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# The Cycle of Sacrifice: Nurses' Health and the Ontario Health System

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## INTRODUCTION

Ten years ago Ontario was hit with the Severe Acute Respiratory Syndrome (SARS). Alongside individuals who contracted the virus, the group that experienced the brunt of SARS was the front-line workers tending most to SARS victims: registered nurses (RNs). In the first wave of the outbreak, in March 2003, the Ontario health system as a whole was caught off guard. Protective equipment for health-care workers – respirators, gowns, goggles, hoods, gloves– were in short supply, and containment practices, in the form of official directives from the province of Ontario, were unclear and constantly changing. Front-line RNs contracted SARS or faced quarantines in the attempt to limit the spread of SARS to their family members and others outside the hospital system.

Toward the end of May 2003, when the second wave of SARS broke out, hospitals had ended daily containment practices and called for nurses to stop using protective equipment following the mid-May provincial directive declaring that the epidemic had ended. Nurses that had escaped SARS in the first wave now contracted the virus, others were reprimanded for being cautious and continuing to use protective equipment, and two front-line registered nurses – Nelia Laroza and Tecla Lin – died of the virus.

From the perspective of ONA leaders who lived through the ordeal, nurses were sacrificed as the provincial and municipal governments attempted to shelter Toronto from the loss of earnings arising from the April World Health Organization (WHO) travel advisory against all travel to Toronto.[1] By hastening the end of SARS, the City of Toronto and provincial government hoped to beckon tourists back to their Toronto travel plans. For the month of April alone, the Canadian Tourism Commission claimed that Toronto hoteliers lost $39 million due to SARS-related cancellations.[2]

This act of sacrificing nurses for perceived larger interests is a glaring instance of an under-recognized but regular practice in Ontario. More than any other health care profession, as a

[1] For a full account of the Ontario SARS experience from the front-line RN perspective, see "Special Report: Nurses were Sacrificed," Ontario Nurses' Association, April 2013, http://www.ona.org/documents/File/frontlines/ONA_SpecialSARSFeature_201304.pdf
[2] Canadian Broadcasting Corporation 2003. *The Economic Update of SARS*, updated July 8.

society we rely on the constant care of RNs to maintain the health of the larger whole – yet the health of RNs is in serious condition and systemic cures are not on the agenda.

The conclusion of the SARS Commission of Inquiry remains true today, but for the Ontario health system writ large. In the words of Justice Archie Campbell, the SARS experience revealed "deep contradictions in hospital worker safety. These problems include a profound lack of awareness within the health system of worker safety, best practices and principles." Using case studies and the latest available statistics, this paper demonstrates how the health of front-line RNs is sacrificed in the Ontario health system, though front-line RNs are the health professionals relied upon to provide the most constant specialized care within all realms of the health system: in hospitals, long-term care facilities and in the range of community health services.

**THE CYCLE OF SACRIFICE**


The *Cycle of Sacrifice* is a tool for understanding the nature of sacrifice endured by RNs on a systemic basis. Beginning the cycle is the reality of RN understaffing in the Ontario health system. The Ontario health system serves the largest population in Canada, some 13.4 million

people today. Despite this, Ontario has the second-lowest RN-to-population ratio in the country: 668 RNs per 100,000 residents. This compares with an average of 785 to 100,000 residents in other provinces and territories of Canada. In order to catch up to the rest of Canada, the Ontario health system would need to employ 15,646 more RNs today. Instead of moving in this direction, the Ontario health system has employed 844 *fewer* RNs in 2012 than it did in 2011. The poor standing of Ontario in terms of RNs employed in the health system to serve the population is not new. As far back as 1999, Ontario was third last among Canadian provinces with 829 RNs per 100,000 population, as compared to the average of 892 RNs per 100,000 in the rest of Canada in 1999.

With the understaffing of RNs in the Ontario health system, RNs who are employed are overworked and overstretched. Combined with the fact that nurses' work is physically and emotionally demanding, the overstretching of RNs makes for added physical and mental stress leading to relatively high rates of workplace-induced injury and illness. As injured RNs attempt to claim and take sick leave, they face disciplinary action and other controls leading to more stress or/and longer periods of leave. The cycle is then reset as RNs remaining on the job or being forced to return to work too early are yet more overworked and overstretched and face yet higher risk of physical and mental injury.

Each point in the *Cycle of Sacrifice* is elaborated below through lived accounts of front-line RNs, as well as the most current descriptive statistics available. It is notable that there has not been a comprehensive survey or report of nurses' work and health compiled in Canada or Ontario since 2005.

This further attests to the low regard accorded to nurses' working conditions and health.

## UNDERSTAFFING AND OVERWORK

While the figures stated above demonstrate in numeric terms the shortage of RNs employed in the Ontario health system, the experiences of understaffing and overwork are best expressed in the words of front-line RNs.

As a front-line intensive care unit (ICU) night shift nurse and ONA leader said:

> I have been working in ICU for just over 20 years. I've seen how the front lines in all units have gotten worse. More sick patients, more assignments, more hospital policies and College standards, more RN responsibilities – with less staff. As more and more RNs are replaced with RPNs, the workload of the remaining RNs increases and clients are at risk because care is fragmented. If the condition of an RPN's patient becomes serious, the RN has to take over. We all start with the same number of patients but if a mistake is made, or something goes wrong and the RPN lacks the knowledge, skill or judgment – it is the RN on shift that is responsible. When an RN is working with an RPN, she can't report to the RPN and then take a break because something could happen while she is on break. If the RN can cope with the guilt, then she can take her break.

> … Most hospitals don't have a standard way of measuring patient acuity. Without this, understaffing persists. If the acuity levels were clear, then it would prove that more RNs are needed. But most hospitals don't want this on the record. Fitting right in with all this is that scheduling is reactive, not proactive. Nurses are not called in for replacement until the very last minute, and often it is too late. No one is available. Then we do overtime and work short.[3]

As demonstrated in the table below, the total number of public-sector RNs reporting overtime work has risen steadily in all Canadian provinces since 1992.

Reflecting both high RN workload and Ontario's larger population and hence RN labour force relative to the rest of the country, Ontario has consistently held top place nationally for RNs reporting overtime work in the public sector.

**Table 1. Public-Sector RNs with Overtime Hours, by Province, Selected Years**

| **Province** | **1987** | **1992** | **1997** | **2002** | **2005** | **2008** |
|---|---|---|---|---|---|---|
| Newfoundland | 300 | 400 | 600 | 1,100 | 1,000 | 1,400 |
| PEI | N/A | N/A | 100 | 200 | 200 | 300 |
| Nova Scotia | 500 | 700 | 900 | 1,600 | 1,600 | 1,600 |
| New Brunswick | 600 | 600 | 700 | 1,900 | 1,400 | 1,900 |
| Québec | 4,800 | 4,100 | 4,600 | 9,900 | 16,300 | 15,600 |
| Ontario | 7,600 | 5,300 | 7,600 | 17,900 | 16,100 | 19,800 |
| Manitoba | 1,000 | 900 | 1,500 | 2,700 | 2,500 | 2,900 |
| Saskatchewan | 600 | 500 | 900 | 1,300 | 1,900 | 2,100 |
| Alberta | 1,900 | 1,900 | 2,000 | 6,500 | 6,800 | 7,200 |
| British Columbia | 1,700 | 2,300 | 4,200 | 6,100 | 6,200 | 7,900 |
| **ALL PROVINCES** | **19,800** | **16,800** | **23,000** | **49,200** | **54,000** | **60,700** |

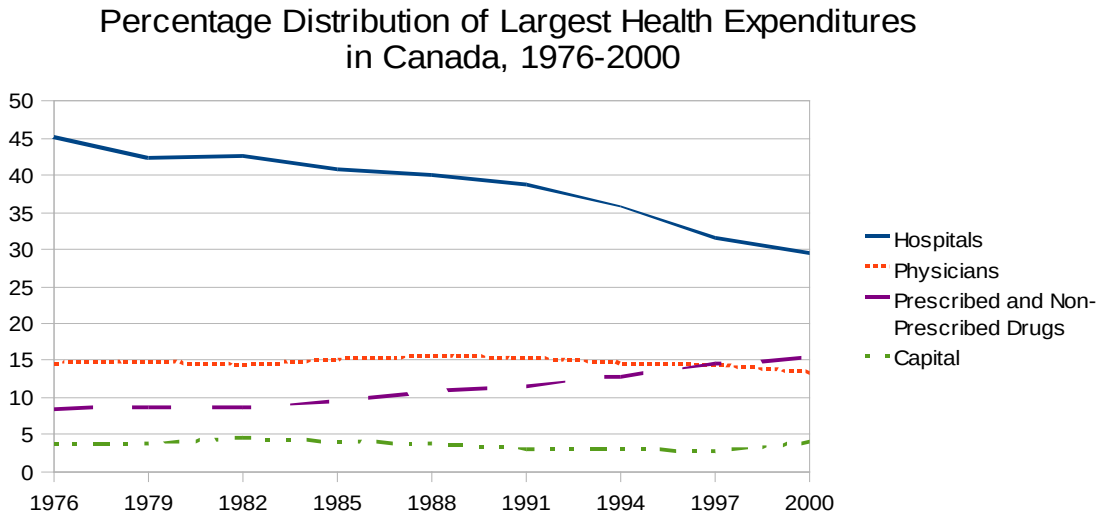
Source: Infometrica 2011. Trends in Own Illness or Disability-Related Absenteeism and Overtime among Publicly-Employed RNs, pp. 43, Canadian Federation of Nurses' Unions (CFNU).

The rise in RN overtime reflects the decreasing proportion of hospital expenditures as a proportion of total health expenditures in Canada from as early as 1976. As the figure below demonstrates, between 1976 and 2000, hospital expenditures in Canada fell from 45 to 30 per cent of total national health care expenditures.[4] Between 2001 and 2010, hospital expenditures as a proportion of total national health care expenditures remained steady at 29 per cent.

[3] Interview with Toronto-based ICU night shift nurse and ONA leader, Toronto, April 4, 2013.

[4] Salimah Valiani 2012. ***Rethinking Unequal Exchange: the global integration of nursing labour markets***, University of Toronto Press, p.88

**Figure 1.**




Source: National Health Expenditure Database, Canadian Institute for Health Information, 2007

Within the category of hospital expenditures (see table below), during the same period, 1976-2000, salary expenditures fell by 11 per cent, representing the bulk of hospital cost savings over the period.

**Table 2. Percentage Distribution of Largest Hospital Expenditures, Alternate Years, 1976-2000**

| | **1976-1977** | **1979-1980** | **1982-1983** | **1985-1986** | **1988-1989** | **1991-1992** | **1994-1995** | **1997-1998** | **2000-2001** |
|---|---|---|---|---|---|---|---|---|---|
| **Salaries*** | 69.7 | 69.0 | 67.2 | 66.4 | 65.4 | 63.8 | 62.1 | 61.1 | 59.0 |
| **Other Supplies and Sundries**** | 15.3 | 17.1 | 17.2 | 17.3 | 17.3 | 17.9 | 18.4 | 16.2 | 17.3 |
| **Benefits** | 6.6 | 5.7 | 7.3 | 6.8 | 7.0 | 8.4 | 9.7 | 10.1 | 9.7 |
| **Medical Supplies** | 2.9 | 3.4 | 3.5 | 4.0 | 4.2 | 3.9 | 3.7 | 4.8 | 5.5 |
| **Physician Compensation** | 3.3 | 2.3 | 2.5 | 2.6 | 2.8 | 2.7 | 2.8 | 3.9 | 4.2 |
| **Drugs** | 2.2 | 2.5 | 2.5 | 2.9 | 3.3 | 3.3 | 3.3 | 3.8 | 4.3 |

Source: National Health Expenditure Database, Canadian Institute for Health Information, 2005, as presented in Salimah Valiani 2012. ***Rethinking Unequal Exchange: the global integration of nursing labour markets***, University of Toronto Press, p.89.

*Within this aggregate category, the "Nursing Inpatient" sub-category accounts for approximately 30-40 per cent, while "Administration and Support" accounts for approximately 20-30 per cent. These estimations are based-on a break-downs contained within *Hospital Trends in Canada – Results of a Project to Create a Historical Series of Statistical Data and Financial Data for Canadian Hospitals Over Twenty-Seven Years (CIHI:2005).* **From 1997, this category was divided in two: "Other Supplies" and "Sundries." For consistency, they are presented here together for 1997-2001.

In other words – contrary to most media and other accounts – Canadian hospitals spending on the salaries of RNs and the rest of the predominantly female hospital workforce has declined over time. In turn, RNs and other female workers across Canada have carried the burden of health care cost savings in the form of increasing workload and overtime work.

Beyond the hospital sector, RNs in community health and the long-term care sectors also face work overload. Comparing first between types of nurses across Canada, considerably more RNs than licensed practical nurses (LPNs) and registered psychiatric nurses (RPSNs) report "often arriving early or staying late to get work done" (RN: 56 per cent; LPN: 48 per cent; RPSN: 41 per cent).

Similarly, considerably more RNs report "often working through breaks to complete assigned work" (RN: 64 per cent; LPN: 55 per cent; RPSN: 54 per cent).[5]

In the long-term care sector throughout Canada, 73 per cent of nurses report "often having too much work for one person;" in the hospital sector across the country, 70 per cent of nurses report the same; and in community settings, 60 per cent of nurses in Canada report "often having too much work for one person."[6]

On a provincial basis among nurses in all sectors, Ontario once again tops the list, along with Quebec and Saskatchewan. For Ontario and Saskatchewan, 68 per cent of RNs report "often having too much work for one person," while 69 per cent of Quebec RNs report the same.[7]

In public and community health in particular, as depicted in the testimony below of an ONA public health nurse and public health sector leader, RNs, along with their clients, face the crunch of the widening wealth gap. For Canada as whole, between 1981 and 2010, economic equality decreased by 23.6 per cent. Put another way, inequality between households increased in all provinces except Prince Edward Island. Ontario saw the largest change in the 30-year period, with inequality between wealthy and other households increasing by 17.2 per cent.[8]

> I work as a public health nurse and I have direct contact with the social determinants of health, especially poverty. The clients I see are mostly healthy and have just given birth, so it's beautiful. But it is the poverty that gets me. It is hard to promote health when there's no job. Sometimes I have to call the food bank to request they allow my clients more than two visits in the month. The food banks usually say yes, but it takes a letter from me and my business card. Or I'll call around to different food banks to find food for my clients that are newcomers – because a can of food means nothing to them. I'll say I am looking for a pound of rice, beans …

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[5] Statistics Canada, Health Canada 2006. *Findings from the 2005 National Survey of the Work and Health of Nurses,* Minister of Industry, p. 137.

[6] Ibid.
[7] Ibid.
[8] Lars Osberg and Andrew Sharpe 2011*. Beyond GDP: Measuring Economic Well-Being in Canada and the Provinces, 1981-2010*, Centre for the Study of Living Standards, p.38.

> Some of my clients on Ontario Works get suspension notices regularly and their welfare benefits are cut while an investigation takes place. They call me for help and I squeeze them in. This is unpaid overtime. I have a client who needs special meds, and when Ontario Works suspended her benefits, I had to find her the meds. I called around to pharmacists and found one who would provide them free of charge. You learn which pharmacies will help and who has what in supply. When you are a homeless woman, how do you buy pads, birth control? No one talks about it. I find these clients the pads, the birth control. You just can't walk away from what you see during home visits – poor families and poor living conditions – and this in itself creates stress. Public health nurses working in schools experience stress from what they see there … a child who doesn't come to school on hot dog day because he doesn't have the money to buy hot dogs like all his friends. It is easy to absorb your client's anxiety and depression. This is when you have to take a break. Do exercise. I haven't done this for six months. I have been told by my manager I have time management issues. That's easy for them to say because they look only at the new cases, not the new cases combined with existing workload. We are in crisis mode, putting out fires.
>
> I try not to bring my job home but it is hard when the job cuts into my own time. New programs like the smoking prevention and C-section prevention have increased the work with no new staff. For public health nurses working in smoking prevention, the extra workload is from the coalition-building work they must do, for example to push for the introduction of non-smoking bylaws. Policy papers, campaigns and other advocacy is all unpaid overtime. Even in Healthy Babies Healthy Children, where I work, I am working with anti-poverty advocates to get Ontario Works to cover bus passes, which are not available in London as they are in Toronto. This is on top of more and more home visits. By Thursday I'll still have four home visits to do, with no time left to chart for the week. For five months I've been charting on Fridays after work, from 4:30 to 7 in the evening. Another three of four nurses are usually there with me. This is all unpaid – but we have to transfer our notes to the clients' charts to meet our obligations with the College of Nurses. The employer has recently given us laptops to work at home during the weekends to do charting, but this too is unpaid. And charting should really be done immediately or shortly after visits.[9]

Additionally what is brought to light in this public health nurse's testimony is that as the Ontario Ministry of Health and Long-Term Care (MOHLTC) attempts to increase health promotion and prevention programs without allocating funds for the new work, as in the recently launched public health renewal, *Make no little plans*[10] – the brunt of the cost is carried by public health RNs in the form of increased workload and unpaid overtime. Reflecting this reality, between 1997 and 2008, unpaid overtime for RNs in all sectors in Ontario doubled, from 7,142 days to 14,284 days over this 10-year period alone.[11]

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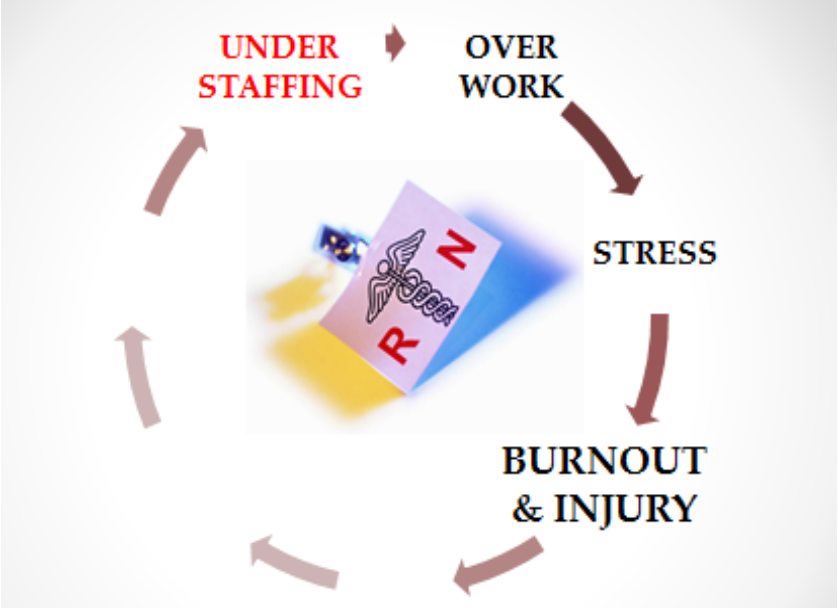
[9] Interview with London-based public health nurse and ONA leader, Toronto, March 19, 2013.
[10] See http://www.health.gov.on.ca/en/common/ministry/publications/reports/make_no_little_plans/
[11] Michelle Lasota (Infometrica) 2009. *Trends in Own Illness or Disability-Related Absenteeism and Overtime among Publicly-Employed Registered Nurses,* Canadian Federation of Nurses' Unions, p. 28.

## STRESS, BURNOUT AND INJURY




From the RN testimonies above, the connection between overwork and stress is not difficult to make. Not only increasing caseload, but the nature of nursing work involves stress. The concept of *emotional labour* is useful to understand the connection between nursing work, stress, and other detrimental psychological effects such as burnout.

According to Arlie Hochschild, the pioneer of the field of emotional labour studies, emotional labour involves the "management of emotion to create a publicly observable facial and bodily display."[12] Adapting this concept to nursing, Smith describes the emotional labour of the nurse as inducing or suppressing feeling in order to make others feel cared for and safe, irrespective of one's actual feelings.[13] The panic of the public health nurse in search of free medications for a client without income is thus suppressed or masked out of the intention to offer the client a sense of hope and calm. But such suppression is not without effect. Hochschild underlines that performing emotional labour has detrimental effects on the human psyche, including emotional numbness and burnout.

Koji Mitsuhashi conducted an interview-based study with care workers in Japan to investigate the mechanism linking the performance of emotional work with burnout. According to Mitsuhashi, care workers who embrace the role of emotional labourer are more likely to experience burnout when the work environment does not allow them to fulfill their roles as caregivers.[14] The following testimony of the ICU nurse and ONA leader cited earlier concurs with Mitsuhashi's finding.

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[12] Arlie Hochschild 1983. ***The Managed Heart: Commercialization of Human Feeling***, University of California Press, pp. 7.
[13] Pam Smith 1992. ***The Emotional Labour of Nursing***, Macmillan Press.
[14] Koji Mitsuhashi 2007-2008. *Emotional labor and Burnout: Does emotional labor cause burnout?* ***Japanese Sociological Review***, v.58, n.4, pp. 576-592.

> Nurses nowadays don't have time to talk with our patients, educate them, mourn with the family when the patient passes. A patient dies in your hands, and as an RN today you have to think about arranging for the bed to be cleaned and getting the next patient into it because there is a line-up. And because we have no time to educate, it is a revolving door. The same patients keep returning.
>
> If I have two patients on ventilators – that's a high-needs patient – I don't have the time to talk to the families … make sure they understand the disease. I like to say to them, go home and think about the questions you have. Some days I don't even have time to say that to the families …This is not the way I want to nurse. It is just task after task – not a holistic, compassionate approach. Everything is on the fly. Emotionally this is draining. The work is unsatisfying. You can't think straight. You are constantly interrupted. Mid-task, the phone rings and another task arises. You go home thinking "Did I do everything I was supposed to do?[15]

In turn, the physical effects are not difficult to connect. This is particularly the case for night-shift RNs. Once again, from the ICU nurse cited above:

> People think we choose night shift because there is less work. In ICU, most deaths happen at night, so there is actually more work. Also, during the night, there is only one doctor and very little other staff compared to days … My kids have grown up and I've recently shifted to day work. It feels good. Natural. And I can fit in the gym. When you put yourself to sleep in the day, you don't sleep well. You get four hours sleep maximum. Then you can't do your three meals per day and snacks. You put on weight as the body goes into starvation mode. You wake up hungry and tired so you tend to eat carbs. When you don't sleep well and you are not eating right, you tend to be on meds: for diabetes, high blood pressure.
>
> We run around and we are not hydrated … this goes for day nurses too. Sure, now we try to carry around water bottles, but you can't drink when you're running, constantly on the go. And then you need to go to the washroom. Who has time for that? The effects of dehydration are conditions like psoriasis. RNs are commonly prescribed special creams for this.[16]

What must also be taken into account is the added strain nurses face as workers who are also mothers. In Ontario 93 per cent of RNs are female,[17] and about 55 per cent of front-line ONA RNs are under the age of 55.[18] The choice to work night shifts is one coping mechanism adopted by RNs in the attempt to attain work-life balance. As the testimonies below

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[15] Interview with Toronto-based ICU night shift nurse and ONA leader, Toronto, April 4, 2013.
[16] Interview with Toronto-based ONA leader and ICU night shift registered nurse, Toronto, April 4, 2013.
[17] Canadian Institute for Health Information 2012. *Regulated Nurses: Canadian Trends, 2007 to 2011*, p. 31.
[18] Ontario Nurses' Association 2010. *Have a Say - Membership Survey Results,* Unpublished document.

demonstrate, this coping mechanism, combined with the reality of heavy RN workloads, is not without consequence for the health of RNs.

> I work 12-hour shifts, part-time in the emergency room. This means 84 hours every two weeks. Night shifts are best for my work-life balance: I can get my work done and can still be there for my kids. Sometimes I don't go to sleep before my night shift because I am so busy cooking, doing laundry, washing dishes at home… Basically I am a stay-at-home mom with a full-time job. My motto: sleep is optional and highly over-rated.[19]
>
> *
>
> I was a night-shift nurse for 20 years. The majority of us choose nights for our kids and families. We miss them less and they miss us less if we work nights. We see them off to school, we have dinner with them, maybe even take them to an after-school activity before starting work.
>
> …Even family members don't understand your needs when you work nights. They will call you mid-day when you are trying to sleep. I wouldn't call them at 3 in the morning – which is what calling someone on night shift at noon means – but they don't think like that. Society as a whole doesn't get it. So you can't just turn off your phone – there may be an emergency or call you can't miss. You have to be there.[20]

Under such a range of emotional and physical strains, it is little surprise that nurses across Canada suffer from more cardiovascular and related conditions than other female workers in Canada. The table below draws out this difference by condition.

**Table 3. Percentage of RNs and Female Workers Reporting Cardiovascular and Related Conditions, Canada, 2005**

| | **High Blood Pressure %** | **Diabetes %** | **Heart Disease %** | **At least one cardiovascular and related condition (including high cholesterol levels) %** |
|---|---|---|---|---|
| RNs | 12.8 | 3.0 | 1.9 | 15.6 |
| All employed♀ | 9.4 | 2.4 | 1.4 | 11.7 |

Source: Statistics Canada, Health Canada 2006. *Findings from the 2005 National Survey of the Work and Health of Nurses,* Minister of Industry, p. 148.

[19] Interview with Hamilton-based ONA leader and emergency registered nurses, Toronto, March 19, 2013.
[20] Interview with Toronto-based ONA leader and ICU night shift registered nurse, Toronto, April 4, 2013.

Compounding all this is the physically demanding nature of nursing work – particularly in the hospital and long-term care sectors. For example, across Canada in all sectors in 2005, 77 per cent of nurses reported having jobs requiring lifting or/and transferring patients, with over one third (33 per cent) reporting that mechanical lifting devices were not always available.[21]

In Ontario these figures were quite similar: 77 per cent of Ontario nurses reported having jobs requiring lifting or/and transferring patients and 34 per cent reported that mechanical lifting devices were not always available.

The first major funding allocation ($60 million) for the purchase of lifting equipment and delivery of lift transfer education programs was made in Ontario only around this time, in fiscal year 2004-05. In 2005-06 a further $29 million was allocated to decrease and prevent the ongoing risk of musculoskeletal injuries for nurses, hospital patients and long-term care facility residents.

Regardless of these efforts, given the work overload and multiple other strains faced by RNs, work-induced injuries and illness reported by RNs in Ontario hospitals continued to outnumber those of other hospital workers by a factor of three or more in 2012. The following table presents the number of Workers Safety Insurance Board (WSIB) claims filed and days lost due to workplace injury and illness for the 10 hospital occupations with the highest claims filed and days lost.

**Table 4. Sum of Number of Allowed Lost-Time Claims and Sum of Days Lost, Top-10 Hospital Occupations, 2012**

| Occupation (Hospital Industry) | Sum of Allowed Lost-Time Claims | Sum of Days Lost |
|---|---|---|
| Registered Nurses | 854 | 6,659 |
| Licensed Practical Nurses/Registered Nursing Assistants | 279 | 2,426 |
| Nurse Aides and Orderlies | 246 | 2,236 |
| Unknown Occupation Code | 139 | 638 |
| Light Duty Cleaners | 113 | 1,079 |
| Elemental Medical and Hospital Assistants | 42 | 731 |
| Visiting Homemakers, Housekeepers and Related Occupations (including Personal Support Workers) | 37 | 289 |
| Other Aides and Assistants in Support of Health Services | 29 | 290 |
| Community and Social Service Workers | 28 | 546 |
| Medical Radiation Technologists | 27 | 167 |

Source: Workers Safety Insurance Board Enterprise Information Warehouse; As of December, 2012.

[21] Statistics Canada, Health Canada 2006. *Findings from the 2005 National Survey of the Work and Health of Nurses,* Minister of Industry, p.133.

In addition to making more WSIB claims than all other hospital occupations, RNs make more WSIB claims than *all* occupations in a number of industries perceived to involve some of the heaviest, dirtiest and most dangerous work. As shown in the table below, the total number of WSIB claims filed by hospital RNs in 2012 is more than the total number filed in 2012 by form work and demolition workers, roofing workers, and meat, fish and chemical manufacturing workers combined.

**Table 5. Sum of Allowed Lost-Time Claims and Sum of Days Lost, Selected Industries, 2012**

| Industry | Sum of Allowed Lost-Time Claims |
|---|---|
| Form Work and Demolition | 285 |
| Meat and Fish Products | 235 |
| Roofing | 206 |
| Chemical Industries | 74 |
| Mill Products and Forestry Services | 68 |

**SICK LEAVE AND CONTROLS**


Regardless of the high number of workplace injuries of Ontario RNs, from as far back as 1987, Ontario is the only province that has recorded work absenteeism rates for RNs due to illness or disability that are lower than the national average, year after year (see the table below).

**Table 5. Comparison of Absenteeism Rates due to Illness or Disability, Public Sector RNs: Canadian provincial average and Ontario, Selected Years, 1987-2010**

| | 1987 | 1992 | 1997 | 2002 | 2005 | 2008 | 2010 |
|---|---|---|---|---|---|---|---|
| Average of all provinces | 5.3% | 5.2% | 6.8% | 8.1% | 7.6% | 9.3% | 8.1% |
| Ontario | 4.0% | 3.8% | 5.0% | 7.5% | 6.6% | 8.8% | 7.4% |

Source: Michelle Lasota (Infometrica) 2009. *Trends in Own Illness or Disability-Related Absenteeism and Overtime among Publicly-Employed Registered Nurses,* Canadian Federation of Nurses' Unions, p. 28.

The consistently lower proportions of Ontario public sector RNs absent from work due to illness or disability reflects the various types of control mechanisms applied to nurses to reduce workplace absences, including the length of leaves due to workplace injury and illness. Rather than designing and implementing plans to solve RN understaffing – the major root cause of work overload, workplace injury, and stress-related illnesses of RNs in Ontario – employers of RNs use various coercive mechanisms to attempt to control absences, as depicted in the testimonies below.

> Our CEO holds staff forums and I suggested in a staff forum on health that the hospital give us gym memberships. Of course there isn't room to build a gym in the hospital, but at least a gym membership would help. The CEO and hospital administrators were not at all interested. Nothing is done for prevention, or to truly promote good health among nurses and other hospital workers.
>
> Instead we have strict rules… We have to phone in to companies hired by hospital management each day we are sick. And then we receive follow-up calls from them. Companies specializing in absence management and other personnel issues. The employer gives us fridge magnets from the company so we don't forget to call them. I was ill one time – missed four shifts in a row – and an RN case manager from the company kept calling me at home. They ask general questions: What is your name and date of birth? Where do you work? Did you get it at work? Is it contagious? When do you expect to return to work? We have to call them if we are still sick and can't return to work when planned. They know our phone numbers, where we work – the location right down to the ward of the hospital. If you are ill you don't feel like answering. One of the nurses in my Local was in Emergency having a heart attack and the company wanted to talk to her. Her family member told the case worker the situation but the case worker insisted on talking to her.[22]
>
> *
>
> Nurses come to work sick because they get grief when they stay home. One of our nurses has cancer and she got grief from management. She was told she should've been cured by now…according to some book.[23]

[22] Interview with Huron-Perth County RN and ONA leader, Toronto, March 19, 2013.
[23] Interview with Toronto-based ONA leader and ICU night shift registered nurse, Toronto, April 4, 2013.

In addition to checking up on RNs during illness-related absences – and hiring workforce management firms operating under such catchwords as "Achieving business objectives through absence management" – employers erect barriers when presented with standard leave or health-related requests covered in ONA collective agreements. This adds further stress. Some examples follow in the testimonies below.

> …The employer is resistant to making accommodations, even if they are health-related. A colleague of mine had a note from her doctor about work restrictions. The occupational health nurse at the hospital ignored the note and my colleague was scheduled for a full load. She is now having to file a grievance. The other day I finished my day-day-night-night schedule and then my colleague, the nurse not accommodated by management, called in sick. I filled in for her, which meant I did three nights in a row. This is how the healthy workers become overburdened and then their health is affected. Not dealing with the initial health accommodation of my colleague likely ended up adding up to more absenteeism in total. I don't know… I am at a loss. I just can't explain it.[24]
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> The attitude of management doesn't empower nurses to do their jobs. There is great dissatisfaction among RNs because they are micro-managed. They are not allowed to make basic decisions – like calling in extra staff if needed. I joined the union leadership to try and do something about management's daily violations of nurses' rights. This is the greatest source of stress of nurses, which then affects the health of nurses. Some can defend themselves. But others cannot. I try to tell nurses if we stick together we are stronger. But management easily divides front-line nurses. Then it is survival of the fittest.[25]
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> Hospital managers are key to making nurses' work life good, but they just don't do it. They don't bring out the best in their staff. How can they do this? By granting personal leaves and holiday leaves as laid out in the collective agreement, for example… All the details are there. Refusing these basic rights creates more stress for nurses. If managers are respectful of our rights, then they will decrease our stress and we can give yet more… We have a nurse manager who refused a member of our Local compassionate leave to go see her brother overseas who was ill… I think it is about control and power. This is why managers take on this behavior. "I can diminish you because I am manager." I can't explain further… I am trying to choose my words carefully. Just like the absence management firms. It is plain mean and there is no need for it.[26]

Though at a loss for elaborate explanations, these front-line RN leaders all articulate the near irrational nature of workplace controls faced by RNs. The extreme regimentation and regulation of these professional workers is remarkable given the extent of decision making and skill required and exercised by RNs in their daily work.

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[24] Interview with Huron-Perth County RN and ONA leader, Toronto, March 19, 2013.

[25] Interview with Chatham-Kent County RN and ONA leader, Toronto, March 19, 2013.

[26] Interview with Toronto-based RN and ONA leader, Toronto, March 19, 2013.

Apart from attempting to maintain workplace presence of RNs within the context of systematic understaffing in the Ontario health system as a whole – it is difficult not to draw the conclusion that RN employers enforce and reinforce a climate of discipline simply to maintain the upper hand.

The effect of this strict discipline is added stress for front-line RNs. This often leads to extended or repeat absences for the relatively small proportion of RNs granted sick leave. In turn, this intensifies understaffing, particularly where hospitals and other health service facilities choose to not replace absent RNs in order to meet budgetary targets – as is currently occurring.

## CONCLUSION: THE CYCLE OF SACRIFICE AND GENDERED RESPECT

Though RNs are widely respected according to various polls commissioned by non-nursing and nursing bodies alike, the reality represented here would suggest otherwise. On a systemic basis, as well as on an individual basis, the labour of RNs is more expected than respected – appreciated in theory but not in practice. The words of an ONA front-line RN underline the gendered nature of respect attributed to public service workers:

> Policemen can talk on the job. People see two policemen talking and they think, yes, they are doing their job. Firemen rest on the job when able between calls. They have beds in the fire hall, and people see nothing wrong. But if nurses are seen talking or resting on the job, what do people say? They report it. There are all the polls that say that nursing is the most respected profession. But nurses are not respected.[27]

On a systemic level, the consistent inability to prioritize funds to raise the Ontario RN to population ratio to at very least meet the Canadian average, the sacrificing of RN health during the second wave of the SARS outbreak, and the tendency to control and discipline individual RNs – are all reflections of a societal lack of respect for the knowledge, skill and importance of RNs in the Ontario health system.

In closing, there is one key action required if Ontario is to stop sacrificing the health of RNs as a means to meeting narrow budgetary goals, which ultimately demonstrate a lack of respect for the health care professionals providing the most constant professional care to those in need. That action is for Ontario to commit to a medium-term plan to create and fill 15,500 new RN positions, in various sectors of the health system.

In the spirit of respect for the front-line nursing experts on the ground, the plan should be created in consultation with ONA and other nursing bodies with the goal of maximizing public benefit in a time of increasing social inequality and diminishing population health in Ontario.

[27] Interview with Toronto-based ONA leader and ICU night shift registered nurse, Toronto, April 4, 2013.