UNA Centennial Project-Linda Long

I Interviewer
S Speaker

S Linda Rose Long.

I Can you tell me how you first started out nursing? What was your training and where did you first come to nursing?

S Well, I guess as a child I always was interested in this, and I went to the Yorkton Hospital School of Nursing, which was about 40 miles from where we lived. And it was the training of the day and you got your lectures and that, as well as experience at one time. And that was a regular route for women. You either went into nursing, teaching, or a stenographer. It was a three-year program, but you got lectures and that primarily from the doctors, who would come when they were free from their offices to lecture, more the science part, the anatomy and physiology, and then the pharmacists and related courses, and the nurses taught the nursing dimensions of it.

And it was a good experience, and a lot of good practical experience. But you did night duty as well. So your classes were pretty well organized around especially when the doctors could give you the time. So you could be on nights and then get up at noon to hear your lecture from the doctors or from the pharmacists, and you know, I still have some of the notes and that. I don't like to burn them now that, you know, I've gone through further education and that. But it was good and it was a very, very small school, which was very good because you had a much more personal investment, and the doctors, as well, really were very ready to explain and help. I recall even then at the time a lot of the experiences that they were giving me, like cleaning the linen cupboards and washing bedpans I kind of wondered how it related to nursing. And so I sometimes got into trouble by asking questions. But, you know, you kept your focus on what you wanted in the end and this, and I think all of these things were things that I very early on felt needed to be changed. So I guess I questioned quite early on in this. Once I graduated, then I practiced just general staff nursing.

I Okay. Before we get to your practice, I want to take a little more detail on this. The first thing is, nurses now would not understand the system of education you were just talking about because of course now it's all colleges, and we're going to talk a bit more about how that came to pass in a little while. But can you describe the system you were trained under where the nursing was directly related to the hospital? Talk a little bit about how that worked.

S Well, first of all, you received what they called a stipend which was your payment. You were considered employees and you got a payment of $6.

I What decade are we talking about here?

S What time?

I Yeah.

S That was in the late 30s, bordering into the 40s.

I Okay.

S That was about '38 -- 1938.

I So $6 was not a great wage, but it was a wage.

S Oh, and you lived in the residence. So you got your free board and room. And that, I guess, added into their wage. But if you broke anything, it was deducted. So, many a time I got 25 cents. So you hardly had enough to buy a pair of stockings at that time. So they counted that. So you were posted as being on night shifts and day shifts, like a regular staff.

I So this is Saskatchewan in the dirty 30s.

S That's right.

I It still was really important to be able to have that in order for you to be able to get --

S Yes. Yes. There certainly were no alternatives; university was just not an issue. But also at that time, nursing in universities wasn't really developed like it is now. I think maybe just a couple. McGill might have been one and I think Vancouver -- the University of B.C. was probably another, and Edmonton, I think, and Saskatchewan. I guess really all the provinces were just in their infancy stage really in the Bachelor's programs. And of course out of bounds expensive wise to do. So this was sort of your avenue that you could go on, you know, for further education. And the supervision you had was like, in many ways, the military system. There were first-year students, second year, and third year, and you acted as sort of tutors and supervisors and that. So we didn't see too many graduate nurses. So your bottle was really your senior student and that in the system.

I Somebody told me one time you could tell by the colour of the cap or something what year the person was in. Is that something that you --

S Oh, absolutely. Absolutely. That's when it was very militaristic and they imposed that too that I'm in the second year and you don't say this to me. And certainly by the time you got into the third year, you know, they were, you know, even much more superior. And so it was. You stood up for them if they come in the room even if you're charting or whatever, and it was very much the military system. And you went on nights and you were just posted like staff. And whenever you got your classes that the doctors gave were during the day, usually at noon. So, if you were on nights, you just got up and you got your classes. So it was sort of a fill-in type of thing. And any opportunity to study was quite a luxury.

I I mean I think one of the themes we're trying to follow here is the increase or the struggle for professional respect for nurses. I mean the change from the Florence Nightingale kind of model to more contemporary practice where nurses are given more respect and responsibility. Do you want to talk about when you started out what the relationship was with the doctors and the hospitals in terms of how they saw your role?

S Well, the administration, which was the lay people, you didn't really see them, you know, as such, other than if there was an issue that, you know, you broke a thermometer. And things that you were called in, kind of an accountability, but it was very much reprimand and we will be doing this. In nursing, if you were called into the nursing office, you usually came out not with praise. It was usually something not necessarily constructive that you did this well or that well, and it I guess all I can do is draw the analogy to the military system. If you were the subordinate to the others, that was very much in practice, and, you know, they could be quite easily reported by your second year or third year student, and the irony was you come out in the end, you know, you felt very close as a group.

I At one point, when we were just talking, you used the phrase that you were treated almost like a servant in this --

S We were.

I Can you talk to me a little bit about that?

S Well, as a servant, you were there and why wasn't this done and why wasn't that done, and, you know, you haven't done this. So there was usually a punishment of some kind that -- I could just site I used the linen cupboard more because it seemed so symbolic of the system. I even notice it when I do my own laundry. If the towels weren't exact, you were called back to take them all down and redo it. It was just out of perspective that they were there, they were clean; they were available. As punishment, you could go in and wash the bedpans a second time around. They'd find a spot. Depending on mood, of your superior, which could be a second year nurse or more primarily the third year because

they felt much more superior, it depended on the relationship or the mood they had or what reprimand they had too. So it kind of goes down the line.

I And what was the relationship with the doctors? I know a nurse in the Crow's Nest Pass talked to me and she said, again it was a little hospital, but she was working alone on a night shift and a young woman came in and she was complaining of abdominal pain and so she sort of got a bit of her medical history and asked her about the pain and stuff and felt there was a serious issue. So she called up the doctor who was on call and said to him, here's what I have observed. This is the work I did. You know, I'm thinking that we have maybe appendicitis or something serious here. And the doctor just said to her, well, if you're so good at getting the symptoms and making a diagnosis, you don't need me, and hung the phone up on her. And was that kind of --

S That's not unfamiliar. You got into a lot of trouble because there was very much this superiority. I'm the doctor, and the administration focused on that. The doctor was a God. If you were to pass a judgment, you weren't given any credit for using your own intelligence and power of observation. And yet you were the one that was with that patient them eight hours a day. We had 12-hour, 14-hour shifts. So you knew that person really in a much better way than the physician, who knew them. And I got into trouble many times, which is why I kept saying, it has to change. We've got to change this because it's two people that are responsible for that person lying in that bed, not one. And so yes, I was penalized for doing that.

I What kind of thing would happen? Just describe to me a kind of an incident that --

S Well, you know, they'd extent my night shift to a week, to two weeks. And usually sometime when there was an exam coming along, you know, that there was that relationship of superiority that meant you weren't a winner.

I So, you're graduating. It's the 40s I presume. You went then into practice for a little while, did you?

S Yes, I did. I did just general for a while, but I was a night supervisor, and that was tremendous -- in Lethbridge Hospital. So I've worked quite a bit in Alberta, as well as Saskatchewan. And that was a tremendous experience. And then I've been a head nurse and a general staff nurse and, you know, I built up a lot of practical experience before a couple of doctors had said to me you really need to go on because you're not being satisfied. And I said I had acquired the practical experience, which I think is very important before nurses go into further education. There's nothing like practical experience to put a value on what you're taking. And so that's when I went to McGill and got my Bachelor's with a specialty in the area of nursing practice related to education.

I Great. Okay. We're going to come back to that in a second. I'm asking this of everybody, but if you could think of a story, something that happened to you in that first decade when you were practicing that kind of, for you, summarizes what it was like to practice at that time. Could you tell me that story?

S Gosh.

I Just think of something that comes to mind as an incident that you remember from nursing in that time that -- maybe that struck you as -- as one of the reasons why things have to change.

S Well, ironically it did happen because one of the teachers who eventually became what we called then the matron, who would be the nursing administrator would ride your back. And I built up quite a dislike for her, very much so. And if anything happened to her, I wouldn't have cried, you know. And she, herself, got into some personal problems and none of us were sorry for her. And I thought, well, we're supposed to be so empathetic and sympathetic, but we weren't for her. But I seemed to feel I had my -- I don't know that it was a revenge, but in a way a form of satisfaction when I went back to that hospital later as an advisor and she was there, and I got my turn. And, you know, I remember her comment saying, well, this is one of the students that I knew would go places. Anyway, so that was my revenge.

I That's great. Okay. Let's talk about this. You've already said that you really felt things need to change in the way nurses were trained, and part of your process to do that was to move into nursing education and get your own education. Talk a bit about what you saw needed to change and how what you were doing related to making those changes.

S Well, I think through the practice, and I practiced for a good ten years in different capacities in nursing, and then one of my last areas was, as I say, a night supervisor at the xxx Hospital, which opened my eyes as to the need for nurses to use their skill in observing and, reporting and being very accountable to that person that's coming. 'Cause usually any person that's sick comes under a great deal of stress and anxiety. And to be able to empathize, but also to really get into a confidence with them that they can share their concern 'cause so often the issue would be that they'd look at the cut, but not the person. And there's so much more behind a cut than that. And I thought, you know, the emphasis has to be more on the people, their illness, the whole human reaction to it. And these need to be incorporated more into the education of nurses. And so this is then when I went onto McGill. And, as I say, a couple of doctors who said, we need someone like you to go on because that's where nurses should be really is in the education field. And to this day, I notice that looking behind a cut and the human dimensions plus helping the student to use their own rationale, their own skills. Why are they a nurse? What is it that makes them become a nurse and help them to use it as they are?

I That's great. So you started to tell me earlier about how you became an employee of the Saskatchewan Registered Nurses Association and were able to now take some of these things that you were thinking about and move them into the system. So tell me a little bit about that story.

S Well, I had always been involved with the professional body because I felt that as a graduate nurse, it's an obligation. You know, to criticize without offering some help, I guess this was part of my family, my childhood, that you had responsibility and that you should offer a solution if you have that. And so I was the director of the nursing program at the Saskatoon City Hospital, and I was there for five years. And at that time, they had approached me to come, and I went back to develop and change their program, and so I was recommended and approached at Saskatoon City. While I was there changing their curriculum because they all, large or small, seemed to have that common denominator of issues, they had the offices in the basement opposite the laundry room. And I thought, if you want to improve the profile of nursing, per se, you know, you've got to get out of that -- where they come to pick up laundry.

I I was going to say, you're back to the laundry again, right?

S But it was symbolic. That's why this laundry room always seems to have been something I focus back on. And this was the first change I had to make is to simply move so that the visibility, psychologically as well as practically, would be there. But they were having problems and the university was trying to develop or had its Bachelor's program, and at that time was wanting to implement a diploma program, which was quite controversial because, you know, they had the Bachelor's and with the others trying to maintain a diploma. But so it was sort essentially trying to compete with them to get student enrolment. And as they called it across the bridge -- you had to walk across -- eventually, it did happen. But through that, I was recommended to the association to take on the job of being the full-time advisor to schools of nursing and make changes more universal throughout the province. And I said, Well, I would do this, but I've always followed the principle that you don't take on something that you, yourself, are not prepared to offer. You should have that preparation. And again, this comes from, I guess, my childhood. You just have a certain not just humbleness but common sense. And I said, Well, I wouldn't do this without finishing and getting my Master's degree. So the Registered Nurses' Association held the position until I finished my Master's degree at the University of Washington. I felt they had that confidence. And I also, at the same time, felt that I had quite a responsibility to help them fulfill it.

I Well, it also speaks of a philosophy of investing in people, which gets lost too often these days, I think, you know, where you say, this is an important person and we need to help them get better so they can help us. And organizations are a bit shortsighted around that now, I think, you know. When you

talk about reforming or changing some of these nurses' training programs, can you tell me a few kinds of specific things which you would do to change the approach to teaching the nurses at that time? Like what were the kinds of specific things you implemented in those colleges?

S I think the first thing was to utilize the teachers that are currently employed in the hospital programs, and it was a process of changing their perception. And I said, well, I can teach, you know, in one environment, but what's the difference in moving into an educational institution, in which the philosophy was education only? It was kind of that support and coaching, in a transition that was this whole strange environment to the teaching staff. So that to me was a very big thing.

I Okay. Well, we're actually just starting to talk -- and this is really good 'cause we need to talk about this -- about your role in the change over from, as you described it, the teaching hospital situation to the dedicated institution, the colleges, that kind of thing. Talk about why that happened and what your role was in doing that.

S Why did it happen? Well, most of the teachers that were in the hospital schools were graduates of that particular program school. Certainly they were very good and the philosophy of what they had inherited really and -- it's been a contentious issue even to this day of when nurses moved. I know I'm kind of not quite hitting your point, but it's when the nurses moved over to the education institution, they lost a lot of the nursing sensitivity philosophy, caring .

There was that whole historical build that a nurse was patient-centred… You know, this was my “training” because most of the teachers that moved into the colleges programs were graduates of those same hospitals that gave up the school. So there was a lot of that adjusting that had to occur. And there were threats, you know, since some of them had not really had a university degree. They were working toward one, but -- so there's a certain perception. It wasn't necessarily true, but there was a perception of insecurity. You were moving into this whole new administration, which was, you know, pretty focused on the education. And so it's taken a lot to work through that to have it kind of be a mutual acknowledgement between, the teachers through the education system and the teachers through the nursing system.

I When we spoke earlier, it seemed one of things that was clear to me was you felt there was a need through all of this that real practical training be incorporated with the theory. Do you want to talk a bit more about that?

S Well, this is where then I saw that it was a potential danger, and it was occurring to a degree that the education, all the courses that were the academic education courses, and it became more programmed and scheduled and with emphasis that we must have all this theory. But at the same time you need the companion to that to run parallel to it, which was a related nursing practice. And

this was where I saw, there wasn't a utilization of the theory or the application, I guess, of it into the practice. That needed much more help and that education would become more the courses and the practicum was there, but it was being shortchanged. And I knew it was just a stage in development. It wasn't being critical of the system at the time, but it's taking its time for that to get a good balance. And integration and a transfer of theory into practice, which is what led me on to do more.

I Great. So at about the same time that you're dealing with some of this changeover, 'cause we're talking about the 60s here in the training systems, we're also seeing the introduction of public healthcare. Do you want to talk about what your experience of that changeover was?

S Yeah. Well, public health at the time, going back to 1938 and 40s were that as an employee of the government, and they'd come in to check your eyes and your teeth, and went into the schools and it was sort of just in a more -- we didn't see it as a rule at that time that, you know, was integral in terms of the whole development of the nurses' performance because you had to relate the community and that together. And it was actually when I moved into being with the registered nurses, and because we had public-health-prepared people on our working groups and committees, I went out with them and got some public health experience. That couple of weeks public health experience eventually became sort of mandatory in an earlier stage that the students had in the same way they went into medicine, surgery, the operating room, and it became mandatory that they had a two-week experience with the public health nurse. And I gradually started to filter more into the system, until now it's become more a part of it, though not as much as I'd like to see it.

I Well, it's interesting because I talked actually to a public health nurse in Banff, and she certainly saw her job as being very heavily an education job.

S Very much so. Very much so. I have a niece of mine who's in B.C. who's a public health nurse, and there's a lot of teaching. She comments to me that she had a lot of practice before she did go into it. But, she said, I don't get the chance to do sort of a lot of the practice part of nursing. And I said, but you are. You are practicing. See, teaching is not apart from, it's inherent in it.

I Let's turn the conversation for a second also to another thing in the 60s which is Medicare coming in. Can you talk a bit about what it was like for people before Medicare was introduced first in Saskatchewan and what changes that made to people's experience with the healthcare system?

S Okay. Well, I could recall just as being a supervisor at the Yorkton General Hospital at the time, and the business office finished at five; so any discharges or admissions you did. And the discharges particularly would be pretty traumatic because it wasn't covered financially through you -- as it is now.

And so it was very difficult if you had to admit someone and they were in pain and they were. The family was anxious to say, we will need a deposit, and then when you were going out, your bill is, giving this amount. And that, to this day, has been very painful to see whereas with Medicare that was removed because you could focus on the problem itself. And that was Tommy Douglas that brought that through. It was phenomenal because you were always conscious prior to Medicare, well, I can't afford this. You'll have to let me out sooner 'cause I can't afford it. And those things then, you know, were erased. And they could focus on the necessary time that they had to spend. And that, to me, was a pretty significant thing. You hear some of it where the abuse comes in now, but I think abuse is -- to human being it's one of the --

I Yeah, I don't think paying for it eliminates the abuse frankly.

S No, but, you know.

I Yeah.

S When I went to finish my Master's at the University of Washington, I was writing my exam -- final exam in social issues, and the professor came over to interrupt me to say he wanted to see me after the exam was over. And at the time, I was quite annoyed because I was writing, and you want to pass, and you have a guilt trip, but you don't know why you have a guilt trip. But later he apologized. I passed. But he said, you know, I would like to talk to you about this -- what's happening in Saskatchewan, and this Tommy Douglas, and the social thing. And so I spent some time with him, and he said he was certainly going to pursue that. And so in a roundabout way, Tommy Douglas has made an input into at least one university in the States on changes in social issues. And United States was following some of those examples. So it was quite a nice experience.

I One of the things you mentioned was the long road out from under the doctors' servants and the fact that hospitals were largely administered by men. Talk a little bit about your feelings about the gender difference, as it were, in this profession.

S Well, I guess I know even when I enrolled at the Yorkton General Hospital in the nursing program, they had an administrator who was a gentleman. And so even though the superintendent of nursing was a woman, it still had his okay. And I could remember commenting on this to my father, who was a pretty proud man and very much a man, and, you know, he couldn't see my problem. Anyway, later on, you know -- but it was just early on, it just didn't seem to connect that it seemed so related. But you accepted it as the system wherever it was, you know, that they were the administrator and eventually their whole focus was on the administration in its totality. And that everyone was answerable, you know, to him. And also, you know, even with the doctors who were primarily at

that time male, we had eventually one or two female doctors and who -- even their demeanor, you know, and their approach to you was different. Because if the man came it was, you know, just a whole different perception that they just seemed to be more expectant that you do this and you do that, whereas the two female doctors didn't seem to be. They said, I'll look for that. You don't need to bother. So it was kind of that and that pervaded for quite a while until I know then at some point just from my own when a doctor come in and I was doing a chart and I didn't stand up, and he reported me for not standing up. And I said, well, if I had, I'd have made a mistake in the charting, and which was more important? And I was called to the office about it and the administrator had to back down. But I said, that doctor later was one that supported me in going to education. So it was those kind of things that pervaded, still do to a certain dimension…It took a while to kind of earn that acceptance that you could make these observations. And ironically even today I notice when I make a visit to my doctor and I'll say, Well, what do you think about this, you know? Well, that doesn't play a part. And I think at some point, Back out, Linda, because he seems threatened, you know. So it is an inherent thing too that is there, but the openness is much bigger; it's a team now -- much more a team, and a mutual kind of regard for the knowledge of the academic as well as the personal..

I There's a couple of things I have that -- that story that you just told about standing up, roughly what decade was that happening in and when did that start to change? 'Cause, of course, nurses don't stand up anymore.

S They don't. No, they don't. Well, that was, I'd say, in the 40s. It was during the war. It was changing. It was changing then. But I was still a student when I did that. So I nearly lost my training. We called it training in those days. So I nearly lost my training.

I I want to make sure we get to this. You mentioned that you were with Indian Affairs, and you had a particular project that you were doing in Saskatchewan to talk about young First Nations women. Tell me what that was about.

S Well, it was what I call, a nice frosting on the cake for me in in my professional career 'cause I was at the University of Washington at that time, and the concern by the Native organizations in Saskatchewan and nationally about their healthcare, you know, and some of that, sadly, is still existing. But if they could have more of their own people as role models--but the attrition rate was always so very high. And they felt that the current existing basic nursing program was based on perception of values that incorporated some of the different cultures, but not the Indian culture. And that had quite a significant difference. And they felt that if they could develop courses like the language in Cree as a course required, rather than French, just as one example of this. Would pick one that had a common denominator of philosophy and values in that other parts in their way of life and their practical view of spiritual worship and this, and so this --

I was loaned through the University of Windsor to come down to help develop this program and work many sessions with the different bands. And I spent the time in a teepee with the chiefs and whatever significant ones that they chose, just to get the feel. And to come out then with what was -- and I felt that was a tremendous test for me. And I learned one thing more than anything, the values of being silent and, you know, being comfortable in that, which so often in nursing we want to say something rather than really listen that person out. And so through that we did. We then worked with the help of the two colleges, Regina and Saskatoon, and the Registered Nurses' Association. We worked on developing a curriculum and developing a course on the Cree to form a bridge that would help the Native students before they move right into this whole other element. And so it was a whole new curriculum that was developed for it. And it was I felt I a wonderful experience. And –

I Western medicine has a tradition of being very suspicious of other forms of healing. Was that something that you were seeking to change?

S Very much. Very much. Just as an example of that was that when you looked into the different religions. The Catholic religion has the incense and that becomes even more important to them when life is threatened. It's part of their support into their spiritual strengths whereas, the Natives have sweetgrass. And I could recall questioning that at that time as well, You'd set the building on fire if you let them use the sweetgrass, which is just a little small amount in the same way that you use incense. But it said a lot to me about the taboos or whatever we have on these different cultures. And I said, first of all, you have to, respect the others, and also, that they, like us, are going to use discretion. And But it was a cultural thing. So you're not only talking about the social value systems when culture starts to come in as well. And, of course, it's becoming more compounded now than it did even then because you've got more immigration and you're dealing with even many more cultures. So you really need to be looking at the different avenues that people use for their spiritual strengths.

I Yeah.

S So it was tremendous.

I Yeah, well -- and I think it's often a shock for white people when they go into a reserve community for the first time to see that there's a huge difference in the living style.

S Very. Very, very, big difference.

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I All right. Was that something that you encountered in working to bridge as well?

S Yes. Yes. Well, you know, even with the meeting, you know, when we were working, you know, in the different groups with the Indian program, I'd have nurses saying, well, what do you say to them? I said, I can't believe you're saying this. You know, they're a human being like you and I are a human being. How do you talk with human beings? And so culture to them gets in the way of the person, and it's changing. Of course, it needs to change more.

I Mm-hm. Great. Good. I wanted to make sure we said that. One of the things that you said to me is that one of the fundamental questions that you asked in terms of trying to change the way people were educated was: what is nursing all about? Do you want to answer that question a bit? What is nursing all about?

S Really it's a one-to-one. It's a human interaction really. I've witnessed by parents both dying. I've been with them. And a brother. And, you know, you're kind of provoked more into that -- answering that kind of question as to when it really comes down to what is the heart behind nursing? You know, what it is that's there and how do you relate and in some way touch that person? And I've seen this. It's not just with a person who's sick…We've tended to think that nurses are just for the sick. They're not. it's a helping relationship that you care if someone has a problem, whatever it might be. You know, you have a sensitivity toward it. And with the skills that you have, you try to help. So it has to be a very integral part that motivates you to want to do that. And in nursing, it's like in any other profession, you have, it has to be there to give it. But we have differences in human beings that some are more pragmatic, and let's get at it, and others are a little bit more the other -- take the time. But time becomes such a factor now that gets in the way of that relationship that you want to spend. And I know just in talking with some of the nurses or just even what you read in the paper, they don't have the time. And so often that's very legitimate in the system because what you're looking at is production. It comes to the administration dimensions of it and that the emphasis is and it becomes more complex with all the new intervention -- you know, equipment. And there's more and more being done in medical practice compared to my back at that library or at the linen cupboard. But nurses are very involved, very educated now, and so in the medical profession. And they're specializing. So it becomes much more complex and the patient is lost. They become an object rather than the person.

I I think that's --

S And that's a concern I have.

I I think that's really important because I know when I talk to nurses who had an experience in an older time in the system, they talk about exactly what you did, where you had the time to get to know a patient, to observe the changes of that particular individual, and that really helped with the recovery. And I know

a lot of nurses now who are still practicing who really are concerned about the fact that you're often moved from ward to ward.

S Absolutely, yeah. You know, it just gets into this administration. It's been a common denominator from when I was in training. You move like checkers. - You see it as quite a concern.

I And also that people are run off their feet. I mean they're dealing with so many patients that they don't have -- well, what one nurse said to me one time was, what's cut out of the system is the hand-holding time. The time to sit with someone, listen to what their concerns are, and just comfort them.

S And that again gets into the controversy of administration versus nursing because if you're sitting with that person, it's not often interpreted as nursing. Any human being, when they're ill, they're very self-focused. And it takes a while to earn that communication comfort that I can unload a little bit more, and that doesn't just happen. You know, you have to physically make the time. But more time is spent on the medications or doing the treatment. Not that they're not necessary, but both efficiency and caring are really important. And I think everybody I talked to agrees. Somehow we have to tell that as part of the story we're telling you.

It's accepting to have a nurse sit and listen, not stand. You know, just that physical message. And that is part of the skill that is being lost because you're in demand, too much in demand, and the high expectation of what the nurse should be doing. You hear that expression often: they're literally run off their feet and not because they choose it, but it's expected. So there's that administrative budget. And wherever you cut staff, it's usually where it shouldn't be. And it shouldn't be cut with the patients, you know. But just from whatever I read in the papers is that nurses, if they don't get the satisfaction, they leave. So we have a shortage. It keeps coming back to the nurses really. It's very personal -- they're the one that has the greatest opportunity and, to me, the greatest reward because they've got that bond between the patient and themselves and the family.

(END OF INTERVIEW)