UNA Centennial-Larry Connell

I Interviewer

S Speaker

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I So first of all, let's start with how did you get into nursing?

S I got into nursing in -- well, I entered the school in 1976, but it was after a number of years of considering various things. I had done lots of jobs. I've done, I venture to say hundreds of jobs. I'm probably in the mark there. And nursing was always something that interested me from an outside perspective, but 'cause I didn't want to do the school thing yet. And then I thought about it and I thought it provided a professional kind of caring, attending work. And it was portable, respectable, and I think portable was big for me.

I Now, you mentioned that you were part of the transition period of training between going from sort of the old school hospital training to college training. Do you want to talk a little bit about that experience?

S Well, sure. Everybody thinks that their program was the best, and I don’t know if ours was the best or whatnot, but it certainly was one of the most unique of its time, and it's been mimicked in various degrees ever since. It was called a cooperative education concept. And it was designed

by Judith M. Skelton. It was Okanagan College in Kelowna. Essentially, we were the first program to introduce the preceptorship concept. Before that, the word preceptorship was virtually a dead word. They didn't invent it; they just sort of revived it. Our first summer in the two-year program was spent working at an assignment in a hospital doing summer replacement, either as orderlies or practical nurses or any healthcare hands-on patient kind of care that we were qualified for. And on a nice note it was union scale--every one of the jobs that we got. And it helped. It was a win-win-win situation; got us experience. It got summer relief for the hospitals, which is always a problem, and also put some ching in our pocket for the next semester. That was pain. The second summer semester, which didn't involve classes, was the preceptorship. And each -- each of us had to do three of the then five major areas, one month each as a preceptor. We followed a registered nurse -- we were assigned to a registered nurse who was willing to take us on, and we essentially started out following them and then eventually, hopefully at best, carried most of their load by the end of each month. And this was the first of the preceptorship. We were written up in the *Canadian Nurse* in, I think it was, 1977, just before we had actually done the preceptorship, in an article called "The Program That Dares To Be Different." And it was different, and it was very, very beneficial. I quite liked it. Again, I don't know if ours was the best or -- but I think it afforded us a great deal of hand- on experience, and it bridged what they considered the differences at the time between the two-year nursing program and the three-year hospital program. And, as a matter of fact, I believe the numbers were 1800 hours clinical for most college programs and 2600 hours plus for most hospital programs. And our program was like 2400 hours. So it was sort of right in the middle there. And we had university transferable credits,

as well as a larger than most other college programs number of clinical hours, hands-on nursing. So, yeah -- and it's quite flattering to see that that preceptor concept has been mimicked right across the country, and I believe in the United States as well.

I You also mentioned that when you started nursing, at first, you were coming in as part of an association, and then the transition happened. I'm trying to remember…. And the transition happens into the BCNU. Is that roughly accurate?

S That's fairly accurate. At the time, the professional associations also negotiated the contracts, and rightfully so, that was seen to be. And I think by oncoming legislation and labour relations laws and professional association obligation, that was seen to be a conflict or certainly a potential conflict of interest. The same organization who represents you in a discipline hearing is the organization that's going to be disciplining you in a professional manner. I don't think it was a proper relationship between the two, and I think the severance was a good thing. And yes, I was there. I was there for the founding meeting of the British Columbia Nurses' Union, and shortly after that, I believe, the United Nurses of Alberta went through the same transition, as did all of the organizations across the country. And I think, yeah, nurses belong in a union, and I don't think that union should be the same organization that's going to professionally guide you.

I I know the answer to this, but I want to get it on tape, which is, I'm presuming that these nurses' unions had a very different feeling about being a member than the association. Is that right?

S Yeah, well, it certainly separated the people who were more interested in the professional development from the people who were interested in their working conditions and negotiating them and collective agreement. Nursing unions have never ever separated themselves from their interest in professional development and the professional responsibilities, but yes, we certainly do take more seriously working conditions. And in later years, now, more than then, also an identity with those other labour organizations. We severed ourselves and tend to sever ourselves still from other labour organizations. We're nurses. We're professionals. I think we can be both quite distinctly…

S April of 1984 I moved to Alberta and at first took a job in the private sector, and I was a nurse in remote sites -- industrial sites, usually of more than 200 workers. I've been within 300 miles of the North Pole. I like to say I've been further north than you've been away from home, and I'm usually fairly close. For a short period of time I was with the private sector, and very, very interesting doing industrial nursing, industrial first aid, etcetera. And then, shortly after, I was working for the Alberta government in a correctional centre, where I was for 16 years.

I Okay. Let's talk a little bit about that now. When people think about nurses, they think about hospitals, right? You know? Sometimes they think about long-term care, but they never really think of other industrial nursing or corrections, right?

S It certainly goes to what I said earlier about my interest in nursing being it's portable and it goes to many places. And I've had a very fortunate career in that respect. A lot of different experiences within the unions and within the private sector as well. Yes, people don't think of nurses in corrections, and it's a field all unto itself. It's very, very interesting and very, very independent style of nursing, and it involves every aspect of nursing I've learned and experience. Psychiatric nursing, first aid, substance dependence. You're dealing quite substantially with the psychopathic personality, varying degrees of it. You get men, women. You have birth situations. We've had pregnant inmates. I'm trying to figure out some confidentiality, but I think it was a matter of record. I dealt with the first person who was arrested for knowingly spreading the AIDS virus. And that's quite an interesting aspect. And where does the professional responsibility of confidentiality cross over into the public sector of courts and matter of record? It's a line that you have to see all the time and consult with your own professional ethics about. But corrections is an area that I don't recommend to every nurse. I would strongly recommend it to some nurses.

I It must be a situation where, not unlike being in a small hospital, you're often the medical care unit. There's no doctor standing over your shoulder. And so that creates a different dynamic, I would assume.

S That's very true, and you bring up another aspect of it. First of all, you're very independent. And with doctors' orders, standing orders, I've been able to initiate many treatments that I wouldn't be allowed to do in a hospital. And the other part of it is in corrections, you're not the main job.

In the hospital, you're another nurse, as one of my friends once said, another white pyjama person. And I like that, white pyjama person. In corrections, you're not. The main job, obviously, is to keep care, custody, and control of inmates within a confined space or certainly some limitations to their mobility. And all you're doing is addressing their healthcare within that environment and their ability to obtain the same level of healthcare that they would on the street within those limitations. So, yeah, it's a lot of different aspects of it that you have to grow to understand.

I But yeah, it speaks to one of the themes we're exploring, which is the changing level of respect and responsibility for nurses over the course of time. So I talked to a nurse in Canmore, and she says, you know, when I was first on, I was on alone in a little hospital, and she said a 28-year-old woman comes in and she's got abdominal pain. So I take her medical history. I'm thinking it could be appendicitis. It could be something else, but it's serious. We need to treat this. So I call the on-call doctor and say, well, you know, here's all of her history. Here's her information. This is what I think the problem is. He just says, well, fine. If you're so good at getting the history and diagnosing, you treat her, and hangs up the phone. Right? And it's that thing where there was, for a long time, a very rigid kind of barrier to nurses using the full range of their skills. So I'm wondering in the correctional context, how that seems like it gave you a bit more space to use your skills. Is that an accurate --

S That's very accurate. And I did nurse in small hospitals and I know what that's like, phoning a doctor at 1:30 in the morning and having him grump at you because you phoned him. And I always like to say, Well, you

know, okay, we can hang up, but I can call you at 3:30. You usually get a very quick answer when you come up with that. But, yeah, in corrections it's similar. We had a doctor on call who was responsible for all the doctors orders, etcetera, and he trusted your judgment and your assessment, or he had to deal with it his own self. And that led to a great deal of trust in our assessment and judgment. And then the flip side was also the correctional personnel, the managers, they would not want to take somebody out to the hospital. And I would just say, well, okay, just sign here that you're saying no to what the nurse recommended. And usually they were out to the hospital fairly quickly. They don't like the heat. But yeah, it's very interesting. In corrections, also, many inmates think you're there because you couldn't be a nurse anywhere else. You know, you're just here 'cause you couldn't work in the real hospital. And that's a perception that has to be overcome merely with your ability to do your job.

I Yeah. Okay. Let's go on. It's '84. You've arrived in Alberta. That's right after the Alberta government basically has declared that it's illegal for nurses to go on strike. There's a whole set of legislation that comes in. Was that the case in B.C. when you left or was this something that was new to you, hearing that you weren't able to exercise your right to collective action?

S I'm trying to remember. No, as a matter of fact, we had a strike vote; I think it was 1979 we had a strike vote. I was working in Nelson, B.C. at the time. And oddly enough that strike vote was 98.6. And we had not long gone from Celsius to Fahrenheit and as you know, 37 percent wouldn't sound near as good. But it was 98, and maybe somebody skewed the numbers to a little bit two or three to make 98.6, but --

I Sounds good to me.

S It was. The employer went right back to the table very, very quickly because we were prepared to walk the line and they went back to the table. And with a strike vote like that and the willingness to do it, the employer's a very, very different person than they are at the table knowing that you're not collectively begging that you have the mandate of your members behind you and saying, you have to address these issues. And they did so, and things improved a great deal at that particular time. But the right to strike for me personally has never entered into it. Nobody ever gave us the right to strike. It's inherent. Rights are inherent. You have them. They can't make laws for them or against them. As a matter of fact, the more laws about them, the worse off the labour movement is. And that's where I'm probably more radical than most nurses who are active in the unions. The right to strike is inherent. Any rights are inherent and you have to exercise them when they're needed. So was it legal to strike? I think it was illegal. We had established our own -- I could be wrong about that, but we had established our own essential services committee. A couple of years later, we were establishing an essential services committee and we had quite a humorous time because we had one of our biggest arguments at the time at the table because there was a shortage of good nursing staff. And the essential services committee established that to have essential services in the hospital, we would need five more nurses than we had. So that strike would have been a lot of fun. If we had five additional people working in the hospital, then it would have addressed our issue. Irony is but I can't recall exactly, but the B.C. government on and off has instituted the typical right-wing, you

can't strike. And they were no different than Ralph is now shaking the finger saying, you're not going to break the law. Well, you know, you keep moving the law. I don't know whether I'm breaking it today or not. So --

I So --

S Did I answer your question?

I You did. To '88. Let's jump ahead a little bit here. So you're here. You've established yourself. Are you in the correction services by then?

S 1988 I was in the Alberta Union of Provincial Employees. That's designated by law, oddly enough, that we're people who work in the right of the Crown are in AUPE. And 1988, the UNA took the brave stand of going on strike. And my wife, who was a member of UNA, walked that line and I walked it with her in support. She was casual, and I've got to tell you, we needed the casual money. But nothing's more important than respecting the line.

I Great. So let's move forward a little bit and let's talk in detail about this chain gang episode.

S Oh, the chain gangs.

I Yeah. Tell me how that started out. You know, how did you get wind -- well, what was the idea? 'Cause we need this on tape 20 years from now. Let's hope they've forgotten what the idea was by then --

S I hope so.

I -- and they haven't implemented it. So let's talk about what the idea was, how you got wind of it, and what you decided to do.

S I'm trying to remember the exact year, and I'm wrestling with my little brain on it.

I It doesn't matter. Dates are the least --

S I'm not -- I don't know.

I It was the 90s. We know it was the 90s.

S It was the exact same year as the laundry strike, I can tell you that, because it was occurring around then. And the Alberta government, under Ralph Klein, had typically raised a bunch of balloons about re-instituting -- they were going to get tough with criminals and tough with inmates, and they were going to get tough on law, and they were going to institute chain gangs, just like down in Alabama, forgetting that Alabama doesn't have 40 below and they have 40 above, not that I promote chain gangs in Alabama either. But they were going to institute chain gangs and put these inmates in their place. Whether or not you agree with the concept of chain gangs, certainly under many human rights laws, we have an obligation to look after inmates and look after their health and safety. I was the chair of Local 10 in AUPE at the time, which represented many healthcare professionals, but

particularly of interest to me in that issue were the nurses who work in corrections. And one of our jobs -- one of our many duties was to ascertain whether and assess whether or not any given inmate was fit to work. Were they fit to work in the kitchen? Do they have open sores? Have they been taught properly about handwashing, etc.? Were they physically capable of working in the greenhouse lifting bundles? Were they capable of working here, there, or the other? Were there any physical limitations, etc.? So it was our responsibility to say, yes, he's fit to work anywhere or yes, to work in the kitchen, etc. Well, with this trial balloon going up and as the leader of a local that represented these nurses, and being one myself, I could not imagine myself being in a situation saying, yes, you are physically fit and medically capable, and with my permission, can go work on a chain gang. I wouldn't do it. It wasn't going to happen. I talked to a lot of my colleagues about it, and they all agreed. And some were really quite concerned that they would be in a position to do this or have to do it. And the employer's a very threatening person, and I don't care what your profession is, this is your livelihood. And if you're told to do something, you have this strong worker ethic to think, I've got to do what the boss says. That gave me a great deal of concern, and I solicited both the support of my union, as well as my professional association at the time. And I got some documentation and I assured my colleagues that you are a member of the AARN, which subscribes to the United Nations and their treatment of prisoners. And putting prisoners in chains, which would endanger themselves -- just tying inmates together is a danger to each other. It also endangers the guards. Never mind the fact that the chains were going to be a factor in the cold weather causing sores, irritation, etcetera. And it's inhumane. It's inhumane. And under the United Nations Charter and the ICN, the International

Congress of Nurses subscribes to it, it says that putting people in chains to work is a violation of that Charter. I drew up a document that outlined not only the professional obligation of the ICN and of the United Nations Charter on Human Rights, but I also pointed out that under the Alberta government occupational health and safety regulations and the Workers' Compensations Act that they would be in violation of their own statutes, which they also hadn't considered. And through the help of my union at the time, after I had put this document together, I had some people distribute this to each and every MLA in the province. It was the night before the Conservative caucus was going to vote on the issue, and they did. They voted on this issue in closed quarters. My own MLA, Conservative Mr. Smith, had spoken with myself and his concern was addressed -- he was the minister of tourism at the time -- and he was concerned with the way chain gangs would look. And he at least led me to believe that he would be supporting me in not wanting chain gangs. But the word was, and there is no official record that I know of -- but the word was that the initiative was narrowly defeated. I think that's a shame. I think that's disgraceful. That it was narrowly defeated tells me that people voted to put people in chains. I'm proud of my initiative, and I'm proud it didn't come out. And like you say, I hope 50 years from now nobody's hearing about chain gangs. But that was -- that was a tough one for me and it was a tough one for my members 'cause they didn't know what they were going to do. I recommended them not to.

I Well, here's a question, slightly rhetorical, but you're somebody who worked in corrections for 16 years, right?

S Mm-hm.

I You know what happens inside. And the argument is always that, you know, it's people in that situation that are supportive of tougher treatment of criminals. We hear these arguments all the time.
The right-wing argument is that we've got to treat these people tougher if we're going to achieve better order and all that stuff.

S Mm-hm.

I Is there any evidence that this is going to work putting somebody in chains ?

S No. And if I'm correct, and in my research I learned that those jurisdictions that do employ chain gangs have, in fact, a higher rate of recidivism. It has absolutely no relationship whatsoever to correction, to rehabilitation, to reducing crime, to correcting behaviour. It has none whatsoever. It's merely a power struggle and a ‘ look what we do to inmates. ‘ We're tough on law. That's all it is.

I Yeah. I mean --

S Rah, rah.

I Yeah. And I mean I think it's really important for people to understand that kind of stuff really just humiliates somebody. I mean it just hardens people, right?

S Well, I guess there's science to prove it that humiliating people merely strengthens the ill behaviour. It doesn't strengthen any positive behaviors.

I Yeah. Okay.

I Just so I get this line clear, when did you leave corrections? Presumably then you go and you start at orthopedic? You're working in there now? That's the point at which you become a UNA member as opposed to an AUPE member.

S February of 2001. I was probably getting tired in corrections. it had been a long time and the recruitment for acute care nurses was really very, very strong. And I thought that this would be a better -- a good point for me to change directions in my career and go back into acute care. I did a short stint in emergency at which point we decided I'd go over to other areas of acute care. And I went into orthopedic surgery. I was only going to go there a little while, but I quite like it. It's bad for a union person to say I have a couple of good managers, but I do.

I I don't think that's a bad thing for a unionist to say.

S No.

I No, I mean seriously there's a whole bunch of false perceptions around that stuff.

S Of course there is.

I So were you involved in the stuff around Bill 11? That'd be the late 90s.

S You'll have to remind me what Bill 11 was.

I Bill 11 was the big privatization bill where we all ended on the Leg steps protesting that the government -- it was the overnight stays in hospitals and all of that.

S Oh, I'm sorry. Oh yeah. Yeah. AUPE was in the house of labour and the house of labour was very, very strongly -- and I as an individual was against the concept, yeah. Their whole idea isn't for the benefit of the patients. Their whole idea is for the benefit of insurance companies and putting healthcare out to market. And it doesn't work. We know it doesn't work. Our system works. They just won't put the resources in to make it work.

I Let's talk a bit about that 'cause I think it's another key issue that we're going to follow through -- this project 'cause we're going to be able to look at Saskatchewan at the beginning of Medicare in '62 and track that through. And it seems to me what we're engaged in right now is a struggle to keep those victories that we won 40 years ago, you know. And let's talk a bit

about, first of all, what are the signs you see that we're moving towards an attempt to privatize? I mean I know them, you know them, but I think it's good to put on the record. What are you watching in your experience that's telling you this is what --

S Signs? I mean if a person hit you with a bat on the head, would that be a sign that you're being assaulted? I think so. We have private hospitals. The health -- HRC down here is doing hip replacements and the Calgary Health Region is referring patients to them. I don't need a sign. It's here, it's there. I mean we -- back -- the big laundry strike in -- we're still trying to remember the year. The laundry strike at Foothills and carried over to the old General was a fight against privatization. Well, it turned out not to be a fight against privatization, but a fight against when they'll be able to do it because they fought against K-bro, who's doing our laundry right now. We don't need signs. It's there. It's practices. This is not a suspicion. This is no longer a conspiracy theory. It's a fact. They're privatizing it and I mean look at Bill 37. It has the adjective "past" that will allow for the purchase of private healthcare insurance. Well, what is that for? Sorry to be so sarcastic with regard to your question, but signs are -- I don't need a sign I'm being assaulted if somebody smacked me with a bat.

I Yeah. I think that's exactly right. And so why is this a bad idea? I mean you've heard all the arguments. I don't have to repeat them.

S I've heard all the arguments. And you know what? We are one of the G8. We are one of the most developed countries in the world. It is disgraceful to think that we wouldn't provide equal healthcare to all persons

that require it no matter what. I don't want to see a rich person get a better healthcare than a homeless person. I want to see them both get a high-level quality healthcare. That's what I want to see. So why is privatization bad? Because it separates them. It gives one a faster avenue, and one a lower, less quality avenue. We know it to be true. Let me address a different concept that people aren't watching, and it's the blue-collar person that's driving this train. And they're buying the sack of camel poop that they're being sold. Oh, I can afford insurance. It's okay. Why can't I spend $1,500 to get my surgery first? They're buying all that. And they will be able to buy insurance, and they know that. I'm an expatriate American. And my mother is down there. A year ago I went down there and literally had to rescue my mother from a healthcare system that wouldn't release. Not because she couldn't get coverage because she does have coverage. This is something we don't think about here in Canada. My mother is covered for everything. She's 86 years old and she had a slight infection in her leg that that I'm going to say through a perhaps a non-liable-ist degree of negligence led to a greater problem. And this is where the healthcare insurance kicked in. She was covered. She was covered for everything. So for a minor exacerbation of an infection on her knee is what it was which went systemic, they admitted her to ICU and they referred her to every consult they could imagine. I couldn't believe why they were consulting her everywhere. She was in the hospital three months later when I finally went down there and she was in a rehab hospital by this time, still had an indwelling folly catheter that under the same circumstances here we would have out in two or three days. She was not allowed to walk from her bedroom to the bathroom. Under our system here, we would have her on a walker doing the very same thing independently. She told me, they don't want me to walk without the

physiotherapist. Why? Because she was covered. You see? She was there longer. And my sister-in-law who phoned me and said, Larry, I just think they're keeping her there because she's got the insurance. I had to negotiate the release of her folly catheter. I had to insist on a referral to a urologist who -- and it wasn't a urologist that I saw, it was his nurse consultant, that's who's doing the work down there now -- the nurse consultant knew exactly what I wanted and he wrote an order. Remove folly catheter, do not reinsert, and teach patient to self-catheterize. She was released in two days. They had no reason to keep her.

I I've never heard that kind of story. That's amazing.

S I don't think that's uncommon.

I I bet you it's not. I mean it makes total sense.

S But it's something that we don't think about. And here's where the hospitals are ripping off the insurance companies, and the insurance companies, they don't fight it. So -- and where do they turn? They turn to increased premiums. There is only one pocket. I don't need to feed six of them. It's my pocket to the cost of healthcare under the system that we have if we were to eliminate the privatization, eliminate the profit. It's mine too -- and everybody along the way should make a good wage. There's nothing wrong with that. And there's nothing wrong with private doctors making a profit. But to extort monies through the system -- and that's what happens. So abuse happens in all kinds of ways that we don't think about. And it's only the insurance companies that win. And we lose 'cause we keep paying.

I Okay. I'm going to shift the gear slightly again and say one of the things we're asking people to do is tell us stories that for them in some ways sum up some sense of the time -- the decade they're in. So let's talk a little bit right now, you're 2000, you're in a hospital -- let's say 2001, you're in a hospital here in Calgary. Can you think of what's happening to you now and talk a little bit about a story that for you sums that up? I'm thinking about things like the incredible kinds of patient loads people have, the kinds of shifting that people are put into, those -- but I don't know if those are your particular issues or not. But we're just trying to say, think of something that's happened that you feel really sums up some of the things you're grappling with in your workplace.

S That's really a tough question when you say in my workplace. It's not my workplace specifically that gives me cause, but things that are happening in my workplace in the assignment of hip replacements and knee replacements going through this board that's signing it out to private hospitals. That's what's giving me concern. What's giving me concern is the ever increasing presence of, oh, it's inevitable we have to have insurance. It's inevitable we have to have private healthcare. It's inevitable we really need to have these private clinics because they fill the void. I think we are growing to accept private healthcare, and we have not been given the chance to confront and say, no, we don't want it. It's ever so ebbing up on us, or should I say flowing up on us. It's being very subtle, I think, as a general workaday citizen, it's been very, very subtle. As a union activist, it hasn't been subtle to me at all. I've seen it all along, and we've raised the flag. And I don't think anybody's believed us till now. But it's going to be believable

when they look back and say, I didn't see it coming, but gee, now, we got -- now, we got AETNA advertising. Every other commercial is AETNA; buy our health insurance. Or State Farm, you're in good hands with. I think that to define this decade and what gives me great cause in my work and it's my work as a nurse because I'm very proud of the fact that on the same day, I looked after an ex-senior government official from this province and a homeless person. And I can say except for affording that politician a little more privacy, which I think is realistic, they both get the same privacy. His notoriety would make me want to guard it a little stronger, you know. But they got the same care. And I'm very proud of a system that does that. And to go back to what we saw as children, 'cause we lived in a time when there wasn't-- when one of my dad's favourite expressions was, don't break your leg; I don't want to lose the house. You can't get sick; we'll lose the house. But it was real -- that was a realistic expectation on the part of a working person who couldn't afford all the insurances in the world. We'll lose the house. It's wrong.

I I hear you. And I think you're in the frontline in Calgary. I really do. I think even in Edmonton it's not as in your face as it is here.

S Is that right?

I That's my perception. And I'm not saying it isn't happening, believe me, but I think between hospital privatizations here and stuff, this is the wedge. This is where they're pushing it through. And I think you're absolutely on the frontline in that.

S We as Calgarians, is that what you mean?

I Yeah.

S Oh.

I You as a healthcare profession in this city.

S Yeah.

I I think you're the people who really are being hit in the face with it.

S The patients don't want it. The patients are starting to see it 'cause now they're being referred. And this is an interesting thing. And this is why it's becoming so evident to me is the patients are telling me, Oh gosh, I've, you know, waited months to get in here, and I was referred by that referral agency, I forget the name of it -- this is that new initiative -- and they wanted to send me to the private place, but I didn't want to go there. I ask, Why didn't you want to go there? I didn't want to go there. No answer. I just leave it be. But I find it interesting that it's those people who are directly being affected who are becoming a little bit more aware. And they're stating their dislike for it. It does scare them. And these are the folks who remember when we didn't have healthcare. They're not labour activists and strong union supporters but they know right from right and wrong from wrong and they don't like this referral thing that's putting out the private sector.

I You've been an activist for quite a long period of time. What do you feel most strongly about having won during that time? Like what do you think --

S Feel strongly about --

I Having won. Like as a union activist, what are some of the gains you've seen in terms of the condition in your work place, the role of healthcare in this society?

S I don't know if I'm an activist or an active member, but I'm an active member. Wins are smalls, and I see them all as small. I suppose when I went to court to have an arbitrator overturned in his interim decision, that was kind of a big, big win, and we won as a result small things for a few people. But I was very proud of that and that was because we didn't say, yes. We just said, no, we will not take that -- we will not take an unfair collective bargaining agreement for those members. And I don't care that it's only four or five members. It's wrong. Other things are small, and I think that health and safety is a big thing for me. It's a big issue for me, and I do think that we've made many, many strong inroads on health and safety. It's probably the labour movement's most obvious area of success, whether or not we claim it's our success or the board claims it's its success. I don't care. The fact that the conditions are won, and the conditions improve and that the workplace becomes safer, and that's an ongoing job. That's what's important. So what do I --

I Give me a specific example of that.

S Well --

I Patient lifting or what --

S Patient lifting is a very, very good thing. We have a patient lifting team now, and we have equipment nowadays that lifts patients. And I hope soon we have a no-lift policy whatsoever. Nowadays, the technology is there and it's affordable to have situations where patients need not to be lifted by physical force. And that's a win for the worker, although we're not fully there. I think we're very quickly going to go there. So lifting is a very strong thing. Nurses have a terrible, terrible history of back injury and multiple RSIs, which is repetitive strain injuries. I think being aware of it and the employer is now taking from the unions. No, you will not blame the worker for their own injuries. And I think that's a terribly important thing. Of course we have to take responsibility for our own actions and be careful, wear warm clothes, walk safely on the ice, but there's a certain amount of conditions that we have no control over. And when they constantly put heavier patient loads or constantly equipment isn't fixed, they cut back, cut back, cut back, when that creates an unsafe environment, then the worker can no longer be held responsible for the accidents that occur. But that's an ongoing fight. It'll never be won to my satisfaction; so let's say that. But small win -- many, many, many small wins add up to a very good feeling. You know, feels like single large win sometimes. But I think the employer, sometimes willingly, sometimes not, has to listen to the worker and the workers' organizations when it comes to health and safety. And I think we've had a great deal of success in that area.

I Excellent. Anything else that we should be talking about today that I haven't known enough to ask you?

S I don't know. There's no perception of males in nursing.

I We could talk about that. I haven't talked to anybody about that yet. Yeah. 'Cause that's a big thing, isn't it? It is -- well, actually, Mike was talking about it a little bit. It's this idea that you could actually have a male nurse is, in North America particularly not common.

S Mm-hm.

I So what's your take on that?

S Well, I'll give you some of the history. First of all, men were the first nurses, and not in terms of the biological definition of nursing, to feed, but in the wars, it was the Christian Brothers who were nursing ,attending, if you will, to the injured on the fields. While they may not take part in the war, they were taking part in the healing. And the forefront of most medical science surgery has been on the battlefront. You know, the wonderful plastic surgeons that came out of Vietnam. That's a sad note, but -- so men have been in the attending, care, treating field, outside of doctors, for centuries, literally. Since the registration of nurses to the best of my knowledge right up until I entered nursing, there was between one and three percent male RNs. Not visible though. They tended to go into psychiatry. They tended to go into urology. And not necessarily be in the visible eye of general care.

And I think we've migrated out to those areas now. I don't know that our percentage numbers have increased much more than that. I don't know. But it's never been an issue for me. I've always maintained that Sally can fight fires. And if the equipment is such that she's not able to carry the equipment, then we should be making equipment that is bearable by workers. So yeah, if Sally can fight fires, Larry can be a nurse. And I don't care what you call it. If nursing is a female term, I'll live with that. The resistance I've had mostly has been through my colleagues and not through the patients. When I was a student, and I was in maternity -- I was assigned to maternity, I had met one of the nurses in a social atmosphere then. Okay, now I'm dating myself. It was discotheque. And she expressed to me extreme, extreme resentment to me being on the maternity ward. And I asked her, well, what about the male doctors? They're on the maternity ward. And she said, that's different. And I said, do you know that most of the patients are very, very welcoming when I introduce myself and provide care? It didn't matter to her. I didn't belong to her. She was an extreme. Very young girl, too, which surprised me. Usually you'd think it with the older girls. But the older nurses were more accepting. Most of the resentment or isolation I've met throughout my career has been through my colleagues and not through the patients so much. But most of my colleagues are very, very accepting. Of course my union has a constitution that constantly says hers and she throughout, but we'll work on that.

I Okay. That's great. On that note, thank you so much for saying that. That's just wonderful. Great. Thanks, Larry.