Ruth Alexander

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RA: I was born in London, England and my dad came from Guyana, which was at one time British Guyana. He went to England and met my mother and created me. This was in the '50s, and that was a big deal because my mom is white and my dad was black. They decided that we would have a better life perhaps if we left England, and we ended up in Canada. I think Australia was the first choice, but black people were not allowed in Australia at that time. So we came to Canada. I grew up in Southern Ontario. I did a business program before I got into nursing, as a way of moving off the farm. Farm life wasn't for me. I got married at a very early age, at 18, and we moved to Edmonton, 1980. I've been in Edmonton for over 40 years. I'm happily divorced; I do have a partner now. I was a banker before I was a nurse, for about ten years. The funny part of that was that I left banking because of the politics, not realizing that nursing was also full of politics, perhaps even more so.

Q: Politics followed you.

RA: Politics followed me. I always wanted to be apolitical, but it turns out you can't be, not anymore.

Q: So you went into nursing.

RA: I graduated in 1989. I thought nursing would be a great place to go, because I thought you could move around. I get bored quite easily. It was even broader than I had ever expected.

Q: Where did you do your training?

RA: In Edmonton at the U of A School of Nursing. Then, because I had a business diploma from Ryerson Polytech with all university courses, I only had to do six courses to get my degree. So I did do that. That would've been about 2004 that I did that.

Q: When you started nursing here, did you encounter any older nurses who were from England?

RA: I did. I trained here of course, but I absolutely did meet some nurses who had trained in England. I don't know if it's a cultural thing or an age thing, but there's definitely a difference in the way people work now with my age demographic than the newer nurses. I feel like we lived to work and they work to live. I could be wrong here, but more of a sense of a team needing to pull together and get the work done as opposed to, no, I have a party to go to on Saturday night, and I don't live for my work. This is just a place I come to. I found that has been quite different.

Q: Which group has that focus?

RA: I find the younger group is more concerned about having the good life that nursing allows them to have, whereas I find with the older nurses nursing came first. We took great pride in it, and perhaps we let it take over our lives more than we should have.

Q: Do you identify with the older concept?

RA: I do.

Q: Even though you're from the newer concept?

RA: I don't know that I'm from the newer concept.

Q: In terms of the degree group.

RA: Yeah, I had challenges with the degree as well. I remember with one of my professors in particular, just sort of challenging the information that we were being taught. It was more about our ability to format things; so I asked if the content wasn't important. I was told that, no it actually wasn't; it was my ability to gather data. That would be why I don't have my Masters. It

didn't really seem to fit with the way I believe nursing is about. I believe it's about that art and that science of helping people as opposed to the academic piece. That's just me. On the frontline I realize that we do need some people up there with a little bit of power to move us forward. But that just wasn't something I was interested in.

Q: What's your concept of nursing?

RA: My concept of nursing is maybe a little bit old-school. I remember having to write a letter to get into nursing school about why you wanted to be a nurse. I really want to help people. I want to help them to get better of course, or perhaps as they die, but help many people become involved in their own health and being able to teach them those things so they can make things better for themselves. In the work that I do, I work with a lot of elderly seniors. I'm involved with transitioning. It's just not patient-centred or anything that they talk about. So I thought maybe I could do my Masters and do a focus on geriatrics, because they had a new program for that. I went to one of the sessions to learn about it, and all they talked about was the prestige in academia that would come to the U of A from having this program. There was no talk about how the research that could be done by having this kind of education could actually help promote the way that we care for our seniors or to look at different ways of providing services for them. I just thought, well I'll just stay in the trenches doing the work, and I'll let other people that are more comfortable doing the academic part, let them do that, and perhaps we can work together and come up with something that actually helps people.

Q: Did you feel like you were in the trenches?

RA: Sometimes. I started off working neuro. So it was very heavy. Our patients were either severely brain damaged or they were quadriplegics. So it was heavy physical work. But they were also very fragile. So sometimes they would change quickly. I think when you're apart from that and not seeing that on a daily basis, you kind of lose that connection of understanding what it is that we really do. I have a step-daughter-in-law who's in nursing right now, and her reasoning for getting in is quite different than 30 years ago. It's just different.

Q: How does that make you feel as a person?

BA: As a person? I can only change me. I can't change what other people are doing. Actually I'm going to say that with hesitation, because I've had at least three people come to me years later, one of them I don't even remember, and she said I changed her life because of some things that I had told her about nursing. We don't even really sometimes recognize how we influence people. I worked out ten years in the community, and it's a little different in the community working as a person of colour than in the hospital for sure, because you're in people's homes. It was not uncommon for people to say to me: could you find a white person to take care of my mother or my loved one? To that I would always have the same reply, which would be, I will tell your new case manager that that's what your preference is. They would say, oh no, you're okay. I would say, well no, because if you're racist you're racist, but people not even recognizing that you're talking to a person who's not white and asking for somebody who is white to care for your family member, not even recognizing it. So it was a little bit different out there, for sure.

Q: So this was in community nursing?

RA: In community nursing people will be more direct with you about your skin colour and how they feel about it.

Q: What drew you to community nursing?

RA: I started at the University Hospital and at that particular time I was working cardiovascular ICU. I came back from lunch three times to have my patient's chest cracked open. I could see their heart; I could see their lungs. They've got the little paddles going and I thought, I don't think I need this much stress every day in my life. It's a pretty big deal to see that. I had applied for a community job, which I was told I would never get because I didn't have my degree at that time. I had never worked with them; thought I might be lucky if I got a casual position and then I might get part-time and then eventually I'd get a position. But they offered me a fulltime job within three days. So I may have said the right things. I don't know. In those days, I'm just trying to think, there was an East Indian girl and there was myself, and I think there might've been an

Asian rehab staff, but virtually everybody else was white. I didn't really notice, because my whole life I've been like that. I was the only Black person in the school when I was a kid. So I didn't really recognize it until things were said to me like, I'd like a white person to take care of my loved one. Or in the hospital at the University Hospital, it was just assumed that I was a housekeeper. It seemed that way. That's how people spoke to me. They actually addressed me that way. I don't remember too many other nurses that were not white, is the way I'll put it, because we do have other people of colour that are not necessarily black. But back in those days it was mostly white, all the prestige jobs – the doctors, the dieticians were always white. Now I go to rounds every day with at least ten people, and there might be one person in the group that's white. I'm finding there's been a big shift, and not just Black, but Brown and Asian and people from all over the world. I actually love it, because the people that we're providing our care to are also really a diverse group. I think for them it's really nice to be able to see somebody that looks like them. Maybe they're not actually looking after them, but they're around them. Sometimes you're pulled aside by somebody if they have something that they want to say to you that they might not want to say to what they usually call a European nurse, which I assume is white.

Q: What are the rounds you're referring to?

RA: I'll back up a bit. My job is called a transition coordinator, so my role is to ensure that supports are in place when you get home so that you don't end up coming back to the hospital.

Q: You're still a community nurse?

RA: I did that in the community for five years, now I'm doing it in the hospital. What we're always trying to do is find a place, if they don't have a home, where they can live and meet their medical needs. We can't always do that, but that is the role that I have. Every morning you meet on the unit that you're assigned to or that perhaps is always your assignment, and the whole team is there. The physicians are there; the social work, pharmacy, the rehab staff are there. There's a very big focus now on discharge. Historically this was looked at when somebody got better and then we said, okay now they're ready to go. In this role, we look at someone from

the moment they enter. Where have they come from? Are they already connected to services? What is wrong with them? What is happening with them? How long might that take? What do I need to get in place so that when they are better we're ready to move them at that time? The whole team is participating in that, and it's really quite awesome. The rehab will say where they're coming functionally – can they brush their teeth? can they get dressed? what can they do? We've got the dietician making sure that they are getting the nutrients that they need; a lot of people don't eat right when they're at home. So the whole team is coming together to provide that support, and that whole team is very mixed now and it's quite interesting to see.

Q: Which hospital are you at now?

RA: I'm at the Royal Alec mostly, but I worked at the University Hospital yesterday. I retired about a year and a half ago. I used to teach the transition coordinators for the last 12 years. I taught it for 12 years and now I'm doing it. It's much harder to do it than to teach it, that's for sure. I'm mainly at the Royal Alec doing a temporary half time maternity leave, and I've kept my casual position at the University Hospital because Connect Care has come into being and I don't want to lose those skills.

Q: In your early years as a nurse, were you impacted by the Klein cutbacks?

RA: It's pretty funny. If there were ten people on our unit being laid off, eight people were told, and there were two of us that weren't told. They didn't tell us, because they thought we would call in sick. I remember phoning my manager and saying, I can't remember what I said. She said, oh, I'm so sorry. I said, what are you sorry for? No one had told me yet that I was going to be laid off. That particular rotation had six days off, and in that six days I was considered to be a senior nurse. So I ended up not being laid off. There was a lot of angst going on. For myself, for example, I wanted to be an ICU nurse, but a nurse junior to me got to have that, because she got laid off and that was a vacancy. I know that has changed since then. I'm just trying to think what it was like.

Q: Was bumping going on?

RA: No. I worked neuro, and nobody would work neuro, and they needed people with those skills I think.

Q: So you survived the cutbacks.

RA: I never got laid off or anything like that, despite having only started in 1990.

Q: What did you see around you at the time?

RA: People were really angry. One of the people I really remember was our unit manager. She'd been the unit manager for about five days. So she lost her job.

Q: Was she bumped?

RA: No, because she'd moved into management. So she just lost her job. When the directors came around to appease us that they didn't know that any of this was going to happen, it was all a big surprise to them, we kind of had a mutiny, especially about our manager, because she'd only been there for five days. You're telling us that five days ago you didn't know that this was going to happen? Actually we just stood our ground, and her name was Joan. Joan actually ended up getting her job back as an in-scope nurse, because we just weren't buying it. I think on our particular unit it brought us a little bit more together. We were very much team- oriented--you have to be on your own unit. But I think we became more cohesive and we were all fighting for the role of what we were actually doing. A lot of us just had to take the cutbacks. We really didn't have a choice. Either we had spouses that weren't employed or we made more than our spouses or two incomes were required. Even if that income was a little bit less, we would just sort of tighten our belts and make it work.

Q: Did you take your protest to the street?

RA: We did not. It wasn't even something that occurred to me. I got involved with the union a few years later, and at that time I would've done it. But at that time no, it was really just fighting to keep our place where we were.

Q: Did you have any relationship with the union?

RA: Not too much at that time. It was probably not until '97 when I actually joined the executive at the U and I was part of when SNA joined UNA. So some of those challenges as well.

Q: What motivated you to take on those responsibilities?

RA: I'm always a person that if I see something I don't think is right, back in the day I used to be quiet and shy. Unless it was something that I felt like somebody was taken advantage of, that's when I start to get strong. I did have union representation from where I was working, but they weren't able to answer my questions. So I thought, why don't I just get involved myself, and then I'll actually know. I'll be happy to share it with other people, but I need to hear it for myself and see how I feel about not necessarily somebody who's in a completely different situation than me on how they might be feeling about it.

Q: Did you or your unit engage in any other solidarity activities prior to you becoming involved in the union? Were layoffs and bumping occurring?

RA: For us it was a little different at SNA. I think in UNA at that time it was bump after bump, but SNA didn't become part of UNA until '97. Back in those days layoffs could only happen if you had less than 2,000 hours, and there wasn't that bumping that just kept on happening with SNA, because they were a little bit different. So I did see people, but everybody seemed to find some kind of work. There were some vacant positions that were available. Perhaps they weren't working where they necessarily wanted to work, but they did have a job, and they had a job that was locked in that did provide them with benefits as well.

Q: When SNA rolled into UNA, did the conditions roll over with you?

RA: The bumping was just done a bit differently; it wasn't as much chaos. If I'm an advocate for a patient, how good is it that if I bump that nurse just as she learns that job, somebody else bumps her, so you never have somebody who actually knows that patient on the unit? We didn't have that happening quite so much, so it wasn't as devastating for us as it might've been if I'd been working at a different hospital.

Q: Were you able to keep all of your working conditions intact?

RA: Yes, for me I did. I know that UNA chose to have their designated days of rest so that more people would be able to keep their jobs; so everybody took that one day off a month. But that didn't happen with us at SNA, and I think to this day the University Hospital and the Cross still don't have that designated day of rest. To go up the ladder on the pay scale at the U and the Cross, you have to do 2,200 hours, and everywhere else is only 1,900 hours, just because of the way the schedules work. There's still people who have mixed feelings about that. That day off you don't get paid for. Personally I don't care. But it can make a difference for some people.

Q: In the late '90s, did you start community nursing?

RA: I hadn't started yet. I didn't start community until 2000.

Q: Tell me about your move into that.

RA: I think part of it was I don't do well on nights, and all the shifts I worked as an ICU nurse they were always 12 hours. One rotation had four 12-hour nights, and I never got more than four hours sleep. I was not a happy camper, and I got all these canker sores and it wasn't good. So I was looking for a job.

Q: So it impacted you by you getting canker sores?

RA: I used to get canker sores if I didn't get sleep, and I never got sleep on nights. So I decided, let's find a job that doesn't have nights. I didn't think that I would like the community at all.

Q: Was your lack of sleep due to stress?

RA: My kids told me I was a witch with a capital B. That's pretty much how that went. If you do four nights of 12s in a neural ICU where you're looking at organ donors, and then you're only getting four hours sleep, yeah I was a wreck. One night I was literally walking in circles and I said, I don't know what's wrong with me. I had my blood sugar taken and it was 1.1, which is very low. I've seen people unconscious at .7. And my blood pressure was 7/30. I wasn't able to think; I had a headache. It was like, I don't think I need this in my life; it's just not really worth it for me. I can't eat at night because I feel sick, and I can't sleep during the day. I need to find something different. I had applied for a community job. I told you how that went. When I ended up in the community, it turned out I loved it. I loved working with older people, I loved that I wasn't in a building where I dictated to you when you came: this is when you'll take your pills; this is when you'll go to sleep. I will work with you in your own home to make you be the healthiest you can possibly be, but we'll work together to get something that works for you and me. So community ended up being a really good place for me. I only did a year of dressing changes and injections and stuff, and then a new team was created called the Community Care Management Team. It's what it's called now. Our role was just for people that weren't managing at home, to try to find housing for them, publicly funded housing. So having to know all the criteria, the legal aspects of the finances, the capacity stuff – I loved doing all that and trying to put all the pieces together and make it work for somebody. So I did that for a few years and then they decided to trial it in the hospital. Meanwhile, in that time my sister-in-law had throat cancer in Calgary, and we had two bleeds where we went to emerg. There was a transition coordinator who made my life just wonderful. They were able to tell me when they would be coming out to see her; they gave me numbers to contact if there was an emergency. Everything was in place and all I had to do was take care of Robyn. It was awesome. I thought if we ever had anything like that in Edmonton, I'm going to be involved. So I just managed to happen to be there on the ground floor. I was there for the community team when it started and I was also

there when we went into the hospital for a year. That year in the hospital was horrible. So I went back to the community.

Q: Why was it horrible?

RA: We were not accepted as transition coordinators in Edmonton. The social workers felt it was their role. But actually the social workers and us have to work like this; so we know the medical piece and we know the social piece. Then when we bring it together we can help somebody in a holistic way. I'm not just looking after your kidney and you're not just looking after their finances; we're actually working together to make sure that this is something that you want to do, that we're finding somewhere that can meet your care needs and also the needs of your family if they need to visit, and perhaps even a place that is more suited for you. If you're a veteran, we have a centre for veterans to go to. So putting all those pieces together: it's awesome now that the whole team is working towards that and recognizing that we each have a piece to play and when we all come together, hopefully we have success.

Q: So during the Klein cuts of the '90s, you weren't really affected?

RA: We just did more work. There was no such thing as a lunch break. I'd eat in my car, because you're just driving all over the city doing things. You need to get your documentation done, and I know if I don't stay and do my documentation tonight then I'm going to be behind the eight-ball tomorrow. So some people will stay; some won't; this is in the community. Some people in the community, some of the nurses actually go grocery shopping for their patients. It depends who touches your heart, I guess, is really how that one went. But during all of that, again I'm going to go back to people of colour. In my office I don't think there was another Black person in my office that I recall, and I would've been there for three years starting about 2000.

Q: Is it different now?

RA: Oh yeah; now there's less white people. I go to rounds and there's ten people in the room, only one of them will be white. There'll be an Asian person, a couple of Brown people, a couple

of Black people. It's great, because sometimes then you have insight into the person that you're providing service to. I maybe don't understand something that's cultural that I never would've picked up on. But somebody else on the team will say, hey, in this culture, this is why they're reacting this way; this is not what they would normally do. So I think we're better able to care for people.

Q: How are things now in the 2000s?

RA: In the 2000s now I'm working in the community. It's not so bad. The hospitals are not yet trying to, although we're looking at people when they come in the door and now it's like, how fast can we get them out? That has really changed. When I started nursing, if you were having brain surgery you came in the day before and we did stuff. Now you go to a day clinic somewhere and they do all your pre-op work, and you come in the day of your surgery. Then it's quick quick quick, let's get you out. That's gradually happened more through the 2000s. People are so sick now, and because there's that push to get them out, they're going back to the community. Those people working in the community have people out there that don't have the resources to provide the care that those people need; they just don't. So that's what I'm seeing more of. I'm hearing more about how we are patient-centred, and I'm seeing and feeling and living that we are system-oriented. We're telling you that we're doing this for you, but you can't do that because our system doesn't allow it. I find that really frustrating. We're not working for our clients at all. In my role as transitioning people, if you kept them for one or two more days we would have success when they get home. But no, I understand you're full of people that need to come up. But we send this person home, they fail, and guess what, they just come back through the system again. We're seeing a lot more repeat customers, and repeat customers within 24 hours. The readiness for discharge: I'm not sure if we need to somehow teach our physicians what actually can happen in the community. Having worked ICU as well when I worked at the Miz ICU, we got all the ALS patients. What we can provide in ICU with one-to-one nursing is not what can be provided in the community. We can't provide it as it's needed, because it has to be scheduled, I have to plan for my day. I've seen that we're more operating to keep the system intact and less that we're operating to do what what we need for our clients, our patients, our residents, whatever it is you wanna call them. We just want to slip a bandaid

on them really quickly. We haven't fixed what's underneath that bandaid, but we can now move them along and get to the next one, and then just keep coming back. Then sometimes we miss things altogether because we're moving so quickly.

Q: So this is in the current period?

RA: In the last five to six years, more leaning towards that for sure.

Q: Getting them out the door as quickly as possible.

RA: Of course, yes.

Q: Do you view that as an austerity measure of the current government?

RA: I don't know. Well right now it's because the emerg is full of COVID patients, and they do need care.

Q: But it started before COVID.

RA: It did start before COVID; it's just more in your face now than it was before. There's always been people waiting in emerg that needed some care. We need more beds. I don't know what it is we need, but we need to be able to let people convalesce. I understand that that's not always possible. Part of my role is people that need to go to the Glenrose or they need to go to a sub-acute or restorative care unit so they have that time to convalesce. But we're making the decisions for people needing that help while they're still acutely ill; so we're not even allowing them to get better first. In my population we've got a 94 year old that came in with a urinary tract infection. They're delirious; they're seeing things. Three days later it's like they've had IV antibiotics now for three days, now put him in a nursing home. It's like, wait a minute, this person was living at home independently before. How do we find that balance so we can give somebody the opportunity to demonstrate that they could get a little better? Maybe they do need a more supportive environment, but not a nursing home. If we would just be able to give

them that time…but I understand the system is bursting at the seams. I don't have an answer on how we are able to give them that time; I don't now what the answer is for that.

Q: But you've recognized the shift to moving the patient out of care as soon as possible.

RA: Yes. Let's figure out what's going on and free the bed, pretty much. In the early '90s I would pick up shifts at the Grey Nuns. If someone had a hip replacement, we had these big circle electric beds so they didn't step on anything. Then on day one they did tippy toe touch, and they had a whole process. Now you have your hip surgery done today and you go home tomorrow. It's very, very quick. Some of that's progress and research has shown that this is beneficial. But it feels a bit like, okay we've done our piece, we've done the surgery, now you can do your rehab elsewhere. You can do it at home; we may be able to get you to a rehab hospital, but we're not maybe taking the time. What I'm seeing now is people that are getting arthroplasties are very healthy. They don't have any comorbidities – they're not diabetic; they don't have COPD. I know that after your surgery you will be healthy and you can leave. However, if I come in and fell and broke my hip, now it's going to take a bit longer. It may turn out that I fell because I had lost balance because something's going on with my heart, and the reason it broke is because I have osteoporosis, and now we have to work on all those sorts of things. It feels like some of those people would've had their surgery in a different era when they would do surgery on people who had these comorbidities, whereas now they seem to be focusing more on the people that they know will be well and be done and move on and we'll be able to do the next one.

Q: Could you explain comorbidity?

RA: Comorbidity is if you have another health condition that's happening. Perhaps I broke my toe, but I had a heart transplant; so that changes everything now. My ability to fight infection might be different because of the medications that I'm on. Or perhaps with the population I work with, I had a dementia before I came in and now if you add a delirium on top of that I might start hallucinating visually and auditory. What we call your baseline, which is how you were before you got sick, I was able to walk and do all these things. When we're older, we can't

get back to that baseline as quickly and they don't have that opportunity to perhaps live independently. They may have been able to live independently longer if we were able to give them that opportunity to get back to whatever their new baseline might be. But we can't, because we've got an emerg full of other 94 year olds that have had a fall or something's happened with them. So part of it is because we're living longer and our expectations are that everybody is to be safe. People who haven't watched The Lion King. . . When I see somebody that's 95 getting lines put in for dialysis, I just get frustrated. I understand that their kidneys are failing and that they're somebody's loved one, but there is a cycle to life, and if your organs are failing at 95, perhaps it's because you're coming towards the end of your life.

Q: So this is something you'll discuss with your team?

RA: I will, and I'll try to do my best. Quite honestly, what will happen sometimes is, well say they have five steps they need to go up to get to their toilet, and they can't do five steps; so they're not ready for discharge. When you come back to work the next day, they've discharged them anyway. We don't have any powers. It's frustrating because the community nurses somehow think that we were complicit in this discharge. We don't have any power to discharge. We can advocate as best we can for our patients; sometimes it's heard and sometimes it's not heard. Sometimes we have to look at other things. They may be doing well now but they may be doing well because they're in the hospital getting three meals a day and getting medication. So then you advocate in a different way. This is their 15th admission for the same thing. That's telling me that despite our best efforts, what's happening out there is not able to support them. So perhaps we need to find a more supportive environment for them to be in. That's harder, because it's not physical like a cut or infection, but they come in as a failure to thrive. It was a complete surprise to me that failure to thrive. I knew it happened for children, but I didn't know it happened for seniors. They're not thriving, because without the structure around them to make sure that they get their three meals every day and that they are taking their medications appropriately, then they don't thrive and we see them in hospital.

Q: What were your community nursing experiences as a person of colour?

RA: It's hard to say now, because the clients are also much different. There's not as many Europeans. So there's a mixed group of people that you're providing care to. I only ever heard it from white people; I never heard it from anybody else. I don't really know how else to say that. Other people seem to be more appreciative of the care that they're receiving. You can also put that into socioeconomics. People with lots of money have expectations. They feel entitled. Their families, more so than the patients, have a sense of entitlement. Working in the community, when I was working in the southwest and the lady answers the door and offers me tea and biscuits, they're not that impressed with what I'm doing. But if I go inner city with Northeast Homecare where they're working in the shelters and stuff, those people really appreciate the care that they're getting. I don't know where colour ties into that. I think more now I feel like people are looking at if they can trust what I say and what I'm doing. There seems to be a bigger shift now to disliking people who have their heads covered; there seems to have been a shift that way. So I'm going to say Muslims. I'm seeing it more going that way than I have in the past. That would just be in the last couple of years. That reaction from the families and stuff seems to be heading more in that direction now than it did before.

Q: But you're still being offered tea and biscuits?

RA: Yes.

Q: Whether a person's head is covered or not?

RA: I don't know for sure; I can't say. But I'm noticing that that seems to be where the distrust in the care seems to be shifting now.

Q: So, as a nurse of colour, you feel that there's more trust now than in the past?

RA: In some ways. In other ways it’s, how can I put it. If I go out anywhere and see a disabled person and they have a caregiver with them, they're either Black or Filipino; that seems to be the way it is. In the hospital, a number of our healthcare aides that do a lot of the hands-on changing of dirty briefs and that sort of thing also tend to be more people of colour. I'm trying

to be politically correct. I'm okay to wipe your bum, but maybe you don't want me to do something else. I guess that's the way I see it; that's the way I feel. I haven't been providing direct patient care for ten years; so I can't say for sure. I also see, because I work a lot at the Royal Alec, I see sometimes some harshness against our Indigenous population as well. There's a higher population of Indigenous I think at the Royal Alec than I see elsewhere. On the other hand, we also have more supports there.

Q: How does that manifest itself?

RA: If you are Indigenous and you're in the hospital, we do have Indigenous workers that can come and work with you and can connect you to some different supports that are available to you in the community. On the other hand, you're going to see me also kind of get ticked off because it's been mandated that all of us must do three hours of Indigenous training. I ended up having to do it twice, because they changed it. My question is, how about some Black training? how about some Muslim training? how about some training for any other culture than European? But I understand indigenous are native to this country. But we have a growing population of very mixed people and I think we need to understand their cultures as well as the the Indigenous culture. So the push has gone that way and I'm hoping that it will grow and will recognize that we need to understand, okay, what is it that will offend a Muslim lady or a Muslim man? What should or shouldn't I be doing, or what can I do to make them feel better? They have a lot of things in that culture that we're just not aware of, and yet we have a bigger population coming in. Or West Indian population. It doesn't matter where you're from, I think we need to recognize that there are differences and that doesn't make it wrong. On a personal level, I've had two partners that are Black, and I thought it would be easier. Absolutely not. I was raised in England and Canada, and I was told that everything I did was wrong. This is the way I was raised, and you're not doing it. I was like, well this is the way I was raised. It doesn't make it wrong; it just makes it different. I think as we become more mixed and intermingled, we can take the best out of all of them and bring them together and make it good for everyone. That would be my hope, but it's not going perfectly right now, is it?

Q: In the late '90s and early '2000s, what led you to become more involved in UNA?

RA: I wanted to have the information for myself. I wanted to know what my rights were as a worker, what it was that the union actually did for us. I saw good things and I saw bad things. One of the things I do recall is after SNA and UNA were joined together, at an AGM. . .

Q: Were you active with SNA?

RA: Oh yes, five years in that, and in the middle of that it turned into UNA then five years I community. It can be very busy working in the union. But at one of the annual general meetings, we had put to the floor that we would like caucuses for people of colour, for gay people, and I can't remember what else. It was voted down. The nurses said, you don't need that; all nurses have the same concerns. That one just literally made me pissed off, there were not other words to describe that.

Q: That was at convention?

RA: That was at convention that the nurses, predominantly white, said, oh people of colour, it's not different for you than it is for me. It generally wasn't or isn't necessarily in your face, but you just know that it's happening. I don't even know how to describe that. Treated differently, and I guess there's also a certain part of who you are as a person. I've always been fairly strong and able to stand up for myself, but I'm not sure that's the case for all people of colour. I worked with people in community and in the hospital who, if somebody said something derogatory to them, they would just take it. I would not just take it. First of all, I'm going to tell you what I think about what you just said, and next I'm going to go to management. I am not putting up with this while I'm at work; I'm just not.

Q: Have you experienced any examples?

RA: Just mostly those people that are telling me that they need white people to care for their loved ones. I would just go straight back to the office, straight into my manager's office and say, you need to find a new case manager; I'm not doing it anymore. Well, why not? They want a

white worker; I'm not white; so I'm not doing it. But Ruth, that's the person that's providing care. I don't care – if they're racist, they're racist. I'm at work, and at work I have the right to feel respected and to be treated the same as everyone else; that's just the way it's going to be. No one ever said no. I worked with an East Indian girl who would let people make fun of her being say a taxi driver, and would never even think of saying anything. She just thought, well I should just take it, because that's the way people feel. But that's just not the way I operate. In the hospital what would happen is I would just say, that family is racist and I will care for them if you want me to, but I will not keep my mouth shut. If somebody says something, I will respond. So they always then reassigned me to somewhere else, because they didn't want me to cause any trouble.

Q: Is that causing trouble – standing up for yourself?

RA: Well I'm going to rock the boat for sure, and if you don't respond, I will go over your head. I have no problem with that. So sometimes they would just say, oh let's give Ruth a different assignment. It wouldn't necessarily have to be a colour thing; it could be a power thing. His brother's a lawyer. So they expect I would treat them specially. No, I wouldn't. I don't know that everybody has that strength and ability to stand up for themselves and just say their piece. I can say it nicely or not nicely, depending how many times you make me say it. But I think we're all people; I don't care. We were all born as little babies, and all deserve the right to live our life, to live it in peace, to be respected for who we are. If I get any sense of that, I do feel a need to speak up. So I do.

Q: So, as a part of your self-defence focus, you decided to take union office?

RA: Yes.

Q: How did that decision come about?

RA: I've always been like, let's fight for the underdog. I used to read these books when I was a kid that old ladies only read – they were Catherine Cookson books. They were always about the

scullery made, and she fought for her rights and believed in what she believed in, and she had success. I guess that's sort of what I base myself on. I just don't like seeing people being walked over. I have a real problem with anybody that feels for some reason that they're better than somebody else, for whatever reason they feel they're better. I feel that we're all equal. If you put it in my face that you think you're better than me, I will call you on it; I can't help myself. We're all just here for one life. I don't understand why we can't sort of go about our business and let other people go about their business. I travel a lot, and wherever you go it's the same – people want to better their lives; they want things to be good for their kids. My brain can't wrap around the difference in the colours, maybe because I had mixed parentage, I don't know. But why can't we just treat each other the same? We all have the same insides and we all have the same wishes in life. So I don't understand why we can't all just work together for that. That's just my own personal opinion.

Q: What position did you assume on the executive?

RA: When I was with SNA, they told me it would be eight hours a month but it ended up being eight hours a week, because we joined UNA. At that time I was an area rep. So I represented a group of nurses. I think I had clinics, neuro, and some other people. One of the key things we need to understand in the union is that we're not representing ourselves; we're representing a group of people. I wanted my voice to be heard but I also wanted to be able to share what other people had to say. So I did that for a while until it just got to be too much. Both executives I ended up being on the PRC, which is the Professional Responsibility Concerns Committee. It was always the same – we don't have enough staff; we don't have enough staff; we're trying to get more staff.

Q: Who would say that?

RA: It's always union versus AHS in our case. Union is saying, we don't have enough staff, and Alberta Health Services is saying, we're trying to hire them. We don't have enough staff; we're trying to hire them. Fast forward ten years. Now I'm in the community, again on the PRC

Committee. I'm the chair of the committee. We don't have enough staff; we're trying to hire them.

Q: Are they just making up a story?

RA: Here's one thing I had one manager say.

Q: Is it because of cuts in the budget?

RA: Absolutely. But nurses don't help themselves. I had a manager that says, we want the nurses to do this much but we know we're only resourced to this much and it's really not possible to do that. So one of our things that we could do with the PRC Committee was present it to the executive board. I'm not sure that we really had any pull in this, but two or three years ago we did present. Homecare was having a hard time because the patients were much sicker when they were coming out, and the workload was just crazy. So we did present it, and homecare got hundreds of new nurses. You know what one of the nurses said to me? Where are we supposed to put them? There's no room for them. You can't make anybody happy. You wanted more nurses, you've got more nurses, and now you're complaining because they didn't come fully trained, which you know it takes at least six weeks to learn community with all their computers and stuff. I don't know what you want. You're asking for more, you got more; now you're complaining because you got more. That was something that I didn't care for so much. It's like, okay we fought really hard to get you more nurses, and now you're still complaining. Again, I don't know what the answer is. I think less and less there's concern about colour, I think. That's the sense I get, but I don't know that for certain. I just haven't had it directed at me in the last few years.

Q: Do the new nurses coming in now represent a different demographic?

RA: Absolutely. In my office, I laugh, I call it the Black girl office, because there's five desks and there's four Black people in there. For me it's actually been wonderful. I've never had, because I was in a mixed family, I've never had four Black girlfriend. So I'm learning how to do my hair, and

it's just been really good for me. I think the white girl in our office, she's loving it. She's learning so many things. She's got curly hair. So now she's using Black hair products. She's learned a lot of things about the Black culture that she never knew before. We don't hold back on anything. I hear her sometimes talking to other people about, hey I didn't realize that this happened. So I think as we get to be more and more mixed together like this, we get to learn the daily stuff that's going on with people and the frustrations. We're not shy about holding back about racism in that office. It's been really good for me to have all different sorts of people working.

Q: So throughout your career you've never really had that.

RA: Throughout my life I never actually had. Even now I'll go to the unit, and there was one particular unit where the occupational therapist had hair very much like mine. So we just kind of bonded. I would never have had that opportunity before, because there would not have been a Black occupational therapist. I still only know three out of two hospitals, but still we're starting to see different sorts of people in different sorts of roles. That even changes, because she's working with people in what they do functionally. What I do in my home may be different than culturally what's done in another home. So that ability to connect with people and support them is fabulous.

Q: Have you ever engaged in any street advocacy?

RA: I picketed a few times, but not on anything about colour. It would just be when it was the nurses, and very few times that I've actually been out.

Q: What causes were you advocating for?

RA: Kenney, I've been at work when stuff's been going on with him. I know we had a day of action, but I was at work that day. I personally haven't done it, but I know people are fighting to at least maintain where we are now. With what they're looking at now, if you have the ability to switch my shift at any time, I could be working until 11. I don't get to sleep until 1, and you want me back at 7 o'clock in the morning. Those are the sorts of things I would get out on the picket

line for, because we are entitled to a work-life balance as well. If I always have to be on call, I mean it's a common thread for a nurse to never answer her phone, because you don't know if it's going to be your employer on the other end asking you to come in for mandatory overtime. That doesn't happen to me in my role, but it does happen to other people.

Q: So they don't answer the phone?

RA: You just don't answer the phone, because if you don't answer the phone, then you don't know that they wanted you. That's not really new; that happened already back in the Klein days as well. I don't even know how to explain it. They might call you to come in to work if you're working on a unit and say, we have no staff. But for me on the other end of the line, knowing that you have no staff, that makes it worse. I know it's going to be a really bad shift, because I know how sick the patients are and maybe I don't want to come in. I'm sorry that I don't want to come in and support my coworkers, but I know it's going to be a killer; so I'm out, I'm not going to do it.

Q: This is because of the shortage of nurses?

RA: It is. We talk about it and I know we just had a local meeting and we talked about if we should have job action and there would be a certain number of people that could be on the unit, and it's interesting to watch what the nurses are saying. Some of them are seeing it as a good chance to pick up more shifts – can I work overtime? Then other people are more like, what if there's nobody there to care for the patients? There's a diversity in the way that people are looking at it. I think nobody wants to leave their patients not cared for. But we also have to recognize that all our managers pretty well are nurses right now until they get that out of the contract. So they also should have the ability to go on the floor and provide care to patients. That could happen not in a job action time as well. We're hearing on the news right now that we don't have enough nurses. In my department, we've had two pulled to ICU and one pulled back to surgical floor. So why can't the managers also be called back and provide that care? I don't know. That has nothing to do with colour, but . . .

Q: So there are still a lot of staffing shortages?

RA: Absolutely there's staffing shortages. One unit I'm covering right now, I think ten beds have been closed for a couple of months because they don't have staff. They might have staff for day shift, but that doesn't help if you don't have evenings or nights. So they don't have enough staff to cover the full 24 hours and they had to close some beds. I'm just one unit in one hospital.

Q: Is that the result of staff shortages, that they close the units?

RA: Or they close the beds or right now they've cancelled surgeries. My personal trainer just texted me this morning. He thought he was still going to get his surgery. No. There's no one to care for you when you've finished your surgery. Or one of my units is ortho; so if they do hips and knees, those doctors are just doing surgery all day. So they're short of doctors as well to provide what needs to be done when they're finished with their surgery. So it's not just the nurses that are short right now.

Q: What is going on?

RA: I don't know. Do we have that many more people that need to have surgery? Have our doctors left? We heard when they were negotiating with Kenney that they were going to leave. Did some of them leave? I don't know that they left in large numbers. I do know that even before any of this was going on, people don't have access to general practitioners. So often our hospitals are being used in a way that you might've used a doctor's office. Or because I'm not going to the doctor and have this sort throat, which ended up being throat cancer, I didn't go to see anybody for months and months and months until it got too bad and I really had to do something. Then I show up in emerg and it's already too late. We're not doing anything to prevent stuff; we're not doing the proactive eat right and exercise and the things we need to do for preventative care. I don't know that we have the resources of both finances and people and rehab and stuff to make people be able to do these things to care for themselves. If I had stronger legs, maybe I would be able to step over that curb and I wouldn't have fallen and broken my hip, and all the things that followed from that.

Q: Has COVID intensified these conditions?

RA: It's like everybody's wound up tight. Yesterday I was at the University Hospital. I had a pulmonary unit and a COVID unit. That doctor came in and was like, we only have 53 people on [1:02:10]. They're going crazy. The end of that sentence was, some of them will die and then I can bring some more up from emerg. I didn't really know what to say. That was yesterday that I heard that and I was like, wow. But I also knew it was said in a way to relieve tension from that doctor because it was just like, I don't know what I can do. How much more can I do? They keep coming in. I have nowhere to take them to ICU. So the ICU doctors are coming around to the patients and saying, no ventilator for you. You're 85 and you're in a nursing home and you can't walk and you can't feed yourself already, whereas in the next bed I've got somebody that's 45. How do you make decisions like that?

Q: Do you feel the strain of that?

RA: I feel the strain in that they want me to move them faster. I still don't have the ability. That's still a 94 year old that fell and broke their hip and now they've got pneumonia, or yesterday I had a person with a developmental delay. When I phoned the group home to send him back it was like, what do you mean he has COVID, because he came in without Covid and now has COVID. So, not everybody's equipped to manage these people when they get back. So it's causing chaos, because that person still has 11 more days of isolation but has no symptoms and is not sick, and they're in a bed that a sick person could be in. But I can't send them back to their group home for fear of the whole group home getting sick. There's that kind of pressure that you're feeling. We're getting emails every day – have you got anybody that's going home tomorrow or the next day? Can you get them out today? Is there some way we could send them home today? Okay, now this facility is open to special units. So, if you've got somebody that's COVID positive but they're not finished their isolation but they're on not too much oxygen, then they can go. Or we've got street people and we don't have anywhere for them to isolate. They can't go to the shelters; so now we have to get hotels for them. So there's just pressure coming in from all directions to move people more quickly. We had a bunch of people from Fort

McMurray that were working the camps; they were younger population. It's like, well this guy's 32, he's been here for three days. It's like, he's on 10 litres of oxygen; he wasn't on any oxygen before. So they're not even taking the time to fully find out what's going on with this person. They're just like he has a number of age, number of days, okay they should be ready to move. It's not just me advocating. It's the rest of the team as well. But you're seeing a lot more of that, which is kind of scary.

Q: How is this impacting the service to patients?

RA: It's not good, with the staff shortages and stuff. I actually had this conversation with somebody just the other day. He was complaining because his bed wasn't made properly. I said, the lady over there can't breathe. He said, I know, I know, you guys need to care more. It's like, well how to help these other people to understand that we still care for you, but even if you've messed your pants, if they can't breathe, then that comes first. We have to prioritize. We've got x number of staff. I've heard your concerns; I'll get somebody as soon as I can. We're not always able to get to things as quickly as we would like to. I'm not the person actually doing it, but I know if somebody's in extreme pain I'm trying to find a nurse and I can't find one anywhere, because something has happened in this room and they're all helping there, or somebody's fallen, or somebody needs to be transported. So you're working with fewer nurses, the patients are sicker; so they're busier doing work, for lack of a better word. So we can't do what I call the nursey things that I used to like to do. I could actually take the time to rub your back for you. Or if you're a lady that's a little older and you have a beard and your family is coming in, I can get rid of those whiskers for you. I call those kind of nursey things; they're soft. But we can't always just be looking after somebody's physical body – there's the whole psychological piece; there's the social piece that comes in. I know for me if I had chin whiskers, I don't care if I got my IV med; make sure my chin whiskers were gone. We're not even able to look at that kind of stuff now. It's just like, I've got another med to give, and that patient needs five more meds, and then this one has to go for another test. It's just very task-oriented and not as much the ability to look at you as a person. I'm just looking at the tasks that I need to do for you. They will help you, but sometimes you need that little soft piece as well to feel better. And the mix has changed. There used to be more RNs and less LPNs, and that does make a bit of difference. RNs are

taught more to critically think than LPNs are, and that's very individual; each individual is different. I get that. But generally speaking, the way we're trained is slightly different. Now we're even getting more healthcare aides. I heard someone saying in an acute care hospital the healthcare aides were giving the meds. I was like, what? They're not drawing them out but they're the ones that are passing them. So things are just changing. I don't know how that's going to go. Hard to say.

Q: Are there any other comments you'd like to make?

RA: I'm glad I got into nursing and I think it was absolutely the right thing for me. It's very rewarding. There's a sense of accomplishment if you can help someone facilitate what it is that they want to do. I think it's a great career. I don't know what it's going to look like in the future. I think more of what I was calling in the trenches is going to be done more by LPNs and healthcare aides. I understand that in the degree program, which everyone must do now to be an RN, there's more focus on management and going on to get your Masters so you can be a clinical nurse specialist or a nurse practitioner. So I see things shifting but I don't know what that's going to look like. But I do think that the expectation to receive the right care is going to remain, and that expectation may be a little higher. People can look at things like what I call Doctor Google, get a bit more information, and just that expectation that everything will be done for you. Perhaps before people were more accepting, but those who aren't accepting now go to the maid process. That's a whole other topic.

Q: Are you involved in any community organizations?

RA: I'm not. When I retired, that was my goal. I didn't know what I wanted to do. I still say it once a month: I have a purpose. It just needs to present itself to me so that I can take my energy and put it there. I don't want to just fish for something and grab something. But if you know of any organizations. . . I donate money to places, but I feel like for a really good donation I actually have to be there and physically do something, and I don't have anybody that I want to do that with just yet.

Q: Why was the SNA/UNA merger done, and how did it happen?

RA: It was big. Jane was our president at the time. I don't know that we had actually thought about it. I hadn't really heard much about it before that. But I had just joined the union when it happened. I think it was so that we could all be unified through the whole province, that all nurses would be under one umbrella and not little offshoots. That leaves the potential to kind of bang against each other. So I got a real sense of unification for sure when it came together. There was a little bit of head butting. It was actually Jane I can remember at another one of our conventions that someone got up to the microphone and said, you are now a small fish in a big pond; so get over it. I remember thinking, wow that sounds really unified. It did come together after that, and I think we were able to pull some of the things that were really good for SNA and UNA as far as policies and all that kind of stuff. We were able to unite those and come up with things that worked well for all nurses. So I think that was really good. I think it was probably time. We'd already gone through the Ralph Klein days, and if we're divided, it's easier to divide us further and conquer. So, if we all came together, we would be stronger; that's what I would've taken from that.

Q: What was the size of the SNA membership at that time?

RA: I'm going to say maybe 5,000, because it was the U and we had about 3,000 nurses there. I don't know about the Cross. I was too young and naïve to know, but there could've easily been the same in SNA also in Calgary. I'm sure there was: the sister party that I didn't know anything about.

Q: Why do you call it "party"? Are you thinking politics?

RA: Well it's turned very political. When I see provincial things happening, sometimes the provincial union is not much different than big companies in the way that they operate. I haven't seen anybody of colour on the provincial UNA member board there that I can think of. Maybe Beryl was at one time. But not very often. That may be that nobody of colour has put

their name forward. But I'm just saying that it's in the same way as corporations, is what I'm seeing.

Q: You chaired the PRC Committee for a while, right?

RA: At the U and in community, yes.

Q: What is the PRC? What is professional responsibility?

RA: PRC is the Professional Responsibility Concerns. As nurses, we are professionally obligated to let people know if some of the things we're doing – a policy, a procedure, whatever it is – we need to let people know so that we can provide safe patient care. I would like to say that when I've chaired the PRC Committee in the community it was quite different than in the hospital. In the community we had a very good relationship with our managers. It wasn't always that way, and had started before I came. But those managers that sat at that table in community recognized that they were also nurses and they also had professional responsibility, and that was amazing. One of the things that happened for us there was we had the Northeast Community Health Centre; we had brought a number of concerns forward. It may not seem like a big deal, but that manager actually worked with her staff to fill out PRCs, to address some of the concerns that were happening, and they were actually able to get some more monitored beds. It was such a simple thing. But they kept saying, we had these cardiac patients; we weren't able to monitor them. We brought that forward, and sure enough we were able to get some more monitors. So it can play a really good role. I've heard that other PRC committees actually have HR at the table and they have management, and they sit very divided. So I really wanted to express that this can be done in a collaborative manner where everybody is working together for that same end result, which is that we are able to provide better care for our clients, our residents. Another one that we had was the people that work, I believe it's called Ark, it's where they go to detox before they go into a program. There were some safety concerns, and those were addressed rather quickly. They had cameras put up. The nurses were given screamers where they could call for help. There was a police officer that, I'm going to call it walking the beat, for a mental health centre that was on 108th Street, and they connected in.

So there are things that can work really well with this PRC Committee. The challenge is that the biggest concern has always been staffing numbers. It's always a challenge, because staffing can't really be based on the number of patients, in my opinion; it needs to be based on the acuity of the patients. Do we have a measurement tool that really allows us to know what would be a safe number of nurses to provide care for this group of people? Having said that, I just ran into a friend when I was on Vancouver Island who's doing a big job around this on Vancouver Island. She's just sent me a bunch of tools for measuring acuity; so I haven't looked at them yet. I plan to share them, and I didn't know who to share them with. My first thought was to send them to the PRC people that I knew and see if there was anything that they could do to work with management to use these tools to make it safe for the nurses to be able to provide care for the people they were servicing.

Q: How can the good practices in the community be used in the hospitals?

RA: Is it even possible?

Q: I don't know.

RA: I'm not sure either.

Q: What's the relationship between the PRC and patient care?

RA: Some of our most powerful PRCs are when there's adverse events that happen at the end of them. We keep saying we're short, we're short, we're short. But if we can say we're short and because we're short this happened, it's unfortunate that's the way it is. But unfortunately, when something negative happens, we're more likely to be heard. Otherwise it's kind of like you're whining and complaining. Well, nothing really happened, but occasionally something does happen.

Q: Do you have an example?

RA: It came in as a PRC. It was again the Northeast Community Health Centre, and it was a child that came in. They didn't have the staff. I don't know if they got there as soon as they might have otherwise. This child was not alive when they left – they passed away. It could've been staffing; it could've been that the family brought them in too late. But the nurses were feeling horrible. He was a four-year-old child. So again, expressing the concern, not just to have these nurses available but you have to have the skilled nurses, especially in a place like that. So you can have these people that can come and start their IVs, but you need somebody that can triage and you need some really experienced nurses. I don't know how you can advocate to get those, because you have to get the experience sort of to get there. But again, those nurses were very frustrated. They felt they could've gotten to that child sooner had there been more nurses. On the other hand, they also said they're not sure that the child would've made it, but they would've felt that they had done everything they could do if they would've had the staff to do it.

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

RA: It is important work and in fact what we did sometimes is we'd know there were concerns going on and people just said, what's the point? Some managers got in trouble if they filled out PRCs; they were encouraged not to do it. So we would actually meet after work in a restaurant somewhere and allow them to voice all their concerns. Some people are afraid to put their name on a piece of paper or sign it, even if we ask them to do it as a group. So we would meet them as a group, usually food involved. I'd like to say alcoholic beverages, but with nursing it was usually food, to be honest with you. And just get all their concerns out on the table. Then sometimes, as a PRC Committee, we would write the concern on their behalf so that people didn't have to put their names forward. There might be some particular managers that we knew how they would react. As the committee, it didn't bother us as much because we didn't have to work directly under that person's supervision. So that was another way of doing it. That didn't happen in the hospital but it did happen in the community.

Q: What are you observing with regards to employee retention? The profession seems to be having trouble retaining people now.

RA: My own personal belief about how that's happening, is higher up, I don't know where this information is coming down, but I believe these managers are being pressured themselves. I think they're being directed from above, from beside, and then they've got all their nurses underneath them. Everybody's coming at them. So they have to do things in a certain way. When I was still working, I had a director – myself and the other educator; she was East Indian. This is something that really bothered me. We were pulled into our office and my work partner was told, you know, you have to pay attention to past and present tense. Ruth, it's your job to read everything that she does out loud and make sure that it's grammatically correct. There was always this micromanaging but like you're an idiot micromanaging, and it just kept coming. In that case it was from a director, but I know at least four of us or five left and two are not nursing anymore because of the way we were treated – being micromanaged, having things done behind your back. For example, my manager was a Black lady, and I kind of embraced her. Everything that she did that she sent to the director was sent back to another manager that was sitting in an office with her where it was worked over and then sent back to the director and then sent back to my manager thinking that no one else had seen it. I every so often would pull her in and say, hey, you know you're being watched and all this stuff is happening. She'd be like, don't tell me this; don't tell me this. I'd be like, just follow this chain. You sent this to the director; the director didn't even look at it. The person that's sitting in your office is spying on you for the director, changes everything, sends it back to the director, and then it comes back to you. But it's happening right in your office and you're not even aware of it. As it turns out, both of those managers ended up leaving and both of those managers are no longer working for Alberta Health Services. I left because I was always being treated like an idiot. Sometimes things I would write would be corrected; the wording would be changed. I'd send it back, and then it would be all changed again. I don't think that they recognized that they had already trashed my work, but they were now trashing their own work. It's like, are you doing this just for the sake of no matter what I send in that's what's going to happen, and you do that to everyone? If you're going to have people working for you or under you, you need to trust the work that they do, and not micromanage it. Maybe if you have a concern about it, you can share it with that person, not go behind their back and show it to other people. So there's no trust in that leadership or that the decisions they're making necessarily even come from themselves. There's a sense that someone else is directing them to do this. I say that because historically managers

all worked in a certain way and now they're all working in a different way. That way is that micromanagement piece of knowing everything that's going on. It's unfortunate that we're leaving at the lower levels, but even middle management I think are getting the same kind of pressure. I don't know exactly where it's coming from, and this is where I think politics ties into it somehow. For example, we're offering nurses a three percent rollback. Now there's a federal election. Nobody likes Kenney; we would like a Conservative federal election. I just feel like Mr. O'Toole talked to Mr. Kenney and said, you need to change that with your nurses, because it's painting a bad picture on all of us. This is the part where you can't be apolitical; you can't. When you look at COVID, it's healthcare. But yet somehow politics is playing a bigger role in what's going on.

Q: The system has become so dysfunctional that people are just saying. . .

RA: Forget it. And I'm hearing it more and more – I'm not going to be a nurse anymore. What we all want and we all don't get is an exit interview. You want to know why I left? You probably don't, but I would like to tell you anyway. You have to really push if you want to get an exit interview to let people know why you've gone.

Q: Are people saying they're leaving because they can't stand it anymore?

RA: Absolutely. Me, I left because I thought I was going to commit hari-kari with my mouth, so I knew it was time to go. Other people, I tend to get made instead of, how do I explain it, the people that are crying around me because they're so frustrated that they're not being heard. What they want to be heard about is how we can actually do what you're saying we're supposed to be doing. So what if we did? None of that; we won't do that. But yet if we have something that needs to be fixed, dementia training, we did dementia training for two days. After that, they decided that every little town would develop their own dementia training based on what we already had. Why we couldn't use it, I don't know. So thousands and thousands of dollars of people having meetings where you sit down and say, do you want the people when they respond to raise their hand or stand up? It's like, so there's $2,000 an hour at the table and we spent two hours deciding whether to raise our hand or stand up. Are you kidding me? Do we

not have bigger concerns where we could direct or energy and our resources? I guess that would be my final statement.

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