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CS: I was educated in England. I went to England when I was 15 years old. I went to college for two and a half years and then I entered the nursing profession starting April 1st, April Fools Day, 1962. I graduated in August of 1965 as a registered nurse. I then worked six months as staff nurse in emergency and then I went to do my midwifery in Glasgow, Scotland. It took roughly 14 months, because you have to write your exams and so forth. Then after that I went back to Manchester where my parents lived, and I joined the Queen's Institute of District Nursing, where I did my certificate. That's a six-month certificate, and once that was completed I came to Canada.

Q: So you were born in England?

CS: I was born in Jamaica and my parents immigrated to England.

Q: In the mid-'60s when you completed your nursing training, you worked for a while in England?

CS: No, I didn't. After completing my midwifery, I worked for three months in Wales. After that, I did my district training and then I came to Canada.

Q: When you came to Canada, where did you settle?

CS: I came to Canada in 1967, December, and I worked in Ontario for a number of years. I first went to work in Oshawa General and I worked on a female general surgery and gynecology floor. Then in '69 I went to Sarnia, Ontario where I worked in labour and delivery. Then I started taking some courses that were coming out of McMaster. So in 1972 I went and worked in Henderson labour and delivery. Once I finished my courses at McMaster, I came to Calgary in 1974, the summer of '74. I worked at the Holy Cross Hospital labour and delivery.

Q: What was the nursing profession like at that time?

CS: I was kind of a rebel in nursing. I'd see something that was wrong, I went for correction. I was a member of the union in Ontario, because the union was formed shortly before.

Q: Which union?

CS: Ontario Nurses.

Q: So when you came to Calgary, you were already involved in union.

CS: Oh yeah, from England I was a rebel. I'd see something that was wrong and I always go after to try and correct it or make it better.

Q: Would you do this through your union?

CS: You had to go to a union rep, but I wasn't as active in it as I could. But if there was something wrong, I did something about it. When I came to Calgary they did not have a union at that time. In 1974 it was Staff Nurses Association, and it was done through the College of Nurses. Shortly after I started working at the Holy Cross they had a habit of moving nurses. They come on duty for the nightshift and they'd say, oh they're short of a nurse, and they'll pull us off labour and delivery to go and work anywhere. Unfortunately, I was just two weeks on dayshift and this was my night orientation, and they sent me to work on a medical floor saying, oh it's fine, there's an experienced nurse there. So she will just lead you through. I got to that floor and a brand new nurse was there. She and I orientated together, and she worked on the surgical floor. They had no one for the medical floor. I thought, this is not right; this is dangerous. None of us know the unit. We had no orientation to this. The evening nurse gave us the report and said, bye. At about 3 o'clock in the morning I was called back to labour and delivery, leaving one nurse to look after 25 patients. A lot of them were disoriented. They were climbing out of bed; they were pulling their IVs out. So I went to the head nurse and said, you know, I don't think that is right. I said, furthermore, I was on orientation for the nightshift and I was pulled off and

sent to a floor where the second nurse and I were both new. We had no idea where anything was. I said, in an emergency we would've been up the creek without a paddle; so I don't think we should be doing that. If it's an experienced nurse, that's fine, but if I'm being orientated I'm being pulled off my floor. Oh well, this is how we do things. I said, well I don't think it's right and I think we should try and correct this. She said, well that's the way it's done. So I decided, no that's not the way it's done. I didn't know they had a Staff Nurses Association there, because you never see a soul from them. So I wrote a letter to the director of nursing. So they had a meeting, and this went on and became much bigger than I had anticipated. I thought it would be settled with the head nurse. Anyhow, after we had a meeting, this person came down and said, well I'm the president of the Staff Nurses Association, you have to come to me first. I said, I have no idea who you are. I said, in orientation you never came and introduced yourself to us. So I said, I don't know anything about you. As far as I'm concerned, we do not have a union here. So anyhow, she told us off and she said, well it's all up to you; you're on your own. I said, that is fine; that's no problem. I continued on and eventually it came to a resolution. They would no longer pull nurses off labour and delivery to go and work in the general surgery or medical floor or emerg. They would just send us to ICM, the nursery, or postpartum. So that was settled, and I was happy with it. I felt everybody in labour and delivery was happy working within the obstetrical unit, and they would not pull a nurse who's on orientation to go and work on another floor. They would also make sure that floors always have a nurse who is experienced in that particular discipline. So I felt happy with that, because it means the patients are getting better care. So when they decided to form a union, I was the first one at Calgary General at the meeting, because things were pretty rough.

Q: What union were they forming?

CS: They were called Staff Nurses Association.

Q: But they didn't exist previously?

CS: Oh they did, but we didn't know who they were. They were there, but we didn't know them. If you look into the history of how the union came about, in 1976 they started talking.

The government of Alberta of the day decided that the registration body for the nurses, College of Nurses, and they had an association, they could not be bargaining for registered nurses working in general duty. Everybody who's a registered nurse, whether you are director of nursing, whether you're a supervisor, whether you are charge nurse, meaning head nurses at that time, belonged to the registration body for all nurses in Alberta. So they can't be in management and bargaining. So they decided, the government of Alberta, which at that time the premier was Lougheed, and that's how come we ended up forming United Nurses of Alberta. So that was a bit of history on how United Nurses of Alberta came to be.

Q: What year was this?

CS: I think it would've been 1976, because in 1977 we had our first strike.

Q: Tell me about that.

CS: The first strike, yes. Working at the Holy Cross in Calgary, we were one of the hospitals that went on strike. I can remember that morning. I worked nightshift, but a lot of our patients were sent away. They closed our obstetrical unit and they went to the Grace Hospital. In Calgary it was the Holy Cross and Calgary General, which was there at the time. So there were the two hospitals that went on strike. I can remember myself and Mike Mearns, the two of us were out there with the picket signs. Unfortunately I don't have any pictures, because when I was leaving Holy Cross I had given them to the union there. We made picket signs in my girlfriend's apartment. We had no money; we were bone dry. Anyhow, we had our strike and finally 8 o'clock came and nobody came out. He's looking at me and I'm looking at him. All of a sudden the door opened. What they did is they stood in the lobby waiting for all the nurses to come down, and they marched out. It was an unbelievable sight. We told them to wear white gloves, because they had to hold picket signs that might have slivers in them. So they all had white gloves. They came out, and as they came out of the hospital coming through the parking lot onto the sidewalk, we were handing out the picket signs. It was unbelievable. We picketed and we were called all kinds of names. They said, once a streetwalker, always a streetwalker. That's what the public was calling us, men especially. Once a streetwalker, always a streetwalker.

Q: What did that mean?

CS: Who walks the street? Who do you see downtown in those areas walking the street at night?

Q: So they were implying that nurses were in the same category?

CS: Once a streetwalker, always a streetwalker. That was right in the heart of Stampede.

Q: Tell me more about the impact of the strike.

CS: Well that strike didn't last very long because we were ordered back to work after about five days by the government. But we did make an impact, because we had a lot of people that were behind us. They didn't think nurses should strike but once they got to know the issues. . .

Q: What were the issues?

CS: Number one was low wages. Can I go in my purse? A paycheque, this is 1974. This is a paycheque in 1977. This was the 27th of March, 1977. I'll give it to you to make a copy if you want. My hourly rate was $6.95; I was a senior nurse, $6.95 an hour. I did 77.5 hours for a two-week pay period. My shift differential and responsibility pay gave me a total, before tax, of $560.33. That was the paycheque. So you wonder why we went on strike? Conditions were not very good. So we had to fight not only for wages but we were fighting for better care, more staff.

Q: You were short-staffed?

CS: We were always short-staffed, even back then.

Q: And you were switched around at the drop of a dime?

CS: If they were short and they needed help, you could be pulled. We did three shifts: days, evenings, and nights. If they were short, they would pull people from different units. If you were not busy in labour and delivery: it's a place you can be busy one minute and then have all the patients delivered and not one patient in. It can turn around and fill up again, because you never know when they're going to come through the door. But any unit, they will pull staff to go help on another unit. I don't have a problem with that. But the point is it has to be done in a safe way so patient care is not jeopardized and the nurses are not jeopardized. If you go to a unit and you do not know what's going on there, and you do something wrong, it's your registration that's going to be looked up on. So I found that was not acceptable. So that's the paycheque. On that I had 77. 5 hours of charge pay, shift differential. So wages were very poor. The people working at Safeway in the 1970s were making more than a registered nurse. I had a preceptor for a student, and she was making more than I was, and she was working at Safeway part time.

Q: Could you take your glasses off and repeat the comment about Safeway?

CS: Safeway staff was making more per hour than registered nurses. I had a student who was going to university, and she made more part-time than I did in two weeks. A Safeway worker at that time.

Q: Were there any other conditions that caused the strike?

CS: Patient care. We were concerned about patient care. We simply didn't have enough staff. It's like you're a minion and you just do what you're told. I was fortunate, because I worked in labour and delivery. I'm a midwife. So I know what to do and we did it. All of us, we bent over and above always. If we had a patient in labour it was nothing for us to say, we will stay with this patient until she's delivered. Especially if it's imminent, within the hour. We would stay. A lot of us did that. I wouldn't leave a patient to not getting good care; I'd stay. It was quite common.

Q: Was it appreciated?

CS: The patients did; the patients did.

Q: What happened in your career after that?

CS: As I said, I worked labour and delivery all the time. I was never pulled.

Q: So you came into the unit in the mid '70s.

CS: Yes, I was there from summer of '74 until 1976 when they started talking about forming the union. By 1977 in the spring, which was March, is when we were fighting for better working conditions, better wages, patient safety. That was always on top, because if you're not going to have safe care the outcome is not going to be good. So those things we were fighting for, and they just refused to budge. Who can live off $5.60 an hour when almost two weeks wages couldn't even pay for you to rent an apartment? In those days oil was doing very well, thank you very much. So everything was priced off oil. Apartments were expensive, unless you're going to live in a dump, or if you end up sharing with someone to keep the cost down.

Q: Was it an active period for your union?

CS: It was. We were young. The union was very young in 1977. Nobody ever talked about nurses going on strike. We didn't know who would come out, because we were just formed in the fall of '76, and in the spring of '77 we're going on strike. Not all the hospitals went out. They just picked us two in Calgary and two up here. But they just picked different ones for that. They ordered us back to work, and since we had no strike money and no strike pay, we all went back. But we did get some improvements.

Q: Did that reinforce your belief in the union?

CS: Oh yes. Here's a bit of my background. I'm from a political family. I'm from a political family. My father's cousin was always fighting for the underdogs. He actually became the Prime

Minister of Jamaica, Donald Sangster. You might know of him. Unfortunately, he died before he could really do the great things he wanted to do. So fighting, well I wouldn't say fighting, but it's just that we were prepared to do what was necessary to improve not just working conditions but patient care.

Q: Did you have PRCs in those days?

CS: No. PRCs came in I think after our second strike.

Q: So the late '70s was a very active period for the union.

CS: Yes, we were just growing. The biggest one for us for UNA was that strike. We learned a lot. We learned what to do and what not to do; we learned a lot.

Q: Tell me about the second one.

CS: The second strike--by then I had a baby and I'd moved over to the Grace Hospital in Calgary. I was working evenings. So we had another strike, but we were very lucky working at the Grace Hospital. The director of nursing and the administrators were behind us. I can remember when we went on strike we were marching outside, and the ambulance would come with patients, because obstetrics was open (they closed the surgical floor), and I remember the director of nursing and the administrator's wife, the hospital chaplain, would bring doughnuts and stuff to us. They said, keep up with what you're doing; we'll make sure the patients are safe. But just keep to what you're doing.

Q: How did you mobilize for that strike?

CS: How did we mobilize? Everybody was ready to go on strike. We had our meetings; you take your strike votes. It wasn't a big staff, because the Grace was a smaller hospital. But everybody was there.

Q: Did any others come down?

CS: We went to different hospitals and picketed, but just the staff. No, it was all the hospitals except the Foothills. All the members of UNA in Calgary, the General and us, we all went on strike. The Foothills at that time was not a member of United Nurses of Alberta, but they supported us. I can remember they said, come and picket in front of us and we will come out; you can picket for an hour before the police come. You weren't supposed to, but we could picket for an hour and then they'd come after that if you're still there. So we would go and picket there. And we had a lot of support from other unions: CUPE, AUPE. Even the ambulance drivers would come. They'd come to the gate, park on the road, and the supervisors would come and drive the ambulance up to the hospital. So we had a lot of support there.

Q: So you found a sense of union solidarity.

CS: Always we did. There's one person I will never forget – Grant Notley. He was behind us all the way. That would've been in '78. Even on the first strike in '77, he was there; he was behind us. The next one would've been 1980. I think that was the next strike. We had three strikes. In 1980 and 1984 I think we had those strikes. The first one was at the Holy Cross and the next two were at the Grace. We had support.

Q: You played an instrumental role in building UNA.

CS: Well we did. Usually I was the picket captain--the first strike, I ended up being. I had people behind me, and we were united. We were united in what we were doing. The second strike, we were even more united. When the government of Alberta ordered us back to work, I was at the Grace until about 8 o'clock at night. Everybody came out: the mothers, the fathers, the husbands, the grandparents, the aunts, the uncles, the kids, the dogs. Everybody came out. I went past the General at 9 o'clock at night. The Calgary General is not on the main road, you had to go off Memorial Drive to go there. People lined up from the General all the way along Memorial Drive. When they ordered us back to work, no, we did not. They were going to put us

in jail and we said, okay fine, we'll go to jail. I've never seen anything like that since. We were determined.

Q: What were your duties as picket captain?

CS: I kind of kept track of staff when they came out, that they did however many hours; so we'd have an idea who was coming. I made sure we had the signs and we had refreshments, and other people donated stuff.

Q: So the hospital wasn't shut down completely?

CS: Oh, we walked out, we were gone. All that was left in there was, well not every nurse went on strike. There were some that couldn't strike for religious reasons. Some of the head nurses did not come out. They stayed in.

Q: Were they union members?

CS: At that time yes, but some of them did not. I know a couple who were very happy to come and picket first thing in the morning, and then they go golfing. They just didn't go. Then we had some nurses, because of religious reasons, they could not strike. But they donated their paycheque, even though they could not because it was against their religion to strike. There weren't many of those nurses, but they did donate their money to the union. They believed in our cause, but religiously they couldn't.

Q: Did you see an increase in wages or improvement in working conditions?

CS: Oh yes, things started improving after the first strike. We did get a bit of an increase in wages. Some working conditions were improving, but you always had to be fighting. For what you got this time, you had to fight twice as hard to keep it the next time. It's always been like that. Our next strike, again we're always fighting for the PRCs. This is one of the big things. Wages kept improving.

Q: You had to fight for PRCs?

CS: Yes, we had to fight for that.

Q: Did you go on strike for that?

CS: Well on the whole we went on strike for better working conditions for nurses, improvement in wages, because we weren't getting a living wage. There are some single mothers with two and three kids, and everything was expensive. Everybody else, well Safeway, were getting paid better than we were.

Q: Were nurses getting bumped around?

CS: No, bumping did not start until they started closing units. Bumping was when they were closing units, and that was back in Ralph Klein's era. The closing of units would've been after the Olympics in '88. That's when they started closing units.

Q: So we're coming up to the '90s.

CS: Yes, 1998 was the fourth strike. They wanted to take things away.

Q: During the earlier '90s, were things relatively peaceful?

CS: The first strike was in '77. Then we had two more strikes after that. Yeah, it was relatively. But coming into the Klein era they were cutting and cutting healthcare.

Q: What cuts were you seeing?

CS: They brought in more supervisors; they were changing the concept. They were taking away director of nursing. Directors of nurses were going out and they were using administrators.

Q: Who would replace the director of nursing?

CS: They had an administrator. They changed it from director of nursing to administrator. Before, director of nursing looked after the nursing side of things; administrator looks after the money side of things. It was coming down to dollars and cents really.

Q: Did patient care suffer?

CS: Patient care will never suffer, because the staff will go over and above. No matter what, patient care was very important. Nurses working on the unit will go over and above so their patients get the best care as humanly possible. You were tired, but at the end of the day you hadn't done enough' could've done more. But you have to work with what you have.

Q: Were there rollbacks under Klein?

CS: They wanted to. One of the big things is they wanted to do rollbacks. They wanted to cut staff salaries. One of the first things Mr. Klein did when they were cutting back is that they wanted us to give them 5 percent back, cut back 5 percent, with the understanding that they wouldn't be laying off staff. So if we gave 5 percent, then they wouldn't lay off staff. So we all got together with the union and said, okay, because they were going through a hard time at that time. Oil was not being sold as it used to be. Back in those days in the '80s and '90s, we started seeing a downturn in the economy. So we're all humans; if we can give 5 percent and some of our colleagues still have jobs, well that was okay. It was just 5 percent. We were making decent wages at that time, so we gave up 5 percent. But that wasn't true. They still closed units. They still laid off nurses.

Q: What is the impact of closing units? Layoffs?

CS: Layoffs. I worked in a unit at Grey Nuns, and they closed that unit.

Q: So you were in Edmonton by then?

CS: I came up here in '85. They closed, the Grey Nuns opened up, and they were busy, much busier than obstetrics at the General, because they had more beds. They were hiring less staff with more patients. It was bad. Then, when they said things were getting really bad, they closed units in hospitals. They closed a couple of units at the Grey Nuns, and all those staff were laid off.

Q: They decided that you were overstaffed?

CS: They decided they didn't have the money. They said they were short of money so they couldn't keep these units open. So they were closing units.

Q: What happened to the patients?

CS: For instance, you have psychiatry. They had long-term patients in psychiatry. They closed units. Where did those patients go? Who knows? They were discharged.

Q: Did they send them to another hospital?

CS: Well, Alberta Hospital couldn't take all those patients.

Q: What other forms of rollback did you see?

CS: The biggest one was closing units and laying off nurses. Also it affected housekeeping. It affected lab, because they took the labs away and they went private. Remember that? We used to have our own labs, and everything was staffed by whichever lab they were using.

Q: So labs were a department?

CS: Within the hospitals, yes. Labs were still there but they were run by the different labs, privatized.

Q: What did privatization do?

CS: The thing is, we could have the lab running and you could go there and get your stuff done. Like at nighttime, sometimes the doctor would order and they'd say, we have to have permission for that to be done at night. Just the basics, but anything over and above. . .

Q: Because the labs were now privatized?

CS: That's right.

Q: But still within the hospital?

CS: They had the lab there, but it was run by different lab companies.

Q: And it was privatized?

CS: Yeah, it's privatized. The lab was there but it wasn't functioning like it used to.

Q: What else has been privatized?

CS: Laundry.

Q: This is what Klein did?

CS: I think that came in after Klein left, but it was coming; you could see it.

Q: How did you see it coming?

CS: When the laundry went private was during the one who came in after Klein, what's his name? Getty. That's when they had K-Bro.

Q: So K-Bro came in in the 1990s?

CS: It's when Getty was premier, whatever time that was. K-Bro came in; so all the laundries were closed in the hospitals. They all did their own laundry, and all those people were laid off. They didn't need laundry workers anymore.

Q: Was this a continuation of the rollbacks?

CS: Yeah, it's all part and parcel.

Q: Describe to me what you saw happening in the overall picture.

CS: The overall picture, because you have rollbacks and it affected everyone from porters, housekeeping.

Q: Porters?

CS: Yes, because everything was limited now because they had less people doing the work. Cleaning.

Q: Was there less cleaning?

CS: They'll come and they'll clean, and then they're gone. Before you could call. The hospital had cleaners and they would usually have people assigned to the floors. But then they may have two floors or two units instead of one unit. So everything was cutting back, cutting back.

Q: So they cut back departments, they cut back staff. . .

CS: And they cut back RNs and brought in more LPNs, because it was cheaper.

Q: What about food services?

CS: A lot of places had their own food services still then. Not anymore. When I worked, because I haven't worked since 2009, at that time I was working at Grey Nuns. They had their own kitchen, their own staff for patients as well as for the workers. They had a cafeteria and they had people who did all the cooking. The dietitian would come up and see the patients and work out what they're supposed to have, and the food was made right at the Grey Nuns. Now it's no longer done – airplane food.

Q: Describe what that is.

CS: If you go down 53rd Avenue going towards 75th, they have a kitchen. Alberta Health have a kitchen that they cook all the food, and then it gets sent out. I think it's Roper Road. You turn off, you go that way, and you can go around this way.

Q: It's run by Alberta Health Services?

CS: Yes, and they do all the food. Then it's distributed to the different hospitals.

Q: What role does a dietitian play?

CS: Well dietitians still have to see the patient and come up with the food they're supposed to have. They communicate back to the computer nowadays I bet.

Q: So the whole relationship has changed?

CS: It has changed.

Q: Do they still have bedside teams?

CS: As I said, I haven't done bedside nursing for quite a long time, because I worked in outpatient for the last nine years. But from talking to my sister-in-law, they don't have supervisors like they used to. They have managers now, and then they have charge nurses who are in charge of each shift. Say for obstetrics, they'd be manager for all of obstetrics, including pediatrics and intensive care. At the Grey Nuns that's what they do. Then they have charge nurses on each shift. The charge nurses are union members, and they do all the administrative work and make sure everything runs smoothly. I think that's how it's working now.

Q: Are you still in touch with the effects the cuts had on Calgary?

CS: I didn't have too much to do with Calgary right now.

Q: So your knowledge and involvement is more in Edmonton?

CS: Yeah, because I think Klein was mayor of Calgary when I left in '85. When did he become premier of Alberta?

Q: Around '90, I think.

CS: He was a good mayor; he was a good mayor of Calgary.

Q: Then he became premier.

CS: That's another story.

Q: Did you play any active role at Grey Nuns?

CS: With the union? Yes. I was part of the PRC Committee. I just helped with stewards, I was ward rep for my area. They would come to me and then you'd go to the union with the problem, and just oversee to make sure.

Q: What kind of problems?

CS: It's usually to do with safety, patient care safety. Or if there was a conflict between staff and the supervisor, you'd try and settle it. And the PRCs, they'd fill out the form and I would submit it to the union.

Q: Was there an increase in the PRCs?

CS: It all depends on the unit. There were a lot of things that sometimes were settled before it came. It could be settled at unit level, and if it couldn't then it would have to go further. I was involved with one to do with patient care. It took us a long time to come to a conclusion. Although it came to a conclusion, it remained on the books.

Q: Was this the victimization of somebody?

CS: No, it was to do with patient care; it was a patient care issue.

Q: And on behalf of UNA, you took up the case?

CS: I fill out the PRC form and hand it over to the president of the local, which was Beryl Scott at the time. Then the committee got together and then we got together with management and had quite a few meetings. As I said, we came to a resolution but it was never closed; it remained on the books. I'm pretty sure if you look around it's still on the books.

Q: So this was an issue that impacted patient care?

CS: Yes.

Q: Was this common?

CS: A lot of PRCs were filled out because of being short staffed, getting more patients than you have staff to look after the patients. But the PRC that I filled out was to do with patient safety and the care of the patient.

Q: Did you have any experiences of patients being threatening to you?

CS: Oh gosh yes.

Q: Can you describe what that was like?

CS: We didn't so much get it from the patients themselves, but from the families.

Q: Was it abusive?

CS: It could've become abusive. One of the cases we had, the husband was becoming abusive with the staff, demanding things. There was no reason for demanding, and even the patient got a little bit uncomfortable. You could tell she was nervous. He was just obnoxious.

Q: Is this common?

CS: I'm not sure if it's common to all the units, but you hear of people becoming not very nice.

Q: Did you get reports from other units?

CS: Yes, we've heard of where nurses were being hit.

Q: Physical assault?

CS: Yeah.

Q: By whom?

CS: Sometimes patients hitting out. A lot of times we find a patient with dementia type of thing. So they're not really sure what they're doing. But still, the nurse is assaulted. And I've had experience with racial discrimination by patients.

Q: Tell me about that experience.

CS: When I worked in Calgary at the Grace Hospital labour and delivery, we had a patient came in. I was in charge, and I sent one of the nurses to admit the patient. She didn't want a person of colour to look after her, because where she came from there's no person of colour.

Q: So you sent a nurse who was a colour?

CS: Oh yeah. She was going to admit her and get her. . . But the funny part of the story is, that day there were three of us working who were people of colour. The obstetrician who was on call that weekend was Oriental. The pediatrician was from Africa. So all of us who worked on obstetrics and delivery that weekend were people of colour. So we called the administrator and said, you handle it. We don't want to go interfere with this lady in case she accuses us of whatever. Anyway, it turned out the husband calmed her down. But the funny part of the story was, he was a visiting prof at the university, and they were just here for a short time. So they weren't even Canadians.

Q: They were from somewhere else?

CS: I guess, one of the European countries.

Q: Were they challenging your credentials?

CS: No, she just didn't want a person of colour touching her. So we called her doctor and he's like, I'm not coming in; I'm not in town. Doctor so-and-so is there, he's the obstetrician.

Q: He was a doctor of colour?

CS: Chinese.

Q: What did the patient do?

CS: She had no choice. But I can tell you one thing: we were so sweet to her; we were so nice. We made sure she got the best care anybody can give.

Q: Did the patient apologize?

CS: The husband did, but not the patient.

Q: Did you have any other experiences like that as a nurse of colour?

CS: Yes, well this one is kind of funny, because it was the husband. He didn't like when I went in, and he wanted a different nurse. I said, well I'm her nurse. He said, well I'd like to speak to the supervisor. I said, well I don't have a supervisor but I'll send the nurse in charge. The nurse in charge was a person of colour. Then he said he did not want the housekeeping supervisor. So we had a good laugh about that. He had no choice. I went and looked after her, and I made sure I dotted the I's and crossed the T's, because I had looked after the patient for three days. But he was away. So he was called back from where he was working. By the time he got back she was almost ready to go home. The poor lady was so embarrassed. But it happens.

Q: Was that experience common in this area in your nursing career?

CS: No, no. I'd never had that problem at all. The first time I had that I was still in Calgary. I came up here in the early '80s and came to Edmonton in '85. The next one where we had the problem with the husband would've been about . . . when was the winter Olympics in Calgary? In '88, right? Yes, so it would've been the early '90s. Fortunately for me, it was few and far between.

Q: Were there any PRCs related to racism?

CS: Not that I recall. It may have happened in other places, but not where I was working.

Q: Did you have any conflicts as nurses of colour?

CS: No, on the whole we did not have any problem as far as I know. I couldn't say for the other units, but I don't think there was. There could've been after I left, because I went down to outpatient and it was a completely different world of course working in outpatient.

Q: In what way?

CS: I worked in the office doing all the bookings for patients coming into the outpatient department. So I worked very closely with the patients, either on the phone or when they came in to book the appointments after they'd seen the doctor. I worked closely with the doctors. So really it's a different world.

Q: In the last ten years was there less need for union action?

CS: I was working in outpatient then. In the early '90s there was on our next contract after 1988 and then four years after that we were looking at another strike. There were a lot of changes happening where they were going to be closing units.

Q: Across the board?

CS: Yes. Alberta Health Services were closing units. When I went down to work in outpatient because they closed our unit, that would've been after the Olympics. We had a strike in 1988. So between that and four years later they were thinking of closing units.

Q: You mentioned being on strike during the Stampede.

CS: That was the first strike in 1977. That was our first strike. July. They ordered us back to work. So we all went back to work. We were doing a rotating strike but before we could do the second round of rotating strike they called us back to work. Of course we all went. We made our point. So we went back.

Q: The strikes continued until 1988 and then you had a period after that. . .

CS: In 1980 we had four strikes. I have to figure this out here. It must've been '97 we were thinking about it, but we settled.

Q: What were the concerns at the time?

CS: There were a lot of issues going on because they were closing units. They wanted rollbacks again.

Q: In '97 under Getty?

CS: Yeah. Well they wanted rollbacks, salaries cutting back. Everything was a mess really because of the closing of units. They were cutting the amount of staff. So you'd end up with more patients.

Q: Tell me about your experience with bumping.

CS: My experience with bumping, well that was another nice one, because they closed my unit.

Q: When was this?

CS: It was about 1990. I was at Grey Nuns. They closed our unit; we were one of the casualties. It was antepartum and postpartum overflow room. So they closed that unit. All of us on that unit, there were jobs that you could apply for that were all vacant.

Q: Would they post other people's positions?

CS: They posted all the unit positions there, and the ones that were open, and then you were bumping according to your seniority.

Q: How did that work? If you saw an open position. . .

CS: You applied for it, yes. When all those positions were filled, you had to bump people who had less seniority than you did. If you had someone who had just come in, you would bump those. You were bumping people with less seniority. They were there, but you had more seniority to them. It wasn't nice, but that's the way it is. We had to bump people on our floor, and we had a lot of senior people on our floor, a lot of senior people. I had seniority too. So I bumped into outpatient. But the person I bumped was one of the administrator supervisors that were put into this position. It was a union job, and she was not in the union because she was an administrator. So they told me, apply for it and see what happens. They denied me, saying she had more seniority. Well she didn't have more seniority at the bedside; she had more seniority as an administrator. So then the union grieved it and it went to Labour Relations Board. They said, no you cannot put a supervisor in that position; it's a union job.

Q: Was there any regard for the profession of nursing?

CS: The experienced people who were bumping had the experience.

Q: They were putting an administrator in a nursing position?

CS: She was a nurse. She was a registered nurse, but she was an administrative supervisor. She was the one who walked around and checked on shiftwork and so forth--the other ones who looked after the hospital on shift, evenings and nights.

Q: And they weren't in the union?

CS: Yeah, because they're administrative; so they were not. She was never a union member ever. And they were cutting people and putting them wherever. So anyhow, I got into that position. I was in that position; then more layoffs came. I was bumped; then I bumped somebody and got bumped again. I was going to bump, and this person decided to retire. So I just took her position working back in maternity. So it wasn't pretty at all.

Q: Did it affect union solidarity?

CS: Not really. After you explain to people what was going on, they realize they're all in the same boat; we were all in the same boat. I felt sorry for the unit supervisors, because they were out of jobs. Very few of them were put in other areas.

Q: They put them into union positions?

CS: No, they could not. They're administrators. So it's different. They could not go and bump a union job. So a lot of them just took the package and left. We lost some really good unit managers. The people they kept didn't have the experience, but they had degrees.

Q: How have the different AHS administrations viewed the profession of nursing?

CS: I was working in outpatients when they had SARS in Ontario; it did not come out here, because they curbed it. But they were ready just in case. We all had to have our masks fitted. You had a chart and you put your name and the type of mask you were getting, and also your fit. There had to be a number assigned to these masks, and that was your fit. They went through, and all patients coming in, especially in outpatient, had their temperatures and were very carefully screened. I don't know if that went on here for this, but they were very strict. If you had a cough, you went automatically into an isolation room when you came in, with SARS. So I don't know how they screened the patients with COVID.

Q: With SARS . . .

CS: We didn't have it; it wasn't here. But anyone who had symptoms. . . They were prepared.

Q: Did that affect the profession? Were people tense?

CS: We were not tense, because you were given all the information. You knew what would happen, how to protect yourself, and everything was there just in case. They were prepared for SARS, but it just didn't happen. Same with H1N1 – we all had to have our vaccinations, so they were prepared. It seems for SARS it was only in Ontario and never came anywhere else, but everybody got themselves ready. When there's a pandemic or epidemic, you have to be prepared. They were prepared for SARS and I don't think; it's my opinion. . . I was not working but I was volunteering at the airport and I saw what was happening.

Q: This was with COVID?

CS: COVID. There were people coming in internationally. They were coming through Vancouver. Well, they may have been tested in Vancouver, but by the time they come here it can be a different story. Or they have come into Toronto or Montreal. I don't think we were as prepared as well as we could've been. My husband and I volunteer there. When I heard what was happening, that it was starting to show up in different places in Canada, I said to my husband, I'm not going back to the airport. We deal closely with the passengers. I said, I'm not going back. I'm also a bowler and I said, I'm not going bowling either. We have people who go away and come back, no masks, just coming straight back, no testing, no nothing. I said: I'm not going. I was about to call the airport when I got an e-mail to say that they were suspending the volunteer program until further notice. I called bowling and said I would not be coming back bowling. She said, I was just about to let you know that we're closing. So, before all that, I was looking and watching and saying the old adage, prevention is better than cure. When in doubt, isolate. It's better to err on the side of caution.

Q: What are the effects of a pandemic? Does it affect cutbacks?

CS: You can't have cutbacks, because if you have patients in ICU it will take four or six of them to roll those patients, because you have to turn them every two hours. When they're on the ventilator, you have to turn them. One person can't do it. If you look on TV, you see how many staff they use to just turn one patient. The nurses are burnt out. Hospital staff are burnt out, doctors are burnt out, ambulance people are burnt out, because it's been going on for so long. My daughter-in-law is a nurse and she's getting burnt out. She works in ICU.

Q: Have you seen erosion in staffing levels even since the Klein period?

CS: Well there has been. I've been out of nursing for nine years and I don't know what staffing levels are, but I do know that from talking to people they're burnt out. It's even worse now than before.

Q: Back in the '60s when you came from England with other nurses, was there a program that attracted English nurses to come to Canada? Or from Jamaica?

CS: I never worked in Jamaica because I left Jamaica as a teenager. So I've never done any nursing in Jamaica at all. My nursing is mostly in England and Canada. But when we immigrated from England to here, there was a shortage of registered nurses in this country, very short. So they were recruiting nurses from England and from wherever. The flight at that time was 60 of us. I can remember it was kind of hilarious, because they were from all over. I came from Manchester. So they were flying into Manchester, and they were going all over. One girl I came with was going to Carrot Creek, Saskatchewan. It was a big joke, Carrot Creek, I think it was called. Her husband was a doctor there; so they came together.

Q: So there were 60 English-trained nurses from all over the world?

CS: No. They came from England.

Q: Were there any other programs like that for Caribbean nurses?

CS: I can't talk about Caribbean nurses, because I don't know much. But in England there were recruitment agencies from all over: United States, Canada, all different countries. I can remember when I went. They had this big room set up and you go to the different stations. I go into this one, and there were two people sitting there. I went up and I told her I would like Canada. She said, if you come to United States, we have a place in Florida, nice and warm. I said, no, I want Canada. So she passed me on to the other lady who was handling Canada. By that time, in 1967, Detroit was burning. Remember that? I don't want to go over there; no thanks; I'm coming to Canada. They were short of registered nurses back in the '60s.

Q: Have you ever formed any relationship with any British nurses' association in Canada?

CS: No not really, there wasn't any organization. I think now they may have, but at that time they didn't. You just worked with your community. I notice in Ontario they're trying to get going, but I don't think there's any out here as such.

Q: How have you taken your nursing experience and training into the community? Tell me about your community life.

CS: My community life? I don't have much of a community life. Well actually I shouldn't say that, because I'm very active in the Jamaica Association. Whatever they're doing there, I get involved. Actually I was more involved in community nursing when I lived in England, because I worked as a queen's nurse. You were seeing a lot of people from all over in the homes, and they were being cared for at home. So you'd get to do that. Because of my association with the Jamaica Association here, we do have a seniors' group. So I try to keep in touch with them.

Q: Are there some nurses in that group as well?

CS: Yes, there are a few nurses who are retired, yes. But we have a seniors' group of everybody – nurses and teachers and whoever.

Q: Did many of them come from England as well?

CS: No, some of them do. Beryl Scott. Coleen Nita, well she came from Scotland. So there are a few. There are some of them that you get to meet. There's a girl who used to be here; she went back to Jamaica now – Verna, a nurse from England. There's a few that trained in England I think, if I was trained in England. But you work in different hospitals and different units. So you get to know the people who are within your unit. I worked in obstetrics and got to know all the staff, and there were a few that were from England of Caribbean heritage.

Q: Is there anything else you'd like to add before Don asks his questions?

CS: No. As I said, I'm retired and I've never gone back. Once I walked away, I was burnt out.

Q: What burnt you out?

CS: I found that just the whole concept of healthcare that people were getting, we were so busy. Because I worked closely with patients who were in emergency, they were seen in emergency and then they were referred to outpatient to see one of the specialists. Sometimes I always felt that they should've been seen that night. They shouldn't have been sent home.

Q: So you've seen some changes in patient care?

CS: Because they were so busy, they were so busy, the staff and space. Emergency was almost like a family clinic, instead of getting a lot of people who really and truly. . . You fell and hurt your foot at 12 o'clock in the afternoon, and you come in at 3 o'clock in the morning? It was being used as a family clinic.

Q: You mentioned that the system is not retaining young nurses.

CS: A lot of them are burnt out.

Q: Young nurses are burning out?

CS: Oh yes. If you look out there, a lot of them are degree nurses.

Q: You have a degree.

CS: No, I have diplomas; I have three diplomas, because I did public health as well. England wasn't a degree program. What you find is how we were, we were trained. You were given x number of patients. You could have six patients to look after as a student nurse, because we ran the hospitals in England. Here student nurses may be given two patients, and all of a sudden they're finished and they're registered and they're out, and they have six patients. It's a different story. You have to know how to organize your time, and a lot of nurses have to do a lot of things that they didn't realize they would have to do.

Q: Such as what?

CS: For instance, you'll say to them, a patient comes back from the OR, I said, you know, you have to check their temperature, do their vitals, and you may have to give them a sponge bath. Well why do I have to do that? Sometimes they come back and when they get them off the stretcher, the sheet underneath is wet for whatever reason. I said, you have to clean them up and make sure their dressing is intact and there's no oozing, and the catheter and IV. And the nurse says, but they've just come from the OR; I shouldn't have to be checking those things. It doesn't tweak; I don't know if it's how they're taught or what. So after a while they get burnt out, because they've been thrown into something that's not what they thought it was going to be.

Q: So then do they leave?

CS: Some of them have left, yeah, or they go and work in community health, which is completely different.

Q: Does it impact on young families?

CS: It does, because they can't cope. There's a lot of young nurses who are married with young kids, and it's a balancing act when you have children and working. I just feel that the older nurses had it harder. So you're seasoned. The young nurses have everything. If you look at the young nurses today and young people today on the whole, everything is handed to them on a platter. Their parents may not have had as much as they do now when they were growing up. So they're going to make sure their kids get everything. It impacts their work life.

Q: You mentioned nurses experiencing culture shock. Were you referring to nurses of colour or from different environments?

CS: Different environments. A lot of people look at the nursing profession one way, but when they come it's just more than checking somebody's blood pressure. You're looking after the whole person, and I think sometimes that's missing, because you get to know your patient. But you also have to get to know their families, because when they're ready to go home, you have to know what they're going home to. Will they need help when they go home? Well, a lot of them say, that's none of our business. Well it is your business. You have to know, do they need help? Do they need a social worker to go in and see? Especially on the medical side of medicine, when they had a stroke or heart attack. What is their home like? If they're going back home, do they have the facilities so that when they go home they have what is needed? If they're in a wheelchair or they're using a walker, what is the home like? Will it be safe for them? If it's a tub, how are they going to get in and out of the tub? Those are things that as nurses we have to make sure that we get all that information from the patient. But they don't think it's their responsibility. They just get them ready to go and send them home.

Q: Are they trained with a whole different philosophy?

CS: I don't know because I wasn't educated in Canada. I'm just going off of my experience of how you look after a person as a whole. Not just, oh she's a diabetic. No. She's a person who has diabetes. That's how we were trained. Or that's a young man who came in to have his appendix out, not an appendectomy patient. If it was a patient who came in who had his

appendix out, it's different than an appendectomy patient. So we always look at the person and what they have, the condition they have, not the condition of the patient. That's how I always looked at my patients at that time. They're going home; you want to make sure when they go home, things will be safe for them there, everything that's needed. Do they need extra things? Especially if you're working with seniors.

Q: If you find out that their home will not be a suitable environment to return to, what do you do?

CS: Then you go back to the doctor and start talking. We used to have conferences way back when. When I first came to Canada on the surgical floor I worked on, it was general surgery and gyne. The patients used to stay in longer. When you had a C-section you stayed in for about five days; now you're being kicked out in 48 to 72 hours type of thing. You don't know what home those patients are going back to.

Q: In that case would you be forced to keep the patient longer?

CS: Before you'd come to the discharge date, you'd already done the assessment from back here. So you know that patient is going to be discharged whenever, but you start investigating, talking to the patient. You're not being nosy; you're just doing your nursing care and you're doing your assessment.

Q: When you realize that they're being discharged to an unsuitable situation, what happens?

CS: If they were on medicine and you were close with the social workers – they used to, I don't know if they still do – but if a patient had major surgery and they needed social work, we had social workers who'd come and visit every patient before they were discharged.

Q: And that's no longer the case?

CS: I don't know. When I worked in obstetrics, they used to have a social worker in maternity. I don't know whether they still have them or not. That was many years ago. When I worked in outpatients, it was different. I hadn't done general duty nursing for nine years prior to retiring. So I have no idea what goes on.

Q: I'm just wondering if that was one form of rollback.

CS: I'm pretty sure on palliative care they would have social workers. I would think so. I don't know whether they still have them in obstetrics. I don't know, because I've been away from it. But with patient care, the nurses have got more patients because they have less staff; so you're going to have more patients. The patients come in sick, and they're still sick when they're going home, because they're discharged so early.

Q: What is causing the early discharge?

CS: Because they don't have enough beds. So, they have to get the patients out.

Q: What happened to the beds they used to have?

CS: They closed the units. That's why in obstetrics they have 24-hour discharge, because they have to get them out so they can have the beds. They used to stay in two or three days years ago, but because they don't have the beds they have to. . . When Grey Nuns is having 24 babies in a day, they're moving out those patients fast in postpartum. If you have day surgery, you come in the morning and have the surgery, and you're home in the evening. Who looks after those patients when they go home? It's left to the families. So a lot of things have changed because they don't have the beds.

Q: It sounds like they're all negative changes.

CS: Well some of it is good; but some of it, they end up back in emerg. Or they end up being on IV therapy and they have to come in every day or twice a day for IV in the IV clinics. That's a burden on some families.

Q: So these changes are negative.

CS: In some cases I would say they're negative.

Q: Besides a strain on the family. . .

CS: It's a strain on the patient too.

Q: How does it reflect on the role of the hospital?

CS: Well, they say they don't have the beds – their hands are tied.

Q: Somebody had to decide that they wouldn't have the beds or the unit.

CS: Why would they close a unit?

Q: That's a decision that's bothering me.

CS: That's a decision that comes from the top, we have no say.

Q: When they don't have the beds, that's as a result of closing a unit?

CS: That's right.

Q: So there's no longer the ability to bring patients into that unit?

CS: Now that they're doing surgery and patients are going home sooner, say you have a 40-bed surgical beds, you have to get the patients out sooner so you can bring in more people. The less beds you have, the sooner you want the patients out so you can bring in more. So that is the problem. It's like what's happening with COVID now – they're using up all the beds for COVID patients. So they can't do any surgery, except emergency surgery.

Q: Prior to that, they had already limited the beds, and then you have a pandemic.

CS: Those beds become COVID beds. That's why they're not doing surgery, except emergency. Look at emerg. Ambulances are backed up. When I was working in outpatients I would go down the back hallway and there were all these stretchers with ambulance attendants waiting for them to get a bed in emerg. You could see three or four beds with patients in the hallway, and they have an ambulance attendant there, a paramedic there with them, because they cannot leave that patient until they've actually been taken over by a nurse. There'd be three ambulances parked when I was working, because emerg would be so backed up, because they can't get their patients from emerg to the beds on the units. So it's a circle; it's a circle. It's very hard on the nurses; it's very hard on the doctors. It's very hard on everybody who's working, and that's why there's so much burnout. The patients, when they come in, they're sick; they're really sick.

Q: What can UNA do to better represent people of colour?

CS: Actually sometimes I blame the people of colour. Why I say that, not too many of them want to get involved in the union. You have to get involved. If you want to make a difference, you have to be there for the change. If you don't become involved, well you're left out there. I notice that and I have to say, well, they're not involved; they're not interested in getting involved. They just want all the benefits, but they don't want to get involved. How are you going to get them involved? Are they going to change their mindset? I don't think so, because I tried when I was working. The ones who got involved, like myself, were Beryl Scott and a few others. When you go to the general meetings you can count the people of colour with one hand. You'll see more of the Asian people. You'll see more Filipinos, but nobody from…you can count them

on one hand. So they just don't get involved. So when they come to me, they used to come and complain, and I said, put it in writing. They won't. Well, we just want to let you know. So I said, if you want me to go further with this, I need it in writing because I got caught once. When they come and tell me something, I say, put it in writing and I'll take it forward. They won't; so they get left behind. So really it's their fault. It doesn't matter how much you encourage them; it's not their business. But it's all our business. It's all our business.

Q: UNA could have more training sessions.

CS: Are they going to go? Are they going to go? No. That's what they have the meetings for. They have the meetings, but they don't go. I've gone to a UNA meeting at the local level, and apart from myself and Beryl at the Grey Nuns, I didn't see anybody else. I talked to Colleen too; very few of them at the Miz, people of colour. They don't go.

Q: Is she still at the Miz?

CS: No, she's retired. But she works with antepartum patients out in the field. She just works casual. But you don't see them. So if you don't get involved with it, they're not going to come and hold your hand and say, come. The invitation is sent out and it's for you to say, I'm coming. When you come, you make yourself known.

Q: So, during pickets, you'd see hardly any nurses of colour?

CS: There were a few of us.

Q: And those nurses are still active?

CS: Well we're all retired now. I don't know what's happening now, but at that time the people of colour were the ones who went to meetings, just a few of us. I'm away from nursing now. But I know my sister-in-law, who's a nurse, and when I hear her talk I just… I used to get at her – you have to go to the meetings; you have to become involved. There's no point complaining if you're

not going to go and do something about it. Oh no, I don't have time, blah blah blah. So I said, okay. But when she was bumped under Peter Lougheed-- and she got bumped--, she ended up going into emergency. She has her degree. She was trained in Calgary. She's from Trinidad, actually. She was having problems. I said, you have to document the stuff and take it to the union. Well what are they going to do for me? That was the attitude. I said, and how did you get into emerg? She had done a course for adult intensive care; so she was in the right spot. But with bumping, they kind of resented some people coming in, especially those who didn't have any experience. So, I said, if you're feeling that they're picking on you, document it and go to the union.

Q: Is she still nursing?

CS: Oh yes, she works in orthopedics now. She's a charge nurse on evenings.

Q: Would you mind sharing her contact information with me?

CS: Oh yeah. I have her phone number and you can call and talk to her. But she's not like me.

Q: You're a rebel.

CS: Oh, I'm a rebel. I'm from a political family and my father's cousin used to say, you always have to fight for the underdogs. You have to be their voice.

Q: I have a few questions, but I want you to keep talking to Donna. You're the first person we've been talking to who actually was there for all of the strikes. In the mid '80s there were quite complex negotiations and discussions to make sure no one was going to be hurt by the actions. Could you talk about the level of preparation that would happen before a walkout?

Q: When we were preparing, the union executives would meet with administrators to see what unit was going to be left open, especially ICU, emergency, and they always made sure there is enough staff there, that the union allow staff to be there in ICU and emerg. Then there were

people who would be on call, but they would have to call the union first to let them know what was going on, and staff who were on call to go help cover in emergency. Like for instance if there was a big disaster, say a plane crash, they're going to need all these people. All that was all laid out. If there's a plane crash, the staff will be going. There were no questions asked that we would be there. So, provisions were made that if they were needed in an emergency, there were people who would be coming. That's how it was. But they were not going to go in just to staff the place, because you were not doing what you're supposed to do. So that's how it was all planned out. A patient was never going to be left without proper care.

Q: Around the '77 strike, you mentioned that there was a lot of learning that resulted from that strike. Could you talk a bit about what you learned out of that first strike?

CS: That first strike? We learned pretty quickly that you'd better have some money in the kitty. Save up your money if you're going to go on strike in a brand new union. But I think in that first strike we were all together. That was the thing. The bond that we formed, that we knew things were not right--how can we correct this? That was the thing. Things were not right. Nurses had no say at all. But we did have a say, because we're part of a team. With that strike, because we bonded on the picket line, we bonded when we went back to work. We were working for each other, and we were working for the patient. We went the extra mile for our patients; we went the extra mile for our staff who were suffering. That's what I got out of that strike is if you work together… I remember my mother telling me this: you have one stick or two sticks together, it can be broken; put 12 sticks in a bundle, you can't break it. I remember telling them that. I said, the bigger the bundle, there's no way anyone can break it. If you stand out there alone, they've got you. So you have to stick together. So I learned from that strike how well we stuck together. I tell you, it wasn't easy. It was not easy to walk off the floors. The nurses walked off crying; that's how bad it was.

Q: Tell me about that emotional impact.

CS: It was, because you're walking off leaving your patients. There were patients on the floor; although they had the supervisors and people were working and the staff who didn't go on

strike were there, but you were still leaving your patient, people you were there to look after. You were trained to look after people no matter what. But things became so bad that you were willing to walk off; but it was still emotionally draining. You were drained. Once you got out of the hospital and out on the picket line, you change your attitude. We're fighting here, not just for ourselves but for our patients. People didn't believe we were fighting for our patients, but we were. It was emotional; it was very emotional to walk off that first time. It was never heard of before. It was very emotional. Even when we walked off, we were always thinking of our patients. Sometimes you have to take the bull by the horn to bring him down.

Q: I'm trying to think of one of those middle strikes. . .

CS: In '77 we had our first; it would've been about three years later – 1980?

Q: Yeah, '80 or '81. Then there's another around '84.

CS: That's right, and then '88. I think when we had that second strike is when that volcano occurred in the northern states, Mt. Helena. It was around Eastertime. That strike, god it was cold. No, the third strike was cold. But that was the one where we went on strike and I don't know how long we were off for. But I think that was the one that they ordered us back to work and we didn't go.

Q: Tell me about that.

CS: We decided we were not going back to work until we got a settlement.

Q: How did the government react?

CS: I guess we're gonna put people in jail and all kinds of stuff.

Q: They were threatening?

CS: Oh yeah. I think it was the third or fourth one. I think it was the fourth one they charged United Nurses of Alberta a quarter of a million dollars. I was downtown then. That was the one they charged. They threatened, but we said, oh hell no, we won't go, and we just did not go. It was the second strike or the third strike, but Edmonton General was still open. I've never seen so many people in all my life.

Q: On the picket line?

CS: Everybody came out. Not just the nursing staff – union people, families, dogs, even dogs with picket signs. It was unbelievable. But that was one of the coldest winters. It must've been the second strike we had the big march, and the coldest winter. I remember it was -30, and we went to picket in Lethbridge with some other staff there. It was so cold. It was so cold, -30, and we were walking the picket line. It was cold, but we were determined. That was the strike that we really got a breakthrough. We got a good breakthrough with that strike.

Q: There's one strike that involved a difference between a 29 percent wage increase and a 33 percent wage increase, which kind of boggles the mind in today's context.

CS: I think that was the third strike. The winter was really bad; the winter was really cold. When I say cold, it was cold. We were driving to Lethbridge and when it got -30 and the wind, we had to be very brave. We had to be committed to be out there in that cold winter.

Q: But it paid off in the end.

CS: It did pay off, yes. They really compromised. Things were pretty bad. We used to do eight-hour shifts then. You'd get off your dayshift and you'd have to work another eight hours because somebody didn't call in; so they had nobody. So you had to do a double shift, and you had no say. And you didn't get compensated for it; it was straight pay. Or they'd call you in on your day off.

Q: Because they had staffing shortages?

CS: Somebody called in sick and they can't find anybody to come in. You can't leave your patients. So you end up doing a double shift. With that strike we got good compensation. That's when nurses really improved working conditions and holidays and sick time. Well, the sick time was always there, but it was a good wage increase.

Q: In the '88 strike, that was the one where the government said you couldn't even take a strike vote.

CS: That's right. We just said, hell no; you can't stop us; this is a free country. They were going to punish us. We did take a strike vote and we did go on strike. They did charge the union a quarter of a million dollars. I remember I was on the picket line and I had my son. Both my kids have walked picket lines. My son was not quite three, and he was there with me. We were talking and I said, well if they want to come and take me, what are they going to do with him? I'm not leaving him here. So he's coming with me. So we're all going to jail together. We were determined that at that time we were not going to give in. A lot of staff were very unhappy. Nurses were quitting. But they were so highhanded they thought they could run over us. I remember listening to the radio and this guy said, these little women should be taught a lesson. You know how people call into these talk shows? These little women. I was at home before we were going to go on strike and I was listening and said to my husband, what little women? Who's he talking about? But a lot of unions respected United Nurses of Alberta. But because we're in a service industry where the bulk of the staff were women, they thought they could do whatever they like. They were taught a lesson. They found out the hard way: don't mess with women. But even now if you look at women, a lot of things are very strong. Don't mess with women.

Q: Do you remember the laundry workers strike?

CS: CUPE? Oh I could tell you about that. I was working at the Grace Hospital in Calgary. CUPE were going to go on strike. All of a sudden they had these sheets that came around the units, and we had to sign up what we were willing to do if there was a strike. I looked at it and says,

nada, nada, none of you are doing any of those things. I said, not one of you are into doing any of those things. I looked at the LPN and said, you're not doing that either; we're not doing it. So anyhow, I was supervising on weekends. So anyhow, I came on the Friday because the supervisor who was supposed to work asked me if I could cover for her because her husband had some big thing that he had to go to and she wanted to go. So I said, sure. So I came in and went through my report, and they gave me a list and asked me which one of those duties can you do. I looked at it and said, none. So they said, well we need to have somebody to vacuum the entrance. I said, I'm not Aunt Jemima; I'm not going to do any housekeeping. It is not my job. I was not trained to do housekeeping. My patients' rooms, I will always make sure they're nice and clean, because I have to prevent infections. So, I said, I will empty the garbage in my patients' rooms and if they throw up I'll clean the bathroom because that's keeping my patients safe. But I'm not cleaning no entrance. If you want entrance cleaned, you come and clean it. They said, but everybody's volunteering. I said, not this girl. I said, slavery was abolished a long time ago and I have no intention of going back there. That put an end to that. So we supported CUPE and would not do anything that CUPE would do, except kept our patient's room clean. That's the only reason why, because we have to make sure the place is clean and keep infection down. That was funny. I said I'm not Aunt Jemima and I said slavery was abolished a long time ago. So if they want slave labour, they ain't gonna get it.

Q: That's one of the reasons the strike worked to some extent.

CS: Support each other. You have to support each other. I know that strike we had, the last strike, the third strike, I was at the Grace. There was this person who wanted to get experience in labour and delivery, and she was applying for a position and never got it. We went on strike, and they hired her. Her husband was a doctor. So we came, and she's still there. So I said to her, oh, are you new? She said, oh yes, I worked during the strike; so they gave me a job. I went, I beg your pardon? They gave you a job? She said, yes. I thought, oh that's not good. So we investigated, and they did. So I went to the administrator and said, how can you hire her? We don't need an extra person in labour and delivery. Why is she there? Well you know, she was looking for some experience in obstetrics, and since she came and worked during the strike. . . I said, she worked during the strike? She got paid? How much did she get paid? Double pay. So I

said, no. I said, she's gone, she's not staying here. None of us is going to work with her. She didn't stay; they had to get rid of her. There was no position for her. We had our full staff, and all of a sudden she's working there? No. So I'm a rebel.

Q: Were you around for the Bill 11 protests at the Legislature when they were talking about privatizing the healthcare system in the Klein era?

CS: I went to so many I can't remember which ones I went to now.

Q: At one point, were they talking about closing Grey Nuns?

CS: Oh, that's another one. What they were doing, they were cutting back. They wanted to make the Grey Nuns a community hospital. They were going to get rid of ICU. They were getting rid of a lot of the surgeries that we used to do. They were all going to the University or to the Royal Alec. A lot of our doctors and surgeons were going from Grey Nuns to the Misericordia and Royal Alec and University. That's where they were doing surgery. Or they were going out to Leduc. They wanted to make it a day surgery, and emergency and everything was being reduced. So we walked, 14,000 people. When the first set of people reached the park across from the mall, Mill Woods Town Centre, we were still at Grey Nuns. That's how many people marched. Mr. Klein had the nerve to say that 14,000 people doesn't make any difference. They were going to close the Grey Nuns, and the Grey Nuns was only opened up in 1988. So we marched, and the Miz marched because they were also downsizing the Miz. That's why the Miz and the Grey Nuns became community hospitals. Then they didn't have an ICU at the Miz. My friend had surgery and ended up with a problem, and they had to transport her to the Grey Nuns ICU.

Q: The Klein cuts created a lost generation of nurses.

CS: A lot of young nurses, the Misericordia, when they had their last school of nursing, I don't think any of their nurses completing their training got jobs. A lot of them left and went to the United States or different parts of Canada. They just weren't hiring. So a lot of those nurses who

went to the States, I don't think too many came back. A few came back, but I don't think the bulk of them who went down. I had a friend who went down and she never came back. She's retired now and living in Florida. She went to Texas. It was a very sad time. We saw a lot of people, a lot of good unit supervisors, we lost some excellent supervisors. When they closed our unit, we lost our supervisor. She was one of those that if we were busy she'd just pull the charge nurse, put her on the floor, and she would take over at the desk. If your patient needed help and you were gone for your break, she went in and she'd do whatever the patient needed done, and when you come back she'd tell you. All those supervisors, we lost them. They were very good mentors, and we lost them.

Q: How has the quality of patient care changed over the years?

CS: The change is in that when you have a patient, you do their patient care. That means you're going to give them a bed bath or help them getting up to the shower – you did all that. At the time you're doing these things for them, you're talking to them and learning about them. You're also observing. For instance, say they had a wound. You're doing the dressing and you're talking to them and you're looking for other things. Are their feet swollen? Is their skin colour changed? A lot of things you're observing. If they're getting up to walk to the bathroom, you're observing how they're walking, what their gait is like. Is their gait off? When you ask them a question, can they answer you, or do they look vague? Those are things you see and you can note. You see them today and they're perfect; you see them tomorrow and they're vague. Your brain starts working: what's going on here? They don't do that anymore. It's not their job. They just go and give them the medication. They're complaining of pain, but you don't stop to find out where is the pain, how long has it been going on, etc. You have a pain. Okay, here's your pill.

Q: How has this impacted your philosophy as a nurse?

CS: I just find it's very disheartening if at the end of the day you feel as if you have not done a good job. I spent most of my working life in labour and delivery. I did 25 years of labour and delivery. That's where I spent most of my working life. When I started working in obstetrics, we didn't have fetal monitors like they do now. Within about 1970 I worked with fetal monitors. At

that time they didn't have the monitors coming out at the desk. It was in the patient's room. So you had to actually go into the patient's room to observe these monitors. When I quit obstetrics and I walked away from it – I used to work postpartum and antepartum – when I went to go to labour and delivery, they were sitting at the desk looking at the monitors. Nobody's in with the patient. The monitor is an added tool, not a here-all end-all. It's an added tool for you to use for the best care of the patient. But the naked eye on that patient, observing and watching that patient, being there--it's an added tool for that, not the major tool. It can have false negatives. If you're observing that patient, it's surprising what you can pick up long before the machine tells you. That's kind of gone. That's when I walked away, because I wasn't giving the care I was trained to do. As a trained midwife, you work with the patient. Everything else is an added tool that you're going to use to make sure the patient gets the best care when you add everything up together.

Q: Is that why you walked away?

CS: I walked away, yes.

Q: Because you could no longer deliver the care. . .

CS: I just feel that's what I was trained to do, I didn't have the time. So I went to work in antepartum and then I went to outpatients. That's why I think a lot of people are going to home deliveries. Is it safe? I don't know. But a lot of them are going to home deliveries because they want that personalized touch. They days when you sit and rub the patient's back and talk them through their contractions, it just doesn't seem to be there as much. As a retired nurse, you meet neighbours and they say, you know, my daughter just had a baby and there was never a nurse around. Or, she needed help with nursing and there was nobody there. They just bring the baby and that's it. Or, my father had surgery and he wanted to go to the bathroom and he needed help, and he rang the bell and nobody came. To tell you the truth, I feel embarrassed. I feel embarrassed when I hear that, because it shouldn't be. Another thing I think they should start doing is cultural nursing teaching. I hear some bad things in nursing homes, especially people from the Caribbean. You want to hear that? At home we have words for certain things.

One word is shooey. You know what shooey is? In Jamaica a person says, I want to shooey. It means they want to go to the bathroom to pee. They will say, I want to shooey, I want to shooey, and they don't understand. So what happens? The person starts getting out of bed. Then they say the patient is restless. So they sedate them. So what do they do? They pee the bed. And the food. Caribbean people are very specific about their food. I'd say to people when I worked, oh, you can cook and bring their food in. Airplane food has absolutely no taste. Talk to Beryl. She was at the Grey Nuns. I was cooking food and taking it to her. It has no taste; airplane food has no taste. They've been warmed up twice. When you put stuff in the microwave and warm it up twice, it's leather. But for the Caribbean people, I find in the nursing home they don't get the care they should, especially the male patients. I've heard they sedate them. If they're a little bit confused, they're afraid they're going to go and attack the other patients in bed, because they have this thing about black men. Sexual attacks. And if they tend to wander, they sedate them. That's what I was told by some of the aides. They sedate them heavily, especially ones with Alzheimer's, because they tend to wander sometimes and some of them are a little bit aggressive. All Alzheimer's patients get aggressive, because that's how it is. But with the black males, they really sedate them.

Q: Because they're afraid of sexual attacks?

CS: Yeah, they're afraid the men will attack the other patients. It's a myth.

Q: With Alzheimer's?

CS: They do wander, part of Alzheimer's. They'll wander into a patient's room. A lot of times elderly patients wander into other people's rooms and crawl into bed. That's how it is. But they sedate them. A lot of people have complained to me how they go in and see their loved one today and he's up talking, and they go back tomorrow, and he's out. I think we should start doing cultural diversity, because we have a lot of seniors.

Q: Has this been going on for some time?

CS: Oh yes. Look at how they treat the Native people, as a good example, anyone who's of a different culture. I can remember I worked in Hamilton and we had a lot of Italians. I can tell you, they believe that when they're having a baby the whole world should know that they're having a baby, because they do sing the blues. But that's how they are. So you treat them accordingly.

Q: Are they sedated?

CS: Only if they need it. When they need it, give them sedation, yes. But they love their epidurals; it was as quiet as a mouse. But there's certain people who make a lot of noise. That's how they are. It's part of their culture. Just accept it.

Q: So you're saying that Alzheimer's patients who are not Black men don't wander into rooms?

CS: They all wander into rooms, but they treat Black men differently. That's what I've been told. I know someone whose husband was, and she couldn't figure out why he was so sedated. He was up one day, and the next day she went to visit him and he couldn't open his eyes.

Q: Does that impact their recovery?

CS: Alzheimer's patients don't recover. The longer they're on sedation, the more and more they go into their… so she took him home for as long as she could, then got him into a different nursing home the next time. She was lucky her daughter was a pharmacist. So she could come and check on the medications he was taking. She said, no he doesn't need that. He doesn’t need that.

Q: Is there anything else you'd like to talk about?

CS: No, I think I'm done. I've said enough.

Q: Could you repeat what you were saying about the younger generation?

CS: I tell them that you have to fight for what you have now. You have to fight to keep it for the future. What we get in one package this time, come next time they want to take it away. We're constantly fighting to keep what we have. If you don't fight, it's gone. You have to fight for what you have now to keep it for the next. You fight for it, you get it, and you have to fight to keep it. That's why we go on strike; it's in your contract. A lot of the time we're fighting to keep what we have. If you don't fight to keep it, they're going to take it away. With Klein, they took away 5 percent and we never got it back, never got it back.

Q: Tell me why you stooped when you mentioned the Kenney cutbacks?

CS: Well the whole point is they expect people to work like slaves during this pandemic, and all they want to do is cut, cut, cut, from the doctors down. The people who are doing the most work in this pandemic are the healthcare professionals, the first responders, and anyone working in the healthcare field is doing the bulk of the work. And they want to penalize them, as far as I'm concerned, by cutting their salaries and asking them to take rollbacks. What's happening in this province today should never have happened. What did he do in July? Didn't he open it up, have a good summer, when all the signs were there that this pandemic was going to come back worse than before? This is what's happening. Why should people not have cancer surgery? Why?

Q: Is that a ward that was closed?

CS: They're not doing any surgery, except emergency surgeries. You know how many people are supposed to be having their hip replacement and they can't, or a knee replacement, and they can't? They've been waiting for years and years. The longer you leave those things, the worse it gets. People who were supposed to have cancer surgery, brain surgery, they can't have it done because there are no beds. They'd have to be in ICU and they have no ICU beds. To me it's like what's happening in Florida, what's happening in Texas, and what happened to some of the other states. All those people you see going around marching and carrying on about no mask and my rights and no vaccine, they're all being paid, I'd bet my last bottom dollar. How can they

travel all over the place if they were working? It comes from the top. If the fish head is rotten, the whole fish is rotten. It starts from the top. You say what you mean, you mean what you say, and you do what you say. As far as I'm concerned, when you have a pandemic, you should take over; everything goes out the door and you do what you say to protect the people. There should be no questions asked. I've always felt that public health safety is the number one priority, but apparently it's not. Prevention is better than cure. That's my feelings, anyhow.

END