United Nurses of Alberta

Diane Poynter

DP: My name is Diane Poynter. I'm a retired nurse now; I haven't worked for 3 years, but I did work most recently at the regional hospital in Lethbridge, and prior to that at St. Michael's Hospital in Lethbridge when indeed it really was a hospital, before they tore the building down. So I went through job relocations as they were changing all the programs at St. Michael's. I was a surgical nurse and they lost their surgery. Then I became a geriatric nurse, and that's the area where I finished my nursing career.

Q: How long a career was that?

DP: I was an adult when I graduated, so just 25 years.

Q: What changes have you noticed?

DP: When I started nursing, interesting enough I graduated in '77, which was the first year that UNA was on strike, and I was in a local that indeed was on strike. That was St. Michael's. The attitude there was always the patient mattered, the patient mattered, the patient mattered. You go the extra mile. We had, for the most part, adequate staffing. It was a smaller hospital; so there was a nice family atmosphere. I suspect because it was run at that point by the Sisters of Martha, that sense of extra mile and a more charitable atmosphere; it wasn't big business. Then eventually the sisters sold the hospital to a group of Catholic businessmen out of Calgary, and the spirit changed a bit then. We were more

into bean counting and the hospital was run by business people and not by nursing sisters. By the way, I'm Protestant. So it's not that that's my… And within Lethbridge we had 2 general hospitals both vying to be top dog. This was a long ongoing saga, but St. Michael's lost out to what was then known as the municipal hospital, and is now the regional hospital. When we finally got transferred to a geriatric unit, they almost literally picked the unit up and moved it over into the regional hospital. It was still for a while owned by St. Michael's. But the whole spirit changed then; we were into a corporation. We're into it's the dollar that counts, the dollar that counts, anything to save a buck. Not that the sisters weren't frugal, but still people mattered most. But now it's just the almighty dollar. I look at things that happen now. My own mother is 90; she spent a morning in emergency because she was having some abdominal pain. I was on holidays at that point. They stuck her into a cab and sent her home by herself. Well that would never have happened a few years ago. A 90 year old person would be kept in until there were adequate arrangements to sent them home. They would be watched for at least 24 hours to see if this problem was going to develop into anything. I hear these stories all the time where you go through emergency, and there are no beds for one thing, but you go home. We used to observe people; we used to watch for things. Somebody would come in with a bellyache and you'd think, appendicitis. The term was, we'll sit on them for a while, which just meant observe, watch the pain, see if this was is going to lead to anything, if the vital signs change, and all those things that you watch for. Very often by the next morning the patient was up in the OR having their appendix removed. But we took better care of people. We understood that a hospital wasn't just a place to visit

quickly where a diagnosis was made and then you're shipped out on your own. It was to provide care. There was the realistic expectation that family can't always provide the kind of care or be there. People can't leave their jobs to look after a sick family member; they just realistically can't. Lots changed. Certainly working conditions are horrendous now, but the care of the patients has suffered horribly. Healthcare is a corporation, even in Alberta where we have supposedly a good medical system.

Q: Overcrowding is happening even in the smaller centers as well.

DP: Certainly. Lethbridge was one of the few cities of its size to have 2 very good general hospitals. In the outlying areas there were the small rural hospitals, which were general hospitals. They provided surgical care; they provided maternity care, pediatrics. More complicated things would come into Lethbridge, and then from there still more complicated issues would be sent to Calgary or Edmonton. But within a community, most illness, most healthcare issues were handled within the community. They destroyed one hospital in Lethbridge, cut services drastically. They closed the hospital in Picture Butte. It's just a long-term care facility now and it's not very big. All active services in McGrath. Raymond still has a little bit; Ft. McLeod, which is near the Blood reserve and the Piegan reserve has no active care facility; it all comes to Lethbridge. So there are fewer beds in Lethbridge and provide far more services. They've done that, the little rural hospitals throughout the province; they've just been decimated.

Q: Did you work at St. Michael's for a while before going to the regional hospital?

DP: Yeah, I was there for, started there in '77 and got moved over in '95. So, do the math.

Q: Were you there when it closed?

DP: No, they closed in stages. They moved our geriatric unit over. They kept two medical units open for probably another several months, and then moved into another building at the regional that was once called the auxiliary hospital. It's since become office space and a bit of outpatient space. St. Michael's closed in stages. So, for a while we had a rather large building with two medical units on it, which were situated around the corner from one another. You could go into that building in the evening; working evening shift was scary. If you had to go from your unit to the lab to deliver something, you were walking through parts of the building that were totally dark. I always claimed that families could set up housekeeping in parts of that building and nobody would really notice them. So it was kind of a scary situation there for several months. But they closed it down in phases and finally they knocked the building down. I guess they had trouble knocking it down, because it was so well built that it just didn't fall apart all that easily. The other thing, of course, going back, we had elected, and I want to stress the word elected, hospital boards in every community for every facility. Then we got regionalization with appointed boards, that I understood the purpose of regionalization was to cut down on management – few boards, fewer management; people could save the money, put it where it belongs. What I have noticed is there's one appointed board that was a puppet of the government, and many, many, many, they have buildings and

buildings and offices full of managers of, heavens, I'm sure there's a manager of poop, for all I know. But really it's just ridiculous.

Q: What role can the union play?

DP: Certainly to be some sort of a lobby group. The union and UNA works closely with organizations such as Friends of Medicare. So we support any kind of lobby group that works towards improved healthcare. We have within our contract, like we went on strike in '82 to have what we call our PRC committee, which is our professional responsibility committee, which deals with being a patient advocate. That's our role as nurses, we need to be patient advocates. We also have to insist on fair working conditions because of course for our own personal health we need them. But that's a safety issue again for the patient. You need a nurse who isn't stressed out, overworked. Also working conditions might keep nurses in the profession a little longer. Money will do it, but working conditions will do a lot more to keeping her there longer. As an example, I'm retired and I wouldn't go back to work because I have a bad back; well, I've got arthritis. But physically, nursing is a demanding profession, and if you want to keep us around longer, let us take better care of our bodies. We try to advocate for the nurse, for the patient. I think we just keep plugging away and being vocal. Being a large body does give us some opportunity to be vocal.

Q: How can retirement age nurses continue to participate in the system?

DP: When I retired, I say 3 years, but I retired really 5 years ago. But I stayed on casual for 2 years. The only way to retire is to let your license go. Right now is flu season. I could easily; it's not a great skill to be able to give the flu shots. But I don't have the license; I'm not willing to put out the bucks for the license, and I haven't worked the hours in the last few years. But there are ways they could ask retired nurses and make some exception is to our licensing body to come in and help with flu shots. That's just a skill we picked up as students. Giving a needle is not a hard thing when you do it 20, 30 times a day. I could still do one, yeah.

Q: Presumably that would also alleviate some of the work overload on staff.

DP: That's my point. Somebody was complaining at the annual meeting yesterday-- this is a health nurse--, following flu season. They don't really need to pull those nurses. Maybe one to oversee, but they could use retired nurses. We'd be glad to give six or eight weeks of our time to go and sit and give flu shots. We could do that. I wouldn't mind. That's just one example.

Q: What about the number of younger nurses leaving the profession?

DP: Younger nurses, most of them are looking to having families, if they don't already. You can't be an adequate parent if you're never around to parent. And you're always cranky. By virtue of the job, you know when you go into it, it's going to be shift work. That can never be changed. But just shift work even without throwing in the overtime is hard on a family.

Q: There's shift work and then there's shift work.

DP: Exactly, that's my point.

Q: Did you become involved with the union soon after you started working, with the strike?

DP: Yes, I was involved at that point, but just on a marginal basis. It was the next strike when I really became involved. That was in '80. The president of our local came up to me one day and said, our secretary is resigning, and you know how elected positions happen in the real world, we can't find anybody to replace her. Here's her books; you're it. So I democratically became the secretary. One thing led to another to another to another and I was finally on the board of the United Nurses of Alberta for many years. I loved it.

Q: What kept you doing it?

DP: Involvement in the union? I guess I was brought up by a family that was totally anti-union. I suppose as a young person I was always a little tad of a rebel. But I looked at the union, the way it operated. It's a very democratic union. I thought, this is good; this is people empowering themselves; this is good. So that's what kept me in it. And all the various issues we dealt with. As I say, things like trying to preserve our healthcare, and empowering people. You're not a cog in a wheel; you're like don't let anybody tell you you're lucky to have this job. Uh-uh; they're lucky to have you. Take that attitude.

Q: Do you have some memories?

DP: Karen, the secretary treasurer, this is just a little internal matter. We used to have a newspaper that went out sort of sporadically when I was on the board. I would get up and deliver lectures about. . .

Our news bulletin. I'd get up at the board table and say we've gotta get one out. The best contact we could have with our members is to get something into their front doors. . . .

Yes, my idea was that I'd stamp my feet and we've gotta get things into the front doors of our members. Karen Craig came up to me yesterday. She says, you notice now that for a number of years the news bulletin is out regularly. She says, you finally made your point, Diane. Things are going into the front doors of our members.

Q: Can you think of any successful grievances?

DP: Back in the early '90s, as things were changing in Lethbridge and they were transferring programs from one hospital to the other as they were preparing to close St. Michael's in Lethbridge, the union and the hospitals – this was the 2 hospitals and the 2 locals from respective hospitals – negotiated a transfer agreement. This is an ongoing thing that goes on now, but ours was the first transfer agreement ever negotiated within United Nurses of Alberta to move staff from one facility to another. It was an interesting time. It was a lot of work, and it was kind of nice to be a part of that initial event. It's too bad that it had to be done…

In the '90s our hospital was folding down, folding down. We got layoff notices every year around Easter time. I never lost a job. I would lose my position in a department but I was

bumped into something else. But because I was involved in the union and helping people find other jobs and working all this out, I literally had people crying on my shoulder. I was fortunate, never lost my position. But then you feel guilty, because people were losing hours and they were losing a lot of entitlement. It was a terrible time; it was a terrible time.

Q: Just being there probably helped people considerably.

DP: I would like to think that I helped somebody, but yeah.

Q: How can new nurses become involved in the union?

DP: The one thing, and I don't know if this goes on anymore – when I was a district rep in Lethbridge, I actually graduated the college there so that probably helped me, but I would go every spring and give a talk to the graduating class of students. I was invited. I didn't push my way in. I would go with the little speech that I was going to ramble off, but there was always something going in the world of nursing, and usually what I had to say got pretty much forgotten, as I asked questions. I enjoyed that, and I could fill that hour easily. Speaking to a graduating class of student nurses, involving them that way helps.

Q: How were new nurses oriented?

DP: The way our contract is written or was written, we were supposed to have time during--the hospital always has a general orientation session for new employees. In most

cases it lasts two or three days. We were UNA, and I guess any other union, but this was in our contract, was given a block of time to go and address these new hires. We would try to sign them up and get the memberships during that time and explain the advantages of being a member, what we would do for them. There wasn't much time to do that. Tried to get them interested and out to meetings. We probably need more of that. It's a lot of work being president of a local. If it's a big hospital, you need to set up a ward rep system, and those people have to mentor the new hires in their area.

Q: The mentoring needs to be acknowledged in a structured way.

DP: There's tw aspects of mentoring. There's the union point of view of getting a person interested, and then there's also, and that seems to be lost too, is just mentoring a coworker as a coworker. I'm here for you and sure you've graduated your course and know all the technical stuff and you've written your exam, but we do things a little funny on this floor and you have to watch out for so and so's temper, and that piece of equipment you have to kick it to make it work-- you know how life is. There used to be time for more of that sort of thing. Just general workplace mentoring and making people feel good about, I'm happy that I'm working here. That would probably help also to bring them into the union local. But that's another point. Now with people in and out of hospitals so fast, it used to be on a unit you'd have people that would be in, in my case it would be for surgery tomorrow. Then you've got the guys that are fresh; they're pretty heavy duty. Then you might have somebody that's had major surgery; they're heavy duty. Then you've got another group of patients that are going home in a few days; they're just

convalescing. They're the ones you spend time talking to and teaching and being a little more friendly with. There's time for talk; there's time for fun for the nurse and the patient. There was just more time; you didn't run flat out. A horse drops dead if you make it run flat out. But you don't run flat out 24-7. Certainly there'd be days that you get to the end of and think, oh my god. But there were good days too. I would think now people are either very ill or they're not in there. So you run flat out all of the time.

Q: Now there's less emphasis on practical training…

DP: I'm one of those college grads that went through and did our two days a week in a hospital. Then we'd have a session in the spring when we were there for five days a week. That's where the mentoring is so important. It doesn't have to last long, but it's important to be mentoring new hires. I don't think I maybe was a little slower the first month or two getting my act together on the unit. But I think I was every bit as good a nurse as any of the three year ones. You do need that mentoring time.

Q: Is it important for UNA to support public healthcare?

DP: Absolutely. In fact, listening to I can't remember his name talking about pharmacare, I also think that, I don't know why our teeth and our eyes are also not part of our body. I think dental care should be covered and I think more of the eye care, physiotherapy also for a longer period of time. I think there should be more coverage. Our public healthcare system--well the hospitals are owned by the government at this point, but it's essentially a very excellent insurance plan, and it should continue. Nobody should be beginning to

push private insurance for anything. We shouldn't even need Blue Cross; we shouldn't be needing any of those things. It costs money out of your pocket and my pocket, and that's where every dime and dollar that the government calls their money comes out of your pocket and my pocket. The government essentially has no money; they're just the stewards of our money. So it's going to cost us, whether through taxes or privately; it's going to cost us a hell of a lot more privately than through taxes.

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