Alberta and left and went to BC, so my first strike was '88. That was my first big issue that I remember. I can't speak to the issues on all the other ones.

BC: Initial precipitating issues were a schedule. Can we have a schedule so we know when we're going to work? You were a nurse; I worked on pediatrics. She went on Monday, created a schedule that went for two weeks. I wanted a weekend off. I might have to work 13 days in a row to be able to have that weekend. I wouldn't know for sure that I was actually going to get a weekend off. Highly unlikely. We had no overtime, no guaranteed breaks. We also had—they could leave you alone. They would have third-year nursing students in charge of the unit. One of my worst nights I ever worked on pediatrics, here I am a nurse, there's a young RN. I just graduated, with a nursing student. That's who was on the whole pediatric unit on a night. We had two very ill patients; one

was dying. Thank goodness I had a nursing student from the Galt School of Nursing that could run the rest of the floor. You had all of these issues. You had no pension. We didn't have a pension plan. No mat leave. If you took a maternity leave—a girlfriend of ours who's a little bit older than us, if you had a baby you had to quit. You had to resign your position and you go off and have your child. When you're ready to come back, you'd have to apply for a new position. When I came along we got six months. You had to go off two months before your child was born, and you came back four months after. That was all it was. If you didn't like it, then you could quit. Your guaranteed job wasn't there. Over the years, we've had it expanded to a year. You get your year of maternity leave plus all the other things that went with it. So wages, like I said, the people at Safeway were making more money than I was, and I had your life in my hands. So, we had very poor wages, no overtime and scheduling. Still, within those first years of striking, we still didn't get a lot of the things we wanted. When we go back to '88, which is our biggest strike that we had, you can talk to Linda—you can talk about the issues we had in 1988.

LB: The biggest issue we had was not working alone. One of the prime examples we gave the government prior to that there'd been a sexual assault of a nurse in central Alberta, and there had been a kidnapping and assault of a nurse in northern Alberta—all working alone in a two-storey hospital, one nurse upstairs and one nurse down. The perpetrator had come in and did what they did. We wanted in our collective agreement not to work alone, so that there was some safety for us. We actually walked for that reason. They threw a whole bunch of money at us. They kept throwing money at us, and they were mad when we wouldn't go back in. But, they wouldn’t give us the wording that would say that we didn't have to work alone, until the 19th day. That's why we stayed out, because we'd taken a stand and we weren't going to go back in until we got that protection. It saddens me that even to this day when the Alberta government finally has the law, after a lady we know, Deb Dore's, daughter was killed in a subway stop in Calgary. She worked and worked and worked to get legislation in Alberta that nobody would have to work alone. It still happened.

BC: To this day, nurses, we get to have somebody working with us. Other people don't have that in their collective agreements.

LB: Our LPNs don't have it. My sister is an LPN, works in a small hospital. They can't send the nurse down to the emergency department because it's considered a different unit. She'd be working alone; but they can send my sister, who's an LPN, and they do.

BC: We won, but we didn't win for everybody. Another one was professional responsibility during that time—was created so that nurses who were worried about the care that the patients were getting or what they didn't like, could take it to a different level and discuss it with management. We didn't have that before. We then got a voice in our professional responsibility committee. That was in '88, too. I remember a woman calling me on the phone. How she ever got the phone of the strike, I don't know. She says, “What do you think you people are doing, holding this government up for ransom in 1988? Who do you think you are?” I said, “Would you like your daughter to be alone with the possibility of getting raped?” “Well, I have to do it; I'm a social worker, and I think you people should do it, too.” Another thing we got is working with toxic substances. Your cancer, your chemotherapy drugs, they no longer had to mix those. Before, we had to mix all chemotherapy drugs, and in that we got it so they didn't have to. A pharmacy would do it under a hood. Before that, nurses had to mix it; god knows what we would've been exposed to over the years.

Q: How do you handle strikes, as a person in a caring profession?

BCB: What was very interesting is UNA gives their strike vote. Interesting enough, the hospitals cleared very quickly. Most of the patients went home; there were hardly any sick people. In 1988, because I was in charge of what we had, was our emergency committee. If you had a child who came into pediatrics who was very ill, they needed a nurse, they phoned me up and I'd send one in. It got to be later on we'd guarantee them a nurse for the OR, we'd guarantee them a nurse for labour and delivery, the nursery. We always guaranteed that at least they'd have enough to look after the patients that were in

there. We didn't feel like we were taking anything away because we were always prepared. They knew they could phone us. We had a child come in during 1988. They phoned me up, “Barb, we have a very ill patient.” I said okay we'd form a list of nurses who were willing to go in, send them in. We had a lot of nurses who crossed the picket line who were still there working, quite a few. What was really interesting was when we went back in they were the first ones to say, “What did we get? When do I get my benefits?” I have to say during all of those strikes I never felt like I was holding anybody, because I always knew that you would be looked after.

Q: Do you want to add something to that?

LB: Well, yeah. We came close in 1992 to going on strike again. We came down to a strike vote, and we came down to the strike vote because they said we couldn't vote. That was enough to make everybody angry enough to vote. We had our highest turnout ever in a vote. We had 80 percent of our local come out and vote that time. Management was parked outside the Sandman Inn waiting. Interestingly enough, they would listen around the hospital. I'd come up with a slogan that helped me. I said, “Most staff can take a day off sick or a day without pay if a kid gets sick. They wouldn't think about it.” I said, “Just give me one day, then you can decide if you want to walk back in or not. But, if you give me one day together, then we'll cripple them and it'll be enough to get our point across.” So, that was going around the building, everybody was like, “Yep, we're going.” At midnight we got the phone call saying it's done. …

BC: When I was out there, I was talking, of course, which I always do. I do have to say something before this goes any further. I have to say, I think when we trained, we loved what we do; we still love what we do, god forbid that we have to move away from it. It's been very difficult to go from looking after patients, and now I look after staff. I really do believe that we love what we do, and I don't think it's fair anymore. I'm proud to say I'm a nurse.

LB: I've enjoyed watching the young staff, and I think a lot of them do care. The age group I find is struggling is the 15-to-20-year age group, and I understand it. It's where you get a bit disillusioned. That was the age group when I got a bit disillusioned, when you woke up and realized, nobody else cares about me, in the hierarchy of the building. It's sort of like I rescued and rescued, and I looked after people and looked after people, and who's looking after me? That's when I started to get more proactive on my own looking after myself and got more involved in my work site life, which was becoming part of the union, and started to care for myself that way.

Q: What's the state of our health care system in Alberta today?

LB: I don't think it's broken, not at all. I think the government is trying to tell you that it's broken because they don't want to pay for it anymore. They figure that you should have to pay for it. It costs them a huge amount of money for your health care system. Patients have changed how they want—they want all the tests, they want the MRIs. Those are very costly tests. But, nursing and the health care system—no, it's not broken. It needs a bit of help and somebody to say, "Yes we care about you and we're proud of you," but definitely not broken. They're trying to tell you that, but, no, it's not.

BC: The statistics are all there; the numbers are there. We spend less on our gross national product that the US does. We have a better system; we have everybody covered. The US has millions without health care. You look at Sweden and other places in Europe, we're doing well. When they talk about dollar and cents, moneywise, we're not broken. What's broken is people's assumptions of what they should get, and their expectations of the system. McDonald's style health care: quick, quick, quick. That's what we want for our whole life. We don't want to wait in line anywhere; we don't want to be inconvenienced in any part of our life. I think sometimes we're so fast-paced that we're jeopardizing our own system just from our needs and expectations.

LB: When you talk about McDonald's—they did a study in Great Britain. They were finding that young people would not go to the dentist; they would not get their hair cut;

they would not do anything because they had to wait. So, their teeth were falling out; their hair was going awful, and their health care was going down. An actual study of young people, because it wasn't instantaneous. Internet: go on the internet; order what I want; get it; it's delivered to my door. There you go—but nobody wants to wait.

Q: One part that seems to be broken is the way we handle our staffing needs. What do you remember about some of the boom and bust cycles?

LB: In the 1990s, I was president and Barb was vice-president. We had 54 layoffs in our region in 1992. It took us eight months to get through those layoffs. There were not jobs. Why? Because we went from a city with 500 beds to 250 beds. That was the government's belt-tightening thing. We lost those nurses, and we've never regained those nurses back. We've never regained those beds back. This city is still working with 252 beds.

BC: Look at Calgary—they blew up a hospital, they cut down. Edmonton, your Grey Nuns hospital is down to a long-term care facility. It's the government tightened so they don't need them anymore. But, you have a bigger population that still wants it. Therefore, you have a lineup, because you now no longer have the beds that we used to have, or the areas.

LB: We believe from the union standpoint—when we were active in the union—we believe this was Ralph Klein's way, who brought in the New Zealand way, and they were doing this on purpose to create a crisis where there wasn't one. If you create a crisis and make people think it's broken, then they're going to happily go into the private sector. It's backfired all the way because of the union's fight and Friends of Medicare and the Parkland Institute, all the things that have been instituted to fight the privatization of Medicare. They just kept changing the bills. We fought Bill 11…

BC: There's always been a five-year cycle in nursing, where you have a boom and a bust. Why I don't know, but since I graduated there's always been this five-year cycle. Now,

since the '90s we haven't had that five-year cycle, because everything has stayed the same.

LB: Any time you're going to do a budget, I think this is the problem; it's a shortsighted budget plan. Whenever you go after your easy money, which is your manpower, it's shortsighted but quick results. What we see is a government that doesn't care about long-term results. Quick results: cut the workforce, you get quick money and look good for a while.

BC: It's going to be very interesting to see what happens now that we're all part of the one big health unit thing. I can't remember what we're called now—Alberta Health Services.

Q: What is the plan for that and how will it affect nursing?

BC: We have no idea. Nobody has said anything. They're all talking. Being that I'm in management right now, you get a bit more information. There's no information, nobody knows what's going on. Oh, they're doing this study group. We don't know and we have no idea. But there is going to be cuts, I can guarantee you, but we don't know what.

Q: Does the nurses union take a stand regarding the single paying system?

BC: The Canadian Nursing Federation of Union and the Canadian Nursing Association have put out statements supporting national pharmacare plans. We've been lobbying; we've been doing political action towards trying to get national pharmacare. We don't have it. Will we ever see it? I don't know. But, that's the stance from the nursing end: that we need to keep our public health care, that we need a total pharmacare plan, and we need people to be looked after at all stages.

LB: Everybody who's interested in keeping your health care system has to fight for it. The government will privatize, you will be done. God knows what you're going to pay,

because they do not want to pay for it anymore. I don't know if they even want to build roads anymore. I'm not sure what they want to do anymore. But, health care is one of the things, and Ralph Klein started this. This whole huge health service—I'm not sure what we're going to see, but I think you're going to see a cut.

BC: What worries me is that they're directly responsible to and accountable to the Minister of Health. It's not a hands-off thing: they're directly under him and have to account to that person. That worries me a lot.

Q: Let's go back to the union for a minute. Are there some union leaders you remember who played a catalytic role in making the union what it became?

LB: You know Margaret Ethier and you know Heather Smith, David Harrigan. He started out as vice-president of UNA. I think of all the presidents we've had from all the different areas, and it's interesting that UNA has not had a lot of change in presidents. We've had three or four. I can't even remember who was the president before Margaret. What's interesting, Margaret was there when we needed to be militant. We needed to get together; we needed to come together; we needed to tell the government this is what we need, and we needed to walk out the door. She made us walk out the door. We needed her at that point in time. Once we established that this is UNA, and we're going to do what we want to do, and you'd better deal with us, then we needed a softer person. That's when Heather came in. Heather has been there for a very long time. Everybody says, "I don't know what's going to happen if Heather leaves." There'll be somebody that's going to be there because we're going to need a change. But it is difficult. You remember the people that you worked with within your local, but UNA as a history itself, it's been a continuous one or two presidents.

Q: Margaret Ethier put the leadership in the members' hands.

LB: It's still today that way. When I've been on the negotiating team—spent two years on there—I went from south district so I represent this huge area, my members told me what

was important. That's what I was there to represent. I had to think of the whole province, but it was your grassroots that made you go.

BC: Just to give you an example of how democratic it was, one of the reasons I fell in love with Heather is because she could articulate that. We had a time in the early '90s when we were amalgamating units down here. We were one of the first places in the province to do that. We tried to instigate, and we did, transfer agreements, the first transfer agreements. We had reciprocal agreements between different locals of the union to bring our seniority, because our setup was different than a lot of others. We didn't have province-wide seniority; we had individual local seniorities, and they weren't transferable. You'd lose everything if you'd move from one hospital to another. We arranged to have all these transfer agreements, and we were the first place to do that. I put forward a motion in our local to have province-wide seniority. I got voted down. Then I had to go and support at the provincial level, and I had to vote against province-wide seniority, which I of course loved and wanted. My members said, "No, you're not going to vote that way," so I had to go against it. That was what and how we were run, and still are running to this day. The members decide what the local president will vote on at these meetings and what they won't. It's not your own personal agenda.

LB: Everybody's voted. If I go to south district and sit on the board of UNA, I'm voted on by my members down here. I'm not hired by a group. My president is elected by the grassroots; my whole president of UNA is voted on by the local. It's all members that speak. You don't have a hiring committee. Heather, to this day, is still paid nurse's wages; she's not paid these huge wages. Same with David.

BC: He doesn't get to just go and do what he wants. The whole collective agreement is fought over in our big demand-setting meetings, and that's what we put on the table. He doesn't get to change it. He can work within it when he does our negotiations.

LB: He'd always say to us, "Okay, why am I asking for this, and why am I doing this?" "David, this is why you're arguing this point, and this is what our members say." "Okay,

if that's what you want, that's what I'll go do." That's the UNA has been and always will be.

Q: What was the government trying achieve in transforming the health care system?

LB: I think what they were trying to do, from looking at the stuff that went on, a lot of the regionalization was a divide and conquer amongst themselves. What you ended up with was program management. It was in a facility now instead of a department of nursing that looks after all of nursing. We have a department of surgery, we have a department of medicine, a department of seniors' health, a department of psychiatry. They have to vie for the dollars, so they're fighting each other for the dollars. What we have is nurses fighting nurses. It just totally divided and conquered. One of the reasons we were doing transfer agreements and trying to get the seniority stuff, one of the reasons I wanted it province-wide, was it would take that power away from the government when it came to anything to do with UNA. They were playing UNA members against each other with all this fear-mongering about closing this hospital and all these nurses being laid off and they couldn't go anywhere. The way our system was; they had no bumping rights. If they closed their facility completely they were just gone. They didn't have any province-wide bumping rights; they didn't have any province-wide seniority. We changed that. We adapted and changed that, and the members got to understand that we were hurting ourselves by being so exclusive. When we could be more encompassing of our own people, then it didn't matter what the government did—closing this place or opening that place, we weren't going to be their pawns anymore. We actually could protect ourselves, and it was no benefit for them to do it.

BC: I think part of the reason we've gone to this whole Minister of Health involvement is Calgary. Calgary has always said, "We're going to do what we're going to do, and we don't care what you say." They're always over budget. When we were told that, we had to cut back our nurse ratio: instead of you look after four patients, you look after six patients, you're not going to look after eight patients. We had to do that; we lost those nurses, that's why we cut back. Calgary says "No, we're still going to look after our four

patients or our two patients. We don't care whether they pay their CEO. How much did he make?" I'm sure that is another reason why the government has done this. They said, "We're not going to do this anymore. Calgary, you don't have any power anymore; we're going to take you all over." So, I think the rest of us are going to suffer. It should be interesting to see how UNA adapts to this, because this changes everything. You become now one large local province-wide.

Q: Do you think that's going to happen?

LB: I think we're going to have to protect ourselves from being a pawn in this government again. We need to come up with policies, and it will be done from the grassroots up, and I'm not sure what it will look like. We do need to come up with something that's going to protect our members. If you've been a nurse for 25 years, you shouldn't suffer when the government does its crazy thing somewhere else. If you've worked for 25 years, you've worked for 25 years, and your seniority should go with you. I've always been a firm believer in that.

BC: In 1999, that was a year that we—and when you talk about one large local, we had long-term care nurses, we had community nurses, and we had hospital nurses. That was the first year that we put everybody together with one collective agreement. It's kind of difficult, but that's how UNA has evolved. Now, everybody belongs to the same thing, and you're going to see where one large local, and they're going to come up with a way that we can deal with this one large local. They'll say, "Fine, we'll just do it this way."

[END]