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COVID-19 and the Labour of Care

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COVID-19 and the Labour of Care

THE COVID-19 PANDEMIC HAS CERTAINLY CONNECTED EVERYONE to the history of disease. There have been many comparisons made with the "great influenza" of 1918 as well as other 20th-century pandemics.[1] Early edited collections documented the impact of the pandemic in Manitoba and in Prince Edward Island, research projects were funded, and discussion groups created – notably "Mon récit covid," which is administered by a leading scholar of nursing history at the University of Ottawa Marie-Claude Thifault.[2] Esyllt Jones has written exemplary, historically informed work to reach physicians, editorials for the general public, and two short reports for the Royal Society of Canada in the past year.[3] Jones's previous work as an historian of epidemic disease was already well-known because of her excellent analysis of the impact of influenza on Winnipeg's working class. She wryly observed in *Influenza 1918* that it was entirely possible to read histories of the Winnipeg General Strike and "have no idea . . . [that] working people were simultaneously confronting a

1 For some perspective, see Agnes Arnold-Forster and Caitjan Gainty, "The Problem with Medical History in the Age of COVID-19," *Nursing Clio* blog, 15 July 2021. https://nursingclio.org/2021/07/15/the-problem-with-medical-history-in-the-age-of-covid-19/.

2 Andrea Rounce and Karine Levasseur, eds., *COVID-19 in Manitoba: Public Policy Responses to the First Wave* (Winnipeg: University of Manitoba Press, 2020) and James Randall, Laurie Brinklow, and Marlene Chapman, eds., *Prince Edward Island: COVID-19 Island Insight Series* (Glasgow and Charlottetown: University of Strathclyde Centre for Environmental Law and Governance and University of Prince Edward Island Institute of Island Studies and Island Innovation, 2021). Both of these reports are available as free downloads. The Newfoundland and Labrador Center for Applied Health Services Research prepared "quick response reports" for the provincial government on a broad range of topics; see, regarding COVID-19, https://www.nlcahr.mun.ca/CHRSP/COVIDQuickResponse.php. In New Brunswick and Nova Scotia, provincial agencies funded 27 and 40 projects, respectively, during the Spring of 2020; see https://nbif.ca/new-brunswick-researchers-rise-to-the-challenge-of-covid-19/ and https://www.dal.ca/news/2020/05/12/40-projects-receive-funding-from-nova-scotia-covid-19-health-res.html. "Mon récit covid" is a public Facebook group (with 326 members in mid-August 2021). The group also maintains very modest Twitter and Instagram accounts.

3 Esyllt Jones, "Surviving Influenza: Lived Experiences of Health Inequity and Pandemic Disease in Canada," *Canadian Medical Association Journal* 192, no. 25 (22 June 2020): E688-9; Jones et al., *Beyond the COVID-19 Crisis: Building on Lost Opportunities in the History of Public Health* (Ottawa: Royal Society of Canada, 2021); Jones et al., *Remembering is a Form of Honouring: Preserving the COVID-19 Archival Record* (Ottawa: Royal Society of Canada, 2021).

Peter L. Twohig, "COVID-19 and the Labour of Care," *Acadiensis* 50, no. 2 (Autumn/automne 2021): 96-114.

devasting disease."[4] The lasting contribution of her book is that it transcended some of the silos of Canadian history and provided an analysis that integrated social history, community history, medical history, labour history, and other subdisciplines. It continues to stand as a model for how to connect the history of health and medicine to other analytical paths, including the history of working people.

COVID-19 laid bare some of the challenges facing Canada's health care system and especially staffing issues in long-term care. In Nova Scotia COVID-19 settled into Northwood, the largest long-term care (LTC) facility in the Atlantic region, which experienced the full brunt of COVID-19 during the early days of the pandemic. On 12 March 2020 Northwood imposed restrictions on visitors, including volunteers, and on 15 March Nova Scotia announced its first three cases of COVID-19 and immediately closed LTC facilities to all visitors. By the time the province declared a state of emergency and closed many businesses and restricted social gatherings, Northwood had become the epicenter of the COVID-19 pandemic in Nova Scotia. In response, the facility created a "COVID Unit" to isolate people who had tested positive and take them out of the rooms they shared with other residents. One such story illustrates what was happening. Gerald Jackson, an 84-year-old resident, tested positive with COVID-19; the 21-year naval veteran shared his room with two other men, separated only by the flimsy curtain that offers residents a minimal form of privacy in the crowded rooms. Jackson died on 28 April 2020, one of 53 residents of Northwood who would succumb to COVID-19. His daughter, Darlene Metzler, described the triple room where he spent his final days: "This was like a hospital room. I challenge somebody to walk in that room at tell me that it doesn't look like institutional living where seniors are being warehoused."[5]

Northwood was hardly unique, and COVID-19 took hold in nursing homes throughout North America. By 20 April 2020 COVID-19 accounted for more than 7,000 nursing home deaths. In states such as New Jersey, nursing homes accounted for 40 per cent of the total deaths.[6] It is a truism in the history of

4 Esyllt Jones, *Influenza 1918: Disease, Death and Struggle in Winnipeg* (Toronto: University of Toronto Press, 2007), 89.

5 Shaina Luck, "Inside the Halifax High-Rise at the Centre of a Canadian COVID-19 Tragedy," CBC News, https://www.cbc.ca/news/canada/nova-scotia/northwood-halifax-covid-19-what-happened-1.5596220.

6 Tracey Tully et al., "70 Died at a Nursing Home as Body Bags Piled Up: This Is What Went Wrong," *New York Times*, 19 April 2020, https://www.nytimes.com/2020/04/19/nyregion/coronavirus-nj-andover-nursing-home-deaths.html.

public health that the burden disease is not shared equitably, and COVID-19 quickly revealed that elders, the poor, racialized communities, and the economically marginal were especially vulnerable. Nursing homes in Atlantic Canada braced for the impact of COVID-19.[7] Tucker Hall, a licensed long-term care facility in Saint John, reported its first cases among residents and staff in November 2020. Cases mounted over the next few weeks, and affected residents were gathered together in a "cohorting area" where they could be cared for by the staff. The facility also worked with the New Brunswick Provincial Rapid Management Team and other government agencies to prepare a response to COVID-19 in the nursing home. By early January, 13 residents and 8 staff were infected at Tucker Hall. Shannex, the corporation that operates the facility, reported the deaths of two residents on 12 January 2021, and another one the next day. Four more deaths followed the next week.[8] Nursing home deaths are often met by a sense of loss that is felt very deeply by the staff, who do the intimate bed and body work of care, and by other residents because of the nature of nursing home life, characterized as it is by shared activities, meals, and opportunities to socialize. Under COVID-19 conditions, family and friends could not comfort residents during their final hours – a situation that further accentuated the sense of loss for each death. This was the low-point for Tucker Hall, and by February testing was not turning up any new cases and the outbreak was declared over by Public Health on 16 February. By that time, there was an outbreak at Manoir Belle Vue in Edmundston; this LTC facility ultimately had 55 confirmed cases, including 34 residents and 21 staff. A second facility in Edmundston, Villa des Jardins, also had a serious outbreak, with 17 residents and 16 staff contracting COVID-19.[9] By February 2021 26 of 766 LTC facilities in Atlantic Canada, slightly more than 3 per cent, had infections among residents or staff. This is an enviable record given the crises that existed

7 Not all provinces were affected. Newfoundland and Labrador managed to avoid any COVID-19 cases in nursing homes during the first wave; see "Did Newfoundland have a Case of COVID-19 in Long-Term Care in St. Lawrence?" https://www.saltwire.com/newfoundland-labrador/news/local/did-newfoundland-have-a-case-of-covid-19-in-long-term-care-in-st-lawrence-512048/. Eastern Health established a dedicated care unit for COVID-19 cases in Pleasantville Towers, though it was not used during 2020; see https://www.cbc.ca/news/canada/newfoundland-labrador/nurses-union-long-term-care-1.5929384.

8 Outbreaks in facilities operated by Shannex in New Brunswick were reported as they occurred via https://www.shannex.com/news/covid-19-community-report-new-brunswick-as-of-december-10-at-530pm/.

9 "Help Arrives at 2 Edmundston Long-Term Care Homes Hit by COVID-19 Outbreaks," https://www.cbc.ca/news/canada/new-brunswick/manoir-belle-vue-villa-des-jardins-covid-19-edmundston-homes-1.5899027.

in other provinces, but the presence of COVID-19 in LTC was nevertheless revealing.[10]

I have thought a lot about nursing homes during the pandemic.[11] I have written a good deal about the reorganization of health care work since 1950 in Canadian settings, including the introduction of new categories of workers such as licensed practical nurses (LPNs).[12] Since the 1970s, LPNs have been joined by personal care workers (PCWs), continuing care assistants (CCAs), and other workers as the labour of LTC has been further rationalized and renegotiated.[13] I also have a personal connection to Northwood. My father lived there at the end of his life. He grew up just a couple of blocks away from where Northwood now stands, near the corner of Cornwallis and Maynard Streets, in a solidly working-class part of the city. He spent his childhood days during the late 1930s and the 1940s playing on the streets to the north of the Halifax Citadel. He attended church at St. Patrick's Cathedral on Gottingen Street with his family every Sunday. When he went to work, it was in the same neighbourhood, and he would eventually open his own small store, which was operating when I was born in the late 1960s, to serve the same working-class neighbourhood in which he grew up.

His last years were not good as he laboured with Alzheimer's disease. Initially, he had some good days. He knew me, and my family, when we went to visit. He asked my daughter about the hockey teams on which she played. He asked my partner about her job and her parents. But as his disease progressed

10 Stu Neatby, "Most Long-Term Care Homes in Atlantic Canada Kept COVID Out. Here's What Worked," 29 January 2021 (updated 4 February 2021), https://www.saltwire.com/atlantic-canada/news/local/most-long-term-care-homes-in-atlantic-canada-kept-covid-out-heres-what-worked-546701/.

11 There are relatively few historical analyses of long-term care in Canada. Megan Davies's *Into the House of Old: A History of Residential Care in British Columbia* (Montreal and Kingston: McGill-Queen's University Press, 2003) remains the essential entry point for most historians. She has also recently co-authored an analysis of homecare in parts of British Columbia using oral history; see Megan J. Davies and Rachel Barken, eds., *Voices from Hornby & Denman Island Home Support, 1979-2019* (Toronto: Authors, 2019).

12 Peter L. Twohig, "We Shall Arrive at the 'Utopia of Nursing': Reconceptualizing Nursing Labour in British Columbia, 1945-65," *BC Studies*, no. 206 (Summer 2020): 9-30; Twohig, "'Everything possible is being done': Labour, Mobility, and the Organization of Health Services in Mid-20th Century Newfoundland," *Canadian Bulletin of Medical History* 36, no. 1 (Spring 2019): 1-26; Twohig, "The Second 'Great Transformation': Renegotiating Nursing Practice in Ontario, 1945-1970," *Canadian Historical Review* 99, no. 2 (June 2018): 169-95; Twohig, "Are they Getting Out of Control?": The Renegotiation of Nursing Practice in the Maritimes, 1950-70," *Acadiensis* 44, no. 1 (Winter/Spring 2015): 91-111.

13 CCAs provide direct client-centred care under the supervision of regulated health professionals, while PCWs provide personal care (such as bathing), light housekeeping, and other tasks under the direction of the clinical leader (usually an RN).

the conversations became more abstract and more difficult. His memories were rapidly fading. I remember visiting on a Tuesday afternoon. By this time, he was mostly confined to bed. I took along some Irish poetry to read aloud. I distinctly remember reading him Seamus Heaney's poem "Digging," which captures how the sons of the working class, if they have been fortunate (as I was), get to make different choices than their fathers or their fathers' fathers. Heaney contrasts the poet's life with that of a man who cut turf, writing "Between my finger and my thumb / The squat pen rests / I'll dig with it."[14] It seemed appropriate in the moment and he died later that day, on the 17 April 2013. The other thing I remember about my father's last months in Northwood was the incredible care he received from the staff. Workers would come into his suite and talk with him and with me. They were always busy, but they always had a moment to do the labour of caring, both for my father and for me.

Focusing on workers in long-term care, and those doing similar work in other areas of health care, offers the opportunity to revitalize working-class history.[15] I want to suggest some analytical paths that have been brought sharply into focus by the current pandemic. The first is how the organization of care has changed over time. This is well-illustrated by the history of long-term care because of the significant presence of a range of workers who provide front-line care. While physicians and registered nurses (RNs) are frequently the focus of studies in the history of health care, tens of thousands of workers do the labour of caring every day across Canada. These include under-studied groups such as licensed practical nurses, continuing care assistants, and personal care workers, who provide so much of the bedside care in nursing homes. A second analytical possibility is to examine the contributions of these workers to the labour movement since the 1970s. Of course, important foundational work has been done by scholars such as Linda Kealey and Kathryn McPherson, who have examined strikes by RNs.[16] Health care workers, including RNs, have engaged in significant and in some cases protracted labour struggles since the 1970s.

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14 Seamus Heany, "Digging" (1966), https://poetryfoundation.org/poems/47555/digging.

15 See Christo Aivalis, Greg Kealey, Jeremy Milloy, and Julia Smith, "Back to Work: Revitalizing Labour and Working-Class History in Canada," *Active History*, 21 September 2015, http://activehistory.ca/2015/09/back-to-work-revitalizing-labour-and-working-class-history-in-canada/.

16 Linda Kealey, "No More 'Yes Girls': Labour Activism among New Brunswick Nurses, 1964-1981," *Acadiensis* 37, no. 2 (Spring/Autumn 2008): 3-17 and Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1996), esp. chap. 7 – "'The Price of Generations': Canadian Nursing Under Medicare, 1968-1990," 348-62. Readers interested in nursing unions can also consult Sharon Richardson's chapter in Christina Bates, Dianne Dodd, and Nicole Rosseau, eds., *On All*

The COVID-19 pandemic revealed the labour of care, and this suggests a third direction. If you look at the images on social media feeds and in the media, you cannot help but notice that these workers complicate the historic whiteness of our understandings of nursing labour.

The organization of care

On 24 March 2020, Janet Hazelton, the president of the Nova Scotia Nurses' Union, stated "I am concerned about the staffing levels we currently have in long-term care. We don't have the . . . RNs and LPNs" to care for a greater number of acutely ill nursing home residents. One issue that emerged is that many long-term care workers have more than one employer, so this means that they may also be moving among facilities. Workers do that because many positions in health care are part-time. One long-term care worker interviewed for Armstrong, Armstrong, and Scott-Dixon's book *Critical to Care* admitted that "in order to make ends meet I held two to three part-time jobs at a time. This is difficult doing double shifts or sometimes working 30 days without a day off. This is stressful for home life. Also on a regular basis my job would either be eliminated, hours cut, heavier workload or bumping out of position. No job security is very stressful."[17]

Health care work became a lot more precarious in the latter decades of the 20th century, and this precarity has continued into the 21st century as workers do not have the ability to control their hours of work and face uncertain paycheques, limited benefits, and poor future prospects. It may take years of casual employment before a permanent position can be secured, if one ever does become available. Jobs have also become more difficult physically as workers face reduced staffing levels and experience greater workloads. A study carried out by the Registered Nurses Association of Nova Scotia examined nurses' employment patterns following graduation, and found that by 1995, only 14.6 per cent of graduates were working full-time in contrast to 61.6 per cent at the beginning of the decade. At the same time, 67.9 per cent of graduates were working in casual positions, up from 24.3 per cent in 1990. With such dismal prospects, nearly a quarter of new graduates embraced working in other roles, including as personal care workers or as licensed

Frontiers: Four Centuries of Canadian Nursing (Ottawa: University of Ottawa Press and Canadian Museum of Civilization, 2005).

17 Pat Armstrong, Hugh Armstrong, and Krista Scott-Dixon, *Critical to Care: The Invisible Women in Health Services* (Toronto: University of Toronto Press, 2008), 128–9.

practical nurses, up from only 2 per cent in 1990.[18] The Canadian Union of Public Employees (CUPE) estimated that nationally the shift to part-time work for its members grew by 118 per cent during the late 1990s and into the new century, encompassing 120,000 workers[19] In Nova Scotia, Louise Riley, a CCA who leads the Canadian Union of Public Employees-NS Long-Term Care Committee, reported that working across sites is a "common" practice among CCAs. Dr. Robert Strang, who has been Nova Scotia's chief medical officer of health since 2007, noted "We're balancing challenges for sure," adding that in "an ideal situation where staffing was not an issue and we had adequate staff to provide essential care for residents, we would have all workers in a long-term care facility who were exposed off for 14 days. We don't have that luxury."[20] Strang's comments, and the pandemic, revealed the consequences of part-time jobs and the casualization of health care work, and how these changes present challenges to meeting the staffing needs in long-term care. Historically the reorganization of health care has been a response to different forces, including the introduction of technology, labour shortages, and the drive for efficiencies. In private, for-profit long-term care settings, having other workers do tasks formerly done by RNs is also part of the quest for larger profits.

On 5 April 2020, the first staff person at Northwood tested positive for COVID-19. The next day, staff were told to wear protective masks throughout their shifts. On 7 April, the first five Northwood residents tested positive for the virus.[21] By 19 April 2020, there were 98 confirmed cases of COVID-19 among LTC residents and employees in Nova Scotia. The largest clusters were at Northwood (51 residents and 33 staff) and the Admiral nursing home in Dartmouth (13 cases). And by the next day, this had increased to 188 people in

18 Frances Gregor, Barbara Keddy, Suzanne Foster, and Donna Denney, "Nova Scotia Nurses and Health Care Restructuring: Strategies to Manage Job Displacement," in *Care and Consequences: The Impact of Health Care Reform*, ed. Diana L. Gustafson (Halifax: Fernwood, 2000), 75. The authors are drawing on Registered Nurses Association of Nova Scotia (RNANS), *Report of Nova Scotia Graduate Employment Survey: Classes of 1990-95* (Halifax: RNANS, 1996).

19 Linda Briskin, "CUPE ON Strike, 1963-2004," *Just Labour: A Canadian Journal of Work and Society* 10 (Spring 2007): 8.

20 Jennifer Henderson, "Nursing Home Workers are Moving Between Multiple Facilities. That's a Big Problem," *Halifax Examiner*, 17 April 2020, https://www.halifaxexaminer.ca/province-house/nursing-home-workers-are-moving-between-multiple-facilities-thats-a-big-problem/.

21 I am drawing on the timeline developed by journalist Shaina Luck; see Luck, "Inside the Halifax High-Rise at the Centre of a Canadian COVID-19 Tragedy."

nursing homes (127 residents and 61 staff).[22] Staff were under such strain that the Nova Scotia Health Authority (NSHA) issued a call for volunteers to deploy to LTC long-term care facilities in the Central Zone, which accounted for the vast majority of cases (585 of 721).[23] In other settings, members of the Canadian Armed Forces were brought in to support the daily efforts of front-line health care workers.[24]

By 30 May 2020, 246 residents at Northwood had been diagnosed with the virus in a facility that has 485 beds. The number of positive cases at Northwood represented about one-quarter of the 1,056 Nova Scotians who tested positive, and 53 of the 60 deaths in the initial wave of COVID-19. Nearly 100 employees at Northwood tested positive for COVID-19 by the end of May.[25] Judy Haiven, a retired professor and leading community activist, asked "How can Northwood, the pre-eminent 'public' care facility in Nova Scotia, one that was only last year accredited 'with exemplary standing,' be in such a desperate situation now?"[26]

The answer to Haiven's question is deeply rooted in the history of LTC. Workers in LTC have been facing challenges long before the COVID-19 crisis. According to a public awareness campaign launched in February 2020 by CUPE's Long-Term Care Committee, workers in those facilities are "working short and we are still being mandated (forced by the employer) to work overtime."[27] Nearly 75 per cent of CUPE members in LTC reported working without the expected complement or mix of workers on a regular basis and many of these are working short on a daily basis.[28] The biggest challenge

22 These figures were reported in Henderson, "Nursing Home Workers are Moving Between Multiple Facilities," https://www.halifaxexaminer.ca/province-house/nursing-home-workers-are-moving-between-multiple-facilities-thats-a-big-problem/.

23 These figures are as of 20 April 2020; see https://novascotia.ca/coronavirus/data/.

24 Members of the Canadian Armed Forces worked in 7 LTC facilities in Ontario and 47 in Quebec between April and July 2020; see Jocelyne Halladay and Stéphanie A.H. Bélanger, "Fast facts on COVID-19 and the Canadian Armed Forces," *Journal of Military, Veteran and Family Health* 6, suppl. 2 (2020), doi.org/10.3138/jmvfh-CO19-0015.

25 "N.S. Reports No New COVID-19 Cases; 15 Active Cases Remain," CTV Atlantic, 31 May 2020, https://atlantic.ctvnews.ca/n-s-reports-no-new-covid-19-cases-15-active-cases-remain-1.4962427.

26 Judy Haiven, "Northwood: A Blueprint for How COVID-19 Raged through Long-Term Care Homes," *National Observer*, 14 May 2020, https://www.nationalobserver.com/2020/05/14/opinion/northwood-blueprint-how-covid-19-raged-through-long-term-care-homes.

27 CUPE Long-Term Care Committee, "Challenges Remain for Long-Term Care in Nova Scotia," 20 February 2020, https://novascotia.cupe.ca/2020/02/20/challenges-remain-for-long-term-care-in-nova-scotia/.

28 Henderson, "Nursing Home Workers are Moving Between Multiple Facilities," https://www.halifaxexaminer.ca/province-house/nursing-home-workers-are-moving-between-multiple-facilities-thats-a-big-problem/.

facing workers is whether there are enough personnel available for any given shift. The emphasis on the ability to fulfill the shift requirements was recently explored by Ashley Buckle in her recent work on the closure of rural emergency departments in Nova Scotia.[29] Buckle highlighted the issues of absenteeism, labour turnover, people being off on sick time, and other factors that made it difficult to fill shifts and which accentuated the challenges of meeting the staffing needs in ERs. Some of these same issues adversely impact the ability of employers to fill shifts in LTC settings. A shortage of nursing labour – whether done by RNs, LPNs, or CCAs – has a very direct impact on hospital patients and nursing home residents.

In LTC, when staff are "working short" on a shift, they still must find ways of providing care to a range of residents, some of whom have a high degree of acuity and complex needs. Analyses of the work culture of long-term care would help us to understand how the tasks get done every day under difficult conditions. Work culture is comprised of the informal ways that tasks and activities are organized, which provide coherence, structure, and meaning for the staff, and which shape the social relations of work. It is through adapting their work culture that front-line staff were able to respond to the challenge of COVID-19 and articulate their own concerns. Work culture can also be shaped in response to labour shortages, the efforts of management or employers, or through changes to the work itself. Importantly, work culture emerges from workers' own experience of their daily activities and their own understandings of what is appropriate. Work culture is not simply defensive or reactive, but rather can inform what constitutes a "good day," a "satisfying experience," a "positive outcome," or other worker-generated meanings. The concept has been used extensively among labour scholars, including scholars of nursing labour[30] There have also been a number of studies of work culture in long-term care.[31] Understanding the labour of care, and how it has been experienced by

29 Ashley Buckle, "A Qualitative Approach to Nursing Staff Shortages in Nova Scotia's Rural Emergency Departments" (Master of Applied Health Services Research thesis, Saint Mary's University, 2019).

30 Barbara Melosh, *"The Physician's Hand": Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982) and McPherson, *Bedside Matters.*

31 This includes work done by historians and sociologists. See, for example, Emily K. Abel and Margaret K. Nelson, eds., *Circles of Care: Work and Identity in Women's Lives* (Albany: State University of New York, 1990); Nancy Foner, *The Caregiving Dilemma: Work in an American Nursing Home* (Berkeley: University of California Press, 1994); and Steven Henry Lopez, "Culture Change Management in Long-Term Care: A Shop-Floor View," *Politics & Society* 34, no. 1 (March 2006): 55–79.

working people in the neoliberal age, is one of the important analytical paths that historians could take up through the study of LTC.

Health care workers and unions

Working conditions, including the level and mix of staff, have been a central concern of unions representing health care workers. Health care unions, and the public sector unions that represent many health care workers, have been an important part of the labour movement since the 1970s. Following a decision of the Supreme Court of Canada, collective bargaining for RNs was cleaved from their provincial professional associations and nursing unions were established across Canada. During the 1970s, RNs experienced both the first cycle of decreasing funding for health care since the advent of Medicare, and the imposition of wage and price controls by the Liberal government of Pierre Trudeau. RNs in Saskatchewan went on strike in April 1976 and in French-language hospitals in Montreal.[32] A few years later, the entire province of Quebec faced rotating strikes by unions representing RNs that began in May 1979. The rotating strikes engaged approximately 12,000 nurses across the province.[33] In Nova Scotia, the Nurses' Staff Association of Nova Scotia (NSANS), which had been set up in June 1973 to bargain independently on behalf of RNs, quickly faced their first struggle. After six months of negotiation, the NSANS held rallies and approved immediate strike action on 11 June 1975. Although it was a coincidence, those rallies took place on Davis Day. This is an important day of remembrance in mining towns, and especially those in Cape Breton. It honours the memory of William Davis, who was a coal miner killed by police employed by the British Empire Steel Corporation during a strike that began in in March 1925.[34] Unknowingly, RNs in the province had connected their struggle to one of Nova Scotia's most important moments of working-class struggle and to the deep labour history that characterized the province's history. The nurses' strike was followed by another labour action in 1981, known as the "Common Front" strike because it involved several groups of workers though not RNs.

But the most memorable strike in this period took place in long-term care, when 90 nursing home workers employed by Keddy's Nursing Home, a 110-bed

32 "Nurses Still Out in Montreal," *Vancouver Sun*, 21 June 1976.

33 "Nursing Conflict May be Easing But Walkouts Will Still Continue," *Regina Leader-Post*, 15 June 1979.

34 David Frank, *J.B. McLachlan: A Biography* (Toronto: Lorimer, 1999), 383-4.

facility in Halifax, began a strike in the Autumn of 1983. The home was owned by Donald Keddy, who operated a chain of motels in Nova Scotia, New Brunswick, and Maine. Although workers unionized in early 1970, becoming CUPE Local 1259, union meetings did not attract much interest from the staff and no contract was negotiated despite the appointment of a conciliator. Many of the workers who had enthusiastically signed union cards in January 1970 were no longer working at Keddy's 18 months later, and the union entered a period of dormancy for 12 years. It sent the money it had collected – $37.25 – to CUPE's national office. In 1980 Mike McNeil was hired at Keddy's, and he quickly went to work getting the place organized. With an invigorated union comprised of certified nursing assistants, nursing aides, housekeeping staff, kitchen workers, and maintenance staff, CUPE 1259 began to identify the issues they faced at Keddy's – including poor pay and poor working conditions. Negotiations were initiated with the employer, but after about 20 hours it became clear that an agreement could not be reached. The workers responded with slowdowns because they felt Donald Keddy was not bargaining in good faith. McNeil's skill as an organizer had attracted the attention of his employer, who tried to dismiss him and several other members of the union executive (including Ed Kravitz and Marion Pick). The union filed a grievance and took it to arbitration to get the executive members reinstated. As negotiations were taking place between the union and Keddy, the Labour Relations Board was simultaneously considering the firing of the union executive. The union won the case and, on 18 January 1983, the workers were reinstated. By that time, however, a strike was imminent for the workers, 90 per cent of whom were women.[35]

On 30 January 1983 picket lines were set up at all the entrances to the nursing home, which was situated in a quiet residential neighbourhood above the North West Arm. The union's resolve was firm from the beginning. Their provincial CUPE representative Harold Martell said that the employer had engaged in "a blatant attempt to break the union." The workers wanted increased wages, improved working conditions, sick pay, and a grievance procedure to protect them against their employers capricious, and anti-union, behaviour. There were concerns about the maintenance of the facility and its upkeep. The laundry service was frequently off-line, which meant that linens and washcloths were in short supply, affecting the cleanliness of residents and

35 This account is based on Susan MacNeil and Sheree Delaney, "The Keddy's Nursing Home Strike, 1982-83," in *Strikes in Nova Scotia*, ed. C.J.H. Gilson (Hantsport, NS: Lancelot Press, 1986), 129-42.

their rooms. Wages were also a key issue. Keddy's workers made approximately $4.00 per hour, which was about $2.50 less than what was being paid to other nursing home workers in Halifax. Male orderlies were also being paid one dollar more than female employees who were doing the same work, which was a fundamental equity issue that CUPE, and other unions, cared about.[36]

In Nova Scotia, Rita Eastman was the only member who was not fired by Keddy when the union became active again and she served as the union executive's secretary-treasurer. But she experienced harassment on the job and recorded such instances in her diary. Excerpts of Eastman's diary were used at the Labour Relations Board hearing that saw her union brothers and sister reinstated. She recounted, for instance, how the nursing home's administrator Dale Keddy, who was also the owner's brother, described unionized employees at the Keddy's Motor Inn in Sydney as "animals." First, the number of rooms under her care increased from 15 to 20. Keddy would time her – shades of early 20th century Taylorism here – and then inspect her work. Eastman faced discipline for using a resident's telephone for a personal phone call, even though the resident had given her permission. One entry stated: "I had a hard day. I had to do 20 rooms and 19 washrooms, plus I had to take the laundry over eight times that day." She was told that she could not speak to her co-workers while working. There were issues with her schedule. Her personal dignity was attacked, too; another diary entry recounted a meeting between Keddy and some of the staff: "When he came into his office he had a can of Arid spray deodorant. He said he wanted all of us to bathe each day and use deodorant." But it was not just Keddy. The head nurse on the south wing asked Eastman whether she had trouble with perspiration and whether she used deodorant. Eastman told her she did and that she bathed every evening. The nurse then suggested that she change brands: "First I was embarrassed. Then a little hurt. Then I went in one of the rooms and had a cry. Then I got angry. I thought, 'How dare they'." And when she suffered a workplace injury, Dale Keddy did not submit the paperwork. As a result, Eastman waited 40 days; she received her cheque three days after she filed a complaint with the Worker's Compensation Board. Eastman, like some of the other workers, lived in an apartment building owned by Don Keddy, so the workplace conflict was quite literally brought to her home. Keddy attempted to evict her, but that order was denied by the residential tenancy board. However, when her lease expired,

36 MacNeil and Delaney, "Keddy's Nursing Home Strike, 1982-83."

Keddy did not offer her a new one and refused to return her deposit. "It was like he was playing God with people's lives," Eastman recalled.[37]

Ten of the nursing home's employees who worked in the south wing did not participate in the strike. It is not clear why these workers remained on the job, but Keddy used them to train new staff who replaced the striking workers. Within a week 54 of the striking workers' jobs had been filled, and this allowed the nursing home to continue operating. The next blow to the union was a court injunction that limited both the number of picketing sites and the number of picketers. Keddy alleged that the striking workers were blocking driveway entrances with snow, pelting cars with eggs, letting air out of tires, and other behaviours. The Nova Scotia Federation of Labour called for a boycott of Keddy's motels and the New Brunswick Federation of Labour followed suit. Grace Hartman, the president of CUPE, held a press conference on 12 April telling the Government of Nova Scotia that it was time to shed its anti-labour reputation and ensure that the employer bargained in good faith.[38]

When the strike began, the union had a paltry $22.25 in its strike fund to support the workers, who were receiving $60 a week from CUPE as strike pay. Financial support flowed in from the Canadian Labour Congress, the Canadian Union of Postal Workers, the Nova Scotia and New Brunswick federations of labour, the Nova Scotia Nurses Union, the Halifax-Dartmouth District Labour Council, and a number of women's group. One Ontario union local "adopted" two striking workers to ensure that their basic needs were being met. As Thanksgiving approached, striking workers received donations of turkeys and vegetables. With the strike still unresolved at Christmas, another round of turkeys with the trimmings were provided by supporters. Although about 20 workers broke ranks and returned to work, those who continued on the picket lines tried to keep morale up by singing union songs mixed with the occasional Christmas carol. The leader of the New Democratic Party, Alexa McDonough, joined them on the picket line. Unions from across Nova Scotia organized a rally, where the leader of the Nova Scotia Federation of Labour, Gerald Yetman, said very clearly that labour wanted to send the "owner the message that the labour movement in Nova Scotia is right behind these workers trying to get their just rights – to sign their first collective agreement." The strike went on with no end in sight.[39]

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37 "Diary of a Nursing Home Worker," *Public Employee* 5, no. 3 (Spring 1983): 16-8.

38 "CUPE Challenges Nova Scotia," *Saskatoon Star-Phoenix*, 13 April 1983.

39 MacNeil and Delaney, "Keddy's Nursing Home Strike, 1982-83."

Keddy sold the nursing home in September 1983. The new investors dumped the Keddy name and called their facility Glades Lodge, and reopened negotiations. Things looked promising, and a deal was seemingly reached within a day on all of the issues except wages and when the strikers would resume work. Rick Beckwith, a brother of one of the co-owners, had been negotiating with the union on behalf of the employer, but he did not have any authority to make an agreement. The workers went back to the picket lines. There were meetings during the first five months of 1984 between CUPE and the Department of Labour. In May, striking workers travelled to Amherst, near the New Brunswick border, to stage a protest outside the home of the other two co-owners, Syed and Gloria Hussain. Yetman appealed to the Hussains to resume negotiations, while Mike MacNeil and leaders from other unions had informal talks with the Minister of Labour David Nantes and his deputy minister. They worked out a deal, even though MacNeil was the only member of Local 1259 present. He also met with the Hussains for the first time, even though they had owned the facility for nine months. In the end, the deal was presented to a meeting that only saw 33 members show up. The strike had had a devastating impact on morale. It was approved by a vote of 22-11, and the 16-month strike was finally over. The workers had their first contract. The contract, which was signed on 4 July 1984, established a joint labour-management committee and procedures to resolve grievances. The workers received job security provisions and a wage increase, but they still earned less than they would in other nursing homes in the area.[40]

The first contract for the nursing home workers was hard-won. The nursing home strike clearly illustrated the struggles of health care workers in Nova Scotia. For example, the employer quickly used scabs to fill the positions of striking workers. The workers who had broken union ranks and remained on the job offered the new recruits training and this severely undermined the union's position. The restrictions on the number of picketers and the placement of picket lines made things even more difficult for the strikers. Finally, no legislation existed in the province to bring a first contract dispute to a timely resolution. It was left to the employer and the workers to negotiate a settlement and the workers were in a disadvantaged state. On the positive side, the workers enjoyed a good deal of support from CUPE national and from other unions. Finally, although there were clearly some challenges with solidarity

40 MacNeil and Delaney, "Keddy's Nursing Home Strike, 1982-83."

among the workers and maintaining the morale, the strike highlighted the strong leadership of executive members like Rita Eastman and Mike McNeil. Eastman, who was a cleaner for three years before emerging as a strike leader, thought that the strike brought the workers together and consolidated the union. "We're proud that we're standing fighting," she told the *Dalhousie Gazette*. Eastman added that although no end was in sight, every day "makes me stronger and stronger. Those are our jobs and we're going to get them back."[41] McNeil would emerge as a CUPE stalwart and his peers recognized him as a leader who worked tirelessly on behalf of his fellow workers. He would serve as the president of Local 1259 from 1980 to 1995, and in other executive positions.[42] The Keddy Nursing Home strike also helps to illustrate the political and economic context within which these workers struggled. We can see how their allies in the house of labour came to their aid, and how their employer and the government placed constraints upon the workers that inhibited their efforts to secure a first contract. We can also see how health care workers, as part of the public sector, have found themselves in the vanguard of the labour movement raising issues that were of general concern to working people and especially working women.

Challenging nursing's whiteness

The labour of care in LTC also disrupts the historic whiteness of nursing labour. In June 2019, the *Chronicle Herald* reported that there were 300 employment vacancies in nursing homes throughout the province, most of them for part-time or casual work.[43] Michele Lowe, the managing director of Nursing Homes of Nova Scotia Association, estimated that half of the nursing homes in her association were at "critical vacancy levels" during the pandemic. In New Brunswick, a study conducted in 2017 found that about half of the staff planned

41 "Strike Continues at Glades Nursing Home," *Dalhousie Gazette* 116, no.19 (16 February 1984).

42 McNeil served as president of the Nova Scotia Division and national executive board regional vice-president for CUPE. Shortly before his death he was elected president of CUPE NS. Details of McNeil's role come from obituary notices published by CUPE on 6 November 2015 (https://cupe.ca/mike-mcneil-regional-vice-president-nova-scotia) and the International Brotherhood of Electrical Workers Local 1928 (https://www.ibew1928.org/news/passing-of-cupe-nova-scotia-president-mike-mcneil.html) and the CUPE Nova Scotia Facebook website and were posted on 13 March 2016; see https://m.facebook.com/CUPENovaScotia/posts/1157116454320542.

43 Jennifer Henderson, "International Hires are Helping But Challenges Remain for Long-Term Care in Nova Scotia," *Chronicle Herald*, 19 February 2020, https://www.thechronicleherald.ca/news/provincial/international-hires-are-helping-but-challenges-remain-for-long-term-care-in-nova-scotia-412732/.

to leave their jobs over the next decade. Sharon Teare, the president of the New Brunswick Council of Nursing Home Unions, highlighted that the "burn-out and the turnover rate is like it's never been before."[44] COVID-19 focused attention on how nursing homes lacked adequate staffing complements, but this has been a longstanding issue. Indeed, a number of scholars have analyzed the role of internationally educated health care workers in filling such labour gaps and, taken together, these scholars have presented a challenge to nursing's presumed whiteness. From 1962 to 1968, almost 20,000 nurses immigrated to Canada according to McPherson.[45] The literature on the migration of international nurses to Canada remains an emerging area of scholarship. Agnes Caliste and Karen Flynn have provided important analyses of RNs who emigrated from the Black Caribbean, while other scholars have turned their attention to health care workers from the Philippines.[46] In some cases, countries have embarked on a conscious strategy to produce nurses for overseas employment, including India, China, and the Philippines.[47] In addition, the relationship between gender and migration has garnered a good deal of scholarly interest from different

44 Neatby, "Most Long-Term Care Homes in Atlantic Canada Kept COVID Out."

45 McPherson, *Bedside Matters*, 213.

46 For the Caribbean, see Agnes Calliste, "Women of Exceptional Merit: Immigration of Caribbean Nurses to Canada," *Canadian Journal of Women & the Law* 6, no. 1 (June 1993): 85–102 and Karen Flynn, *Moving Beyond Borders: A History of Black Canadian and Caribbean Women in the Diaspora* (Toronto: University of Toronto Press, 2011). For the Philippines, see Charlene Ronquillo, "Leaving the Philippines: Oral Histories of Nurses' Transition to Canadian Nursing Practice," *Canadian Journal of Nursing Research* 44, no. 4 (December 2012): 96–115; Valerie G. Damasco, "The Recruitment of Filipino Healthcare Professionals," in *Filipinos in Canada: Disturbing Invisibility*, ed. Roland Sintos Coloma et al. (Toronto: University of Toronto Press, 2012); and Jon G. Malek, "The Pearl of the Prairies: The History of the Winnipeg Filipino Community" (PhD diss., Western University, 2019).

47 Catherine Ceniza Choy, *Empire of Care: Nursing and Migration in Filipino American History* (Durham, NC: Duke University Press, 2003); see also Barbara L. Brush and Julie Sochalski, "International Nurse Migration Lessons From the Philippines," *Policy, Politics, & Nursing Practice* 8, no. 1 (February 2007): 37–46. Most of internationally educated health care workers come from a small number of countries, and the Philippines accounted for 56 per cent of these licensed nurses in 2014; see Margaret Walton-Roberts and Jenna Hennebry, "Indirect Pathways Into Practice: A Comparative Examination of Indian and Philippine Internationally Educated Nurses and Their Entry into Ontario's Nursing Profession," Centre of Excellence for Research on Immigration and Settlement (CERIS) Working Paper No. 92 (Toronto: CERIS, 2012), https://scholars.wlu.ca/cgi/viewcontent.cgi?article=1024&context=imrc. Canada also relied on internationally educated physicians; see Laurence Monnais and David Wright, eds., *Doctors Beyond Borders: The Transnational Migration of Physicians in the Twentieth Century* (Toronto: University of Toronto Press, 2016) and Sasha Mullally and David Wright, *Foreign Practices: Immigrant Doctors and the History of Canadian Medicare* (Montreal and Kingston: McGill-Queen's University Press, 2020).

disciplines.[48] These studies have situated the recruitment of health care workers within a much larger context of international mobility, migration, gender, and race. At the same time, the relationship between workers from different groups, described by Moon-Kie Jung as working-class "interracialism" – wherein a political community of interest is forged across distinctive and racial boundaries – needs further attention, although there have been a few excellent Canadian studies of the intersections between race and employment.[49]

According to the Canadian Institute for Health Information's latest figures, there were 37,370 internationally educated nurses licensed to practice in Canada in 2019, just under nine percent of the total.[50] Many of these work in long-term care settings as RNs, LPNs, CCAs, and PCWs. Facilities owned or managed by Northwood have added 40 to 50 new CCAs a month since October 2019, when a change in regulations allowed internationally educated RNs or LPNs to work as CCAs while their credentials were being assessed to determine their eligibility to work in Nova Scotia. Most of these new workers came from India or the Philippines, and their presence offers an opportunity to disrupt the prevailing narrative of nursing's presumed whiteness. Racialized women have, then, provided the labour of care in hospitals and long-term care for a long time, but their labour has largely been unacknowledged.[51] If we

48 John A. Tyner, *Made in the Philippines: Gendered Discourses and the Making of Migrants* (London: Taylor & Francis, 2005) and Nicola Piper, *New Perspectives on Gender and Migration* (Oxford: Routledge, 2008).

49 Moon-Kie Jung, *Reworking Race: The Making of Hawaii's Interracial Labour Movement* (New York: Columbia University Press, 2006). For Canadian studies, see Tania Das Gupta, *Racism and Paid Work* (Toronto: Garamond Press, 1996); Tania Das Gupta and Franca Iacovetta, "Whose Canada Is It?: Immigrant Women, Women of Colour and Feminist Critiques of 'Multiculturalism,'" *Atlantis* 24, no. 2 (Spring 2000): 1-4; Meg Luxton and June Corman, *Getting By in Hard Times: Gendered Labour at Home and on the Job* (Toronto: University of Toronto Press, 2001); and Leah F. Vosco, ed., *Precarious Employment: Understanding Labour Market Insecurity in Canada* (Montreal and Kingston: McGill-Queen's University Press, 2005).

50 Canadian Institute for Health Information, "Nursing in Canada, 2019," https://www.cihi.ca/en/nursing-in-canada-2019.

51 While racialized women negotiated nursing's whiteness in settings across Canada, their numbers in the ranks of RNs remained small; but they were present. An interesting example is Anna Lam, the first Chinese Canadian to qualify as an RN in British Columbia. According to Michael Valpy, Lam was refused admission to several schools of nursing in Vancouver. She eventually graduated from King's Daughters Hospital in 1929. See her obituary in *Globe and Mail* (Toronto), 1 April 1996. Women of Chinese and Japanese descent at UBC are briefly described in Glennis Zilm and Ethel Warbinek, *Legacy: History of Nursing Education at the University of British Columbia, 1919-1994* (Vancouver: UBC School of Nursing, 1994), 76-8. The story of nurses of African descent in Canada includes Marissa Scott who, after being denied entry to the Owen Sound General Hospital, was admitted to St. Joseph's Hospital in Guelph, Ontario, in 1947 following a national campaign. The story also includes Ruth Bailey and Gywneth Barton, who gained access

needed further examples of the legacies of colonialism and the ways in which health care is part of settler society, Laurie Meijer Drees has noted that the unrecognized labour of Indigenous people was the "nearly invisible backbone" that supported the delivery of health services to Indigenous people.[52] As Maureen Lux has poignantly noted, "Racialized and professional hierarchies rendered [Indigenous workers] all but invisible in the documentary record."[53] It has been estimated, for instance, that Indigenous people made up to 15 per cent of the staff of Indian hospitals during the 1960s. In other words, as Mary Jane McCallum has written, Indian Health Services (IHS) and Medical Services Branch (MSB) "relied in every way upon the labour of Native people."[54] Indigenous labour was also unacknowledged in other settings, too. In 1960 the Grenfell Mission's magazine *Among the Deep Sea Fishers* published a photo essay on the northern community of Nain in Labrador. Several of the photos show Inuit women in caring roles and one shows an Inuk woman, Amalia Igloliorte, providing care to a patient.[55] Although there were Indigenous RNs throughout the 20th century, most of the Indigenous workers providing health care laboured as orderlies, ward aides, nurse's aides, or nursing assistants. What is clear is that analyses of these groups, many of whom are critical to long-term care, present an opportunity to write histories of health care that engage with the experience of racialized workers.

The COVID-19 pandemic revealed many of the challenges facing health care delivery in Canada, including working conditions in long-term care. As this brief research note suggests, by bringing these challenges into focus, COVID-19 has also provided an opportunity for historians to consider the history of work in long-term care and, specifically, to expand our understanding of health care work in new and interesting ways. I have set out only a few of the possibilities, including how care has been reorganized, the importance of health care

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to nursing education at the Children's Hospital in Halifax in 1948; see Karen Flynn, "'Hotel Refuses Negro Nurse': Gloria Clarke Baylis and the Queen Elizabeth Hotel," *Canadian Bulletin of Medical History* 35, no,. 2 (Fall 2018): 284.

52 Laurie Meijer Drees, "Training Aboriginal Nurses: The Indian Health Services in Northwestern Canada, 1939–75," in *Caregiving on the Periphery: Historical Perspectives on Nursing and Midwifery in Canada*, ed. Myra Rutherdale (Montreal and Kingston: McGill-Queen's University Press, 2010), 185.

53 Maureen K. Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s–1980s* (Toronto: University of Toronto Press, 2016), 73.

54 Mary Jane Logan McCallum, *Indigenous Women, Work, and History 1940–1980* (Winnipeg: University of Manitoba Press, 2014), 194, 197.

55 Joan Stedman, "These for Their Comfort," *Among the Deep Sea Fishers* 57, no. 4 (January 1960): 110–14. I first noted this in Twohig, "'Everything possible is being done.'"

workers to Canada's labour movement, and disrupting nursing's presumed whiteness. Each of these areas could benefit from further analyses that would, cumulatively, make a substantive contribution to the study of women's work in health care and, through that, aid in the revitalization of working-class history in 21st-century Canada.

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