

A. HISTORY OF THE MANITOBA NURSES UNION

1975 has been called “The Year of the Nurse.” It was the year the Manitoba Organization of Nurses’ Associations (MONA) was formed, and the year nurses won greater recognition, through collective bargaining, for the value of nurses’ work. The motto for the first nursing school in Canada was, “I see and I am Silent.” The history of health care reflects this feminine code of silence, and the values of a health care system, which encouraged it. Nurses’ experiences as health care workers, and their contributions to patient care, are often lost in accounts of the development of our health care system. At a time when nursing is changing so rapidly, and when insecurity has entered the profession, talking about the growth of nursing unionism means more than exchanging stories of old struggles and proud achievements; knowledge of our past provides an awareness of what it means to go forward.

Although nursing unionism came of age in the 1960’s, collective action by nurses to improve patient care and working conditions goes back much further than one might think. The legacy of Florence Nightingale, profound in so many ways for nurses, is not one of subservience in the workplace. The first recorded labour dispute in Canada involving nurses was in 1878, between Nightingale nurses and the Montreal General Hospital. The nurses wanted improvements in their working conditions, and threatened to withdraw their services and return to England without them.

In Manitoba, psychiatric nurses (then known as ‘attendants’) working at Selkirk

and Brandon mental hospitals organized early this century. The Sanitorium Employees’ Federal Labour Union was formed at the Brandon Mental Hospital in 1919, and employees of the Selkirk Mental Hospital also formed a union that year. Brandon workers proposed a contract to include free uniforms, free room and board, hot meals for night staff, overtime pay, two week’s holiday a year, and the eight-hour day and the 40-hour week. The momentum of these struggles was lost in the aftermath of the 1919 General Strike. But workers in the Brandon Mental Hospital tried again in 1926. The union signed up both male and female employees. Union organizers were fired, and management intimidated the female nurses. Nurse Ruth McRann told a government inquiry that the facility administrator told her that unless she promised to quit the union and never engage in union activity again, she would not be allowed to attend professional development lectures. A decade later, nurses at Selkirk also used collective action to achieve “one day’s rest in seven.”

Nursing leaders felt that professional standards were the best way to protect both nurses and their patients, and to improve the status of the occupation. Nurses in Manitoba were the first in the country to achieve standards for nursing schools, and mechanisms for registration and discipline, through provincial legislation passed in 1913. Nevertheless, these early years were marked by abysmal pay and working conditions. Hospitals used nursing students as a source of cheap labour, a practice continued by hospitals into the 1970’s. Nurses usually had to “live in” and

generally worked every day, long hours, for very little pay, few holidays, no pension, and limited recreational opportunities. They faced employment discrimination based on age, attractiveness, and ethnicity. Prior to World War II, unemployment among graduate nurses was very high, and wage rates for private duty nurses were extremely variable.

During the Second World War, hospitals began to experience a nursing shortage. In 1945, a training program for Licensed Practical Nurses (LPNs) was introduced in Manitoba to increase the supply of nurses. This had little effect, since nursing schools would not accept married women, and immediately ended the training of nurses who married or became pregnant. Many hospitals would not employ married women. These practices continued into the 1960's. At the same time, a growing variety of careers became accessible to women in the post-war period. Nursing had difficulty competing. Low wages and benefits, and poor working conditions, made nursing unappealing. Shift work played havoc with women trying to raise their families.

At the close of the war, the federal government passed Order-in-Council PC1003, which required employers to negotiate with unions, and recognized workers' right to bargaining collectively and to strike. In 1944, the Canadian Nurses' Association (CNA) passed a resolution supporting collective bargaining, provided it was done with the registering association as bargaining agent. The CNA, however, did not support nurses' right to strike, and passed an anti-strike policy in 1946.

Despite CNA's conditional support for bargaining, unionization among nurses was slow to develop. There were probably

several reasons for this. Organized labour during this period was dominated by industrial unionism, very much a male movement. These unions believed in men's right to earn a family wage, to be breadwinners, so that women could remain in the home. Women's need to earn a living wage was not given much weight, and unions did little to defend the rights of women workers. The often aggressive bargaining approach of industrial unions could hardly have appealed to nurses. It jarred with the role of nurses as caregivers and healers. Militant unionism was also viewed as both unprofessional and unfeminine. On a more pragmatic level, nursing leaders feared that the formation of unions would split their profession, as labour law often did not allow for management nurses to be part of the bargaining unit. Up until the 1950's, many nurses worked in private-duty, making unionization unlikely.

As an alternative to organizing unions, nurses' registering bodies formed labour relations committees, which drew up salary schedules, and pressed for the standardization of working hours. In 1948, the labour relations committee of the Manitoba Association of Registered Nurses (MARN) released a report, which documented the reasons why Manitoba could not recruit and retain nurses - long hours, low salaries, poor living conditions, too few holidays, and instability. The average workweek for nurses at this time was 48 hours. The average in industry was 40 hours, and 38 - 40 hours in public health agencies. In at least three Manitoba hospitals, the workweek was 66 to 90 hours. A general duty nurse made a maximum of \$140 per month. Some hospitals paid as low as \$90 per month. Many facilities did not allow nurses to take

statutory holidays, or only allowed 1/2 days off. Living conditions were particularly poor in small rural hospitals, where there were no separate residences for nurses. Nurses had to live where they worked, most facilities had no pension plans, and shift scheduling was poor.

While the MARN report did much to inform the public about nurses' working conditions, it did little to improve them. MARN recommended that nurses should be better introduced to community life, and that their living conditions be given some consideration. Wages did subsequently rise. The province approved a new salary scale for nurses, which increased their pay by 16%. Even so, nurses in Manitoba were among the lowest paid in the country, and their working conditions did not change.

As time passed, the nursing shortage in Manitoba intensified. While the health care system expanded rapidly with new technology and government funding, it was uncertain who would care for the patients in a growing number of health care facilities. The province announced in 1949 that new hospital funding would not be given to hospital boards unless they could guarantee they had found nurses to staff them, and would not be 'raiding' other facilities to find nurses. The government recommended that hospitals create pension plans for nurses as a way to encourage women to work in their facilities.

This potential solution was not taken very seriously. Nursing was considered a natural extension of a woman's caring and nurturing role as mother, wife, and daughter, and was devalued as such. While women were expected to do the physically and mentally demanding tasks of nursing for very little money, no one expected this

of men, as a *Winnipeg Tribune* headline reflected: "Low Wages Make Male Nurses a Rarity - It's All a Question of Cash." Of course, nurses knew they were not working just for the fun of it. Miss Rae Chittick, Assistant Professor of Education at the University of Alberta, pointed out to a meeting of the MARN in 1950...

"We are getting away from the idea that nursing is something unique, a noble calling to care for the sick. Now we know that not so many people think of nursing as that sort of tradition. It is a job for which girls have acquired a skill and training and for which they want to earn a living."

The nursing shortage placed nurses in a position to demand better wages and working conditions. Unfortunately, the leaders of the Manitoba nursing profession were only willing to go so far as to recommend. In 1950, the MARN labour relations committee drew up proposed hospital personnel policies. These policies were voluntary, and not adhered to by administrators. The ineffectiveness of voluntary salary schedules and personnel policies was one of the main reasons for growing interest in unionization. Staff nurses began to show their willingness to use collective action to improve their working conditions. Although they were not unionized, nurses at the Virden District Hospital walked off the job in October of 1957, striking for better wages. They had been attempting to negotiate a pay increase for three months with no success. The women were immediately fired, and replaced by former nurses who had left the profession when they married.

The first Manitoba nurses to work under the protection of a collective agreement

were nurses employed by the City of Winnipeg, in municipal hospitals or as public health nurses. In 1953, they discovered they were union members when they were included in the first automatic dues check-off negotiated by the Federation of Civic Employees. [The Federation later became part of the Canadian Union of Public Employees (CUPE)]. Their union status did not enjoy the support of MARN. In 1963, MARN lobbied the government to introduce an amendment to labour legislation, which would exclude Winnipeg civic nurses from union membership. MARN argued that the nurses were professionals, and under the purview of the Registered Nurses' Act. According to media reports, the industrial relations committee of the legislature "decided against the MARN viewpoint after questions ... revealed the nurses concerned had not indicated their desire to leave the union and that the nurses' organization does indeed not negotiate wages and working conditions for nurses in Manitoba."

The committee did not have it quite right - although the nurses did not want to lose their union rights, some of them did want a separate nurses' union. When the RNs employed by the City of Winnipeg left CUPE in 1965 to become the Winnipeg Civic Registered Nurses' Association, they became the first nurses-only union in Manitoba history. Some years earlier, they had approached MARN to act as bargaining agent on their behalf, but MARN had declined to do so. The RNs decided to pursue independence on their own, led by four extremely courageous women, all single parents. They met in each other's homes and discussed what course they should take. Public health nurse Christine Byquist describes the experience...

"We felt we were a professional body ...we just wanted our own thing. We decided we had started this union, and we had everyone behind us ... the four of us met until we decided what to do. We lobbied in each [public health] office, and then made sure that the municipal hospitals were with us too."

They hired a lawyer, to handle the certification of their new bargaining unit and negotiate a collective agreement, and paid his fees by mortgaging their homes. Their determination guided them through opposition from CUPE, a certification vote which they won with 55% of RNs voting in favour of the new union, and a hearing in front of the Labour Board. The LPNs stayed with CUPE for the time being, but they left to become part of the Winnipeg Civic Nurses' Association in 1976.

The Winnipeg Civic Nurses' lawyer publicly deplored MARN's unwillingness to engage in true collective bargaining, and demand improved wages and working conditions for its members...

"I understand the MARN did not want to do it because it concerns itself more with professional ethics, standards, licensing, and so forth, rather than getting into wage talks. The result of this is that the great bulk of our nurses in Manitoba have to take what is thrown at them. But the day of the nurses is coming, mainly because there is such a shortage of them and because there is an increasing unwillingness on their part to live on the small wages they are getting. Maybe more nurses should set up negotiating bodies of their own."

That is what they did. Canadian nurses began to unionize in earnest in the late 1960's, part of a wave of unionization in the public sector, which brought women into the labour movement in full force. In 1968, the Misericordia General Hospital Registered Nurses' Association and the Victoria General Hospital Registered Nurses' Association formed in Winnipeg. Meanwhile, in Brandon, nurses formed the Assiniboine Registered Nurses' Association and the Brandon General Hospital Registered Nurses' Association. The St. Boniface General Hospital Nurses' Association was certified in 1969. An Employee Relations Officer hired by MARN assisted in these early organizing efforts, but most of the work of organizing and negotiating the collective agreements was done facility by facility, by the nurses themselves.

MARN's role was problematic. A conflict of interest existed between MARN's representation of the interests of staff nurses, and the influence of management nurses in the organization. This situation was partially addressed through the creation of the Provincial Staff Nurses' Council in 1970. Although still part of MARN, the Council was elected only by nurses eligible to be included in union bargaining units; that is, the Council excluded management nurses. The Council was whole-heartedly committed to organizing nurses across the province, and acted as bargaining agent for unionized nurses. Employee Relations Officer Joyce Gleason, who later became the first Executive Director of MONA, contributed a great deal of energy to encouraging and assisting nurses to unionize. She described nurses' attitudes...

"The nurses were rather starchy and they had to learn to think union ..It

was a sell job for the younger nurses especially. The older nurses had been overworked and underpaid for so long that they were ready to join the union and do something about their position and their profession."

Some nurses also had to overcome the attitudes of the doctors in their facilities...

"There was some interference by the medical staff in certain areas. I remember going to a meeting [in the Minnedosa area] and being opposed by a doctor. The doctors thought they were looking after the nurses, the old ideal that the nurses always had to be under the thumb of the doctor, inferior to him."

Initially, the Council represented only RNs. At that time, MARN did not support the LPN category of nursing, making it impossible for the Council to bargain in good faith for LPNs. When the Winnipeg General Hospital Registered Nurses' Association applied for certification in September 1970, the Labour Board rejected their application on the basis that RNs, LPNs, and RPNs shared community of interest and that RNs should not be in a separate bargaining unit. The RNs tried again in August 1972, and this time, the application was granted, despite the employer's opposition. From 1968 on, RN-only bargaining units had been certified several times by the Labour Board. The applications were not contested, until the Winnipeg General Hospital case. The Labour Board ruled that the earlier dismissal was a departure from Labour Board policy, and re-established the right of RNs to form separate bargaining units.

Both Joyce Gleason and the Labour Board were aware that RN-only bargaining units

fragmented the unionized nursing workforce. The Labour Board laid this problem at the feet of government, because RNs, LPNs, and RPNs were each governed by separate Acts. For its part, the Council promoted nursing unity where it had influence. In 1972, the MARN passed a resolution supporting the role of the LPN in nursing services, thereby eliminating the barrier to RNs and LPNs bargaining together in good faith in one bargaining unit. In 1974, the bylaw governing the Council was amended to allow for representation of LPNs and RPNs. New bargaining units were certified to include all nurses, and existing certificates were amended. The Council continued to stress the importance of collective bargaining for and by nurses. The motto of the Council was "To care for nurses is to care for patients." These issues became inseparable as nurses prepared for the first major round of collective bargaining.

The Year of the Nurse arrived in 1975, with an unprecedented show of strength at the bargaining table. Collective agreements were set to expire at the Winnipeg General Hospital, St. Boniface General Hospital, Misericordia Hospital and Victoria Hospital, and nurses demanded a wage increase of at least 50%. Grace Hospital nurses, who had recently voted to form a union, were also involved in these negotiations. Nurses in Ontario and British Columbia were earning 50-60% more than nurses in Manitoba. Those higher wage levels were drawing nurses away from the province. Winnipeg employers, who set trends for nurses' wages across the province, offered a 30% increase, which was rejected by the nurses. Irene Giesbrecht was then a nurse at the Grace Hospital...

"As the bargaining representative for the newly certified Grace Hospital association, I remember the feeling of empowerment in that room where nurses were prepared to stand together to fight for fair and just wages and for respect. It was bread and roses we were fighting for in 1975."

Nurses at Winnipeg hospitals (with the exception of Grace Hospital nurses, who were too newly certified to strike) held their first ever strike votes, and voted overwhelmingly to go on strike if their wage demands were not met. Strike votes followed in Brandon, and at rural hospitals. Informational pickets were held at the Manitoba Health Services Commission, and at the Legislature. A strike was averted last minute, when the employers agreed to wage increases ranging from 32% to 36.5%, plus a \$500 signing bonus.

Later that year, the Provincial Staff Nurses' Council became the Manitoba Organization of Nurses' Associations (MONA), completing the separation of collective bargaining from licensing and regulation. This change was probably inevitable, but was hastened by a Supreme Court decision, which denied the Saskatchewan Registered Nurses' Association (SRNA) the right to bargaining collectively for RNs. As in Manitoba, the bargaining agent for RNs in Saskatchewan was originally the labour relations committee of the SRNA. However, labour legislation was changed to allow professionals to belong to other workers' bargaining units, opening the way for other unions to organize nurses. The Service Employees' International Union (SEIU) and SRNA both sought to represent nurses in Nipawin, with SEIU contesting SRNA's right to represent staff nurses, because it was

dominated by management nurses. The case went all the way to the Supreme Court, where the decision ruled against SRNA. This case forced the collective bargaining 'arms' of the nursing registering bodies across Canada to become independent.

With issues involving MARN resolved, organizing proceeded very quickly. By early 1977, MONA had 55 bargaining units, and 5750 members. The union was working towards province-wide bargaining for nurses, a dental plan, building a strike fund, defending part-time employment, fighting for the preservation of LPNs, and improving wages, job security, union security, and other contract provisions. With the election of Sterling Lyon as premier that year, nurses were building their union at a time when the attack on public sector workers was just beginning. The federal Anti-Inflation Board strictly controlled wage increases. Nurses heard rumours of staffing cuts and reductions in hours. When bargaining began, employers at the central table refused to consider a dental plan, to increase shift premiums, or to rescind their proposal to roll back shift scheduling provisions. Wage increases of 3% and 2% were offered. While AIB provisions limited wage increases to 4%, employers could give higher increases if arguments were made. In this case, the wages paid Manitoba nurses were again falling behind those in other provinces. After conciliation, and a threatened strike vote, wage increases and shift premium increases were achieved, but dental insurance and improved shift scheduling were not.

The union continued to grow, along with other nurses' unions across the country. Ties were built amongst each other, as well as with the labour movement. Nurses'

unions began meeting in 1978 to discuss forming a national body, to speak for Canadian nurses. Provincial counterparts circulated discussion papers on what the organization might look like. MONA was very interested from the beginning, and participated in debates, which led to the creation of the National Federation of Nurses' Unions (NFNU). The founding meeting of NFNU was held in Winnipeg in 1981. NFNU President Kathleen Connors believes this was a milestone for Canadian nurses...

"The birth of the NFNU marked the beginning of a new era for communication and strategizing amongst nurses' unions and nurses in Canada. NFNU became a national voice to speak out on issues affecting nurses and Canada's world-class health care system. Within the NFNU, nurses found a united front for action on issues, which directly or indirectly affect nurses and the quality of care we provide."

The Manitoba Council of Health Care Unions (MCHCU) was formed on November 9, 1979. It originally included MONA, IEU, CUPE, MGEU, UFCW, and IUOE. MCHCU was created to establish a relationship between unions representing health care workers, in order to achieve common goals, such as improving employees' conditions of employment, and patient care. MONA also worked to improve relationships with the licensing bodies. MARN, the Manitoba Association of Licensed Practical Nurses (MALPN) and the Registered Psychiatric Nurses' Association of Manitoba (RPNAM), were approached, to form liaison committees.

Growth also occurred internally. The union expanded its educational programs, improved communication with its members and the public, and lobbied governments on a variety of issues affecting nurses. In June 1981, the MONA council increased the President's paid time to attend to union business from one day to two days per week. In September 1982, the President's position became full-time. More staff were hired to help the union fulfill its mandate.

A dental plan, along with improvements in overtime, shift premiums, standby allowance, responsibility pay, transportation allowance, vacation, and pre-retirement leave, were achieved during 1980 negotiations. Language was also negotiated which provided for referral of concerns related to quality of patient care to joint committees. These were the precursors to the Nursing Advisory Committees. Forms were designed to document unsafe patient care related to nurses' workload.

Nurses began to speak out more often on issues such as the importance of preserving Medicare. Vera Chernecki, as president of MONA, led the new MCHCU ad hoc committee on the Preservation of Medicare, working with the Canadian Health Coalition to protest against extra billing, user fees, and other erosions of Medicare.

The union's growing confidence led to a more militant stance. In 1983, the President's keynote address to the annual meeting was entitled, "Silent Nightingales No More." 7,000 members strong, and continuing to organize, MONA was concerned that wages for Manitoba's nurses were still behind counterparts in other provinces, even after a hard round of

bargaining in 1983, which saw a last-minute settlement just before strike votes were carried out. At the same time, the union was again defending LPNs against job loss and supporting their valuable role in health care. Health minister Larry Desjardins announced a task force on nursing, to review the role of LPNs in the health care system. MONA was promised participation, and was co-operating with MALPN to protect the LPN role. The MONA submitted its brief to the committee, emphasizing the cost-effectiveness of LPNs, and stressing that they should be allowed to practice to their full potential. When the government's report was made public in 1985, it addressed the majority of MONA's concerns, and was very supportive of the value of the LPN.

In 1984, Vera Chernecki reminded annual meeting delegates of how far they had come in a very short time...

"In 1974, prior to MONA, I was working part-time at a Winnipeg personal care home for \$3.60 per hour, while temporary helpers were being hired to fill sandbags to prevent flooding of the Red River in St. Norbert at a higher rate. In 1974, a general duty nurse earned \$3.87 per hour, often worked 10-day shifts with split days off, and received only a minimum in benefits. Today, this same nurse earns \$12.48 per hour and receives many benefits not heard of ten years ago, including responsibility pay, paid sick leave, and overtime. What we have achieved in our contract to date is a result of what we have fought for as a union."

That year, MONA and six other unions negotiated Essential Services Agreements

(in the event of a strike) with eight Winnipeg hospitals, providing for an independent committee to rule in case of dispute between union and management. This was done with the support of the NDP government, at a time when nurses and public sector workers in other provinces were seeing the erosion of their collective bargaining rights. Alberta, for example, had passed legislation denying nurses the right to strike.

By the time the MONA celebrated its 10th Anniversary, the union had 80 Locals/Worksites, and 9000 members, and was still organizing new members. MONA was influential in persuading the provincial government to introduce a post-diploma baccalaureate program for RNs and RPNs, as well as expansion to the Masters level nursing program. Easier access to post-diploma and post-graduate training was an important issue for MONA members.

As the MONA headed into the 1987/88 round of central table negotiations, hopes were high for improvements in vacations, job security, paid maternity leave, LTD and pension, wages, overtime, weekend premiums, and a professional responsibility clause. An agreement was not reached until April 1988, after a strike vote was held. The wage settlement was 3% and 3% plus cost-of-living. Improvements were negotiated to vacation, LTD, weekend premiums, parental leave, responsibility pay, and employment security. Although it was not all that the membership hoped for, the agreement was ratified.

The political and economic climate of the late 1980's made it more difficult for the union to sustain continuous growth and gains in contract language. The government announced in 1987 that, as of

April 1, 1988, it would no longer fund the operating deficits of urban hospitals. The facilities began to implement temporary and permanent bed closures and staff cuts, achieved by not hiring vacation relief, shortening periods of orientation, and deleting positions through attrition. The election of the Conservative government in 1988, with its promise of a leaner public sector, left nurses bracing for further cuts to health care budgets.

While government funding cuts threatened MONA members on one side, controversy over entry to practice loomed on the other. The Canadian Nurses' Association's (CNA) new position on RN education was that by the year 2000, the requirement for entry into the practice of registered nursing would be the baccalaureate. Nurses' unions were very concerned about the impact of this in the workplace, upon the availability of jobs for diploma nurses, the accessibility of post-basic baccalaureate programs, and the costs to nurses for upgrading. In Manitoba, MARN endorsed the CNA's position several years later.

Despite the significant gains made through collective bargaining, quality of working life for nurses was still poor in many ways. For generations, women had been thought of as temporary employees, who did not need to work, and who only had marginal attachment to their jobs. There were no rewards for long service in nursing, limited opportunities for promotion, and little differential in pay for higher education and training. A nurse often reached her maximum salary after only a few years of service and stayed there. The Ontario Nurses' Association released a study, which found that one in seven nurses said they planned to leave nursing. The main reasons for this were working conditions, lack of

control over work environment, patient care concerns related to staffing, and the relationship of nurses to hospital hierarchies. Physicians still tended to view nurses as their assistants or handmaidens, and management operated without consideration for nurses' views. Communication between management and nurses was poor. Nurses wanted greater autonomy, respect, and recognition for their vital role in delivering health care.

The continued momentum of the union was focused on achieving those goals. In April 1989, nurses staged their first rally to protest working conditions and inadequate health care funding. The President stated, "We are no longer willing to go along with the conspiracy of silence, to cover up the problems in hospitals and personal care homes which are not in the best interests of patient care in Manitoba." An informational picket was held in Pine Falls to bring attention to the impact of the loss of three full-time LPNs in their facility. MONA and the University of Manitoba sponsored a provincial workshop on the issue of nurse abuse. MONA presented to the government their brief, "All In A Day's Work," which dealt with issues such as workload and staffing, non-nursing functions, funding, lack of nursing input into decision making, work environment, health and safety, education, compensation, and management issues. The brief received a great deal of public attention. The government made a commitment to include four staff nurses in a review of MHSC funding practices.

The MONA, and other members of the MCHCU, went to court to win the right to full pay equity for their members who worked in the 23 facilities covered by the Pay Equity Act. With its high proportion of

female-dominated occupations, which have traditionally been devalued, the gap between comparable male and female jobs in health care facilities averaged 96 cents per hour. Although the civil service, crown corporations and universities had already received full pay equity, the wage gap in health care facilities had not been closed within the four-year time frame specified in the Pay Equity Act, which limited pay equity increases to 1% of payroll per year. At the end of four years, there was still an average 24-cent gap remaining at health care facilities. The Conservatives announced that they were only prepared to fund 75% of the cost of addressing wage gaps in health care. Health care unions proposed phasing-in the entire gap over four years, but the employers would not agree to this, because of the government's refusal to provide funding. When the dispute was taken to the Labour Board, the Board sided with employers.

The MCHCU challenged the government's position on pay equity at the Court of Queen's Bench. Madame Justice Ruth Krindle ruled that Manitoba's pay equity legislation violated the Canadian Charter of Rights and Freedoms, by allowing the province to stop funding pay equity after four years, regardless of whether or not wage gaps had been eliminated. MCHCU Chairperson Irene Giesbrecht knew the decision forced the hand of government... *"If the government chooses not to close the gap they are saying, in effect, that the hundred years of discrimination that women workers have endured should continue."* Shortly thereafter, MCHCU negotiated fifth and, where needed, sixth year adjustments to close the gaps. Pay equity for nurses at the remaining facilities would prove central in upcoming negotiations.

In 1990, annual meeting delegates changed their organization's name from MONA to the Manitoba Nurses Union (MNU), a symbol of their determination to achieve a collective agreement that acknowledged the value of nurses' work. The meeting's guest speakers included nurses from B.C. and Quebec who spoke about their own experiences as nurses on strike.

As the MNU prepared for negotiations, an in-depth membership study revealed that nurses were prepared to mobilize to defend quality patient care, even to the point of striking. Manitoba RN wages ranked 8th in the country. As nurses left to find more lucrative jobs in other careers or other provinces, the nursing shortage led to heavy workloads and extensive overtime. Nurses did not have time to give quality care to their patients. Vera Chernecki explained the position in which nurses found themselves as negotiations approached...

"Our bottom line is wages and working conditions. We have fallen so far behind the rest of the country that we cannot recruit or retain nurses in Manitoba. Unless we improve the situation soon our health care system will continue to deteriorate as we continue to lose more and more nurses. We entered nursing because we care. Many of the nurses I talk to around the province are extremely upset that patient care is suffering. Many of us have devoted many years caring for the sick, infants, the elderly and we are deeply troubled by what we see. As funds keep getting tighter health care is being strangled. We cannot just sit by and watch. It is because we care that we are willing to stand up and say 'enough'."

A nurse from Thompson commented on conditions for nurses in the north: "In the north it is especially bad. Why should a nurse stay here?...Nurses pay rent, hydro and food bills like everyone else. Most of us are supporting families. Our day care costs are higher because we work shifts. Our standard of living has been eroded yearly and our workloads continue to increase. We have no choice but to go all out and fight for a fair settlement." St. Boniface General Hospital nurse Shirley Delaquis explained, "I've been in nursing for 25 years and I can honestly say I have never been more concerned about the problems in our health care system than I am now."

The union commissioned public opinion polls to ensure nurses had the support of the public for their contract demands. Along with other nurses' unions, the MNU contributed to the production of "Canadian Nursing in Transition," a five-part television documentary about the state of the nursing profession.

The central collective agreement was set to expire on December 31st, 1990. The Provincial Central Bargaining Committee (PCBC) identified seven major areas to be addressed in negotiations: wages, working conditions, job security, pensions, benefits, time off, and education. The PCBC proposed a 30% across-the-board increase to all wage scales in a 1-year contract, a 10% premium for nurses working north of the 53rd parallel, and a long service pay bonus. Improvements to the pension plan, including joint trusteeship, were proposed. Workload, patient care, and input into decision-making were addressed through the proposal to establish joint union-management Nursing Advisory Committees, joint Workload Staffing Report forms, and the right to appeal to an Independent

Assessment Committee, which could make binding recommendations on nursing and patient care issues.

Negotiations broke down in mid-December, when the government refused to give employers a mandate to table a monetary offer. In an effort to divide nurses and the labour movement, Minister of Finance Clayton Manness publicly stated that any increases given to nurses would come at the expense of other public sector workers. This did not diffuse the nurses' determination. MNU received a strong message from the membership when 91% voted in favour of strike action on December 15. The strike deadline was set for 7:00 a.m. January 1st, 1991. Essential services agreements were in place in most facilities. Membership had been educated regarding strike pay policies, guidelines for picketing, and who their bargaining committee were and where they could be reached. Union leaders wrote letters to their Local/Worksite papers, stating their case. The union was ready to strike, but did not give up the hope of achieving a settlement: "We do not take our right to strike lightly," Vera Chernecki said to MNU members. "We will only use it as a last resort and upon direction from our membership."

Despite the hopes and efforts of the nurses' negotiating team, the strike deadline passed without a settlement being reached. 9,500 nurses were on the picket lines across Manitoba on January 1, 1991, braving winter morning darkness and brutally cold temperatures to begin the union's first province-wide strike. It was the largest strike in Manitoba since the 1919 General Strike, and was to become the longest-running nurses' strike in Canadian history. The government attempted early on to

break the nurses' solidarity by offering LPNs 0% in the first year, while others were offered 8%. Vera Chernecki told the media, "LPNs are valuable members of the health care team and we will not settle a collective agreement with 0% for LPNs." The government bargained in the media, running advertisements outlining the MHO offer to the nurses, and misrepresenting wage proposals by including pay equity wage adjustments in their offer.

Not only were nurses responsible for running a successful strike; they also coordinated essential services from their strike headquarters. In an effort to put pressure on the employers to settle, nurses began to work to the letter of their essential services agreements, but always guaranteeing the safety of their patients. Brandon Local/Worksite President Brenda Francis stressed that continuing to provide adequate patient care, under extremely difficult and stressful circumstances, was as important to the nurses as walking the picket lines: "We would like the public to know that we are there for them. They are our priority."

The medical establishment made an orchestrated effort to pressure nurses into returning to work, holding almost daily press conferences. There were rumours circulating in Winnipeg newspapers that the Manitoba Medical Association (MMA) was considering requesting the government to legislate nurses back to work. This was later denied by the MMA, which instead suggested that MHO and MNU should resolve the strike through binding arbitration. In a blatant scare-tactic, Dr. Neil Donen, of St. Boniface General Hospital's staff medical advisory committee, stated to the media that it was only a matter of time before a patient died, and

that St. Boniface doctors were considering transferring patients out of province. There was absolutely no evidence that patients' lives were in danger. Essential services agreements assured that patients were adequately cared for.

Morale was still very high ten days into the strike, when 4,500 nurses and supporters held a rally at the Convention Centre, then marched to the Legislature, chanting "We Care." Rallies were also held in other communities. Support poured in from the labour movement nation-wide, from other nurses' unions across the country, social activists, and community members. Unions organized mass pickets, and donated thousands of dollars to the strike fund. For nurses, their friends, and families, the strike demonstrated the many ways in which working people support each other. Friends brought food to the picket lines with tears in their eyes. Former patients collected money. Husbands and children joined picket lines, and brought hot soup to fight the bitter cold. Local/Worksite merchants provided things like coffee and donuts, and Chap Stick and hand lotion. In many communities, hospital and nursing home management offered support, such as a place to warm up after walking the picket line.

Negotiations resumed on January 13th with assistance from a conciliator, but little progress was made. MHO offered a signing bonus of \$800 to LPNs, but still 0% wage increase in the first year. The offer for RNs was 14% over 3 years. This offer was rejected by 94% of the membership. As the strike lengthened, nurses were motivated by their determination to achieve respect and input into decision making in their workplaces. Wage increases were only a part of the reason for remaining strong.

One nurse told the media, "I've been asked to come in as a consultant to improve emergency room care in places like Kuwait, but I've never been asked to study [emergency] here....Nurses have lots of ideas that could save the health-care system money."

With negotiations broken off, and the government refusing to improve their offer, nurses became incensed at their attitude. As one nurse put it, "We're not an unfair group, we're not unreasonable, but I think we're being treated in an unreasonable and unfair way." Negotiations finally resumed January 24th. On January 26th, the government announced that it was approving demands from physicians that patients be sent out-of-province for urgent surgery. The union condemned this as a pressure tactic.

After several days and nights of intense negotiations, a tentative settlement was reached early in the morning on January 28th. It was ratified after 61% of the membership voted in favour of acceptance. The 2-year agreement achieved an 11% increase for LPNs, and 14% for RNs. Nurses won the right to provide input into patient care and working conditions through Nursing Advisory Committees. Other achievements included: breakthroughs on the issue of joint trusteeship of pensions; pay equity increases at facilities that had not previously received pay equity wage adjustments; improved language on health and safety and nurse abuse; and improvements for casual nurses. Nurses in Thompson and Churchill, and at St. Amant Centre, stayed on strike until they had reached agreement on issues specific to their facilities.

The settlement did not achieve everything the nurses had hoped for, and some felt disappointed, and angry with the government. A nurse from HSC commented, "I think [Don Orchard] thinks we're all providing extra pin money. It is a women's issue. We wouldn't be here if we weren't women." Although they were difficult days, the strike is remembered by many as an emotional and empowering experience. Vera Chernecki urged her members not to lose sight of the courage and commitment they had shown: "We can be proud! We stood together as an example for everyone willing to fight for fair treatment." One nurse described her sense of accomplishment after the strike: "The strike meant many things to many people. I felt very proud that nurses fought for what they believed in. Yes, there was a financial price, but no price can be attached to self-respect and quality of patient care." Others spoke of the relationships that grew up between nurses during the strike: "The most notable [positive outcome] was the camaraderie that blossomed amongst the members of the Local/Worksite. New friendships grew as nurses bonded together. We were separated from our usual co-workers to walk the picket lines, keep the soup hot in the kitchen, care for one another's children, and provide essential services." Nurses also came to believe in each other's leadership capabilities: "The [Local/Worksite executive] earned the respect and appreciation of all of us ... They had to coordinate essential services and picket lines, interact daily with sometimes disgruntled hospital management and physicians, and be our link to the central bargaining table. Under the extreme

circumstances, and despite their inexperience, they performed admirably."*

The 1991 strike left the MNU with a greater sense of the importance of political involvement in seeking to address nursing and patient care concerns. Vera Chernecki talks about this new awareness...

"Since the strike, the pace of change in the health care system has been furious. The MNU's public credibility as a voice for front-line care providers has put the union in a position to act not only as a source of information on health reform, but also to influence the future direction of health policy. It is critical that the individual nurse become more politically active in trying to influence decision makers, as it is in the political arena that battles regarding future changes in health care will be waged and won!"

Don Orchard released his Action Plan, *Quality Health for Manitobans*, in 1992. Behind the rhetoric of reallocating resources to community-based health care, the government implemented deep cuts to health spending. It paid American health care restructuring consultants American Practice Management, headed by Connie Curran, \$3.9 million to cut \$45-65 million from hospital budgets at Winnipeg's Health Sciences Centre, and St. Boniface General Hospital. Although this target was never achieved, significant cuts in hospital budgets came through eliminating hundreds of nursing positions and closing hundreds of hospital beds. The LPN category of nurse was completely eliminated at St. Boniface Hospital. Further

* These two quotes from an article on the strike by Beverly Cumming and Garlen Leverington in *The Canadian Nurse*, February 1992.

lay-offs were threatened in rural health care facilities. The job losses undermined the morale of nurses across the province. However, what resulted was a determination by members to become more politically active, and to hold the government accountable for jeopardizing patient care.

Poised to continue the attack on labour, contract negotiations in 1993, between the MNU and the employer were arduous. The two year agreement, ratified in June, ensured protection from Bill 22 until 1995 in exchange for a 2% salary reduction. Bill 22, The Public Sector Reduced Work Week and Compensation Act, or as it became known 'Filmon Friday's' allowed employers to implement up to 10 days off without pay per year. Membership agreed that the salary reduction afforded the most protection at the least cost and in an equitable manner to all members. Gains were realized in seniority and recall rights and parental leave.

In addition to MNU's ongoing efforts to educate membership on labour and union issues, a scholarship was established in recognition of Keith Lambert's hard work and years of service to the Manitoba Nurses Union and the labour movement. The Keith Lambert Fund was established to provide financial assistance to MNU members seeking educational opportunities in the field of labour studies.

The fall of 1993 saw the government call five provincial by-elections. A new Minister of Health, Jim McCrae, was appointed during the by-election campaign to replace unpopular Don Orchard. However, over the coming 18 months it was to be realized that McCrae could also be as unpopular as Orchard. McCrae began his reign by

promptly announced a lay-off freeze of rural staff. LPN deletion notices in Portage and the north were immediately held in abeyance. Unimpressed by obvious political maneuvering, the MNU proceeded with an ad campaign that depicted the deteriorating condition of the health care system. The by-election resulted in the defeat of every Conservative candidate.

As a continuing effort to expose the detrimental effects cutbacks have on the health care system MNU presented the Minister of Health a brief entitled "*The Effects of Cutbacks on Health Care Delivery.*" The report was compiled from workload staffing reports and documented situations submitted by 1000's of members where patient care was being jeopardized. The report generated much media attention and heightened the public's awareness of the declining quality of health care available.

The Connie Curran debacle was far from over entering the New Year. The opposition repeatedly called on the Tories to request a \$4 million refund from Connie Curran and her team because her projected savings had not been realized. Ignoring the taunts and the disgust of the public, it was discovered in April 1996, through pressure by the opposition, McCrae had secretly sought out Curran's services once again, in early January, to the tune of \$160,000 for advice on home care reform.

The MNU membership adopted a proactive approach to influencing public policy on health care, consistently emphasizing that successful solutions to the problems facing the health care system are possible, with input from front-line care providers. In the case of restructuring, nurses expressed the so-called consultative process as a farce,

demanding meaningful input into decision-making, not an invitation to eliminate each other's jobs. Committed to a viable health care system, MNU delegates at the annual meeting, in 1994, endorsed a model for health reform entitled, *Health Care In Manitoba ... There Is A Better Way*. The MNU document provided a comprehensive analysis of the evolution of health care, reviewed evidence on alternative health care delivery and assessed the government's plan of reform. The report revealed that government reform...

"[H]as degenerated into a confusing and contradictory set of government initiatives. Little has been accomplished other than massive layoffs of front-line caregivers and a deterioration of patient care in Manitoba's hospitals."[†]

Well received by membership, the document also received widespread praise and support from the health care community, seniors, other unions, and social activists.

Health care was again the target of downsizing, when in December 1994, the government released staffing guidelines for rural and northern facilities, which led to the loss of one-third of the nursing positions in Thompson, The Pas, and Flin Flon in early 1995.

Nurses, and other health care workers who lost jobs because of workforce restructuring, were covered by a virtually province-wide union-management redeployment agreement, which guaranteed them priority over external applicants for any future job openings in the

system, as it underwent change. Nurses retained their benefits, and if agreed by Locals/Worksites, seniority was portable. The Provincial Health Care Labour Adjustment Committee, established in 1993 with funding annually from both the federal and provincial governments, worked to negotiate a voluntary severance package, and employee counseling assistance, to help laid-off health care workers and their families cope with disruption and insecurity in their lives.

In March, the Tories called a provincial election for April 25, 1995. The MNU encouraged members to become more politically active in the upcoming election. Health care issues dominated the political forum. The election witnessed the union movement spending an unprecedented amount of money on advocacy, third-party advertising. The MNU defended their action as a member endorsed initiative passed at the 1994 AGM. The ads were non-partisan and were developed in an effort to "depict the hardships inflicted on nurses and patients by Tory health care reform."

Within weeks of Gary Filmon winning a third consecutive term as premier, health care and health care workers became targets for cost cutting. Blaming the federal government for a decrease in health care funding, the Tories began to introduce massive cuts in funding through out the province and began to back track on the pre-election promise of \$191 million earmarked for health care. Targets included the two tertiary hospitals and community hospitals in the city, Brandon General Hospital, and rural facilities such as the Grandview Hospital.

After several months of postponements and cancelled meetings, the province finally met

[†] Manitoba Nurses Union, *Health Care In Manitoba ... There Is A Better Way*, p. 63.

with the MNU and demanded a permanent 2% rollback of nurses' wages. On June 15th, with the assistance of a mediator, an agreement was reached. The MNU conceded to a 2.66% wage reduction effective July 1, 1995 through to March 30, 1996, the contract expiry. The MNU had won the fight to have wages restored to the 1995 level at the end of the agreement.

Continuing the fight for health care, MNU introduced the document, *"Community Health Centres: The Better Way to Health Reform"* to community leaders, health care professionals and government representative, in June. A collaboration of the MNU and renowned health experts Dr. Michael Rachlis and Carol Kushner provided a detailed action plan for community based primary care health centers as a viable alternative to the health care reform, which was occurring in Manitoba. The community based primary care vision would use teams made up of physicians, nurses and other health care providers.

Throughout the year, staffing cuts were announced for several facilities throughout the province, Grandview, Brandon, Dauphin and once again, the North faced another round of cuts. Services were also victim to the swing of the axe. In October, the government announced that Emergency Room closures were to be implemented at the five community hospitals in Winnipeg. Justification for the closures was reverted back to the ability of the tertiary facilities to manage during the three-week doctor's strike.

As the government began the assault on health care services across the province nurses responded quickly. Throughout the province, nurses, as advocates for the sick, elderly and disabled, took to the streets to

demonstrate their commitment to their patients and the future of health care. Nurses grasped the slogan "Standing up for the front lines of health care" and the Yellow Ribbon Campaign. The Yellow Ribbon was introduced as a symbol of nurses standing up for health care. The Yellow Ribbon pin was worn by thousands of nurses across Manitoba as a visible demonstration of pride in the profession of nursing and in the nurses' role as advocate for patients and colleagues.

Nurses at the five community hospitals, slated to have their Emergency Rooms closed, were determined to make the community aware and solicit their support to lobby the government to reverse its decision. With assistance from the MNU provincial office, the "Yellow Ribbon Campaign" was developed. MNU President Vera Chernecki and representatives from the five community hospitals, HSC and St. Boniface, officially launched the campaign at the Grace Hospital Emergency Room in mid-October. Within a few weeks, nurses distributed thousands of yellow ribbons and had collected over 65,000 signatures. In early November, nurses met with Minister of Health Jim McCrae to present petitions signed by concerned citizens throughout the province.

Under immense public pressure, in large part due to the efforts of MNU membership, McCrae announced in December that four of the five community hospital Emergency Rooms would begin to re-open. However, statements in the media, by McCrae alluded to the fact that changes would be occurring at the Misericordia and Seven Oaks Hospital. The health care fight was far from over, the public and MNU would continue to battle

the government for the survival of services and facilities.

Building on the momentum of the Yellow Ribbon campaign, an intense, year-long, membership mobilization campaign was conducted throughout the province, in 1996, in an effort to reach out to the grassroots. Issues focused on were regionalization, privatization, and deskilling. The program included the development of a network of workplace leaders and canvassers prepared to educate nurses not currently active within the union. The internal campaign was very successful, receiving an excellent evaluation by membership. Immediately following, the development of a second phase was coordinated.

Fears of privatization in health care were realized in February 1996 when a leaked document regarding the privatization of homecare became public. The document outlined the government's intention to propose the contracting out of home care services to the private sector.

In protest of the government's move to cut LPNs and replace them with health care aids, a Black Ribbon campaign was launched by Licensed Practical Nurses. Nurses feared that the trend toward replacing nurses with unlicensed aides would further erode the quality of care patients were receiving. MNU argued that if LPNs were allowed to practice to the full extent of their license, LPNs would be seen to be cost efficient.

The government continued its assault on health care with the April 1st announcement that the Provincial Government would be removing 2% from health care facility budgets. Facilities faced with reduced budgets, began to target the workforce. Another threat of lay-offs loomed.

On April 17, 1996, the public, MNU and other unions threw their support behind 3000 homecare workers as they began a five-week strike demanding a freeze on the plan to privatize 25% of home care services. MNU members throughout the province showed up at picket lines in a show of support of the workers. Delegates at the AGM spent their lunch hour rallying in support of Home Care workers and their clients. Nurses joined hundreds at the Legislature participating in a rally sponsored by the Coalition to Save Home Care.

Acting on the September 1995 announcement that a regionalization plan had been developed for the north and rural Manitoba, Bill 49 was introduced into the legislative assembly by Minister of Health, Jim McCrae, in late summer 1996. In response, the MNU presented a brief on Bill 49, the Regional Health Authorities Act, in October, outlining the concerns MNU had with the lack of clarity, the concentration of power in the hands of the Minister of Health, the contradictions of the principles of the Canada Health Act and the threat to the collective bargaining rights of nurses.

Concerned about the increased growth of discretionary power of the government, the lessening of public accountability, and the possibility of soaring pharmaceutical drug costs, the MNU presented a brief to the legislative committee on proposed amendments to the Pharmaceutical Act, in the fall of 1996.

In October, negotiations concluded with no wage increases, but more importantly, wage rollbacks were kept off the table. Faced with the government removing 2% from health care facility budgets, negotiations proceeded cautiously, but aggressively regarding wages. Concessions

faced included: the increased casualization of nurses, gutting of layoff clauses, reduction of standby allowances, deletion of academic allowances, freezing of yearly increments. A significant gain was the restriction on the use of private agency nurses, the first of this type of clause in Canada.

The Winnipeg Free Press reported the year 1996 had been the worst year for labour strife since 1978, with 1919, the year of the General Strike, having been the worst. In total, 267,000 working days had been lost due to strikes and lockouts. In response to the labour unrest, the government introduced two pieces of legislation that restricted worker's right to organize, unions to strike and the ability to participate in the political arena. The union and labour movement vehemently opposed the proposed changes. The MNU immediately prepared and delivered a presentation to the legislative committee that outlined MNU's opposition to the proposed amendments to the Labour Relations Act. Unfortunately, the government proceeded with changes to the Labour Relations Act that altered the balance of power between labour and employer, restricted union certification and interfered in the democratic process of the union movement.

Community hospital restructuring, announced in the fall of 1996 and the finalization of regionalization were at the top of the government agenda in 1997. Facilities throughout the city braced for announcements that occurred almost daily, while the north and rural Manitoba coped with the day-to-day uncertainty of the regionalization process. Although intense lobbying efforts had been undertaken, MNU members and the public lost their

fight with the fall announcement that the Grace Hospital would be forced to close the obstetrics ward.

On April 1, 1997 Bill 49, the Regional Health Authorities, and *Consequential Amendments Act* became a reality in the province and the responsibility for health service delivery from the existing governance structures was transferred to Regional Health Authority's. The Act created ten rural and northern health care regions.

Exhibiting a commitment to unionism and the labour movement, delegates at the AGM approved affiliation with the Canadian Labour Congress (CLC). As part of the largest labour organization in Canada, the MNU hoped for a stronger voice for health care and an opportunity to communicate to the union movement a nurse perspective. Affiliation with the CLC also offered the opportunity to build a stronger, autonomous voice at the national level. Federal lobbying is an ambitious venture and the CLC had proven itself as a leader in fighting adverse federal policy.

The MNU continued to lobby the provincial government on key issues. In response to the government move to extend The Essential Services Act to cover all health care workers in Manitoba the MNU presented a brief to the legislative committee reminding the committee of the voluntary essential services agreement currently in place and argued that the proposed changes are an unnecessary and coercive attempt to undermine the right to withdrawn nursing labour during strike action.

Although supportive of legislative measures to ensure the privacy of personal health

information, the MNU presented a brief to the legislative committee on Bill 51 the Personal Health Information Act, outlining aspects of the legislation that needed revision and/or strengthening.

Utilizing collective agreement language regarding unresolved staffing and/or workload issues, nurses at Killarney's Tri-lake Health Centre initiated the first Independent Assessment Committee (IAC) hearing by referring the issue to the IAC. Killarney nurses, frustrated with inaction, referred workload/staffing problem to IAC in early 1995. The documenting of heavy workloads, inadequate staffing and patient care concerns, filed over a two year period, were vindicated in recommendations put forth by the IAC in April 1996. Issues related to staffing levels, orientation, and facility design were addressed in the IAC report and implemented.

In early November, Locals/Worksites launched Phase II of the Standing up for the Front Lines campaign. The "*I am a Nurse*" campaign involved nurses displaying their professional designation pin and participating in the Nursing and Health Care Survey. As well, a workload/staffing campaign was organized to reiterate to membership the importance of documenting workload/staffing concerns. Simultaneously, a public survey on health care was carried in newspapers across the province. Public response was overwhelming. The data from the nurse and public surveys together with the workload/staffing reports was compiled and an in-depth analysis of health care in Manitoba was produced in 1998.

Health Care in Manitoba – a report from the Front Lines, released April 1998, was well received by other health organizations and

the public. The province-wide study conducted by the MNU involved over 5000 nurses. The documented evidence from both nurses and their patients clearly demonstrated the health care delivery system was in crisis.

Nurses' anger and frustration once again spilled out into the street in protest. Overcrowding at the St. Boniface General Hospital Emergency Room was in a state of crisis. Hallway congestion was chronic and nurses feared for patient safety on every shift. In March, MNU membership and the public joined frustrated emergency nurses to protest the overcrowding situation. A leafleting campaign was organized to highlight the backlog of admitted patients in Emergency. The term 'hallway medicine' coined by the media at this time inaccurately reflected the concerns of the nurses, who saw the issue to be the number of admitted patients who have to be maintained in ER because there were no beds available for them in the hospital. The backlog of patients severely hindered the ability of the nurses to provide urgent/emergent care to true emergency patients.

Unable to resolve the emergency room issue through the Nursing Advisory Committee, the nurses referred the matter to IAC and presented to the committee in May 1998. The second IAC in the history of the MNU put forth several recommendations concerning staffing, workload and patient safety in October of the same year.

MNU already represented the vast majority of nurses in the province, however, through the regionalization process the MNU won the right to represent **all** unionized nurses in every region that held run-off votes. In

total MNU gained 297 new members, these included community health nurses, previously represented by the Manitoba Government and General Employees' Union (MGEU). Consistent with the government's commitment to regionalization, in April 1998, the Winnipeg Health Authority assumed authority for urban acute care centers. The Winnipeg Community Authority assumed authority of long-term care facilities and community health respectively – for the time being.

After 17 years as President of the MNU, Vera Chernecki announced her plan to retire in August. Delegates at the April AGM elected Maureen Hancharyk as the eighth President of the MNU.

The October and November 1998 nurse protest of the closure of the Misericordia Hospital as an acute care center did not halt government action. In December 1998, the Misericordia Hospital was converted from an acute facility to a long-term care facility and the Emergency Room was converted to an Urgent Care Centre while overcrowding in all other facilities continued. Nursing staff was gutted, almost half of the nursing staff received lay-off notice.

Following the government's imposition of regionalization, the MNU determined that there was a need to re-evaluate and restructure both the boundaries and the internal structure of the organization. The Resolutions & Constitution Committee, expanded to include the executive officers, were directed at the 1998 AGM to provide a full report and recommendations to Locals/Worksites by December 1998 in response to regionalization and MNU's structural organization. As a result of concentrated efforts on the part of committee members the Board, MNU Staff

and legal counsel, several recommendations regarding the organizational structure of the MNU were implemented.

Regionalization had resulted in the creation of a 'new employer' – the Regional Health Authority (RHA). The MNU responded with the conception of a "regional local". An executive continues to exist at each of those worksite units whose facilities were transferred to the RHA, however, an additional structure, comprised of a Regional President, Secretary and Treasurer, was added to ensure a strong political structure to deal with the RHAs. The Regional Local is elected by and from the Worksite and Local Presidents. Non-transferred sites continue to exist post-regionalization. Those locals continue to function with elections of local executives as per the local constitution. However, these locals also participate in the Regional Local structure.

In addition to, but not as a result of regionalization, the Board recommended that the election process of MNU executive officers, effective the 1999 AGM, should be from general membership by voting delegates at the AGM.

The "It's Raining" campaign, an intense radio and print campaign to demonstrate to Manitobans that the government's decision to continue to funnel funds into a pre-election slush fund or Rainy Day Fund was to the detriment of patient care, was a success with membership and the public throughout the province. The campaign was lunched with nurses once again taking to the streets. A demonstration held March 15, 1999, at the Legislative building was well attended by hundreds of members and supporters with umbrellas in hand.

Demonstrators opened their umbrellas, signaling the government, *“it's pouring and it's time to open the Rainy Day Fund.”*[‡] A settlement mediated by government appointed Wally Fox Decent was ratified on May 1, 1999. Significant improvements in contract language had been negotiated. Recommended was a 13.5% increase in wages and benefits and the inclusion of a mobility agreement.

The Nurses Recruitment and Retention Fund was established, by the government in April 1999, to support one-time funding costs for specific strategies or initiatives to attract and keep Registered Nurses, Licensed Practical Nurses, and Registered Psychiatric Nurses in Manitoba, and to promote nursing as a profession. The MNU has been involved in the decision making process since the Funds' inception and continues to have two representatives on the committee, Maureen Hancharyk and Irene Giesbrecht.

After eleven years of Tory rule, the New Democratic Party (NDP) was elected on September 21, 1999. Elected on a platform of ending hallway medicine and fixing the problems in the health care system, the NDP promised to hire more nurses and open more beds. President Maureen Hancharyk remained cautious of the new government, pointing out in a membership newsletter mail out...

“...the role of the Manitoba Nurses Union has not changed with the election of a new government. We

will continue to speak out for nurses and our patients. We will hold this government accountable for their decisions regarding health care...we will be their loudest critics...”

In early January 2000, the government announced the amalgamation of the Winnipeg Community and Long Term Care Authority (WCA) and the Winnipeg Hospital Authority (WHA) into a single structure – the Winnipeg Regional Health Authority (WRHA). The WRHA is responsible for coordinating health services in Winnipeg, which include hospital, community health, home care and long-term care services.

The year 2000 ushered in MNU's 25th Anniversary. An advertising campaign celebrating 25 years of achievement began in April. The campaign was comprised of billboards, newspaper and radio ads. Billboards featuring Health Sciences Centre Local 10 nurses, Candida LaClare, holding a 4-day old premature baby were designed to send a positive message to the public – nurses really care and are “Standing Up for the Front Lines of Health Care.”

The MNU continued to pressure the government to deal with recruitment and retention issues. The MNU lobbied for the reintroduction of the RN diploma program, an increase in the number of nursing school seats and delivery of the LPN program outside of Winnipeg. In March 2000, the Minister of Health, Dave Chomiak, announced a five point plan that included the initiatives put forth by the MNU. Designed to help Manitoba's health sector reinvest in the nursing profession, the government reintroduced the RN diploma program, increased enrolment in the LPN program and began to deliver the LPN program in rural locations.

[‡] David Square “Manitoba's nurses say they're through singing in the rain” CMAJ 1999;160:1280 May 4, 1999

Staff development and educational needs of the nursing profession were addressed in the second point. RHAs were allocated funds based on the number of nurses in their region. A committee made up of employers and front line nurses established in each region were to identify continuing education needs and priorities such as changes in nursing practice or treatment and working with new equipment. Thirdly, to improve the use of available nursing resources, and as a result of intense lobbying by the MNU, the government began a reversal of the Tory policy of LPN deletions and directed RHAs to change the staffing mix within health facilities to allow more flexibility in hiring practices, such as adding more LPNs to the mix. The MNU viewed the re-introduction of LPNs into facilities as an affirmation of the important role LPNs play in the delivery of health care.

The fourth point addressed the need to improve working conditions. In a joint initiative with Manitoba Labour and Manitoba Health, the government established a three-member team mandated to examine quality of life issues that affect nurses' working conditions and the overall workplace environment. This group was asked to identify specific pilot projects that would improve working conditions and morale. Speaking at the 2000 AGM, Health Minister David Chomiak announced two of the members of the three-member task force: MNU member Brenda Lesyk and retired MNU member Anne Wright.

Lastly, the fifth point was to establish a nursing advisory council made up of representatives from labour, management and educators from across the province to advise the health minister on issues and

concerns related to the role of nursing in the health care system. The new Manitoba Nursing Advisory Council was established in June 2001, co-chaired by the Assistant Deputy Minister of Health for Regional Affairs and the Vice-President of the MNU, to support the development of strategies that improve nursing resource planning and management, and to guide the implementation of the Worklife Task Force recommendations. The 21-person council is comprised of nurses, health employers, regulatory bodies, educational institutions, union representatives, and government staff. The council liaised with the federal Canadian Nursing Advisory Council to gather and share information on a national basis.

The province also amended existing regulation to give nurses and other health care providers the opportunity to have a voice on health facility boards and regional health authorities. As a result of the regulation amendment, in April 2000, an MNU activist, Shirley Delaquis, was appointed to a three-year term on the newly formed Winnipeg Regional Health Authority Board.

The much anticipated MNU Long Term Care Report was released at the 2000 MNU 25th Anniversary AGM. The report highlighted long-term care (LTC) issues by presenting the results of LTC nurse surveys and data gathered from workload staffing reports. The report concluded with the following recommendations: a minimum standard of 2.25 hours of nursing care per day should be established; increase the number of LTC beds; level of acuity must be a determining factor in funding and staffing levels; a needs outcome monitoring based system that measures both quality and care issues must be implemented; and finally, health

providers must be utilized as resources in determining LTC health policy.

In support of the government's move to reverse the draconian labour amendments introduced by the previous government, MNU presented a brief to the legislative committee on Bill 44. MNU pointed out the policies and legislative changes of the previous government had a profoundly negative effect on the profession of nursing. MNU argued the aggressive anti-nurse and anti-labour policies contributed to the acute nursing shortage in the province. The brief outlined the MNU's support of the amendments, but offered suggestions to strengthen aspects of the Bill that the MNU viewed as weak.

An IAC hearing was held May 2000, at the Pediatric Intensive Care Unit (PICU) at the Children's Hospital, Health Sciences Centre. At issue were staffing, workload, and patient safety concerns. The IAC process concluded with the committee putting forth several recommendations addressing the nursing staff concerns.

Nurses at the Victoria General Hospital and Concordia Hospital, in 2001, referred unresolved concerns to IAC. Once again, as had been the case in all previous IACs, at issue were staffing, workload, and patient safety concerns. Nurses at each facility were satisfied with the IAC recommendations in which resolutions to be considered were detailed.

The Joyce Gleason Memorial Scholarship Fund was established by the MNU in 2001 in recognition of her dedication to the union movement and the nursing profession. Joyce Gleason was the driving force in organizing many of the MNU locals and was instrumental in the founding of the

MNU. In 1975, she became the first Executive Director of the MONA, now known as the MNU. The scholarship is open to any Manitoban, registered in the first year of an LPN, RN, or RPN nursing program.

Continuing to be politically active, the MNU actively lobbied the NDP to amend the Essential Services Act introduced in 1996 by the Filmon government. The NDP chose instead to invite the health care unions to discuss working out a voluntary agreement with the current legislation as it stood. Delegates at the 2001 AGM passed a motion to not participate in any discussions regarding the Essential Services Act and continue to endorse the MNU position that prior to any discussions on voluntary essential services the current legislation must be abolished.

The year 2001 culminated with the move of the MNU provincial office from the fifth floor of the Union Centre to the third floor. Based on projections and calculations of future membership, MNU negotiated an option on the remainder of the third floor in anticipation of membership growth.

Negotiations commenced September 2001 with a proposal exchange meeting with employers. The MNU's suspicions were confirmed that the employers were not prepared to bargain with a speedy resolution in mind when a package of regressive language and 29 rollbacks was presented. Meetings continued throughout the fall and into the New Year for a total of 80 days of negotiations. The lengthy and arduous negotiations resulted in a tentative agreement being reached on April 1st, 2002. The agreement, ratified mid-April, contained the highest wage increase for nurses in fifteen years. A wage and benefit

package of 24.5% over 2.5 years included a 20% wage increase over two and a half years, increases in standby, night, evening and weekend premiums, portability of benefits and significant language improvements. Significant gains were made for the North with an additional 5% increase on each wage scale for the entire North. In addition, an Isolation Allowance for Churchill of up to \$30,000 for RNs and up to \$24,000 for LPNs, for nurses who maintain employment through the life of the agreement, was negotiated.

nurses became part of MNU Home Care Local 97.

Regionalization continued with the government announcement on June 30, 2002, that the original 12 RHAs were to be reduced to 11 with the amalgamation of Marquette and South Westman authorities into the Assiniboine Regional Health Authority. The creation of this new region presented a challenge to the MNU regarding the administration of the respective collective agreements. Discussions over several months between MNU and the RHA resulted in the amalgamation of the collective agreements.

In the summer of 2002, the Winnipeg hospital bargaining units were rationalized which meant each hospital would only have one union represent nurses. In Winnipeg, the Manitoba Labour Board ruled that if a union represented 80% of the classification in a facility, that union would attain the remaining classification without a run-off vote. Therefore, 76 RPNs at the HSC, formerly with the Canadian Union of Public Employees (CUPE), became part of the MNU Local 10 bargaining unit.

Former Victorian Order of Nurses, now employees of the WRHA in Home Care, voted in favour of MNU representation in run-off votes held in August 2002. The

The history of nursing in Manitoba reveals that nurses will adopt new ways of collective action to meet new circumstances. They have learned to integrate the caring nature of their work and their vocational calling, with their right to enjoy a decent standard of living and satisfaction in their jobs. Indeed, nurses insist that these are inseparable issues, which complement each other in creating a functional health care system. Over nearly thirty years, a period of tremendous growth and achievement for the union, Manitoba nurses have come to believe that their union has relevance not only to their own lives, but also to the lives of their patients and the society in which they live and work.

**Past Presidents of the
Provincial Staff Nurses' Council, MONA,
and MNU**

Glen Smale (1970-1972)
Marie Rondeau (1972-1973)
Ruth Mann (1973-1975) [Deceased 1999]
Shirley Codd (1975-1976)
Kathy Connors (1976-1979)
Sonny Arrojado (1979-1981)
Vera Chernecki (1981 to 1998)
Maureen Hancharyk (1998 to 2008)
Sandi Mowat (2008 to present)

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