Race, Class, and Gender: Black Nurses in Ontario, 1950-1980

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ABSTRACT

This dissertation examines the working lives of black nurses in Ontario between 1945 and 1980. This dissertation engages with recent scholarship in the fields of women and work, anti-racist feminism, Canadian immigration history and black diasporas to analyse how black nurses were located within the post-World War II health care system. Using archival resources gleaned from the oral interviews conducted with black nurses, the research uses race, class and gender as critical categories to explore the experiences of Canadian born-black and Caribbean nurses in the post-war era. By using the interlocking systems of race, class and gender, this dissertation focuses on questions of black nurses identity, their experiences at the workplace, their encounters with racism, and their efforts to resist discrimination and subordination. How immigration officials and nursing administrators responded to the immigration of black nurses educated in Britain and the Caribbean is also addressed. I argue that the socially constructed categories of race, gender, and class shaped the nurses subjective sense of themselves as professionals, workers, mothers, wives, citizens, and immigrant women. This dissertation also explores the ways that class, gender, race constructed common experiences black nurses, but also had the potential to fragment those commonalities.

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Chapter 1
Writing the History of Black Nurses in Ontario: Challenges and Prospects

> I'm so glad that someone is telling the nursing story. I don't know that anyone has ever researched the history of black nurses in Canada. I did hear that the first black nurse graduated in this area [Windsor]. I remembered reading that a black girl was refused training in Nova Scotia when I was in my second year. I tried to find out about that when I was in Nova Scotia. I inquired at the black museum, but no one there at the time knew. The one black nurse I spoke to wasn't sure when the first black nurse graduated from there.[1]

In 1954, Frieda Steeles and another black Canadian student began their training as nurses at the Hotel Dieu of St. Joseph School of Nursing in Windsor, Ontario. Expected to live in residence, Steeles began as a probationary nurse, or a probie, the colloquium used to refer to the fact that they occupied the lowest rank in the hospital hierarchy. Steeles spent the first six months taking classes to ascertain whether she possessed the aptitude to be a nurse. Once this was determined, Steeles participated in the capping ceremony, an indication that she had successfully passed the probationary period and was officially accepted into the school. As a junior, Steeles was gradually introduced to the regular hospital duties working twelve hours per day, a schedule interrupted with lectures. At the end of her junior year, Steeles wrote an exam which she passed and

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[1] Frieda Steeles, interview by author, Tape recording, Windsor, Ontario, 9 June 2001.

continued her training. At the end of three years, Steeles earned her Diploma as an RN that reflected the successful completion of her training.

Other than a few special assignments, Steeles's training and entire working life was spent at Hotel Dieu until she retired in the early 1990s. Steeles is one of the few black Canadian women who were the trailblazers in Canadian nursing, an occupation that once denied admittance to black students. Based on her experience, Steeles knows that there is a story to be told, a history to be written. The quotation at the beginning of this chapter speaks to two related issues: the absence of historical materials about black nurses and the importance of documenting their experiences. This dissertation takes up that challenge. It examines the experiences of black Canadian and Caribbean-born nurses who have worked and lived in the post World War II decades. While the dissertation focuses on the years 1950-1980, where relevant, the dissertation extends back in time to the nurses childhood, and then forward into the 1980s with an emphasis on work and family. This dissertation seeks to make visible the otherwise neglected story of these black women. At the same time, I should add that finding black nurses in the period under discussion is rather difficult given their small presence overall. One study revealed that during the mid 1950s to mid 1960s there was only about 1,000 immigrant nurses from the Caribbean[2]. Of course, this does include Caribbean women trained in Britain who immigrated to Canada during the same period.

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[2] Agnes Calliste, "Women of 'Exceptional Merit': Immigration of Caribbean Nurses to Canada," Journal of Canadian Women and the Law 6 (1992), 98.

The goal of attempting to retrieve women from historical obscurity is not a new endeavor. Over the last three decades, there has been a preponderance of research detailing the complexity of women's lives across various historical junctures. Similar to their counterparts elsewhere, Canadian feminists have utilized various methodologies, conceptual frameworks and theories to demonstrate that women's experiences, although perhaps different from their male counterparts, are legitimate and are worthy of study. While the resulting research has contributed enormously to our knowledge about women's lives, most studies have focused on white women. Inspired by social historians whose main mandate is to research and write about those conventionally deemed undeserving of a place in the historical record, I set out to examine the lives of a group of black women whose voices remain marginal in feminist scholarship.

In making black nurses' lives the focal point, this dissertation also contributes to the growing body of scholarship, which posits that relations of gender, race, and class are systems of oppression and processes that shape and determine the lives of people. Using the evidence gathered from oral interviews, archival resources, and a variety of secondary sources, I use the interlocking systems of race, class, and gender as constituting the primary analytical framework to examine how various groups of nurses explained, interpreted and understood their experiences in nursing. This dissertation addresses questions of black nurses' identity, their experiences at the workplace, their encounters with racism, and their efforts to resist discrimination and subordination. I argue that categories of race, gender, and class although socially constructed shaped the nurses'

subjective sense of themselves as professionals, workers, mothers, wives, citizens, and immigrant women. This dissertation also explores the ways in which class, gender, race constructed common experiences among black nurses, but also had the potential to fragment those commonalities.

This dissertation engages with various theoretical frameworks, while drawing from and building on several related bodies of academic scholarship pertaining to women's work, immigration history, anti-racist feminism, post-colonial and feminist post-structuralism critiques. The purpose of this chapter is to map out the terrain on which to write and locate black women's history within a Canadian context. I begin with an introduction of the nurses and the interview process. From there, I highlight the various themes from a range of scholarship, which has influenced my own thinking and inform this research. In the final section, I show how in light of the limitations of other resources, oral history as a methodology, provides answers to questions that would otherwise be difficult to obtain.

But Why Nurses? Defining the Project

Following within the tradition of the few authors who have written about Caribbean immigrant and black Canadian women, I also wanted to focus on women's experiences as workers. I decided against a focus on domestic workers because their experiences have been well documented[3]. As a result, I was interested in another

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[3] See for example, Makeda Silvera, Silenced: Talks with Working Class Caribbean Women about their Lives and Struggles as Domestic Workers in Canada (Toronto: Sister

occupational category, and decided on nurses for several reasons. First, until the late 1940s black women were excluded from nursing training in Canada. Second, over the last four decades nursing has been a particularly important skilled occupation for black women, a fact brought to my attention initially by the disproportionate number of Caribbean nurses in the congregation at my place of worship. Third, the education, training and credentials required of nurses raises questions around identity and professional status that are different from those pertaining to domestic workers. Although, there is a substantial scholarly debate as whether nursing and other white collar occupations should be considered "middle-class", there is no doubt that within black communities nurses enjoyed economic stability and social respect and prestige that located them within the communities' elites.[4]

The importance of black nurses emerged in my preliminary perusal of the documentation available on black and Caribbean women, when I discovered Joyce Cole's

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Vision Press, 1983); Patricia Daenzer: Regulating Class Privilege: Immigrants Servants in Canada, 1940-1990 (Toronto: Canadian Scholars Press, 1993); Sedef Arat-Koc, "In the Privacy of Our Own Home: Foreign Domestic Workers as Solution to the Crisis of the Domestic Sphere in Canada," Studies in Political Economy 28, (Spring 1989), 33-58; Agnes Calliste, "Canada's Immigration Policy and Domestics from the Caribbean: The Second Domestic Scheme," in Jesse Vorst ed., Race, Class, Gender: Bonds and Barriers, 2nd ed. (Toronto: Garamond Press, 1991).

[4] For two positions on the question of nurses' class see: Mary Kinnear, In Subordination: Professional Women (Montreal: McGill-Queen's University Press, 1995) and Kathryn McPherson, Bedside Matters The Transformation of Canadian Nursing, 1900-1990 (Toronto: Oxford University Press, 1996).

MA thesis, "West Indian Teachers and Nurses in Ontario: Study of Migration Patterns,"[5] and Agnes Calliste's groundbreaking article, "Women of 'Exceptional Merit': Immigration of Caribbean Nurses to Canada."[6] Relying on the traditional sociological questionnaire, Cole examined the impetus behind Caribbean migration and argued that it was primarily economic. Unfortunately, there was no analysis of the work or migration experiences of these immigrants. Cole concluded that Caribbean migrants experienced upward mobility, which would have been unlikely had they stayed in the Caribbean. This was an indication of success and integration in Canadian society. Despite the fact that her subjects were primarily male (more than half of her participants were men and her study did not address gender difference), Cole's thesis confirmed Steele's general observation; that there is much to unearth about Caribbean nurses' migration.

Similarly, Calliste's article not only added legitimacy to the research I was about to undertake, but also provided information about the conscious effort on the part of the Canadian government to permit the migration of Caribbean nurses on a differential basis compared to white nurses from Europe. Calliste also revealed how race, gender, and class were deployed and used to determine how Caribbean nurses were absorbed into the nursing profession. Despite the obvious contributions of Calliste and Cole's studies in

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[5] Joyce Cole, "West Indian Teachers and Nurses in Ontario: Study of Migration Patterns," (MA thesis, McMaster University, 1967).

[6] Agnes Calliste, "Women of 'Exceptional Merit': Immigration of Caribbean Nurses to Canada," Journal of Canadian Women and the Law 6 (1992): 85-103.

focusing exclusively on the migration process, they stopped short of examining the actual work experiences, or the identities nurses forged once in Canada.

As I began the research phase of my dissertation, a number of issues emerged, which subsequently shaped the parameters of this project. First, it proved difficult to determine the total number of black nurses practising in Canada before 1981. Calliste has established that between 1954 and 1965, 982 trained or graduate nurses and 286 nursing assistants emigrated directly from the Caribbean,[7] but there seems no way to quantify the number of Afro-Caribbean nurses who trained or worked in England before moving to Canada. Census data does provide a sense of the number of migrants from the Caribbean overall; the number of Caribbean immigrants who arrived in Canada in 1967 was 5, 641 and in 1971 it was 10, 843.[8] By 1981, Ontario alone boasted more than 130,000 residents born in the Caribbean or Guyana – many, but not all, of whom were of African descent.[9] Those emigrants who considered themselves Afro-Caribbean joined African-Canadians and black migrants from the United States to make up Canada's "black" community. Overall, black people comprised only a small proportion of the Canadian population –

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[7] Calliste, Women of 'Exceptional Merit', 87.

[8] Census of Canada, 1971, Immigration, "Arrivals by Country of Last Permanent Residence."

[9] Census of Canada, 1981, Population, (Catalogue 93-930, Vol.2 Provincial Series), Table 8, "Population Born Outside Canada by Sex, Showing Selected Countries...."

just 0.2% in 1971.[10] Given that nurses would have represented a small minority of black Canadian, the cohort of black nurses being discussed in this dissertation would have been quite small. An ambitious estimate of 3% of the black population[11] would suggest that in Ontario in 1981, for example, there would have been 4500 black nurses, a figure that placed black nurses in a minority within Canada's black population and a minority within the ranks of Canadian nurses.

Secondly, although archival and textual sources were available with respect to this small group of black nurses, it soon became evident that the richest source of primary data lay in the stories of nurses themselves. As a result, oral interviews emerged as a key evidential base for the dissertation. Twenty-five Caribbean and Canadian nurses between the ages of 45 and 85 were selected for this project. In the Caribbean contingent, as among Caribbean immigrants more generally, the majority of nurses were from Jamaica followed by Trinidad and Grenada. Individual nurses were also from Guyana, Dominica and Barbados. Most of the Caribbean-born women received their nursing education in Britain. The emphasis on Caribbean nurses in this study reflects the changes to Canadian immigration policies in 1962 and 1967 where "objective" criteria such as education and

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[10] Wosley Anderson, Caribbean Immigrants: A Socio-Demographic Profile (Canadian Scholars Press, 1993); Peter S. Li, Cultural Diversity in Canada: The Social Construction of Racial Differences, Research and Statistics Division, 2000.

[11] This estimate builds on Calliste's findings pertaining to the 1954-1965 years. In those years nearly 1000 nurses migrated from the Caribbean. Given that by 1967 over 5000 Caribbean migrants were arriving in Canada per year, it is safe to estimate that in the 1954-65 years, perhaps 3000 Caribbean migrants arrived in Canada per year, on average. Nurses thus represented 1000 out of 33,000 migrants, or 3%.

skills were used as the basis to determine migrants' eligibility to enter Canada. The number of Canadian-born black nurses in this study is smaller, for despite my efforts to locate retired Canadian-born black nurses I was only able to identify seven. This small number may reflect black Canadian women's historical exclusion from nursing which led many nurses to seek training in the United States. The small number may also reflect the limited financial resources black Ontario families had to offer their daughters in this era. I chose to focus on the geographic location of Ontario for practical purposes but also because of its diverse immigrant population. Moreover, a number of black Canadians who grew up in black communities in Halifax and Winnipeg moved to Ontario because of employment opportunities.

Scholars tend to differ on what constitutes an appropriate number for an oral history project. Some researchers suggests that after a certain number of interviews the information becomes repetitive and patterns begin to appear, thus the rewards of oral research can diminish after a certain number of interviews.[12] My goal was not to count how many women had similar experiences but to demonstrate the diversity of experiences, that is, to explicate where experiences converged and where they differed. Although all the nurses shared comparable socio-economic status, they are far from a homogenous group and are differentiated by age, training, education, citizenship and

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[12] An explanation of why twenty-five interviews is a sufficient number in a project such as this is found in Denyse Baillargeon, Making Do: Women, Family, and Home in Montreal during the Great Depression, trans. Yvonne Klein (Waterloo: Wilfred Laurier Press, 1999).

birthplace. Some of the nurses are married or divorced with children, while others remained single and childless. For some, the church is an important institution and for others it is has very little significance. Even though the majority of nurses emphasize a racial identity; they all stress a commitment to nursing forging an occupational identity rooted in caring.

When this project first began in 1995, as part of my MA program, I interviewed five Caribbean nurses who trained in Britain and subsequently immigrated to Canada. At that time, I was interested primarily in their work experiences particularly as they related to the differences between nursing in Canada and Britain. We also talked briefly about their experiences of racism in nursing and the wider society. From these interviews, I found out how the nurses conceptualized their work experiences in Britain and Canada. Equally important, their stories encapsulated how the nurses' sense of themselves was transformed in the context of migration.

For my doctoral research, I extended my analytic framework substantially. Influenced by socialist feminist scholars who argue for a more nuanced picture of working women's lives, I added additional questions for the second phase of this project in order to explore topics such as: growing up, schooling, family, and parenting. I interviewed an additional twenty nurses, seven of whom are Canadian born. A conscious effort was made to include black Canadian nurses because for over four hundred years the presence and contributions of indigenous black Canadians has rarely been acknowledged. The failure to recognize indigenous black Canadians supports the

stereotype that to be "Canadian" is to be white; ironically, analyses of Caribbean migration in the 1960s has served to reinforce this image of an historically "white" nation. Thus, the presence of black Canadian nurses in this project disrupts how Canadianess is defined even as it illuminates how race served as the organizing principle that governed Canadian society, a society that was viewed by fugitive slaves, loyalists, and free blacks as the land of freedom. Secondly, the fact that until the mid 1940s black nurses were excluded from Canadian nursing also illustrates how white nurses relied on construction of "whiteness" and a particular notion of "womanhood" to determine who could be considered nurses. Finally, including black Canadian nurses in this research challenges the notion of black people as a monolithic group bounded together on the basis of race. As this study will show, black Canadian nurses grew up in a society where they were in a distinct racialized minority and thus understood race and racism differently than their Caribbean counterparts: they trained in a Canadian, rather than British, educational system; and they developed a different set of expectations about what it meant to be "Canadian".

Most of the Caribbean-born nurses were educated in Britain, but I also interviewed five nurses who were trained in the Caribbean in an "English-style" nursing program. Focusing on diverse groups of nurses allows for a more complicated picture of their lives, because, I am able to examine the migration process from different standpoints, whether from the perspective of black Canadians whose ancestors came to Canada decades or centuries before, or from the perspective of more recent immigrants.

All the Caribbean nurses included in this study hailed from the English-speaking Caribbean,[13] and immigrated to Britain or Canada primarily for work, family or personal reasons. Out of the twenty-five nurses, ten nurses were working either full or part-time at the time of the interviews. Several were close to retirement and the rest have retired. Regardless of where they were educated, the majority of nurses entered nursing school during the mid 1950s or early 1960s. Except for one black Canadian nurse who worked until retirement in the United States, the others worked primarily in Canada. In terms of status, most of the interview participants are Registered Nurses (RNs), but because the Ontario College of Nurses accreditation process required some migrant nurses to upgrade, some of my interview participants worked as subsidiary health-care personnel such as nurses' aides. To reflect this important part of the history of black nurses the experiences of Registered Nursing Assistants (RNA), Nursing Assistants, and Nurses Aides are also included in this project. As a result, this study differs from most nursing history that focuses only on "fully trained" nurses who reached the highest professional status of RNs.

To identify interviewees, community organizations such as the Jamaican Canadian Association Centre and the Black History Society proved helpful in providing me with the names of a few nurses. Acquaintances and friends also came to my aid by

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[13] Defining the "West Indian" or Caribbean territory is open to multiple definitions depending on the perspective of the writer. Some adopt a narrow view while others adopt a more expansive definition. Even though my focus is on the Anglophone Caribbean, for

providing me with the names of family members or other contacts. It was the snowball sample approach, however, which was used to locate the majority of nurses. A number of the nurses provided me with the names of their friends who they felt would be interested in the project. The interviews were done between 1995-2001. I made initial contact over the phone to explain my research and once the women expressed interests we selected interview dates. The research participants were also provided with a written outline delineating the objectives and purpose of the research. On, or prior to, the actual interview, the nurses were also asked to sign a consent form. The interviews ranged from two to four hours in length and except for five interviews most took place in the participants' homes. Once the interviews were transcribed, follow-up interviews took place over the phone for clarification purposes or to find out additional information. Because I was unable to locate the nurses involved in the 1995 group for my MA research, they were not consulted for follow-up sessions though their experiences are included in the overall project.

Once the nurses were aware of my goals, they were eager to be interviewed because they clearly understood and appreciated my efforts to place their experiences within the larger historical record. These nurses were cognizant of the limited historical information available about blacks as a group and nurses in particular. The fact that I shared a similar social location (other than my age) with the nurses allowed me to glean

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the purpose of this project, the "West Indies" will include non-Hispanic countries in the Caribbean Sea, and includes territories in Central America, such as Guyana and Belize.

information that white interviewers might have had difficulty obtaining. Penny Summerfield explained, for example, the tensions that some white interviewers might face when talking with black participants about racial discrimination. In her study of women's experiences during World War II, Summerfield observed that in one interview "the presence in Britain in the 1950s and 1960s of racist discourse was implicit in Nadia's account. But although she banished it as irrelevant, it hovered unspoken between narrator and interviewer as a set of negative possibilities."[14] In another interview in which experiences of racism figured prominently in the interviewee's narrative but were recounted using humor and irony, Summerfield explained that this approach "...eased the exchange between Black narrator and white interviewer...and put the interviewer at ease, enabling her to laugh at the gross injustices perpetrated by white people (like herself) forty years previously."[15] As a black woman, my experience with these nurses was different from Summerfield's. That was evidenced by the questions they asked about my family, and personal experiences. Following back-to-back interviews with three black Canadian nurses, I was invited to lunch where two of the nurses and I engaged in a lively discussion about a variety of issues affecting the black community. If the nurses expressed any emotion, their sadness or anger was about the information rather than any apparent discomfort with how I might react.

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[14] Penny Summerfield, Reconstructing Women's Wartime Lives (Manchester: Manchester University Press, 1998), 223.

[15] Ibid.

Some of the nurses disclosed personal or painful information as long as I excluded it from my project or used pseudonyms for hospitals where racist incidents occurred, or minimized identifiable information that could implicate them. In addition to trusting me with their narratives the nurses also took for granted that as a young black woman I did not live my life unscathed by racism, and as a result, they expected that I have had comparable experiences to themselves or their children. For example, discussions about systemic and institutionalized racism within the school system were a common topic that came up during and after the interviews. At the same time, the fact that I was doing a PhD and focusing on nurses made the interviewees proud. Like the children they raised, I represented a beacon for what a good education can accomplish despite the inequalities in the education system.

As well, when I interviewed Caribbean immigrants there was an unspoken assumption that I was aware of some of the idiosyncrasies, cultural expressions, and knowledge of Caribbean cultures. For example, Orphelia Bennett, one of the earliest migrants to Canada, would vacillate between English and the Jamaican dialect, which became more prominent as she passionately explained why it was important that upon her death, she wanted to be buried in Jamaica. As a Jamaican immigrant, I could decipher Bennett's patois, even if it meant listening to sections of the interview repeatedly.

Language and Theoretical Frameworks

Determining the kind of language used in this dissertation relates to both practical and political considerations when it comes to the issue of naming. Trying to decide the

appropriate language use is difficult given that people have their own ways of defining themselves, which may be "obsolete." While I kept these issues in mind, I made a conscious decision to forgo using certain terminology. In my MA thesis, I used the term African-Canadian, but chose for this research to use the term "black" instead. Black is more inclusive and denotes that "blackness" is not based on a natural or essential or ethnic connection. Rather, black used in this sense demonstrates a political connection based on the historical, social and structural location inhabited by those of African ancestry. Although I have chosen to use black to describe the nurses as a group, I also use Caribbean immigrants to differentiate them from Canadian born blacks. When quoting directly from the nurses, I use the terminology they use to identity themselves.

Similarly, I use (despite its problematic usage) the phrase women of colour when referring to women that historically have been subjected to racist and sexist oppression in Canada. This would include women of Asian, Chinese, Japanese, and Latina ancestry. Given how Native Canadian women are constituted in Canadian society they are also included in this category. Even though I am using these categories, I take into account the range of differences within these groups based on culture, class, age, and sexuality. I use these wider terms to avoid incessantly bifurcating these categories to the point where the possibility of an analysis based on shared historical and contemporary experiences of racism, sexism and other forms of oppression is no longer possible. I also try to refrain from using the term non-white, because according to Beverly Daniel Tatum, "this term is

particularly offensive because it defines people in terms of what they are not. (Do we call women "non-men"?")[16].

To interpret and understand evidence gathered from the nurses' testimonies requires drawing on the various analyses, concepts, and theoretical frameworks advanced by scholars in a range of disciplines. Socialist feminist analyses of women and work have provided me with a framework to think about the contradictions in power relations in an occupation such as nursing. At the same time, anti-racist feminist scholarship has proved especially useful in terms of understanding how immigration policies are gendered and racialized. Studies on the black diaspora provide a framework to critically think about identity as multiple and fragmented and constituted within and by various historical activities and cultural settings. It is to these studies that have informed my own thinking and work that I know turn.

Influenced by Marxism, scholars writing in the area of women and work have transformed the class-based analysis that tends to reduce all forms of inequalities to economics. In order to understand women's work lives, some feminist scholars have focused on how capitalism and patriarchy converged to shape women's lives. They argue that patriarchy-- defined as men's control over women's labour power and sexuality -- combines with capitalism--which exploits women through wage labour--to produce

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[16] Beverly Daniel Tatum, "Why Are All the Black Kids Sitting Together in the Cafeteria?" And Other Conversations About Race (New York: Basic Books, 1997), 15.

women's subordination.[17] As a result, socialist feminists insist that neither paid nor unpaid work can be studied in isolation from larger social structures and processes. Within this trajectory, scholars have also explored the notion of the public vs. private sphere, the sexual division of labour, and sex-segmentation in occupations. Implicit in these studies is attention to how systems of oppression contribute to women's subordination, which results in a different reality from their male counterparts.[18] Sociologist Pat Armstrong, for example, emphasized the important role played by the state in shaping relations between capitalist and patriarchal societies in the World War II era.[19]

Socialist feminist analysis is particularly useful in theorizing the complex relationship between physicians and nurses, and in teasing out how nursing has been gendered and subordinated vis-à-vis the medical establishment. Although their position as the "physicians hand" has changed over time, nurses are often expected to follow doctors' orders as well as perform other nursing tasks at the bedside. While nurses are in a marginal position relative to physicians, the hierarchy in the medical field

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[17] See for example, Heidi Hartman, "The Unhappy Marriage of Marxism and Feminism," in Women and Revolution: The Unhappy Marriage of Marxism and Feminism: A Debate of Class and Patriarchy (London: Pluto Press, 1986).

[18] See for example, Cecelia M. Benoit, Women, Work and Social Rights: Canada in Historical and Compartive Perspective (Toronto: Prentice Hall Allyn and Bacon Canada) 2000).

[19] Pat Armstrong, Labour Pains: Women's Work Crisis (Toronto: Women's Educational Press, 1984).

simultaneously places them in a position where they have power and authority over the auxiliary staff. In these positions, nurses direct the work of groups like nurses' aides and assistants. But given the post Second World War political economy of health care, nurses are often placed in a precarious position whereby they are not only competing with other health care personnel for resources but are often the recipients of the impact of reduced funding. For my research, I am interested in nursing as work, the work process, and how that process shapes nursing identity, and how work is both gendered and racialized. It is not enough, however, to examine paid work in isolation but to also focus on unpaid work because as Bettina Bradbury maintains, understanding women (and men's) identity in the workplace means having some understanding of their lives outside of work. In addition, women's reproductive work within the home also raises the issue of how women combine unpaid work with work for remuneration. Since black women in North America historically have had high labour force participation, paid work has often been the focus of scholars. As a result, it was important for me to find out about unpaid and paid work from the nurses.

While socialist feminists have enriched our understanding of the relationship between women's productive and reproductive work, a major weakness of socialist feminism, according to Daiva K. Stastiulis is that "in the 1980s, notwithstanding its efforts to incorporate race and class into its theory and practice, its analysis of racism and its understanding of the relationship between racism and class exploitation are frequently

left unspecified or inadequate."[20] Scholars writing in the early 1990s point out that, "the concerns of white feminists continue to dominate feminist theories and practices."[21] The inattention of feminists generally to how social identities besides gender and class impact upon women's lives have led to a proliferation of studies by anti-racist feminists. By giving race equal theoretical weight, these scholars have generated a number of studies on the themes that dominate socialist feminist scholarship, thereby challenging the idea that a commonality of experiences exists among women, and that gender and class together structure unequal relations. The areas that anti-racist feminists have focused on that are beneficial for this project are the role of the state in shaping relations of domination, how black and women of colour are situated within the Canadian economy, and their experiences of race and racism.

An important contribution made by anti-racist feminist scholars is their critique of immigration scholarship. Some analyses of immigration focus on the Canadian state's humanitarian motivations, and the Canadian state is depicted as a benevolent institution especially in terms of dealing with the placement of displaced persons and its efforts to

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[20] Daiva K. Stasiulis, "Theorizing Connections: Gender, Race, Ethnicity and Class," in Peter S. Li, Race and Ethnic Relations in Canada (Toronto: Oxford University Press, 1990), 269-270.

[21] Vijay Agnew, Resisting Discrimination: Women from Asia, Africa, and the Caribbean and the Women's Movement in Canada (Toronto: University of Toronto Press, 1996), 64; See also Evelyn Brooks Higginbotham, "African-American Women's History and the Metalanguage of Race," Signs 17, no. 2 (1992): 251-72.

integrate immigrants into the larger Canadian society.[22] These analyses have been criticized by anti-racist researchers who highlight Canada's restrictive immigration policies .[23] They argue that Caribbean migrants, for example, were deemed worthy of entry to Canada only as temporary workers or during labour shortages. These critical scholars, however, often neglect the role gender plays in the formulations of state policies. Hence, the goal of anti-racist feminists is to reveal that a discussion about patriarchy and capitalism does not exist independently of other social relations, especially racism. As such, anti-racist feminists have provided an important corrective to the male bias in critical immigration scholarship.

Using race and gender as important dimensions to think about how the Canadian state is structured, anti-racists feminists have exposed how state polices operated to produce racial difference. A number of these studies focus on the state as crucial to the organization and demarcation of the Canadian labour force on race and gender lines. Besides making explicit the male bias in immigration scholarship and delineating how

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[22] Robin W. Winks in his defense of Canada's racist immigration polices, point out that it was, in fact, rather generous towards displaced persons, and less restrictive compared to Australia and New Zealand. Winks pointed out that between 1947 and 1954 Canada admitted 165, 697 immigrants. The Blacks in Canada: A History (Montreal: McGill-Queen's University, 1971), 435.

[23] Vic Satzewich, Vic, "Racism and Canadian Immigration Policy: The Government's View of Caribbean Migration, 1962-1966," Canadian Ethnic Studies 21, no. 1 (1989): 77-97; John A. Schultz, "White Man's Country: Canada and the West Indian Immigrant, 1900-1965," American Review of Canadian Studies, 12, no.1 (1982): 53-64; B. Singh Bolaria and Peter S. Li, Racial Oppression in Canada, 2nd ed. (Toronto: Garamond Press, 1988), Chapters 5-10.

state policies have been constructed in relation to the needs of the labour market, anti-racist scholars have also revealed how state polices negatively impact upon the families of black and women of colour. While white women could settle in Canada, Caribbean and other immigrant women of colour were allowed into Canada primarily as temporary or contract workers.[24] Tania Das Gupta points out that, "it has been the policy of governments not to encourage the possibility of developing families among women of colour who came as domestic workers."[25] For anti-racist scholars, the underlying point is that general discussions about family and work cannot take place without recognizing that the state does not treat all women equally whether as workers or as mothers.

With respect to immigrant women who do settle in Canada, anti-racist feminists ask: what role does race play in the structure and organization of Canada's workplaces? The work of scholars such as Dionne Brand and Roxanna Ng, Makeda Silvera, and Sedef

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[24] See for example, Makeda Silvera, Silenced: Talks with Working Class Caribbean Women about their Lives and Struggles as Domestic Workers in Canada (Toronto: Sister Vision Press, 1983); Patricia Daenzer: Regulating Class Privilege: Immigrants Servants in Canada, 1940-1990 (Toronto: Canadian Scholars Press, 1993); Sedef Arat-Koc, "In the Privacy of Our Own Home: Foreign Domestic Workers as Solution to the Crisis of the Domestic Sphere in Canada," Studies in Political Economy 28, (Spring 1989), 33-58; Agnes Calliste, "Canada's Immigration Policy and Domestics from the Caribbean: The Second Domestic Scheme," in Jesse Vorst ed., Race, Class, Gender: Bonds and Barriers, 2nd ed. (Toronto: Garamond Press, 1991).

[25] Tania Das Gupta, "Families of Native Peoples, Immigrants, and People of Colour," in Nancy Mandell and Ann Duffy, eds., Canadian Families: Diversity, Conflict and Change (Toronto: Harcourt Brace, 1995), 157.

AratKoc[26], while drawing on different epistemological frameworks and analyses reveal similar conclusions about the location of black and women of colour in the Canadian economy. Brand, for example, argues that capitalist relations of production are structured in such a way that black women's labour is seen as expendable, exploitable and cheap. The conclusions drawn by these researchers are that black and women of colour are often concentrated in poorly paid and least skilled sectors of the Canadian economy. In separate discussions, Das Gupta and Agnes Calliste explain how race functions in a gendered occupation such as nursing so that black woman are socially subordinated, which subsequently affects the social relations between themselves and their white counterparts.

While the work of anti-racist feminists such as the ones mentioned previously are invaluable in terms of incorporating race and gender into their respective studies there are still some limitations that need to be addressed. The state is often presented as a single all-powerful entity that was stuck in time and place operating without interruptions as it devised policies and regulations to exclude immigrants of colour. In these analyses immigrant women of colour are constituted as a reserve army of labour who, upon

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[26] Dionne Brand, "Black Women and Work: The Impact of the Racially Constructed Roles on the Sexual Division of Labour" in Enakshi Dua and Angela Robertson eds., Scratching the Surface: Canadian Anti-Racist Feminist Thought (Toronto: Women's Press, 1999); Roxana Ng, "Racism, Sexism and Immigrant Women," in Sandra Burt, Lorraine Code, and Lindsay Dorney eds., Changing Patterns: Women in Canada (Toronto: McClelland and Stewart, 1993); Linda Carty, "African Canadian Women and the State: 'Labour only, please' in Peggy Bristow et al., We're Rooted Here and They

migration, found themselves working in the lower echelons of the Canadian economy that white Canadians had abandoned. While this was often the case, these analyses tend to lump all groups of immigrant women and places of origin together without an examination of how skills, experience and education are differentiated in the market place. Analyses of Caribbean domestic workers are not always generalizable to the experiences of other Caribbean migrants. For example, while the Canadian state ensured that Caribbean domestic workers only received temporary status, some immigration officials actually facilitated the migration of Caribbean nurses hoping that those nurses would assist white Canadians to become familiar with black migrants.

Undoubtedly research on immigration and anti-racist scholarship has provided much needed information on some of the challenges that Caribbean immigrants and black people have faced living in Canadian society, yet there are very few studies that explore questions of identity. While there is some acknowledgement that immigrants, whether they migrated in the nineteenth century or in the last three decades, underwent a process of adaptation upon arrival in a new country, this process appears to be linear and one-dimensional. The supposition is that migrants encountered racism along with living in a white society for the first time, which influenced how they subsequently viewed themselves.[27] There is no indication of how with migration, the values and traditions of

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Can't Pull Us Up: Essays in African Canadian Women's History (Toronto: University of Toronto Press, 1994).

[27] For a similar argument about Jamaica migrants in Britain see Nancy Foner, "The Jamaicans: Cultural and Social Change among Migrants in Britain," in James L. Watson,

other Canadians were also transformed. Another theme that resonates in the literature is the idea that migrants carried with them and sustained values and memories of their former life. In his book, Black Like Who? Writing-Black-Canada, Rinaldo Walcott uses various forms of black Canadian cultural production to demonstrate the process of hybridization or creolization – that is, the intermixing, borrowing or the process of reinvention that descendants of Africans have undergone --to demonstrate the complexities of a black Canadian identity.[28] For my work, the formation of a black Canadian identity cannot be explained by cultural production only, but also in other areas such as the political economy of nursing, where black nurses articulate an identity that is linked to their work as nurses.

This dissertation thus speaks to the work of socialist feminists, anti-racist feminists, and cultural analyses of the black diaspora, and in doing so contributes to the social history of nursing. Despite the fact that nursing has, and continues to be, one of the primary occupations for women, the scholarship on the every day realities of nurses has not kept pace. Outside of a few exceptions, nursing scholars emphasize the prominent individuals who started nursing schools; the establishment of hospitals as institutions that provided nurses with the opportunity to enter the realm of a "respectable" occupation, and the initial consensual relationship that supposedly existed between doctors, nurses,

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Between Two Cultures: Migrants and Minorities in Britain (London: Basil Blackwell, 1977).

[28] Rinaldo Walcott, Black Like Who? Writing-Black-Canada (Toronto: Insomniac Press, 1997).

matrons, and supervisor; and the pursuit of professionalization -that is a focus on registration, educational attainments and standards.[29] Recently, however, some scholars have taken into consideration the complex relationship among the various hierarchies that existed within nursing. They challenge the usefulness of professionalization and proletarianization as conceptual approaches; and the role of patriarchy in subsuming nurses' skills. Other scholars have identified the ways nurses have resisted, and continue to resist, subordination through political organizations and personal acts of resistance.[30]

In Canada, Kathryn McPherson's Bedside Matters: The Transformation of Canadian Nursing, 1900-1990[31] utilizes the tools of social history to delve into more than just the daily work of nurses; she examines the various strategies they deployed to improve work conditions, and how nurses negotiated the power relations that were endemic to the medical profession. While McPherson points out that nurses occupied a particular position defined by ethnicity, class and gender, she recognizes how racism and

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[29] Janet Ross Kerr and Jannetta MacPhail, Canadian Nursing: Issues and Perspectives, Third Edition (Toronto: Mosby, 1996); Janet Ross Kerr and Janetta Macphail, Concepts in Canadian Nursing (Toronto: Mosby, 1996); Donner, Gail et al., Towards an Understanding of Nurses Lives-Gender, Power and Control (Toronto: Faculty of Nursing: University of Toronto, 1994); Alice Baumgart and Jenniece Larsen, Canadian Nursing Faces the Future 2nd ed. (Toronto: Mosby, 1992).

[30] For a historiographical analysis on nursing see: Veronica Strong-Boag, "Making A Difference: The History of Canada Nurses," Canadian Bulletin of Medical History 8 (1991): 231-248.

[31] Kathryn McPherson's Bedside Matters: The Transformation of Canadian Nursing, 1900-1990 (Toronto: University of Oxford Press, 1996).

racial difference impacted the occupation. As a result, McPherson calls for further historical analysis that probes the racial dimensions of Canadian nursing.

The work of scholars Darlene Clark Hine and Shula Marks have contributed immensely to showing how racist ideologies affected the nursing profession in the United States and South Africa. Hine in her study, Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890-1950 explores black women's long-standing relationship to domestic work in the United States and how that association contributed to black women's entry into the profession. Moreover, Hine reveals how elite white women's quest for professionalization simultaneously created barriers for black women entering the occupation and stymied the potential for a powerful bond of sisterhood[32]. Building on Hine's study, Marks's Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession considers the implications of colonialism, apartheid and democracy on the existing tensions between black, elite and Afrikaner nurses. Analogous to Hine's study, Marks demonstrates how sexual ideologies, state policies, and racism shaped not only who became a nurse but also how nurses eventually organized as a political group.[33] Both Hine and Marks concur that the professionalization quest can concurrently divide as much at it unites nurses.

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[32] Darlene Clark Hine, Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890-1950 (Indianapolis: Indiana University Press, 1989).

[33] Shula Marks, Divided Sisterhood: Race, Class, Gender in South African Nursing Profession (New York: St Martins Press, 1994).

It is impossible to write about the experiences of black nurses without paying attention to current debates regarding critical categories such as "women", "agency", and "experience"-concepts which have been the foundation of feminist theorizing. These categories have come under intense critique by post-modernists and post-structuralists, many of whom who favor an approach that focuses on language and discourse with attention to texts and modes of representation. With respect to the writing of history, post-structuralists argue about whether there is a historical reality that is "real" and knowable. Concerned about this perspective on historical writing, Joan Hoff argues that:

> Postructuralism causes stable meaning into doubt. It sees language as so slippery that it compromises historians' ability to identify facts and chronological narratives and it reduces to mere subjective stories the experience of women struggling to define themselves in particular historical contexts.[34]

For post-structuralists it is language and discourse that constitute historical events as opposed to the other way around. In addition, their critique of a history that can be written in a linear fashion and presupposes cause and effect raises a challenge to how history traditionally has been written. These debates are critical for this historical study of black nurses because criticisms of essentialism are often leveled against black and women of colour feminists who insist on the significance of race and gender in feminist theorizing. Post-structuralist critics assert that it is difficult to talk about black women's

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[34] Joan Hoff, "The Pernicious Effects of Poststructuralism on Women's History," Chronicle Of Higher Education, (20 October 1993): B2.

experiences with racism because, like the essentialized category "woman", there is no unitary homogeneous category named "black women".[35]

These debates shape this dissertation in two important ways. First, post-modernists interrogate the assumption of an autonomous, unitary, individual or collective identity, and focus instead on fragmented, multiple, and unstable subjectivities. The supposition of feminism and feminist scholarship is that women as a category exist with shared commonalities and experiences. As Judith Butler notes, "within the terms of feminist theory, it has been quite important to refer to the category of "women" and to know what it is we mean."[36] While scholars like Butler and Joan Scott view with trepidation the use of "women" as a category of analysis, Denise Riley argues that for political purposes there is a significance of refusing to reject the category altogether. Instead, Riley points out that feminist scholars in their quest to write about women's experiences should place these discussions within a historical context. She insists that being a woman was defined differently during the 15th century in Western Europe where there was a growing sexualization of women, than for example, in the 19th century as

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[35] See Sherene H. Razack, Looking White People In The Eye: Gender, Race, Culture in Courtrooms and Classrooms (Toronto: University of Toronto Press, 1998), Chapter 6.

[36] Judith Butler, "Gender Trouble, and Feminist Theory, and Psychoanalytic Discourse," in Linda J. Nicholson, ed., Feminism and Postmodernism, (New York: Routledge), 324.

women struggled to obtain the vote.[37] Riley's insistence that "woman" cannot be studied independently of historical factors is applicable to thinking about race.

Secondly, the objective of scholars such as Riley, Scott and Butler is to demonstrate that women's subjectivities are multiple, malleable and contradictory, and as a result, it is impossible to generalize or make universalistic claims about women as a group. Ironically, this particular argument was made earlier by black and women of colour feminists (and socialist feminists) who pointed to the importance of race, class and gender as dimensions of identity and a major determinant of their social location in society. bell hooks, for example, asserts that "white women who dominate feminist discourse today rarely question whether or not their perspective on women's reality is true to the lived experiences of women as a collective group. Nor are they aware of the extent to which their perspectives reflect race and class biases...."[38] Post-structuralism has reinforced the importance of recognizing the contradictions produced by race, gender and class structures.

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[37] Denise Riley, "Am I that Name? Feminism and the Category of "Women' in History (Minneapolis: University of Minnesota Press, 1988).

[38] bell hooks, Feminist Theory: From Margin To Center (Boston: South End Press, 1984), 3. See also bell hooks, Aint I Woman: Black Women and Feminism (Boston: South End Press, 1981"; Cherrie Moraga and Gloria Anzaldua, eds., The Bridge Called My Back: Writings by Radical Women of Color (Watertown, Mass.: Persephone Press, 1981); Gloria T. Hull, Patricia Bell Scott, and Barbara Smith, eds., All the Women are White, All the Blacks Are Men, But Some of Us are Brave: Black Women's Studies; Trinh T. Minh-ha, Women, Native Other (Bloomington: Indiana University Press, 1989).

Even though this research has been influenced by some post-structuralist theorizing, it differs from it on the question of experience. Speaking specifically about identity and experience, Scott points out that "it is not individuals who have experience, but subjects who are constituted through experience,"[39] and that experience is constituted within language. In this vein, experience of economic uncertainties or racial discrimination does not necessarily shape a person's identity or influence their behavior. This rigorous examination and historizication of these terms means, according to Scott, "that the story is no longer about the things that have happened to women and men and how they have reacted to them; instead it is about how the subjective and collective meanings of women and men as categories of identity have been constructed."[40] According to Scott, the focus should not be on the "things that happened" to black women and their reactions to them, but how their experiences are constituted in discourse. While post-structuralists may discount the possibility of shared experiences among women, the interviews conducted for this project demonstrate otherwise. Even when there were divergences in interpretations and meanings of how "blackness" was lived and constituted in Canadian society, black nurses recognized that their experiences were influenced by the significance of race and other social identities. In other words, the majority of nurses in this study were able to draw commonalties based on their

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[39] Joan W. Scott, "The Evidence of Experience," Critical Inquiry 17 (Summer 1991), 774.

[40] Joan Scott, Gender and the Politics of History, (New York: Columbia University Press, 1988), 6.

experiences of being black nurses in a predominantly white occupation and Canadian society generally. Black women's social realities have been shaped by histories of colonialism, imperialism, slavery and migration. As a group black women have been subjected to racist immigration policies, subordination in various workplaces, racist and sexist ideologies and images that construct them as "Other." Thus, black women's current social positioning in Canadian society cannot be discretely separated from the processes mentioned above and discussed in terms of individual particularities.

While there are some scholars who have taken seriously the criticisms of post-structuralists when dealing with evidence, or to complicate how stories get told, there still exists a political project of writing counter histories that reflect the experiences of women who have been marginalized. Feminists who remain committed to allowing women to name their own reality within a male dominated society have endorsed this particular position. For example, Dorothy Smith, in The Everyday World As Problematic, argues that it is important to examine the everyday reality of women and how their experiences are constituted within and by the power relations in society.[41] Likewise, Patricia Hill Collins's Black Feminist Thought argues specifically for a black feminist standpoint based on the "those experiences and ideas shared by African-American women that provide a unique angle of vision and society."[42] While relying on the category black

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[41] Dorothy Smith, The Everyday World As Problematic: A Feminist Sociology, (Toronto: University of Toronto Press, 1985),110.

[42] Patricia Hill Collins, Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment (New York: Routledge).

woman, Collins maintains that "women do share common experiences, but the experiences are not generally the same type as those affecting racial and ethnic groups."[43] She further contends, "all African women share the common experience of being Black in a society which denigrates women of African descent."[44] While she recognizes that there is a shared commonality among black women, she does acknowledge that the diversity that exists among black women will produce divergent experiences, which shapes how they respond to their oppression. Similar to scholars such as Smith and Collins, I contend that it is important to focus on the things that have happened to women in tandem with their reactions to dealing with the inequalities and obstacles faced.

Telling the Nurses' Story: Using Oral History.

Afua Cooper asks, "Is there a need to study Canadian black women's history? If the answer is yes, then how do we do it, how do we get to it? How do we theorize and construct it?"[45] The questions Cooper raises are especially welcome because they legitimized my own struggles with trying to write about a group of black women at a particular time in Canadian history. At this point, I want to now turn to the usefulness of oral history as a methodology in light of the other sources used for this project. I also want to address some of the issues raised using oral history that pertain to memory,

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[43] Hill Collins, Black Feminist Thought, 236.

[44] Hill Collins, Black Feminist Thought, 379.

[45] Afua Cooper, "Constructing Black Women's Historical Knowledge," Atlantis, 25 no. 1 (Fall/Winter 2000), 39.

interpretation and ethics. First, I begin with a discussion regarding the limitation of the primary sources.

The paucity of resources available on black women necessitates exploring whatever sources are available to try and piece together a narrative of their experiences. In addition to the secondary research already mentioned at the beginning of the chapter, oral interviews were my principal source of primary data, supplemented by archival evidence, yearbooks, and the Canadian Census. Despite their obvious value the textual primary sources did not adequately answer the questions that are central to this research. For example, immigration records were not initially produced for public consumption and thus showed the extent to which immigration officials went to enact policies and regulations to prohibit the entrance of black people to Canada. Other archival sources provided glimpses into the agency of individual nurses and the Canadian Negro Association, which challenged the state racist practices. In addition, the correspondence between various immigration officials, nurse directors, and hospital administrators also give some insights into how these various bodies acted in response to the migration of Caribbean nurses. Despite the information gleaned from archival evidence it remained limited, because it tells the migrants story primarily from the point of view of immigration officers, nursing leaders, or political activists and provided very little information about the nurses themselves.

Another drawback of the immigration record is that immigration officials were principally responsible for defining and constructing ideas about race and "blackness."

The construction of 'blackness" as a category and mainly as a signifier of those deemed unworthy to enter Canada was, for the most part, what these documents show. Sure, Caribbean nurses "as cases of exceptional merit," did not always fall into the category of "undesirables," due to the labour shortage, but there were still attempts to limit how many could enter Canada. Overall, the archival evidence relied on ideas about "blackness," which were linked to biological and scientific explanations that reinforced the inferiority of blacks as not belonging to the "right" stock. Subsequently, blacks were excluded from entering Canada in mass numbers. In other words, trying to find out what "blackness" meant from the perspective of immigration officials revealed the racist ideology and structures of the time period.

At the same time, though, the immigration documents provide only minimal information on how immigrants either from the Caribbean or descendents of black Americans who appropriated "blackness" in ways that were counter-hegemonic to normative discourses that rendered "blackness" negative. While racist ideas relating to "blackness" have been used to justify racial oppression, alternately, "blackness" has been used to instill a sense of pride in peoples and communities. Evelyn Higginbotham and others have pointed out that, race often operates as a "double-voiced" discourse- fortifying both racial subordination and racial affirmation and liberation.[46] Higginbotham contends, "racial meanings were never internalized by blacks and whites in an identical

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[46] Higginbotham, "The Metalanguage of Race," 266.

way."[47] Outside of a few exceptions, the only method available to find out, for example, how black Canadian nurses experienced "blackness" growing up in Canada, and, alternately, how Caribbean nurses conceptualized what it meant to be identified as black upon migration, is to interview them.

Besides the archival sources, I also examined yearbooks to see whether there was any information available on black nurses or women of colour. As a conduit into the culture of nursing, yearbooks through stories, poems, and the various social activities organized by nurses provide a wealth of information especially about white nurses. I selected three yearbooks from nursing schools in Ontario and another in Halifax in the years 1950 to1970. For the Atkinson School of Nursing, for example, based on the socially- constructed features that are often used (however problematic) to identify black and women of colour, I recognized about six nurses of colour who were of Asian heritage, and four black women who graduated from the Atkinson School of Nursing during the period under discussion. Three of the four black women were born in Canada and another was from the Caribbean. Overall, the number of Canadian nurses admitted to the nursing schools was very limited, which was corroborated by the interviewees.

Besides pictures of the graduating classes, images of black nurses were also sporadically included in "candid" photos of different wards throughout the hospitals. The Metropolitan General Hospital, for example, where Bonnie Shadd started her nurse training in 1960 had a record high of six black nurses by 1963. Shadd appeared several

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[47] Ibid.

times throughout the yearbooks during her tenure at the school. Following in the footsteps of her ancestors, Shadd was very involved in the political and social life of the nursing school. In 1962, Shadd was chair of the house committee, a student organization whose goal was act as "police force in residence."[48] She was also the Vice-President of the nursing school student council; its goal was "to provide opportunities for socialization."[49] Shadd was shown having fun with her white colleagues or as a member of a variety of committees. While the pictures are certainly open to multiple interpretations, taken at first glance, they do provide some information about Shadd who passed away several years ago, suggesting her active participation in student life and her place of comfort with her classmates.[50]

The 1971 yearbook also featured pictures of Grace McFarlane who was the class valedictorian of that year. McFarlane's address not only summarized the joys and challenges of nurse training over a three-year period but also provided her perspective on how she viewed the profession and her place within it. Speaking specifically about their third year as nurses McFarlane wrote:

> Our most binding harness, however, is the third one-our education and knowledge. To be sure we have spent three years gathering the basic and essential skills of our trade, but it's just the beginning of a lifetime adventure. We owe it to ourselves to grow and expand as

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[48] Lampadian, The Metropolitan General Hospital (Windsor, Ontario), 1963, 49.

[49] Ibid.

[50] Phone conversation with Adrienne Shadd, Bonnie's niece. April 24, 1999.

> individuals in order to be fully equipped to handle each and every problem that may confront us in our career and our day-to-day existence. Let's make the most of every opportunity and experience that comes our way.51

The information provided by nurses like Shadd and McFarlane allow for some reconstruction, albeit fragmented of their presence in the occupation.

Not all photos reveal black nurses' centrality to hospital life. For example, photographs included in the yearbook from the Toronto Western Hospital throughout the mid 1950s-1970s – which was one of the main recruiters of black nurses' aides and assistants during the post-World War II decades – depicts black nurses as marginalized. Their white counterparts were featured in a variety of social activities throughout the yearbooks, while the black staff looked on. The pictures of black nurses in these yearbooks does testify to their strength and resilience in breaking down barriers in an occupation that up until the late 1940s excluded them from the occupation premised on racist ideologies about their capacity to nurse. Similar to the immigration records, the yearbooks are useful, as they provide some information about black nurses, and indirectly give some idea as to the kind of climate that black nurses worked in. Still, they are unable to provide adequate information about for example, why black women chose nursing, what was their training like, how they integrated family and work, and whether they experienced inequities throughout their tenure as nurses. For Caribbean nurses, yearbooks or the archival evidence about student life does not tell us why they migrated or the

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[51] Lampadian, The Metropolitan General Hospital (Windsor, Ontario), 1971-72, 6.

impact of migration on their sense of self. In order to circumvent the limitations of the sources mentioned thus far, oral interviews were utilized to provide answers to questions that immigration records and yearbooks were unable to.

Oral history has long been accepted as a methodology by feminists because of the challenge of getting women's voice in the historical record. Kathryn Anderson, Susan Armitage, Dana Jack, and Judith Wittner maintain: "Oral history is a basic tool in our efforts to incorporate the previous overlooked lives, activities, and feelings of women into our understanding of the past and the present. When women speak for themselves, they reveal new realities: new experiences and new perspectives emerges. They challenge the 'truths' of the official accounts and cast doubts upon established theories."[52] Feminist scholars, however, are not the only ones to use oral history. Scholars of immigration, Aboriginal and black history have been able to use evidence to shift the focus of inquiry to produce scholarship about groups that have largely been ignored.[53] As with any other methodology, oral history has it own set of issues pertaining to how it is deployed. Some of the concerns raised by advocates of oral history involve memory, the relationship between participants and interviewer, and how the narratives are interpreted once the

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[52] Kathryn Anderson, Susan Armitage, Dana Jack, and Judith Wittner, "Beginning Where We Are: Feminist Methodology in Oral History," in Feminist Research Methods: Exemplary Readings in the Social Sciences (Boulder: West View Press, 1990), 95.

[53] See for example, Kim Marie Vaz, Oral Narrative Research with Black Women (London: Sage Publications, 1997); Gwendolyn Etter-Lewis, "Black Women's Life Histories: Reclaiming Self in Narrative Texts," in Sherna Berger Gluck and Daphne Patai eds., Women's Words: The Feminist Practice of Oral History (New York: Routledge, 1991), 43-58.

interviews are completed. Indeed, interviewers have to come to accept that the narratives are not an unadulterated access to the past, and that we have a role in shaping the interpretation of what is revealed and what is concealed.

With respect to the scholarship on black Canadian and Caribbean women, two authors have employed oral history and both have provided the same rationale for their choice of methodology. In her study, No Burden To Carry: Narratives of Black Women Working Women in Ontario 1920s to 1950s, Brand provides multiple reasons for the use of oral history. She makes the argument that the histories written are a reflection of those who occupy a dominant place in the social organization of Canadian society, who often speak of on behalf of those who are subordinated. According to Brand:

> The dearth of information about and references to Black women's history led me to employ oral history as a method of inquiry. But this was not the only reason: the historical relationship between Black peoples in Canada and the "mainstream" society has been one of subordination, which doubtlessly taints a historical record often written by, and spoken about and interpreted by those who hold power within the relationship. An oral history, therefore, affords a primacy to the opinions and interpretations of the people so subjected.[54]

Makeda Silvera gives a similar explanation in the introduction to her study on Caribbean domestic workers:

> We rarely hear about women like Molly, Irma, Myrtle, Hyacinth, or Angel, and when and if we do learn about their hopes and struggles and vision, it is often heard through the words of others.

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[54] Dionne Brand, No Burden To Carry: Narratives of Black Women Working Women in Ontario 1920s to 1950s (Toronto: Women's Press, 1991), 31.

> It is not their lack of education and lack of writing skills that have served to silence many of these women. It is, rather, that their silence is a result of a society that uses power and powerlessness as weapons to exclude non-white and poor people from any real decision-making and participation.[55]

Instead of interpreting or placing the domestic workers' narratives within some kind of context to demonstrate that oral histories are far from transparent and are shaped by the social and historical context, the authors allowed the women to tell their stories without inferring their own meaning or what they said. This approach is less common because scholars realize that the stories research participants reveal are one of many "truths," but that "...only through interpretation...we can fully understand life stories, paying careful attention to the contexts that shape their creation."[56] For me, it is important to explain and interpret the narratives by using race, class, and gender, which do not inevitably translate into a negation of the nurses' experiences.

What role do I as interviewer have in editing and shaping the meaning of the final end product? Outside of checking for clarity so that the interviewees meaning is clear, and grammatical errors to make the information readable, it is the experiences of the participants that reverberate throughout this project. At the same time, the framework used (namely race, class, gender, professionalism) to analyze the experiences of the nurses means that their voices are not always at the center of the discourse. This

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[55] Silvera, Silenced, 6.

[56] Yvette Y. Kopijn, "The Oral History Interview In A Cross-Cultural Setting: An Analysis of its Linguistic, Social and Ideological Structure," in Mary Chamberlain and Paul Thompson's, Narrative and Genre (New York: Routledge, 1998), 142.

particular position is critiqued by sociologist Dorothy Smith who advocates maintaining the standpoint of interviewees, which enable the subject to be a 'knowing' actor, "... an embodied subject located in a particular historical setting."[57] While recognizing the importance of maintaining the "standpoint" of the women interviewed, oral interviews, like other sources used in this project, cannot serve as the only data, without the use of an interpretative framework. As the spoken word is influenced by social determinants of which the women themselves are often unaware, it is incumbent upon me to acknowledge the historical, social, and political context that produced what they reveal. Moreover, while I accept that the women are indeed "knowers" in their own right, this "knowing" cannot be accepted as the ultimate "truth." Relying on various theoretical orientations to interpret, explain and describe the nurses' narratives helps to make sense of their experiences.

Another issue raised by scholars who utilize oral history pertains to questions of memory and the reliability and accuracy of the interviews. Since, according to, Louis Starr "...memory is fallible, ego distorts, and contradictions sometimes go unresolved...the scholar must test whenever possible, by corroboration from other sources, often including the oral memoirs on the same topic."[58] This argument raised

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[57] Dorothy Smith, The Everyday World As Problematic: A Feminist Sociology (Toronto: University of Toronto Press, 1985), 106.

[58] Louis Starr, "Oral History" in David K. Dunaway and Willa K.Baum, Oral History: An Interdisciplinary Anthology (Tenneesee: American Association for State and Local History, 1984), 5.

some issues for me as it relates to demonstrating the multiplicity of black women's experiences. If the narratives have to be consistently corroborated against each other, where does this process allow for variation? But Anderson, Armitage, Jack, and Wittner's insist that "from the view point of feminist scholarship on women...oral history should involve more than simply gathering accounts from informants...these bits of evidence we collect-subjectively reconstructured lives-contain within them formidable problems with interpretation."[59] The task, the authors continue, is to figure out "what theoretical conclusions to draw from these accounts is the additional and enormous task that oral historians face." [60]

I wanted to resist the pressure of presenting black nurses as a monolithic group, yet I also hoped that there would be commonalities or themes in the stories being told. For example, during the first interview with a black Canadian nurse, she revealed that when nursing schools made a decision to admit black students the school did so in pairs. I was intrigued by this piece of information, and wondered if there was any evidence to corroborate whether this practice was in fact institutionalized. I chose not to interrupt the interviewee or probed further about this practice but wondered whether this information would resurface in other interviews. In a different interview, another black Canadian pointed out that her roommate during training was black. Again, I refrained from seeking

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[59] Anderson, Armitage, Jack, and Wittner, "Beginning Where We Are: Feminist Methodology in Oral History," 97.

[60] Ibid.

further corroboration. The practice of allowing black students to enter nursing in pairs was not necessarily surprising given the fact that black nurses had been excluded from the profession. Admitting black students in pairs, I surmised, could be a multi-pronged strategy to prevent the lone black student from feeling isolated, but to also protect white students from being forced to interact with black students outside of training. Still, I would have felt on surer footing had this information came from the nurses' association minutes as opposed to the nurses I interviewed; somehow I felt this would make the information more legitimate to those who might question the authenticity of memory in the interview process. When another black Canadian nurse mentioned (again without my asking whether she had heard of the practice) that her cousin was accepted at the same nursing school because it was common practice to accept two black students and also explained that with her cousin in residence they could be roommates, I felt vindicated. While this information might seem inconsequential, it reveals much about nursing itself and the climate that black nurses were entering even if they unable to recognize it at the time.

Another concern that I had in relation to the question of memory was how to interpret the narratives that nurses who are currently working tell about the past. The question for me is how does present day issues about nursing influence how these nurses remember the past. Once I listened to several interviews, it became increasingly clear that the nurses drew on a particular discourse. It was obvious that in order to construct their own understandings of what it means to be working in the current climate the nurses

drew on dominant and available discourses of the past and present. For some nurses, there was hardly any recollection of the difficulties they experienced during training, the twelve-hour shifts, harsh disciplinary rules, or the Matrons and Sisters who made their lives miserable. While these nurses did not necessarily forget, they chose to downplay the difficulties they might have faced during the early years. Speaking directly to the issue of participants' desire to forget, Naomi Norquay's argument is certainly applicable to my discussion. She argues that, "the imperative to forget may be one's own choice; forgetting is often socially organized. What is worth remembering and what is to be remembered can be determined and regulated by larger sources and structured and maintained through authoritative discourses." [61]

Given the public discussions about the Canadian health care system and the adverse impact transformations had on nursing, it is not surprising that nurses drew on the discourse that suggests they are overworked, and with hospital budgets being cut that patient care is compromised. This is not to negate what are legitimate concerns about the current state of the occupation but I am more concerned with how the present influence what nurses' recall about the past. Thus, nurses who are currently working (and those who are retired) are often critical of the current direction of the profession. They frequently bemoan the "glory days" when nurses often worked together and stress how caring was central to the occupation. Despite the introduction of technology and unions,

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[61] Naomi Norquay, "Identity and Forgetting," Oral History Review 26, no.1 (Winter/Spring 1999): 3.

there is a nostalgic desire for the past. Being aware of how these various discourses at different times affect how nurses construct their identity helps me to demonstrate how complicated the process of memory selection is.

The entire process of interviewing, transcribing, and interpretation is marked by a number of social factors that determine what the interviewees reveal, my own personal agenda via the questions that are asked during the interview, and, finally interviewees own understanding of their role in the project. As Kristina Minister points out, interviewees also have their own agendas-they have some idea that something is expected of them-thus the interview while it takes place in private, that is, in the homes of the interviewees or some other private area-they are aware that this information is for the public record.[62] Prior to the actual interview, the women were well informed about the project and were given the option of using their own names or pseudonyms, which also influenced what stories they told.

Since I begin from the premise that the stories the interviewees tell are often shaped by larger social forces, but also by whether participants see themselves as being outside of historical events, in the middle or on the periphery, I consider how the interviews proceed (with long pauses, tears, omissions, anxiety, laughter) as part of how the interviewees construct their stories. During several interviews, there were moments when silence would accompany the telling of an incident. Silence was also common

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[62] Kristina Minister, "A Feminist Framework for the Oral History Interview," in Gluck a Daphne Patai ed., Women's Words, 28-29.

when the participants were reluctant or felt uncomfortable in answering certain questions. Sometimes they would respond with "I didn't know." I accepted their responses. In addition, there were also many occasions when interviewees would ask me: "did I answer the question, the way you wanted?" Others worried about whether they were articulate enough, and if the information they provided was useful. On these occasions, I was told by some of the women to make sure that during the writing process I clarified these particular points to ensure that they made sense. Cognizant that others will read this project, it was also obvious that some of the nurses omitted information about their experiences that would taint the occupation. On the other hand, black Canadian nurses in particular who knew they had a story to tell used this opportunity to speak about their accomplishments in nursing, the various contributions of their family members of other black Canadians. These women were not passive recipients in this process but actively chose which part of their memories they chose to share with me.

While paying attention to the deficiencies in oral history, Franca Iacovettta reminds us that acknowledging such limitations "...hardly justifies dismissing [oral history], anymore than the fragmented and biased character of preserved written records should prompt us to abandon the archives."[63] Alice Hoffman further explains that, "one might say that oral history is simply one of among several primary sources also. It is no worse than written records. Archives are replete with self-serving documents, with edited

and doctored diaries and memoranda written "for the record."[64] Thus, I use oral history critically, while being mindful of the importance of language, the cultural and ideological influences that shape the nurses recollections, and issues surrounding subjectivity.

Despite the criticism leveled against those post-structuralists who have adopted the "linguistic turn" in their scholarship and for their inability to develop a political agenda on which to organize against oppression- even if constituted in language –there is much to benefit from the critiques. Scott's caution about how historians utilize evidence is especially constructive when relying on oral histories as a methodology and I have kept these criticisms in mind in relation to how I utilize and reflect on the sources. Posited as authority of their own experiences, there is a concern that the nurses' narratives revealed in the following chapters will be presented -as "uncontestable evidence,"[65] without elucidating how language and narrative constructs meaning within specific contexts. As the interviewer, I need to be aware of how memory operates, which entails addressing how and why the nurses attach meaning or importance to certain events to the exclusion of others while keeping in mind the specificity of ideological and cultural influences on the impact of memory. The use of archival evidence is also subject to similar cautions by

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[63] Franca Iacovetta, "Manly Militants, Cohesive Communities, and Defiant Domestics: Writing about Immigrants in Canadian Historical Scholarship," Labour/Le Travail, 36 (Fall 1995), 227.

[64] Alice Hoffman, "Reliability and Validity in Oral History," in Dunaway and Baum, Oral History: An Interdisciplinary Anthology, 72.

[65] Scott, "The Evidence of Experience," 400.

post-structuralist feminists, that is, as a source it cannot be accepted as self-evident and straightforward factual truth without placing it within a historical context.

In addition, post-structuralist use of discourse analysis is also helpful in terms of thinking about competing discourses. In this vein, the immigration records, while they might be viewed as the "official" discourse, are not the only ones that emerge in deliberations about migration. Discourse analysis helps to also explain why black nurses in this study explained their experiences primarily through a racial lens. Why is the meta-narrative of race to use Higginbotham's terminology, so salient while other social identities and inequities remain obscured or underemphasized? Another important issue pertaining to discourse is how racist discourses about "blackness" which have their origins in the plantation continue to influence, although with some distinctions, constructions of black women in nursing. These representations of black women as "beasts of burden", angry or as troublemakers can be used to elucidate why vocal black nurses are targeted and why others have been dismissed for challenging racism in the workplace.[66] Finally, while black nurses share similar experiences this does not mean that they automatically attach a singular meaning to all their experiences. That is, there is more than one story to tell as the nurses themselves differ based on education, age, training, and whether they were born in the Caribbean or Canada. My goal is to avoid presenting black nurses as a homogeneous group with uniform experiences, or to suggest

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[66] Karen Flynn, "Bridging the Gap: Women's Studies, Women's History, Gender History and Lost Subjects," Atlantis, 25, no.1 (Fall/Winter 2000): 13-90.

that the twenty-five women interviewed in this project reflects the experiences of all black Canadian or Caribbean nurses.

Unlike their white predecessors especially and those in leadership roles who left records of their activities, there is no similar evidence that I am aware of left by black nurses who first broke the colour barrier in nursing. Furthermore, at this juncture, the writing of black Canadian women's history is underdeveloped and the experience of black women remains peripheral to larger feminist goals. Taking into consideration the critiques of post-structuralist and relying on sources however fragmented, the goal of this research is to present the experiences of a group of women whose narratives are indeed worthy of sharing.

Moving beyond this chapter, which introduces the interviewees, and which outlines the various analytical frameworks that inform this research, and builds an argument for employing oral history as a methodology, the next chapter explores identity formation. Drawing primarily on post-colonial and anti-racist scholarship, Chapter two is devoted to exploring how the family and other institutions contributed to identity formation. Here, the nurses discuss their childhood, the gender division of labour in their households, and the significance of the church. In addition, Caribbean nurses discuss the impact of migration on their values and identity. Relying on the use of archival sources, Chapter 3 examines how notions of race and racism were deployed by the state not only to prohibit the entrance of black people to Canada, but also to make distinctions between Anglo Caribbean and Haitian nurses. Ongoing discussions about the migration of

Caribbean and Haitian nurses also included hospitals and individual nurse leaders who had different and often conflicting agendas. In Chapter four, I place the nurses' experiences within two core concepts in medical scholarship, professionalization and proletarianization, to complicate how feminist labour historians have used these terms traditionally. A primary concern in this chapter is to explore how black nurses were situated in an occupation that was undergoing severe transformation, and what were their responses to these changes. In Chapter five, I explore the different ways black women understood and explained their experiences of gendered racism within and outside of the workplace. I also highlight the multiple and creative strategies that these nurses used to resist forms of inequality. The final chapter reiterates the importance of black nurses having their histories written and highlights the divergences and similarities in these women's experiences.

Chapter 2
Family, Education and Migration: Identity Formation among Caribbean and Canadian Black Nurses

What a joyful news, Miss Mattie,
I feel like me heart gwine burs'
Jamaica people colonizin'
Englan' in reverse.

By de hundred, by de t'ousan
From country and from town,
By de ship-load, by de plane load
Jamaica is Englan boun

Dem a pour-out a Jamaica,
Everybody future plan
Is fe get a big time job
An settle in de motherlan.

What a islan! What a people
Man an woman, old an young
Jusa pack dem bag an baggage
An tun history upside dung....[1]

The preceding poem, "Colonisation in Reverse" by Louise Bennett, presents a vivid image of the paradox of the exodus following World War II of over two hundred thousand Jamaicans[2] to England, the "motherland" in which they were traditionally unwelcome. While Jamaicans and other people of colour had migrated to England in

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[1] Louise Bennett, Jamaican Labrish (Kingston: Montrose Printery Limited, 1994), 179-180.

[2] Bennett, Jamaican Labrish, 179.

small numbers earlier, it was only after the post-World War II transformation in the economies of industrialized countries that mass immigration of Caribbean and other people of colour to Britain began. A similar transition occurred in Canada where the modification of post-war immigration laws, especially after 1967, led to the migration of large numbers of South Asians, Chinese and Caribbean people.[3] The next chapter will examine these shifts in state policies in greater detail, incorporating both archival and oral evidence. This chapter draws on the life experiences of Canadian and Caribbean born black nurses to examine the formation, redefinition and reconstruction of their identity. I argue that these women's sense of themselves and changing understanding of their own identities and where they belonged were forged in the social relations and cultural dynamics of work, home, family, schools, and churches. My goal is to demonstrate how identities are reinforced, challenged and contested. The multiplicity of these nurses' experiences influenced by race, class, age and training, cautions against positing a singular notion of identity. Therefore, the notion of identity discussed throughout this chapter is an anti-essentialist one, but recognizes how for various reasons, nurses may perceive, and reinforce or claim a singular notion of an identity at a given time.

Current scholarship stresses that identity is in a constant state of flux: it is fluid and multifaceted, and always in the process of being shaped and re-shaped. Writing about identity, Stuart Hall notes that it is never unified and that in a globalized society, idenity

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[3] B. Singh Bolaria and Peter S. Li Racial Oppression in Canada (Toronto: Garamond Press, 1988).

is "increasingly fragmented and fractured; never singular, but multiple constructed across, different, often intersecting and, antagonistic discourses, practices and positions."[4] The concept of hybridity[5] -the cross over or intermixing of various cultural elements to generate new identities-developed by post-colonial scholars, notably Homi Bhaba and Paul Gilroy, is relevant when examining the narratives of Caribbean and black Canadian nurses. In The Black Atlantic Gilroy argues that the historical movement of black people within, between, and across various diasporic locales, coupled with the intercultural interaction between the dominant cultures, has produced multiple identities, which cannot be articulated as distinctively Caribbean, American or Britain.[6] Similarly, until recently, feminist scholars often posited a singular identity based on the category woman as an explanation for women's oppression. At the urging of black and Third World feminists and post-structuralists, there is now a recognition that a gendered identity needs to be considered along with other axis of difference not merely in an additive way but as integral to feminist analysis. As Daiva Stasiulis states, "the inclusion of race and ethnic differences as lenses through which to understand the diverse experiences of women

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[4] Stuart Hall, "Who needs an Identity," in Stuart Hall and Paul du Gay eds., Questions of Cultural Identity (London: Sage Publications, 1996), 4.

[5] Chris Barker, Cultural Studies: Theory and Practice (London: Sage Publications, 2000), 385.

[6] Paul Gilroy, The Black Atlantic Modernity and Double Consciousness (Massachusetts: Harvard University Press, 1993); Homi Bhabha, Nation and Narration (New York: Routledge, 1994).

reflects a serious intent to represent, and free from oppression, all women."[7] Identity formation is a dynamic and ongoing process that involves discovery and rediscovery-taking from the past, appropriating the present, moving in-between and a preoccupation with elsewhere. Thus, black Canadian nurses' articulation of their everyday realities appears contradictory and fragmented but reflects the realities of living "blackness" in Canada.

To understand the experiences of black Canadian nurses, including the influence of migration, means considering the political, economic and social climate of the Caribbean during the post World War II era. Following independence from Britain, the majority of the English-speaking Caribbean economies depended largely on the export of sugar, bananas, and bauxite and, in the case of Trinidad, oil and tourism. Although investments in the Caribbean during the 1950s and 1960s created what some scholars characterize as a "boom period," the majority of the people did not share in the prosperity of the gross national income. Unemployment was high in most Caribbean regions.[8] With few opportunities locally, growing numbers of women and men began to leave for England, the United States and later Canada. Seeking the opportunity for well-paying

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[7] Daiva K, Stasiulis, "Theorizing Connections: Gender, Race, Ethnicity, and Class," Peter S. Li ed., Race and Ethnic Relations in Canada (Toronto: Oxford University Press, 1990), 281.

[8] Faye V. Harrison, "Women in Jamaica's Urban Informal Economy: Insights from a Kingston's Slum," in Chandra Mohanty, Ann Russo, Lourdes Torres eds., Third World Women and the Politics of Feminism (Indianapolis: Indiana University Press, 1991), 173-196.

jobs in industrialized nations, most Caribbean migrants chose Britain because as members of the British Commonwealth they retained the legal right to enter, settle, and work there.[9] Thus, Caribbean migration is integrally related to the broader processes of uneven development within the Caribbean periphery and the world capitalist system.

Although the Canadian post-war economy was far more buoyant than that of Caribbean nations, black Canadians did not share equitably in post-war prosperity. While discussions of segregation are often made in reference to the Southern United States, Canada too had its set of legal ordinances that prohibited blacks from sharing similar public facilities as whites and from purchasing property. Blacks also experienced difficulty procuring employment.[10] With limited opportunities available to them, blacks were forced to find creative ways to survive as evidenced in the recollections of the women interviewed. Until 1945, Canadian nursing schools refused to accept black students, but even after the war few black Canadian girls were able to achieve the educational pre-requisites or tuition fees needed to be accepted into a nursing program. As with other racialized groups, the climate in which black Canadians lived was not hospitable; this was a period where blacks continued to struggle for basic human rights.[11]

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[9] John Solomos, Race and Racism in Contemporary Society (London: Macmillan, 1989).

[10] Alvin Finkel and Margaret Conrad, History of the Canadian Peoples: 1867 to the present 2nd ed. (Toronto: Copp Clark, 1998).

[11] Constance Backhouse, Colour-Coded: A Legal History of Racism in Canada (Toronto: Osgoode Society, 1999) especially her discussion of Viola Desmond's fight to de-segregate movie theatres in Nova Scotia.

With the exception of Edna Black Searles[12] (who was born in Canada, though her parents had migrated from the Caribbean), the black Canadian nurses in this study are the descendants of ex-slaves, loyalists and free blacks who came to Canada to escape the entrenched racism in the United States that denied them economic, political and social rights. The ancestors of these nurses settled primarily in Southwestern Ontario, and Nova Scotia where they participated in building communities that scholars such as Shirley Yee, Suzanne Morton, Adrienne Shadd, and Peggy Bristow have written about.[13] Two of the nurses in this study were born in Nova Scotia; others were born in Windsor, Maidstone Township and Dresden, Ontario, and another nurse was born in Winnipeg. Hence, the black diasporic experiences as Naz Rassol argues "have their origins in the voluntary and involuntary migration of groups of people from different parts of the world. Scattered and dislocated from their countries of origin these colonial and now post-colonial peoples bring with them their own historical and cultural experiences within which both group

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[12] Edna Black Searles, interview by author, Tape recording, Scarborough, Ontario, 4 September 1999.

[13] See for example, Shirley Yee, "Gender Ideology and Black Women as Community Builders in Ontario," Canadian Historical Review 75 (1994): 53-72; Suzanne Morton, "Separate Spheres In A Separate World: African-Nova Scotia Women in Late-19th Century Halifax County," in Janet Guildford and Suzanne Morton eds., Separate Spheres: Women's World in the 19th-Century Maritimes (New Brunswick: Acadiensis Press, 1994); Peggy Bristow et al., We are Rooted Here and They Can't Pull Us Up: Essays in African Canadian Women's History (Toronto: University of Toronto Press, 1994), chapters 1, 2, and 3.

and individual subjectivities have been shaped."[14] Subjectivities, however, are not only formed in relation to migration, but are also created in various institutions such as the church, educational institutions and the family, sites which are also important to examine.

Learning to be Girls: Family, School and Church in the Caribbean and Canada

Parents' influence over their children is substantial, so it is important to explore the role of family coupled with other institutions in contributing to the formation of identity among these women. What were the expectations that parents had for their children? What life lessons did they impart that shaped their daughters' ideas about women's roles? Furthermore, how did the mothers' position in the family influence how girls saw themselves? Equally important, what expectations did daughters have for themselves? Oral interviews provide a way of addressing questions of childhood memory as it pertains to the understanding of self within the context of adulthood and the processes involved in reconstructing memory.

The gender division of labour across the black diaspora has common configurations with respect to the responsibilities of family members. Whether born in Canada or the Caribbean, the women included in this study reported that girls were encouraged to assume female responsibilities, like their mothers, while their brothers and fathers participated in activities that were defined as male. Even when mothers worked for wages outside of the home or participated in volunteer activities, they were still

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[14] Naz Rassool, "Fractured or flexible identities"? Life histories of 'black diasporic women' in Britain," in Heidi Safia Mirza ed., Black British Feminism: A Reader (London: Routledge, 1997), 189.

expected to take on the additional burden of household work. Once black women entered the world of nursing, especially during their training, they encountered a similar organization of labour as experienced in their households.

Canadian-born Edna Black Searles, the sister of Ruth Bailey, the second black nurse to train and work in a Canadian hospital, described her household in the late 1940s as a "typical West Indian" one. Speaking about the men of her father's generation, Searles emphasized that "some of the men in those days never even knew where the kitchen was," and as result, she often wondered how her father was able to secure a job as a chef working on the Panama Canal. "He went and applied for the job and he got it. So whether the men lived or died, he was the chef and he never boiled water," Searles joked. At the same time, she also acknowledged that her father was a "go-getter" and maintained that upon migrating to Canada, he made certain that he received the formal education required for his position as a chef. Searles father's decision to pursue extended education played a role in his children's desire to pursue their own education and aspirations. Reflecting upon her responsibilities as a girl growing up, Searles remembered:

> We did everything, we did the washing, the cooking, the ironing, anything, so mother would have an easier life. On Saturdays, mother would go down to St. Lawrence Market to get fresh fruit and vegetables. At six o'clock in the morning, and at eight o'clock, we'd go down and meet her, and help with the parcels.

Despite being a chef, Searles's father rarely entered the kitchen. Most of the cooking and other household duties were left up to Searles's mother and her daughters.

The division of labour in Marlene Watson's[15] household was similar, but she was more conscious of the sex segregation of tasks because she had a brother. Until their household had free running water, Watson's brother had to make sure there was enough water in the house and wood for the fires. The girls performed such tasks as keeping the house clean and doing the dishes. On Saturdays, while their mother worked, Watson and her sister Yvonne would head down to the well for water to wash the clothes even though this task was designated for her brother. On the weekends, Watson baked and as expected of the older girls she also had to take care of the younger children. In illustrating the pervasiveness of the gendered division of labour in the household, Watson emphasized "it was always Yvonne and me, and my brother Ivan, he was more or less allowed to run scot free as far as that was concerned, he is a boy, and as far as managing children, it's a woman's responsibility...." Watson remembered the gender division of labour quite early along with divergent expectations that her parents had for their sons and daughters growing up in the late 1940s.

Unlike Watson, Laura Tynes,[16] had a brother who "...didn't do anything in the house in the line of chores." As children in Kentville, Nova Scotia, Tynes's brother had to carry water from the well, while the girls were responsible for the laundry, the cooking and cleaning; tasks Tynes admitted were tedious. Yet, she was hardly perturbed by her

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[15] Marlene Watson, interview by author, Tape recording, Toronto, Ontario, 18 January 2000.

[16] Laura Tynes, interview by author, Tape recording, Mississauga, Ontario, 6 December 1999.

brother's limited responsibilities. Rather, she felt that had her family possessed the modern day appliances purported to make women's lives easier, household chores would have been simpler. While black Canadian girls recognized the gender division of labour in their household, most of the women in this study accepted it as "natural" and did not question the way things were even if they were disadvantaged compared to their brothers in the process.

Besides the gender division of labour in the household that influenced how girls saw themselves and their roles, their lives were also shaped by their parents' economic status in conjunction with the realities of race. Despite the fact that her mother worked occasionally as a domestic and her father as a quarry worker, Tynes's parents' meagre earnings were not enough to support the family. As a result, Tynes's father insisted that as soon as his daughters were old enough he wanted them to find work. According to Tynes:

> [He] would have had us all working as domestics by the time we were thirteen years old, but she [mother] wouldn't hear of that. She was a very ambitious woman, and she expected us to excel in education and do what we wanted, except she wanted one of us to be a nurse.

In explaining her father's urgency in wanting his daughters to contribute financially to their household, Tynes continued, "it wasn't that my father wanted us to be domestics, it's just that he probably found it very difficult to support us and with five children, he was anxious to get us out and let us help." Tynes's father's choice of work for his daughters demonstrated the absence of occupational opportunities available to black women during

this period. Sensitive, however to their family's economic status, Tynes and her sister picked potatoes, strawberries, "anything in the line of farm work," for the people in their neighborhood to earn extra money. When she was accepted to nursing school, Tynes explained with pride how she carried a 22-foot ladder to pick fruits in order to purchase her nurses' uniform and books. The extra money Tynes and her sister earned performing odd jobs eased the pressure on their parents.

Growing up in Dresden, Ontario during the early 1940s, Virginia Travis's[17] father worked as a laborer and a night watchman, in addition to any other odd jobs he could find to ensure that his family did not have to struggle. Since her father's income was neither sufficient nor consistent, Travis's mother also worked a variety of jobs, which included cooking in a nursing home and in the school cafeteria. As soon as her brothers were old enough to work they also began to contribute. Agnes Ellesworth[18] grew up in Maidstone Township outside of Windsor, Ontario, during the late 1930s. She recalled, "we were very poor, we grew up on a farm, we were never hungry, but we didn't have the best of nourishment." Ellesworth maintained that it was only in looking back that she realized the majority of people, including whites, who lived in her community were poor. Like her black Canadian counterparts, Ellesworth's parents worked at odd jobs whenever they could to provide the bare necessities for their family. The prevailing middle-class ideology that men are the natural breadwinners who provided for their families is rarely

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[17] Virginia Travis, interview by author, Tape recording, Windsor, Ontario 5 June 2001.

[18] Agnes Ellesworth, interview by author, Tape recording, Windsor, Ontario 5 June 2001.

applicable to black Canadian families. Without a doubt, the income provided by the mothers and children in this study were essential to the family's survival. The structure and organization of Canadian black families were impacted upon by the larger social and economic processes that placed them in a marginal position, which then impinged on the choices made about work, parenting and even leisure.

Class inequalities definitely played a role in how these young girls experienced growing up in Canada, but it was the contradictions of race and their experience with racism that most shaped and informed their memories. While, black Canadian girls grew up in supportive families that attempted to protect them from the painful experiences of racism, it was sometimes impossible for their parents to explain to their children the complexities of race and racism. Black Canadian girls' consciousness of race was formed within the context of living in segregated Canadian towns, where racism was embedded in all aspects of daily life and reinforced by diverse institutions. As Becky Thompson and Sangeeta Tyagi pointed out: "Living through childhood amid these contradictions [about race] is, in effect, how people *become* raced, since children's exposure to racial contradictions-and their strategies for dealing with them-has everything to do with racial formation."[19] To exemplify the racialized facts of life in Windsor, Frieda Steeles[20] conveyed two experiences that took place in her formative years as a child. One of her

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[19] Becky Thompson and Sangeeta Tyagi, Names We Call Home: Autobiography on Racial Identity (New York: Routledge, 1996), xii.

[20] Frieda Steeles, interview by author, Tape recording, Windsor, Ontario, 9 June 2001.

first memories involved going to a restaurant with her family and being refused service. At the time, Steeles believed her father would intervene and they would be allowed to dine at the restaurant but there was nothing he could do except leave. "That was a horrible experience for me, because I never experienced my father being powerless before," Steeles recalled. When she was nine years old, Steeles's mother attempted to enrol her at the Ursuline School of Music, which was run by Catholic nuns. When Steeles and her mother arrived at the school they were greeted by one of the nuns who was speechless once she saw them; they assumed her mother was white, because, according to Steeles, "she was fairer than me and my father." Unsure as to what steps she should take, the nun then called the Mother Superior for her to make the decision as to whether Steeles would be permitted to attend the school. Although the Mother Superior's refusal was subtle, Steeles's mother immediately knew that racism was the reason behind the nun's decision to deny her daughter the opportunity to play the piano. Her mother refused to acquiesce. Before leaving, Steeles recalled, "my mother took me and she told them about themselves, about their religious self. But she didn't lose her class, she was a very classy person." Despite the fact that segregation was a fact of life in their community, Steeles's mother felt that Christians should be at the forefront of critiquing as opposed to endorsing racism.

Tynes described the town in Nova Scotia where she spent the early years of her life as "a really prejudiced town," with "unfriendly people," where they "were restricted as to where they could go." While some public facilities excluded blacks entirely, the

theatre had a separate section for blacks and whites. Because they loved the theatre, Watson's father allowed his children to attend as a treat on the weekends. Their weekly visits to the theatre, however, served as reminder of their subordinate status as blacks in Nova Scotia:

> Dad would let us go to the theatre on the Saturdays. We had to do our chores before we left. We had to walk 2.5 miles and we got 25c to spend however we wanted, plus 10c for the theatre. I loved the theatre, but being in a hick town they showed a lot of western movies. Most of the movies were cowboy oriented. They used to show some of the love stories with Bing Crosby. There were always too many Westerns. We didn't have a choice, we had to sit upstairs; we were not allowed to sit on the main floor. Blacks were just not allowed to sit on the main floor.

Black Canadian girls' memories of growing up were laced with experiences of racism and its various manifestations. As children, they were denied access to public places and treated differently, while at home they were supported and loved. This contradictory message was especially confusing for Travis, who pointed out how hard it was to "assess how you were treated as a child, when you know there was a difference in how you were treated publicly." Travis's parents attempted to protect their children from racial hatred, and according to Travis did not allow them to "get ice-cream where you were discouraged from eating inside." These compelling stories -- filled with pain, sadness, and confusion -- also demonstrate resilience and resistance and remained a part of the repertoire of recollections for black girls growing up in Canada during the mid-twentieth century. This awareness of "blackness" as having social significance would later shape

the nurses in this study's sense of self, values, ideas about work, and their community involvement within and outside of the black community.

There were commonalities and distinctions between the experience of Caribbean girls and their Canadian-born counterparts with respect to the gender division of labour and issues of race and class. Both groups had no choice in determining how gender roles were constructed in their homes and most took them for granted. While girls were always responsible for household tasks designated for their gender, some of the Caribbean girls managed to escape participating in arduous tasks. In addition, most of the Caribbean nurses did not recall being treated differently growing up in the Caribbean from other girls due to their colour.

In her reminisces of growing up in colonial Jamaica, Monica Mitchell[21] pointed out that based on the standards of the district where she lived, her family would be considered comfortable, though she often referred to them as poor. Mitchell's criteria for determining her parents' class position were that they owned their own home, and had lots of land and cattle. Mitchell's parents also employed a helper although Mitchell admitted that hiring domestics was common in those days due to the meagre wages domestics earned. To further delineate the differences between those who were comfortable and those who were poor, Mitchell continued "I think a marker of not being poor was that I always wore shoes and socks to school and wore uniform to school."

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[21] Monica Mitchell, interview by author, Tape recording, Scarborough, Ontario, 7 April 2000.

Similarly, Lilli Johnson's[22] family employed a nanny and a yard boy. This allowed girls like her and Mitchell to escape some of the household tasks normally reserved for them. Johnson's family also owned "at least one horse at any time" and she often rode around with her father. Unlike the majority of Caribbean and Canadian girls in this study who emphasized the gender division of labour in their household, Johnson remembered that:

> We were brought up to do everything. It wasn't boys and girls. But boys had to clean the shoes. These my father said are things you must do for a woman. I always remember he said, 'never hit a woman, they'll provoke you, but walk away.' That was one hundred years ago, but that was how we grew up.

Though Johnson stated that there were no distinctions in gender roles, there were times when she was expected to do some washing and ironing. Likewise, Guyanese born Jean Harry[23] described her family as middle-class. She had five brothers and was the only girl. Harry vehemently pointed out that there were no gender specific duties in her household that "everyone had to do everything," which included making their beds, helping around the yard as well as the house. While some of the girls noted that a gender division of labour was absent from their household, Antiguan born Jeanette Prince[24] pointed out that it was prevalent in theirs. As a result, Prince and her sisters were vocal in challenging its unfairness:

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[22] Lilli Johnson, interview by author, Tape recording, Scarborough, Ontario, 9August 1999.

[23] Jean Harry, interview by author, Tape recording, Scarborough, Ontario, 9 August 2000.

[24] Jeanette Prince, interview by author, Tape recording, North York, Ontario, 8 October 1999.

> Because all my brothers were older, except for the sixth one, we used to complain because we thought he got away with murder because he had sisters. So he didn't do anything and we'd complain. We [the girls] had to take turns doing the dishes, and we got fresh fish everyday so we had to clean it. I still hate cleaning fish, and didn't do this, and we found it was unfair and we used to complain.... And on Saturdays, we had to do our school uniforms, we had to wash them even though my mother had somebody washing my brothers' shirts, pants, and the sheets and so on... My mother made sure we knew how to iron and that sort of thing.

While she was cognizant of the gender division of labour in her household, Prince was rather surprised to find out that scrubbing floors was viewed as "women's work" because in her household it was the boys/men's responsibility. Laughing, Prince explained her first reaction:

> Until I left home, I thought women did not scrub floors because we didn't do the floors; my brothers and father did that. I remembered going to England and being quite shocked that women scrubbed floors. My father also polished all the shoes. I never polished a shoe in all my life, and so I was taught in every household this is what happened, because in those days we really didn't visit other people's houses-never ate in anybody's house, so I didn't know what went on in other people's houses. I just thought that in their houses, their fathers scrubbed the floors, cleaned up the yard, and polished the shoes because in our house that's what happened.

Thus, certain responsibilities that were constructed elsewhere, as "women's work" were the responsibility of Caribbean men. Jamaican born Lilli Johnson also pointed out that in her household scrubbing floors and polishing shoes were considered "men's work."

In large Caribbean families older girls in particular were expected to care for their younger siblings. Trinidadian born Brenda Lewis[25] was the eldest of ten children and despite the fact that taking care of her siblings impeded her own success as times, she relished the role of being able to assist her mother. Highlighting her responsibilities, Lewis stated:

> I was a bit of a surrogate mother to the younger kids. And because they really looked up to me, you know they see me as a good friend, a counselor, providing guidance to them and also support, encouraging them in whatever activities. It was kind of tough, we were a poor family... It was also tough being the eldest kid, I had to do a lot of household chores. I used to be late for school. My mom wasn't sure whether or not I would be educated, 'or to take education' as she would say. But I was determined to make something of myself and that didn't stop me from doing what I really had to do.

To ensure that her life would be different from her mother's, Lewis's only hope was to pursue an education and avoid having as many children as her mother (Lewis has three children).

Despite the colonial legacy of creating a complex colour hierarchy in the Caribbean that accorded those with lighter skin or whites a higher-class status, only a few Caribbean nurses remembered being disadvantaged by this hierarchical differentiation as children or as young adults. Prince's retelling of her father's experience as a policeman within a system controlled by whites speaks to the intricacies of race, class and power in Antigua. According to Prince, "the police system in Antigua and the whole Caribbean,

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[25] Brenda Lewis, interview by author, Tape recording, Toronto, Ontario, 24 February 2000.

was run on military lines with a Colonel and so on. In those days the Colonel was usually English or a white local." The police system, according to Prince, was corrupt but her father managed to maintain his integrity. "He never took part in all the bribes and stuff that went on. He suffered for it, in that he never made Sergeant whereas all the people he trained did." Prince's father's upward mobility as a police officer was hampered by his decision to remain honest but also because he was a black man. Still, his ability to stand up to his white superiors earned him the respect of the black people within the community. These reminisces of her father "doing what's right" remained etched in Prince's memory and served as a key lesson influencing how she dealt with the various situations that arose later in her own life.

Growing up in rural areas, where there were very few white families, protected some of the Caribbean girls from the colour hierarchy that was more visible in the emerging industrialized areas. Many of the Caribbean nurses pointed out that their understanding of "blackness" racial prejudice, and racial awareness only emerged within the context of migration. In explaining this phenomenon, sociologist Milton Vickerman observes that Caribbean people are referring to "the social meaning attributed to skin colour, rather than to skin itself."[26] Although the legacy of colonialism and slavery has marked people of African descent as inferior in the Caribbean, Vickerman argues, "...in the West Indies, negative attributes have also long attached to black skin, but

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[26] Milton Vickerman, Cross Currents: West Indian Immigrants and Race (New York: Oxford University Press, 1999), 26.

significantly, these have tended to be less pervading and have not acted as an absolute bar to upward mobility."[27] Further, "because of this relative difference, black West Indian immigrants can, in migrating, discover the full implications of anti-black stereotyping. They learn what it means to be "black" because in the transition from one country to another, the social expectations of those having African ancestry are constrained."[28] These insights are also applicable to Canada.

Growing up in the parish of Manchester in Jamaica during the1940s, Mitchell pointed out that she was not exposed to the light-dark skin differentiation. However, once she relocated to Kingston, she immediately recognized the demarcations along class and colour lines. As a teenager, Mitchell remembered how "people with lighter skins got better job opportunities than people with darker skins." Nepotism was also common in that it accorded some people access to certain privileges and jobs. According to Mitchell, one had to have someone "who would pull strings for you." Coming from the country, Mitchell had no connections, and had to work as a clerk in a clothing and dry goods store, which was not commensurate with her educational background.

Moving from a rural area in Jamaica to attend the elite Wolmers' Girls School in Kingston, Johnson, who is dark skinned, was reluctant to discuss the preferential treatment based on skin colour in her school. Instead she downplayed this differentiation by focusing on her educational goals:

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[27] Ibid.

[28] Ibid.

> Our teachers in public school were all right. In high school some were nice and others were not. Some teachers were prejudice [sic]. In Jamaica at the time, some teachers were white, and some were brown-skinned, and there was a lot of favoritism. But you know you had a goal and that was to get that certificate.

Johnson's reaction, according to Vickerman, reflects the complexity of race in Jamaica.[29] He asserts that even though there is a correlation between skin shade and wealth, there is this underlying belief that education is the path to a better life. Caribbean scholar Carolyn Cooper argues that there is a "persistent belief in the instrumentality of book learning as an engine of upward mobility."[30] Most of the other Caribbean nurses spoke highly of their teachers--teachers who were interested in their welfare and had the girls best interests at heart. At the same time, it is important to note that only Caribbean migrants and students who had at least a secondary education and whose parents were in a good position financially could afford to migrate. The luxury of migration was not available to the majority of Caribbean citizens.

In different ways the family, church, and the school system interacted in defining Caribbean and black Canadian girls' individual identities. Since identity formation is an ongoing process that is not fixed, these girls participated in actively negotiating and reshaping identities within and between these institutions. Although in the case of some

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[29] Vickerman, Crosscurrents, 44.

[30] Carolyn Cooper, "Only a Nigger Gal Can!" Race, Gender and the Politics of Education in Claude McKay's Banana Bottom," Caribbean Quarterly, 38, no. 1 (March 1992): 40-54 as quoted in Vickerman, Crosscurrents, 45.

Caribbean students favoritism based on skin colour existed, the school also represented for girls and parents the belief that a "good "education offered the promise to escape from the realities of inequality. Again there were differences in relation to Caribbean and black Canadian girls memories about school.

Tynes's hometown of Kentville, Nova Scotia was racist, but her experiences at school proved the exception to the larger pattern. Except for one teacher whose practices towards black students revealed racist tendencies, she described the teachers as exceptional and it was they who Tynes chose to remember. Of note was her high school principal, Mr. Giles, who made every attempt to treat all students equally. He made certain that Tynes and her siblings were aware of educational opportunities that they might not have otherwise known about.

In contrast to Tynes, Travis's narrative of her experiences with the school system revealed a more harmful history. "There were some negative experiences in public school and high school," she said. Travis was forced to negotiate her survival in a school where sometime students and teachers ignored, dismissed, and belittled her. But Travis's parents taught her at an early age to "only associate with those who want to associate with you, if you identify with someone who didn't identify with you, then you didn't [hang around them]." This advice proved fruitful and Travis "had friends from both races," whom she pointed out, "I chose very carefully." Moreover, the teachers were often biased, and there were those "times when I was not chosen to do certain things, for example, I knew for a school play, it was a racial issue," Travis responded matter-of-

factly. Even though the lead in the school plays were always white, and she was sometimes ignored by some teachers, Travis chose to underscore the positive memories about growing up as opposed to focusing on the more painful situations. Growing up in a household where parents stressed, amidst entrenched racism, that their black children were as capable as whites, Travis and her siblings were encouraged to participate in those extracurricular activities where they were welcomed.

The church has had a significant role in black life since slavery, thus it is not surprising that religion and the church have a unique place in the memories of black Canadian nurses. The scriptural-based life lessons "do unto others as you would have them do unto you," and "honesty is the best policy," were values expounded in the home and reinforced by the church. Excluded and marginalized in the larger community, the black Canadian churches provided leadership and community. Besides being a meeting place for worship, the churches served multiple functions and hosted numerous activities in the community. Searles remembered the Baptist church as an integral component of her life growing up and pointed out that the Biblical teachings of the church served as important tools throughout her life. Illustrating the importance of the church on her outlook on life, Searles explained: "We are all children of God, and if you want to go in the front door, red door or green door, it doesn't matter, we are all one. You're entitled to your beliefs and your ways of living, anything I can do to help, I will help." At the same time, Searles recognized some of the limitations of Christianity:

> One day one of the girls came to me and said, 'I don't know that you are a Christian.' I said, 'well Christians don't have any sign on their door-its in

> your heart and how you live your life, and that's all that matters.' You know the saying, your actions speak so loud but they can't hear what you say; so you have to speak the talk, and walk the walk.

The church was seen as an extension of the family as members participated in instilling Christian values in children.

Steeles declared that her parents embodied the very values of Christianity, "they had a solid system, they were Christians and they practiced it and demonstrated it, it was what that generation did." Steeles, also a Christian, is the first female deacon in an association of ten churches. She was adamant about the significance of the Black Methodist Episcopal Church (BME) to the black community in Windsor, and the reasons for maintaining black institutions:

> Our association was organized in 1841, we were organized because of prejudice, and we decided to move away. As long as racism is alive and well in our communities, we are better able to support each other in our communities because we have a unique understanding of things. When I was a kid everyone went to BME if you were black and that was the centre of our society. We do everything in our church. We are now all over the place, which is good, but it was great that as a people we had our church and there is still some of us that choose to support each other.

Travis also grew up in the church and is currently writing a history of the Baptist church, which has been central to the lives of the black community in Dresden. While four black Canadian nurses remain active in the church, it does not have the same meaning for all of the interview participants. Darlene Barnes[31] and her twin brother were baptized as

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[31] Darlene Barnes, interview by author, Tape recording, Toronto, Ontario, 22 October 1999.

Anglicans even though her mother was Baptist and her father was Catholic. She explained why she left the church after a minister sexually assaulted her brother:

> As I got older I started going to the Anglican Church with my girlfriend. I went to the Anglican Church until we found out that our minister was a homosexual and tried to assault my brother...he must have been about 16 or 17 at that time. He couldn't figure out when they were at camp why everybody was sleeping away from this minister. One day, the only spot that was left for him to lie down was next to [the minister]. [My brother] realized that he was trying to put his hands on him, he jumped up and ran out and everybody, you know, was upset. In the end, [my brother] found out that this guy ... this minister tried it with everybody. We all got together and talked, we felt that there was no way that anybody would believe us if we told them.

Barnes, her brother and friend decided they would quit going to church. While Barnes still believes somewhat in a higher power, her brother identifies himself as an atheist.

Like Barnes, most of the Canadian-born women interviewed included painful or hurtful experiences in their stories of growing up. By contrast, most of the Caribbean-born women emphasized the pleasurable aspects of growing up. Looking back they remembered their childhood as a time devoid of all the conflicts present in today's society. While some parents were strict disciplinarians who used physical punishment to reinforce acceptable behaviour, some of the nurses who endured the strap argued that physical punishment was necessary because it contributed to who they are in the present day as upstanding citizens. They compared their experiences with children who they believe lack obedience and respect, especially towards their elders. Joan Sangster in her study on working women in Peterborough found similar recollections about childhood. She argues that "ideological influences on memory are especially problematic in relation

to childhood. Power relations may be repressed or forgotten, and the expected feelings and cultural images of joy, play and leisure that are associated with childhood may come to shape one's recollections." [32] Despite her admission that, they were very poor, Jamaican born Orphelia Bennett[33] maintained: "We had no electricity, because they didn't have any where we were living. But we had everything we wanted. We had lots of food, lots of love." Bennett's parents often used the strap to punish their children, but they never complained because "we had the utmost respect for our parents." Outside of Johnson who briefly mentioned that her brother might have had some anger problems and Prince who pointed out that her father's stringency accounted primarily for the decision to leave Antigua, most of the women presented an idealized version of their childhood. There was no disclosure of intimate details: no unwanted pregnancies, physical abuse or infidelity. Instead the majority of the nurses described their childhood as "fun."

Recounting growing up in Jamaica, June Heaven[34] had this to say:

> Only yesterday, some friends and I were talking about the many things we used to do as a child that they don't do now. Growing up, it was lots of fun-it really was. But it was a different kind of fun. We didn't have T.V....but I could still remember the first radio. I could remember my mother getting this radio, and of course, all the district people came around to hear this man talking in this box. So for us it was making our

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[32] Joan Sangster, Earning Respect: The lives of working women in a small-town in Ontario, 1920-1960 (Toronto: University of Toronto Press, 1995), 27.

[33] Orphelia Bennett, interview by author, Tape recording, North York, Ontario, 14 October 2000.

[34] June Heaven, interview by author, Tape recording, Rexdale, Ontario, 11 November 1999.

> own fun. A big thing at nights would be my mother telling us stories, so we would all gather around her because there was no T.V.

Heaven also loved attending school and thought it was also "absolute fun." She does not understand why her children disliked school while in Canada. In discussing her own "happy" childhood, Jeanette Prince maintained that the community she grew up in Antigua was a safe one where people looked out for one another. Prince provided the following example to support her point:

> I had a happy childhood. I didn't have to worry about all the stuff kids have to worry about these days, drugs and stuff. You couldn't get up to much because before you got home from school somebody would have already told your mother, 'I saw your daughter up the road there.' So you just finished school and they [parents] have an idea that you should be home by 3:30 p.m. If you are out there by 4:00 p.m. and by the time you planned your story, if you went to pick grape, tamarind whatever. My older sister and I would hang out with her and friends and by the time we got home with our story planned, my mother said, 'you needn't bother. Mrs. so and so saw you up by so and so cutting cane.'

Prince admitted that it is only in retrospect that she appreciated how community members took an avid interest in her when she was younger. At the time, she felt it was a nuisance being watched constantly. For the most part, none of the women identified any tensions within their families. Instead they focused on events that took place such as death or illness, which affected the regular flow of their lives.

How their mothers were positioned in the family was a concern for a significant number of the nurses. As young children, they recognized how disadvantaged their mothers were due to the promulgation of what was accepted as common sense gender ideologies regarding women's role in society. The idea that the family is integral to and

shapes how individuals see themselves and their future is evident in the discussions the nurses had about their mothers. While black Canadian families represented a safe and supportive space from the racism in Canadian society, and while Caribbean families were described as providing fun and memorable childhoods, both groups of women recognized that patriarchal assumptions about women's roles influenced the organization of their families. Joan Sue Mendelson Freeman's findings about the parental influences on the careers of forty women are certainly applicable when exploring how these black women's mothers' influenced the choices their daughters made. Freeman contends that:

> Parent-child relationships are especially critical to one's growing understanding of identity and future. Self-image is subject to many other sources of influence throughout the course of development, but the first impressions emblazoned through the intimacy of family carry considerable weight. Our relationships within the family not only become the prototype for subsequent ones outside but also teach us who we are and what we might expect to do with our lives[35].

Prince maintained that her mothers' life revolved around hard work. The fact that she had 12 children made it difficult for her to participate in any leisure activities until much later in her life. On the other hand, Prince's father was able to attend the dances held for police officers, while her mother remained at home taking care of the family and household. Prince maintained that "in those days, you don't use a baby sister, she [mother] was not expected to go to dances because she was married." Single women and

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[35] Joan Sue Mendelson Freeman, "Parental Influence on Women's Careers," in Paula Dubeck and Dana Dunn, eds., Workplace/Women's Place, 2nd ed. (Los Angeles: Roxbury Publishing, 2002), 28.

married men could attend these dances, which speaks clearly to how gender roles were constructed with respect to public activities and acceptable behaviour for married women. Prince's decision to remain unmarried and childless may well have been shaped by her mother's experience.

Johnson's family's economic position did not translate into an easier life for her mother who she described as a martyr:

> She raised nine of us even though we had a maid, you don't call them maids anymore, you call them helpers now-but sometime they didn't do the work and we had to chip in. But she always wanted to do the work. She impressed upon me, into my subconscious mind, that before I die, I have to talk to women. How they [women] can space their children. I have done it and accomplished it. In those days they didn't know anything about family planning. I am not knocking my mother or my father.

Instead of deriding her parents for having nine children, Johnson understood and elucidated their choices within the context of the time period in which they lived.

Johnson's mother's life was partly the catalyst for her career. It definitely played a role in her decision to return to Jamaica as a response to her mother's wish that she "talk to women." Johnson returned to Jamaica and volunteered at a birth control clinic with the intention of staying two years but remained for six years due to the demands for her services. Recognizing how class shapes access to reproductive information and birth control, Johnson insisted that her clientele be working class and poor women. "The middle class have the information, they don't need anyone to tell them, it's all there for them to get," she stated. Volunteering at the clinic, Johnson was able to utilize her public health nursing and maternal health skills to make a difference in the lives of women who

faced barriers similar to her mother. Armed with few resources, and the only nurse trying to implement a range of health programs with a clientele of more than a thousand people, Johnson was unable to complete the work she began and eventually returned to Canada. This decision caused her great sadness. Even though parents are supposed to be powerful role models who children often imitate as adults, unlike her mother, Johnson remained unmarried and like Prince did not have children.

The traditional division of labour in Carmencita Gomez's[36] household meant that her mother was solely responsible for raising seven children in addition to the daily demands of housework. As the second eldest child, Gomez had a close relationship with her mother, and made every effort to reduce the onerous burden she faced day after day:

> I always felt sorry for mommy and all the children she had, so I was always helping my mother, whether going to the groceries, going to the market. I always find that my mom had a lot to do. As a big sister, I took the role of a little mother with my younger brothers and sisters and up until today, I still maintain it even though we are all adults.

Gomez attributed her desire to be in "a nurturing profession" as stemming from assisting her mother with domestic responsibilities.

Their mothers' experiences shaped these nurses' lives as adults, as they sought a life that was not confined only to the world of domestic work and childrearing. Even though the Canadian-born black nurses' mothers had fewer children than most of the Caribbean nurses' mothers, the native Canadians recognized that their mothers were

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[36] Carmencita Gomez, interview by author, Tape recording, North York, Ontario, 14 October 1999.

over-worked especially in a period when there was no electricity and running water. Searles and Tynes mentioned how they often made an effort to alleviate their mothers' domestic and child-care responsibilities in whatever way they could.

Mothers also used their own lives as a lesson that their children's lives should not replicate theirs. This was obvious in the reminiscences of both groups of women, but more so for the Canadian-born. Watson's mother had expectations for her children that surpassed those she had for herself. Besides her hope that her children would grow up to be law abiding and educated citizens, Watson's mother told her girls, "I don't want any of you children to grow up and be left like me." She insisted that her children's lives should not mirror hers. Watson's mothers maintained that, "I always remember that (her mother's wishes) and I said to myself, 'you'd never catch me scrubbing a white woman's floor.' I made up my mind a long time ago." Some of the mothers also persuaded their children to be nurses because they had not had the opportunity themselves.

Thus, the motivation to choose nursing as an occupation for Caribbean and black Canadian girls was driven by a number of factors including economics, culture, and their early socialization. Moreover, limited career choices for women during the period under discussion meant that girls with the privilege of securing an education would become teachers, nurses or secretaries. Regardless of race, the desire of women to choose nursing as an occupation is rooted heavily in the belief that women possess natural and innate characteristics that intrinsically relate to healing, caring, and nurturing. These beliefs are a result of doctrines propounded in the sermons at church, in the early education of young

girls, and within the household where domestic duties were the responsibility of women. Statements such as "I've always wanted to be a nurse and care for others" were reiterated throughout the interviews. Family members who were nurses and spoke highly of the occupation influenced a few of the women's choice to become nurses. Equally important, nursing was viewed as one of the few occupations available that provided respectability, fulfillment, and reasonable wages in contrast to domestic and secretarial work.

Learning blackness: Migration to Britain

For Caribbean girls who migrated to England to study nursing other factors besides limited career opportunities influenced their choices. England provided the added incentive of academic scholarships to Commonwealth students who were unable to meet the financial requirements for their education. In 1949, for example, at the age of 17, Vera Cudjoe[37] left Trinidad for England on a government scholarship. She applied to the nursing program because "they [England] needed nurses." It took Cudjoe five years to complete her training, four years for her nursing diploma, and another year for a midwifery certificate. Cudjoe remained an extra year, but returned to Trinidad once her training was completed because immigration policies stipulated that students on scholarships had to return to their country of origin once their education was completed. Cudjoe would later migrate to Canada in the early 1960s.

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[37] Vera Cudjoe, interview by author, Tape recording, Toronto, Ontario, 5 January 1995.

When Sandra Ward[38] was in Grade 11 in Dominica a white Canadian woman was invited to her school to talk about nursing. Once the talk was concluded, Ward went to the library and read Hospital Careers for Girls. After completing the book, Ward decided that she wanted to pursue nursing but preferred to study overseas. Her grand aunt then suggested that Ward consider England because she already had family who resided there. Subsequently, Ward applied to a hospital in England and was asked to write a composition explaining why she wanted to practice nursing. She did this and was later approved. Dorothy Jones[39] who emigrated to Britain from Grenada in the mid-1960s, succinctly captured how economic opportunities in Grenada provided very few opportunities for high school boys and girls who turned the thought of migration into "seeking adventure." She states:

> If you didn't have a teaching job, or you didn't have anything, you wanted to make better of yourself, so you had the opportunity to go to England, so it was the excitement, it was like an adventure, something fun. We didn't know what lay ahead of us, we didn't know about snow, what the country was going to be like, well for me, we just wanted to go. It was an experience then for us.

Even though Johnson's parents expected their children to have careers and gave them the impression that they could choose based on their own aspirations this was not the case. When Johnson told her parents that she wanted to be a nurse, her father replied,

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[38] Sandra Ward, interview by author, Tape recording, Toronto, Ontario, 5 January 2000.

[39] Dorothy Jones, interview by author, Tape recording, Rexdale, Ontario, 29 February 2000.

"over my dead body." He felt that "nurses have a hard time," and that his daughter would be more suitable as a teacher. At her father's behest, Johnson went to teachers college and taught for seven years, but she "still wanted to do nursing and serve others." By this time, Johnson's mother had passed away, and in 1954 much to her father's disappointment, she applied to a nursing school in Scotland because she strongly believed that nursing was her calling. Even though immigration literature often points to seeking employment as the primary rationale behind migration, migrants provided other valid reasons for migrating. To make better of one's self," "to get a better life" and "to follow one's dreams" were a few of the other reasons Caribbean students gave for migrating to England. Those who already had families there hoped that the transition to this new place would "not be so bad."[40]

Migration to another country contributes to the process of identity reformation as immigrants attempt to create a home and settle in a strange place learning to adapt and incorporate the worldview and culture of a new society. Furthermore, the perceptions of how immigrants are viewed by the inhabitants of the new country may contribute to how they in turn think about themselves. It is this process of looking at the self that led some immigrants to consciously downplay their own culture and modify or accept the values

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[40] For similar rationale surrounding migration to Britain, see for example, Beverley Bryan, Stella Dadzie and Suzanne Scafe, The Heart of the Race: Black Women's Lives in Britain (London: Virago Press, 1985), Chapter 1; Milton Vickerman, Crosscurrents: Chapter 2: Audrey W. Bonnett, "The New Female West Indian Immigrant: Dilemmas of Coping in the Host Society," in Ransford Palmer ed., In Search Of A Better Life: Perspective on Migration from the Caribbean (New York: Praeger Publishing 1990).

and ideas of the dominant society. Another strand in theorizing identity suggests that in the late twentieth century, the transformation of modern societies impacted upon identities once assumed to be stable, coherent and unified. This recognition of a loss or questioning of self is what Kobena Mercer and other scholars identify as dislocation or the decentering of the subject. Mercer argues, "identity only becomes an issue when it is in crisis, when something assumed to be fixed, coherent, and stable is displaced by experience of doubt and uncertainty."[41] But it was not just "Englishness" and all that it entails that threw these women's lives into conflict. Caribbean girls had to contend with their own inner disruptions. Caribbean girls' migration to England affected their sense of who they were as people who lived in Grenada, Trinidad, and Jamaica. At the same time, British national identity constructed "through the narrative of the nation by which stories, images, symbols and ritual represent 'shared' meanings of nationhood,"[42] was being denaturalised as migrant communities expanded in Britain.

While discussions regarding the destabalization and fracturing of national identities often refer to the globalization of the late twentieth century, this process began as early as World War II. This is clear in the reaction of Britain to the mass migration of Caribbean and Asian immigrants. Avtar Brah writes that despite the economic opportunities available to Asians in Britain, colonialism continued to influence how these

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[41] Kobena Mercer, "Identity and Diversity in Postmodern Politics," in Les Back and John Solomos eds., Theories of Race and Racism: A Reader (London: Routledge, 2000), 503.

[42] Homi Bhabha, Nation and Narration (New York: Routledge 1994).

groups were viewed and situated. Brah states that "as ex-colonial subjects, they once belonged to a country that was once ruled by Britain. From the beginning the encounter between Asian and the white population was circumscribed by colonial precedents."[43] Although Asians and Caribbean people were incorporated differently in Britain, Brah's analysis could be extended to include Caribbean migrants who still had a colonial relationship to Britain. Once immigrants of colour began to arrive in England on a large scale they began to be perceived as a problem. This was reflected in the intense public and private debates about the need to control black immigration that took place within parliament and in the media during the late 1940s and 1950s. Discussions on the impact of immigration on housing, the welfare state, crime and other social problems were abundant, as were concerns about the effect of black immigration on the racial character of the British people and on national identity.[44] It was against this backdrop of increased concern about the influx of immigrants into Britain that these young women from the Caribbean trained and worked as nurses. And it was in this context of that they began to rethink their own identities.

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[43] Avtar Brah, Cartographies of Diaspora: Contesting of Identities (London: Routledge, 1996), 21.

[44] For detailed examples of the impact and responses of black migration to Britain see, Bob Carter, Clive Harris and Shirley Joshi, "The 1951-1955 Conservative Government And The Racialization of Black Migration," and Claudia Jones, "The Caribbean Community In Britain," in Kwesi Owusu ed., Black British Culture and Society: A Text Reader (London: Routledge, 2000).

Migrating to England was difficult for some of the Caribbean girls. Their expectations of England as the land of opportunity (complete with myths of wealth and castles) that circulated in the Caribbean led to feelings of disengagement and loneliness. Unlike her mother's close-knit family back in Dominica where "everybody was everyone sister's and brother," Ward was unacquainted with her father's family in England. The absence of family support and community in Britain left Ward without a buffer against the isolation and loneliness she would subsequently experience. Had her first day in England turned out differently, Ward might have adjusted easier but for her it remained one of the worst days of her life:

> My uncle had to meet me there [at the train station] because the hospital did not arrange for someone to pick me up because it was a holiday. My uncle picked me up, and dropped me off at the hospital. I didn't know that uncle very well, and when he dropped me off, I dropped my bags and cried myself to sleep.

After twenty-one days at sea, Jones waited with anticipation for her brother to pick her up in South Hampton but as she surveyed the surroundings, a sinking feeling settled in her stomach, which she identified as disappointment. Here, Jones poignantly captured her first reaction to Britain:

> The first thing I noticed were the houses, I thought that going to England would have been like the fairy tales, the nursery rhymes right from the books. I thought you'll see castles, and it wasn't like that. I know I wouldn't find the streets paved with gold, but the houses, well, my heart sank, and I thought, 'that's England.' It was also May or June but it was still cold, and I was cold, it wasn't what I expected.

Jones's reaction is not atypical but is indicative of other migrants' response as well. In oral accounts compiled by Wendy Webster, Caribbean women who were versed in colonial literature and fairy tales were shocked to find upon arriving in England that the stories were, for the most part, myths.[45]

Prior to making a decision to migrate in England in 1954, Johnson asked a few of her friends to migrate with her but they refused, so Johnson made the sojourn on her own. Although she was older than Ward and Jones at the time of her migration, Johnson also felt out of place and lonely, but told herself "if I want to go the end of the world and nobody's going with me-I'm still going." Johnson explained that she did desire companionship but recognized "that I have one life to live and I'm going to get on with it." As a child, Johnson's parents moved repeatedly which made it difficult for her to maintain and build close friendships, a disadvantage she sadly acknowledged. The experiences of having few friends made leaving Jamaica and adjusting to her new life somewhat easier.

The ambivalence about England resulting from differences in climate and cultural practices also extended to the demands and restrictions of nurse training. Once she commenced training, Ward recalled that, "there were so many restrictions, you couldn't do this and you couldn't do that," and even though she concurred that some of the

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[45] Wendy Webster, Imagining home: gender, "race" and national identity, 1945-64 (London: UCL Press, 1998).

restrictions were necessary Ward still found it tough to adapt. Ward provided the following example of how her upbringing in Dominica differed from England:

> One time they [the sisters] thought I was rude because I didn't come for supper. They said 'if someone prepare dinner for you then you have to come. I said, I refuse to come.' At home, I was encouraged to say what I feel, you shouldn't be rude, but you should say what you feel. I'm not used to this, if I'm at home, I eat when I want to, if I don't want to eat, I shouldn't have to. I had to conform.

Caribbean girls who had families already established in England had less difficulty adjusting than those who were estranged from, or were reunited with family members they had never met on arrival. Jones, for example, considered herself quite fortunate, because her family served to ameliorate the "strangeness" of England. Highlighting the role her family played in the migration experience, Jones pointed out:

> When my sisters and my brother Nick came for the weekend everybody was together. So you forgot about the coldness and the climate, and the houses, and everything because it was like you were back home, meeting up with everybody, until the Monday morning when they left for work and you were left alone in the house by yourself, and you got up, and you don't know anything. You opened the door and it was cold, the sun was shining, but it was cold. And you are not used to having six-seven people living in one house and those sorts of things. It was an experience, but like my brother say's 'this is England.'

Unlike Jones, Ward's links with her family in Britain were not established. Feeling displaced, she yearned to go "back home." Home for Ward meant not just the familiar physical space that she shared with her mother and siblings, it also meant the geographical space of Dominica, a place, which encompassed in Ward's mind a fixed, unitary origin with a history and culture to which she is intricately connected and where

she was legitimized. As Ward was struggling with settling in England, she met Jenny, a Jamaican student nurse who took it upon herself to get Ward accustomed to living in Britain. It was not an easy task. When Ward broke into tears, Jenny jokingly told her, "next time you cry, I will give you something to cry for," a common Jamaican saying, which meant that Ward's crying, was in fact unwarranted. Whenever Ward insisted on returning to Dominica, Jenny repeatedly told her "you cannot go home, you cannot go home, " because returning home would symbolize failure; the inability to take advantage of the opportunities that the myth of the motherland as the 'land of milk of honey' had to offer. Ward credited her friendship with Jenny as the reason she survived England: "She would take me to her family, and we would have West Indian food, they were so good to me and that really helped..." Ward stated gratefully.

Interestingly enough, Ward's reminiscences of her friendship with Jenny suggest that the cultural affinity, which West Indians forged in England as Caribbean people reduced the antagonisms that existed between the various Caribbean islands. This process of building friendships was based on mutual recognition and affirmation of Caribbean cultures as a result of living in Britain as marginalized peoples. Writer, Claudette Williams points out that "it has been the experience of living in Britain and our struggle against racism which allowed many Caribbean people to learn about neighbouring islands who shared similar colonial histories with the rest of Europe, and forced us to leave some

of those unfounded inter-island rivalries."[46] Thus forming friendships and building alliances with people from other Caribbean countries was utilized as a mechanism to counteract not only racism but also loneliness and alienation. In the process, these women constructed new identities for themselves as Caribbean.

In 1957, at the age of eighteen, Prince left Antigua for England to begin her training as a nurse and to escape her father whose strictness she feared would lead to tensions between them. "I figured if I lived here, I would have gotten into trouble…I don't like conflict" Prince explained. When Prince arrived in England, she too was surprised by the physical landscape and found the "arrogance" of the British people revolting. Prince's initial reaction was to leave England and return to Antigua once her training was completed, but at the same time she wanted to obtain a certificate in midwifery. Prince would have preferred to complete her midwifery training in Scotland, but she had no choice and was forced to do the first portion of her training in West Middlesex, before finally getting to a Scottish hospital. Besides her dislike for the English, Prince added, "I wanted to choose a nursing school that wouldn't have me riding on a bicycle going to places. I wasn't buying any bloody bicycle to go any place in England, that was my criteria for midwifery, and I found one [a nursing school] in Scotland, Kirkcaldy across the river." When she finally arrived in Scotland, Prince's first reaction was:

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[46] Claudette Williams, "Gal You Come From Foreign," in Inderpal Grewal and Caren Kaplan eds., An Introduction to Women's Studies: Gender in a Transnational World (McGraw-Hill Higher Education, 2002), 465.

> I couldn't understand a word they said when I went there first, and the funniest thing, of all, the midwives, none was Scottish, and again, I was the only West Indian, only black person, the rest were Irish, and a few English. But I liked it, I liked the Scottish people, I couldn't stand the English.

Despite having a sister who lived in London, and the more senior nurses who encouraged Prince to continue her education in nursing in England, she returned to Antigua instead.

While it was true that Britain experienced its share of disruption due to the presence of Caribbean migrants, it was also the case that people from the Caribbean also had to grapple with the result of profound change. The process of migrating from the Caribbean to Britain definitely affected how the Caribbean women saw their own cultures, behaviours and expectations within the context of the new country. The idea that identities operate through the exclusion of the "other", and the concomitant "loss of the stable sense of self, "is exemplified in their recollections. The Caribbean-born nurses recalled initial feelings of being "outsiders" and, according to Ward, of having to conform in order to fit in. Thus, migration to a new environment accelerated how identities are reconstituted.

Unlike Canadian-born girls whose racial identity was formed in the early stages of their lives, most Caribbean nurses' awareness of a racial identity emerged with migration and developed over time. It took these women some time before they realized that the meanings attached to blackness were used to exclude them from equal participation in, and access to, resources in Britain. In his discussion of how racism contributed to the formation of a racial identity among Caribbean people in Britain, Winston James argued

that, "Indeed the whole experience of living in a white racist society has helped to forge a black identity where in many cases such an identity did not exist previously or was not consciously thought. The colour of your skin matters here."[47] This realization that skin colour took on the significance it did in England occurred at different moments and contexts for individual nurse-migrants.

Dorette Thompson[48] was the only interviewee to attend high school in Britain and her experience in the British education system was one of confusion, alienation and marginality. Only fifteen at the time she arrived, Thompson found it difficult to attend school. Even though there was a light skinned black British girl in her class, Thompson still felt like an "outsider." She also found it curious that her peers only spoke to her in class, not outside the school. She reflected "it was interesting, and I couldn't understand, they didn't want to be seen talking to a black person, that people might think something, that's what the bigotry was." Fred D'Aguiar, remarking on his journey growing up as a Guyanese child in England, cogently echoed Thompson's experience:

> I had this accent that was not East London, nor South London. Because I spoke rapidly too it was Guyanese, more commonly referred to as West Indian. It made being understood difficult...I felt apart from the other children in my school (Black children included, since they spoke with a Cockney accent and developed an acute sense of my difference...)Why did I feel like the lone 'nigger' in the world when there were other Black

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[47] Winston James, "Migration, Racism and Identity Formation: The Caribbean Experience in Britain," in Winston James and Clive Harris ed., Inside Babylon: The Caribbean Diaspora in Britain (New York: Verso, 1993), 243.

[48] Dorette Thompson, interview by author, Tape recording, Mississauga, Ontario, 17 August 1999.

> kids around? My accent, my newness in the school and area, my lone status that set me apart from the little groups of boys (a boy's school), my reserve....[49]

As black Caribbean immigrants in Britain, Thompson and D' Aguiar occupied multiple subject positions. On the one hand, they all shared with black British people a history shaped by colonialism and "an outsider" status in Britain. For D'Aguiar a boy's school should have been the place where he was validated, except his Guyanese accent coupled with his immigrant status separated him from all the boys regardless of race. Hence, Caribbean youth felt further marginalized because they were born and raised in the Caribbean.

In addition to being ignored by her peers once she vacated the school premises, Thompson had to deal with the racism of individual teachers. The messages she received from them echoed that of the dominant society: only white people, not black people were intelligent. Coming from an environment where she was accustomed to supportive teachers, Thompson's teachers in England undermined her sense of her own capabilities as a student. This affected her sense of self and forced her to think about her racial identity, an issue she had not given much thought to living in Jamaica. Psychologist Beverly Tatum, author of the influential, "Why are All the Black Kids Sitting Together in the Cafeteria? And Other Conversations About Race, argues that black youths' preoccupation with racial identity is a result of how the rest of the world views them. She

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[49] Fred D' Aguiar, "Home Is Always Elsewhere: Individual and communal regenerative capacities of loss," in Kwesi Owusu ed., Black British Culture & Society, 196.

explains, "our self perceptions are shaped by the messages we receive from those around us, and when young Black men and women enter adolescence, the racial content of those messages intensify."[50] The following excerpt from Thompson confirms how some white teachers participated in diminishing immigrant and black students' academic capabilities[51]:

> I got a good background in Jamaica my English was good and I wrote very well. But when I look and saw the reports that I have, I can't believe some of the reports. Some of my reports from school and from college in a sense [state] 'oh, she lacks good command of the English language' and 'how she's come along very well.' I was born speaking English. When I read them, I thought, my God, you know, like an imbecile. I always kept them, because, I can't believe what they wrote about me considering I had a good background in English.

Even though the English speaking Caribbean education system was based on the British system, Thompson maintained that some of her British teachers were ignorant and offered very little support and validation. Here, she recounted another incident regarding an essay she turned in:

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[50] Beverly Tatum, "Why Are All the Black Kids Sitting Together in the Cafeteria?" And Other Conversations About Race (Basic Books: New York, 1999), 54.

[51] Scholars have looked at this phenomenon in different parts of the industrialized world. For Canadian studies see, I. Alladin ed, Racism in Canadian Schools (Toronto: Harcourt Brace, 1996); Esmerelda, Thornhill "Fight Racism Starting With the School", Currents: Reading in Race Relations vol 2 no. 3 (1984), 3-7; Keren Braithwaite, "The Black Student and the School: A Canadian Dilemma," in S. Chilingu and S. Niang eds., African-Continuities/L Heritage African (Toronto: Terebi, 1989), 195-216; George J.S. Dei, "The Challenges of Anti-Racist Education in Canada." Canadian Ethnic Studies 25, no. 2 (1993), 36-51.

> I remember I wrote one essay... that's the time I think one time when I really felt devastated. I really was shocked when I wrote an essay, which was the best essay in the class. I'd never forget, the English teacher was a very bright lady and she spoke French, and she loved Shakespeare and a very good English teacher. She said, 'oh [Dorette] of course I have to read this essay, it was one of the best essays in the class.' She added 'of course [Dorette] is a bit older than most of you.' That's what she did she could not congratulate me on writing a good essay.

Thompson's dream to be a journalist was shattered, "all of a sudden the whole joy went out of writing the good essay because she [the teacher] had to give a reason ... she had to counteract it, I only wrote it because I was about a year or so older than a couple of students.... she made it appear like I was years older," she recalled.

The importance accorded to these various incidences in these women's recollections obviously speaks to there impact; such incidents also raise other issues about belonging and home. Thompson's experiences with the school system mirrored those of black Canadian girls, but there were differences as well. The fact that their racial identity emerged at a younger age helped Canadian-born black girls learn such discordant racial experiences. Furthermore, they also had familial support and the grounding to deal and cope with racism in school and the wider society whereas for immigrants like Thompson this was not the case. The lack of knowledge about racism and how to manoeuvre as a black youth in Britain were important lessons not learned by most migrants until much later in life. As a result, much of her adolescence in Britain was spent in confusion. Thompson pointed out that the scars of living in Britain still remain.

The American Civil Rights Movement and the Black Panthers' message of black self-love and affirmation in the 1960s and 1970s raised black consciousness beyond the borders of the United States. In Canada, Steeles remembered watching television and seeing black people organizing against racial inequality through protests, boycotts and marches. This radical rearticulation of a black identity had an impact both in the Caribbean and Britain. Speaking about the impact of these various movements on her, as a Caribbean migrant in Britain, writer Claudette James notes:

> I was presented with a history, a people and a struggle of which I was a part; and I found that that there was much beauty and pride in being a Black woman. I was able to recognize the significance of pressing my hair and bleaching my skin. While I consciously did not want to be white, everything I learned and was surrounded by told me that to be white was "good," but there for the first time in my life other Black people were addressing me and my personal doubts and inadequacies. I was being told not to be ashamed or afraid of what and who I am.[52]

And while these movements had their internal contradictions with respect to the role of black women, they served a purpose in that they created a new self-awareness among blacks in Britain.

When Darlene Barnes arrived in England in 1971 to train as a nurse, she was not surprised at the overt and covert forms of racism she found in Britain. Even though she had experienced bouts of racism growing up in Canada, Barnes's father warned her that she "would never know true racism until she went to England." Based on his experiences being stationed in Britain during World War II, Mr. Barnes relayed to his daughter the

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[52] Williams,"Gal You Come From Foreign," 465.

intense racism he encountered and attempted to prepare his daughter for what she would face. As well, Barnes's knowledge of the Black Power Movement influenced how she felt, thought and reacted to racism:

> So we are talking in the 70s where Black Power had already come out and people were really rebellious and radical. Although I was never a Black Power person, I just knew that I wasn't going to tolerate that [racism] no matter where I went.

Barnes also pointed out that when she arrived in England, Caribbean migrants were politically active around issues of racism.

Caribbean women did not have to reside in Britain long before they confronted the realities of discrimination. Certainly, the 1958 riots and the ensuing discourse in the media and British Parliament made it hard to ignore the public debates that were taking place. Some nurses experienced racism in Britain first hand, while others learned about it through their families, the media and other people's experiences. For Jones, race combined with gender and age played a role in terms of how she was treated by her peers. Being the youngest nurse in hospital during her training, Jones noticed that even though it was standard practice to use the title nurse along with the first name, her mostly white colleagues ignored this practice when they referred to her. It was not until the head nurse, who was also white, overheard the nurses and openly chastised them that they used the appropriate title.

In addition to the subtle forms of racism that Jones described, black nursing students and nurses also had to also deal with more overt forms of racism expressed by patients, nurses, kitchen staff and cleaners. Jones related the following incident:

> I remember this one woman said to me, 'is it true that black people live in trees'? I used to think these people were so stupid. I used to say 'these white people come to the West Indies and preach Christianity and all sorts of things to us, and when you go to their country, you find out that they are the stupid ones because of the things they would ask and what they could come up with. You'd wonder how could these people think about some things you wouldn't think about.'

Jones continued:

> And they really thought we were monkeys, and they'll talk to you on the floor, but once they got off the floor, they didn't bother with you. But then most of the black nurses knew that's what it was and they cared for themselves...they keep to themselves. At least that's what I did, some of the other black nurses mixed with and had white friends that they were close to and would go out with them.

Jones's experience of racism while working and training in England was definitely not unique. Yet, Jones and her colleagues did not allow themselves to be victimized by racism. Instead they developed survival strategies to deal with the various forms of discrimination they faced working and training as nurses. Jones, for example, chose to socialize with Caribbean nurses when the opportunity presented itself, or she chose to be alone. Some black nurses also socialized with their white counterparts who they felt accepted by and were comfortable with.

Scholar Anima Mama contends that "black people growing up in Britain in the 1950s, 1960s, and 1970s soon learnt that whiteness is very often equated with

Britishness, an equation which puts them in an ambiguous and dislocated position."[53] This outsider status meant that the reality of living in Britain was marked by state violence, lack of upward mobility in certain occupations, and inadequate housing.[54] Bob Carter, Clive Harris, and Shirley Joshi discussed the housing situation in Britain in the 1950s:

> For black people the alternative to council housing was the private sector, and here discrimination, made easier by the relaxation of rent controls in 1954, ensured that only areas designated for slum clearance and or areas with short lease properties were generally available. The difficulties of finding accommodation were underscored by the reluctance of local authorities to implement redeveloping programmes, which might involve rehousing black tenants for fear of antagonizing white tenants who were on long waiting lists.[55]

When she arrived in England during the 1950s nurse Jean Harry was surprised at the level of inequities meted out towards blacks "because [racism] was not something I expected, but it was there," especially in terms of housing. Because she lived in the hospital residence Harry escaped some of the blatant acts of racism experienced by people she knew. For example, she pointed out:

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[53] Amina Mama, Beyond Masks: Race, Gender and Subjectivity (New York: Routledge, 1995), 112.

[54] See for example, Claudia Jones "The Caribbean Community in Britain," in Kwesi Owusu ed., Black British Culture and Society, 49-57.

[55] Bob Carter, Clive Harris, and Shirley Joshi, "The 1951-1955 Conservative Government And The Racialization of Black Immigration," in Kwesi Owusu ed., Black British Culture and Society, 27.

> I personally didn't experience that [racism] looking for room, because I didn't have to. But going with other people to look for accommodations, it was there. They would advertise room for rent: 'no coloureds.' Other times they advertised 'room for rent, or house for rent,' and when you go and they see you are black, they would tell you it's gone and close the door in your face. You would send a white person, they would accept them and say it was available.

In some way, entering nursing protected student nurses from having to find a place to live because they already had their own nursing accommodation. In England, young women from the Caribbean who went to train as nurses learned for the time that blackness was symbolic and had meanings, which were not always positive in mainstream Britain. At the same time, they managed to maintain their sanity by developing various techniques to ensure their survival. These strategies will be discussed in greater detail in Chapter 5.

Identity and Qualifications: Migration to Canada

The same reasons for migrating to Britain were offered to explain nurses' decisions to move to Canada. While the Caribbean region was experiencing high unemployment, none of the nurses in this study made any reference to the lack of job opportunities in the Caribbean as the impetus behind their decision to migrate to Canada. Inez Mackenzie[56] immigrated to Canada from Jamaica in 1960 because her partner, who was attending school in Canada, encouraged her to migrate. According to Mackenzie "things were serious between us" to the point where they were discussing marriage. While her partner pursued his studies at Ryerson Polytechnic University, Mackenzie

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[56] Inez Mackenzie, interview by author, Tape recording, Markham, Ontario, 13 October 1999.

found employment at the Oshawa General Hospital. Once their studies were completed, they were married. Nurses who were single and had no responsibilities viewed migration as a form of adventure. Monica Mitchell was working at the University Hospital in Kingston, Jamaica when her roommate approached her one-day and said, "Monica, we have to start to travel. I just went to the Canadian High Commission, and I've gotten us the applications." Mitchell thought it was a great idea, filled out the forms, and six months later, they left. According to Mitchell, "the world was our oyster and we were having a great time."

Many nurses migrated to Canada after gaining their education and/or experience in Britain. Even though opportunities were available for her to stay in England, Prince refused and returned to Antigua. She found the island changed. Since returning to England was not an option, Prince noticed nursing jobs in Canada advertised in English magazines. She remembered, "I looked them up and found a hospital, I didn't even know there was a London, Ontario till I looked it up and found this hospital looking for nurses, and I wrote and got offered the job. They told me to write immigration and I wrote them." Others recalled hearing of the nursing shortage and migrated because of the wage opportunities; other nurses were encouraged to immigrate because they had family members who were already settled in Canada. Canadian hospital personnel in Britain on a recruitment drive recruited two of the nurses. One of the nurses who made the decision to migrate did so because, "it seemed like the right thing to do." Thus economic uncertainty alone did not determine Caribbean nurses' migration patterns nor was migration driven

by the single goal of earning a better salary. Whether migrating directly from the Caribbean or from Britain to Canada, black nurses encountered new challenges that continued to shape their consciousness as black immigrants.

So far the experiences of black Canadian and Caribbean nurses reveal their changing understanding of identities, which were influenced by immigration, social, economic and political processes. These women articulated a variety of subject positions as they moved from family to school and, in the case of Caribbean nurses, migration to a new country to train and work as nurses.

Even though the nurses interviewed stressed the forging of their racial identity, gender, class, language, place of birth, age and other factors were also constitutive elements in the ongoing formation of identity. Scholars maintain that most migrants are incorporated into industrialized societies as workers but that they articulate their identities in terms of origins, race and ethnicity. While this supposition is generally accurate, Caribbean and black Canadian nurses placed a great deal of emphasis on their identities as nurses. For the nurses in this study, pursuing nursing as an occupation was not only about economic gains, but held personal meaning especially in a modern society where people are often defined by the kinds of work they do.

Whether they trained in the Caribbean, Canada or Britain, at the end of the process, the women thought of themselves as nurses--they assumed the identity that they had been seeking, and had professional confirmation of that status in the qualifications they received. Six of the Canadian-born nurses interviewed trained in hospital-based

nursing schools where they received their diplomas, and were subsequently registered as Registered Nurses (RN). Of the nurses who migrated to Canada directly from the Caribbean, three were Registered Nurses and one nurse had midwifery training. Another had special training in psychiatry. Of the Caribbean nurses who trained in Britain, the majority were State Registered Nurses with Midwifery, and one was a Registered Mental Nurse (RMN). Two of the nurses were State Enrolled Nurses (SEN). Although there were some difficulties with the accreditation process for some nurses trained in the Caribbean and Britain, (which will be discussed in detail in Chapter 4), these women identified themselves not only in terms of their racial identity, country of birth, gender, but also as workers.

Family, Community and Identity in Canada

When Caribbean and black Canadian nurses talk about community what do they mean? Is it possible for Caribbean migrants who have spent the majority of their lives in Canada to refer to the different Caribbean islands as home? And, how does being a person of colour, a racialized "other", contribute to how Caribbean and black nurses identify themselves as well as determine their political commitments? Community, like the nation, is an imagined entity that is given meaning by the political, economic and social processes in which individuals and groups participate. There is no one black community. Race, class, gender, sexuality and a host of other factors divide blacks. Yet, these differences are often subsumed in favour of the idea of a monolithic black community based on shared skin colour or any other phenotype that constructs one as

black. More importantly, shared colonial histories and experiences are also the basis for reinforcing a unitary notion of a black community. Therefore, meanings attached to community and its links to blackness depend on the context, and thus meanings often shift for individual nurses over the duration of their lifetime, a political struggle, or even day-to-day. At this juncture in the chapter, I continue to explore how black identities continued to evolve in Canada drawing comparisons when necessary between Canadian born and Caribbean nurses.

When the first Caribbean migrant nurses (including those who trained in Britain) arrived in Canada in the1960s there were very few blacks in Canada. The 1967 immigration policies, which used skills as opposed to race as criteria to determine eligibility to enter Canada, were not yet in place. Until more blacks arrived in the late 1970s and 1980s black nurses had to develop ways of building community and forming friendships that were not exclusively with other black people or based on island affiliation. Here, Cudjoe provided a glimpse of what Toronto was like in the early 1960s:

> When I came to Toronto, the only other blacks here were students at U of T, and there were some domestic people. I didn't see any black families on the street. If you saw a black person you would be very curious.

Cudjoe pointed out that the Caribbean students at the University of Toronto held dances and invited the nurses. She often looked forward to this. "We'd get to see some black faces among the students, not many, a few." Undoubtedly, the class divisions of the Caribbean were being enacted in Toronto, although in a more subtle form. Those able to study at the University of Toronto were part of the Caribbean elite, people who most

likely had their own servants and did not hold them in high regard. It is not surprising then that nurses, who constituted a professional and respectable group, were invited to the activities organized by Caribbean students at the University of Toronto. On the other hand, the domestic workers, who probably experienced more isolation and working in oppressive conditions compared to the nurses and students, were marginalized in this black community. They were never invited to any such events. Domestic workers although they were from the Caribbean were also 'outsiders' among the 'outsiders'.

At the same time, newcomers to Canada formed communities that submerged race, gender, and sometimes class differences. Discussing the dances coordinated by the YWCA for immigrant men and women, Cudjoe recalled, "it was very multicultural, they catered to everyone. I met a lot of men from Europe who came to work. They included Germans, Hungarians, Italians and we dated some of these people. Some of my friends got married to some of these men." Daphne Bailey[57] who was recruited by Canadian officials during the 1960s socialized at the German Club. "Because there were not any black men then, we used to go out a lot with the fellows there." For nurses such as Cudjoe and Bailey the ability to form mutual friendships and relationships with men and women from other ethnic groups was something they took pride in. "There is not much community among ethnic and racial groups nowadays. Today, we tend to stick to our groups, I wonder what happened," Cudjoe queried.

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[57] Daphne Bailey, interview by author, Tape recording, Toronto, Ontario, 29 May 1995.

Unlike Cudjoe and Bailey who were able to find community among immigrants, Eileen Jacobson[58] was not so fortunate. Jacobson's first years working and living in Brantford during the 1960s were lonely times owing to a lack of social activities. Comparing the differences between Canada and England, Jacobson noted:

> It was much harder socially, over here [Canada] you need a partner, here everyone was getting married... if at twenty-one they [white women] were not married, they thought it was the end of the world. Here it was a couple thing and you did not fit in if you didn't have a partner.

Jacobson further pointed out "In England, the fire fighters would have a dance, and they would invite the nurses, I did not find that here." It took Jacobson some time before she was able to develop meaningful and lasting friendships with other nurses. Eventually Jacobson met and married a white male from Brantford.

All the nurses do not share the conceptualization of a unitary black community because their idea about community has shifted over the duration of their lifetime in Canada. When for example, Myrna Blackman[59] immigrated to Canada in 1971 she immediately noticed that that the Caribbean community in Canada was divided along Island lines, unlike in Britain. In Britain, according to Blackman:

> We were more like a family; there were no distinctions between Jamaicans, Trinidadians, or Grenadians, we all moved as Caribbean. In Canada, however, Caribbean people seem to be going their separate ways...people are no longer friendly, even when you say hello to them.

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[58] Eileen Jacobson, interview by author, Tape recording, Toronto, Ontario, January 1995.

[59] Myrna Blackman, interview by author, Tape recording, Brampton, Ontario, 29 May 1995.

Blackman described this "new" attitude as "you stay in your corner, and I stay in mine," a cold and individualistic attitude which she believed was a Canadian one to which Caribbean immigrants had adapted. For Blackman, a part of Caribbean identity was a feeling, not necessarily based on race or territorial affiliation, but on the common inheritance of shared values. By adapting to a Canadian way of way of life that disregarded the significance of shared values meant, according to Blackman, "we have lost our identity." These, and other changes, Blackman and other Caribbean migrants identified are partly the result of the syncretic merging of cultures.

While most Caribbean and black nurses imagine a unified black community, Gomez emphatically disagrees because she thinks it is not politically constructive when placed within a larger context. Gomez explains that individual communities who isolate themselves miss out on the richness of other cultures as well as the growth that takes place from cross-cultural interaction. As a result, she has no inclination to join any Caribbean or black organization even though she pointed out that one of the disadvantages of being in Canada as opposed to Trinidad is that she has missed being around black people. Still, Gomez maintains, "I don't think I would join a group that promotes blackness, I went to one West Indian group and left because it was a waste of time." When Gomez expressed her view that it would be better for the black community to form coalitions and alliances with other communities with similar political strategies she was dismissed by one gentleman who chastised her for having white ideals. Gomez

would "prefer to join an immigrant society, where people have more in common, where we could fight towards a common goal. We can all march to Parliament Hill, the Greeks, Chinese, and Somalis as a united front." Gomez's response paralleled discussions about segregation that divided the black community during the 19th century.

For Black Canadians, though, forging strong communities was a necessary response to racism in the larger society. Black Canadians credit their own positive sense of self and survival to their community strength. Even though, as retired nurses, their activism has allowed them to work with other communities, they continue to emphasize the importance of a black community especially because of inequalities that continue to plague blacks. Commenting on the importance of the black community growing up, Steeles maintained that "the community contributed to us, it influenced me." Travis pointed out because she has a variety of cultures in her background; she has to move within a number of communities, but identifies herself as black even though others might identify her as "fair-skinned."

An examination of how black nurses responded to belonging to the Canadian nation may in part explain why many choose to reify a monolithic black community. In separate discussions, Canadian scholars Renaldo Walcott and Eva Mackey point to the exclusionary practices involved in the process of constructing the Canadian nation that place some people on the margins of the nation. While the nation is socially constituted and owes its continued development to various social, economic and political processes,

it too is fictionalized. [60] Benedict Anderson cautions that nations "are imagined as limited because even the largest of them...has finite if elastic boundaries, beyond which lie other nations."[61] In using the language of "imagining", theorists like Anderson also understand that the nation is a "real and objective entity" that divides people in real ways. In Canada for example, Walcott argues that black Canadians are "living the in between...conditioned by their inside/outside status; whether 'indigenous black' or otherwise, in-between-ness is Canada is conditioned by a plethora of national narratives, from the idea of the 'two founding peoples,' to multicultural policies, to immigration policies, to provincial and policing practices and so on."[62] Thus, historically being "Canadian" has been synonymous to being white and even though there have been attempts to make the nation inclusive, an "us" and "them" mentality continues to marginalize people of colour.

In this context, Caribbean nurses offered varying testimonies as to where and what constitutes "home": some suggest the idea of multiple homes-here in Canada and there, somewhere in the Caribbean. Others defy ongoing racism and stake their claims to calling Canada home. Still, for most of nurses interviewed (even those who have lived in

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[60] Renaldo Walcott, Black Like Who? Writing Black Canada (Insomniac Press, 1997), 42; Eva Mackey The house of difference: cultural politics and national identity in Canada (New York: Routledge, 1999).

[60] Benedict Anderson, Imagined Communities: Reflections on the Origin and Spread of Nationalism (London: Verso, 1983), 16.

Canada longer than their country of birth) a nostalgic and sometimes contradictory longing for home remains.

Despite being Canadian citizens who have participated in and contributed to the social, economic and political life of Canada, Caribbean-born nurses, for the most part feel displaced and in the words of one nurse, 'transient.' In reflecting on what home means to her, Lewis stated:

> [It's] a place where you feel comfortable, at home and at ease. I feel comfortable here [Canada] to a certain point; when I go back home, I'm myself again; I think people accept me a little bit. I feel comfortable when I'm home because that is where I was born and bred. I'm used to the people there, they are used to you, I'm used to the culture, I am used to that sort of stuff. It's such a more relaxed feeling when I hit the ground back home.

Here, Mackenzie struggles with the notion of what it means to be Canadian and to think of Canada as home in the same way she considers Jamaica:

> I can never change to be Canadian; I will always be a Jamaican. Although I have lived in this country all these years, I don't feel I am a part of this country. Maybe I had to be born here to give me that feeling of being Canadian. I am just a Canadian on paper.

Simultaneously, Mackenzie acknowledges the privileges, benefit and status she has accrued from living in Canada, which might not have been possible in Jamaica:

> I live my life here; it has been a fantastic country. I work hard, they pay me. I have my kids, and I can educate them, I get involved in community, church, the homeless and everything, but there is something about me that I don't feel I am a true Canadian. There is something about the culture.

Even as Mackenzie participates in charitable and social activism, which can be construed as symbolic of being a good Canadian citizen, that sense of marginalization continues to persist. After giving it some thought, in a counter reflection Mackenzie pointed out "there is no true Canadian, because we are all immigrants to this country," but she adds " there are those who, despite being immigrants themselves, were able to fit in. I cannot answer for Canadian Indians but what I see [are] some Europeans who have come here after me, years after me... [They] seem to think they are Canadian and I am wondering how I can't fit in." These conflictual feelings around cultural identity "relates directly to the Caribbean émigrés search for 'rootedness' a sense of historical 'belonging.' This, in turn relates to their historical experience of social displacement and rootlessness grounded in the slave experience and colonization."[63] Yet, in their every day routines these feelings of not belonging are not always at the centre of the nurses' consciousness rather they come to the fore depending on the situation.

When Heaven came to Canada in 1967, her only intention was to attend McGill University and return to Jamaica. Heaven met her then-husband who insisted that they stay in Canada, and after extensive discussion they eventually agreed that once Heaven had children they would return "home," an agreement that never came to fruition. Retired and divorced, Heaven often imagines what direction her life would have taken had she remained in Jamaica:

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[63] Naz Rassool, "Fractured or flexible identities"?, 197.

> When I look at my brothers back home, I always felt they were better off financially, and they stayed at home. Somebody asked 'how do you enjoy living in Canada' and I've always said, I've adjusted to living in Canada. I don't know if I've been able to truthfully say I've totally enjoyed it. By the time you really start to see yourself as living here, I was becoming very much aware of racism.

In addition to racism underpinning her experiences living in Canada and being one of the determining factors for leaving, another issue for Heaven is whether she could live comfortably in Jamaica because she retired at the age of fifty and her current pension is rather limited. Heaven resolved that she would either return to paid work or sell her house; a decision that she emphasized requires her immediate attention.

In today's globalized and transnational world, internet access with news about "home," "inexpensive flights" to the Caribbean which allow regular visits home, and the presence of Caribbean communities in certain enclaves in North America, have made the desire of a permanent return home less urgent for some Caribbean nurses. Here Cudjoe articulates the claims of many migrants at the same time pointing out her own success living in Canada:

> I have grown tremendously as a person and this country; it has been good to me. I've never let the thought of home disturb me. A lot of people say they just came to this country for five years, and they are going home. I never said that because of I'm cool. I can hang out wherever I have to. I went into the arts, then sold mutual funds successfully for five years.

Jacobson, who married a white Canadian, has never really entertained thoughts of returning to Barbados permanently:

> There is something I like about Canada and there are some things I don't like, but I made a choice to live here. Canada is my first home, it's where my husband lives, where I work, all the things that make up home (with the exception of not having blood relatives) are here

She further contendeds that she self-consciously selects from the various cultures that make up Canadian society:

> I am not one of those sentimental people. I tend to pick up what I like from other cultures. I pick the things up that suit me and live with it. I can cook West Indian meals, but I never joined a West Indian Club. I don't see the need for it.

The above statement reflects how the process of hybridization operates on another level. "To belong" does not always translate into an imposition of the dominant culture on immigrants. Nurses such as Jacobson exercise their own agency by making choices to adapt to or reject certain values, ideas, from their own individual islands and from Canada's culture that suite their needs. Moreover, these nurses recognized that despite their feelings of being outsiders at times, it is never consistent. They incorporate remnants of their Caribbean culture into Canadian culture creating a synthesis that is beneficial to them. These uncertainties about home, identity and belonging are indeed a reflection of how identities are complicated and contradictory because as Jonathan Rutherford surmises…"there are no ready-made identities or categories that we can

unproblematically slip into."[64] Since their arrival in Canada, Caribbean nurses have negotiated and continue to negotiate, living at moments in the in-between in order to survive.

Gomez also acknowledged the benefits of living in an industrialized country such as Canada. Because she is gainfully employed, Gomez is able to send remittances home to her parents, and assist her nieces and nephews when she can. Besides sending money home on a regular basis, Gomez was able to assist one of her sister's who needed medical attention; she was able to sponsor her and pay for the cost. The fact that she grew up in a culture where, according to Gomez, sharing and helping is crucial, it is imperative that she continues this legacy even though home is elsewhere. Gomez's kindness and generosity evoked the following response from her mother:

> For all the amount you have given us, you could have saved that, and be rich. Gomez then tells her mother "don't think about it...it is one of the benefits of living in an industrialized society. I can get the most up to date, and I can share with you guys.

At the same time, Gomez also pointed out one disadvantage of living in Canada. For example, when she visits Trinidad, the conversations that take place between Gomez and her sister are spent on comparing the value of both countries. For Gomez's sister, the opportunity to be educated in Canada is a huge benefit. While Gomez concurs with her, she also explains:

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[64] Jonathon Rutherford, "A Place Called Home: Identity and the Cultural Politics of Difference," in Jonathon Rutherford ed., Identity, Community, Culture and Difference (London: Lawrence and Wishart 1990), 25.

> Sometimes I miss having a lot of black people with me and [they have it there], so we have pros and cons to everything. I might have the exposure to industrialized living and whatever but I miss my family, I miss my community. But you can't have it both ways; you take the best from everything.

Being able to send money home and assist family members is not unique to Gomez but is typical among Caribbean nurses who feel that it is their responsibility to assist relatives who remain in the Caribbean.

While some Caribbean nurses speak of displacement, of not belonging, focusing on home in another place, black Canadian nurses' own narratives are different. For them, Canada is home and there is no desire to be elsewhere. Their families struggled to make Canada home, and this is the legacy they have passed on to their children. When Steeles was twelve years old, her father, Halton B. Parker, became the first uniformed black police officer on Windsor's force, and eventually Canada's first black detective. He was involved in various community organizations and pressured the local city government to hire more blacks. Although racism was an integral part of his experiences, Parker epitomized the kind of success that is rare for even the average Canadian. Parker was the recipient of the Order of Canada, Harry Jerome Award and he earned an honorary Doctors of Law from the University of Windsor. Although Steeles' father was in many ways an exception, the other black Canadian nurses parents were also involved in community activism. This is not to suggest that there were moments when black Canadians did not and continue to feel marginalized in ways that are similar to there own

Caribbean counterparts, it is that their sense of belonging is much stronger due to their own sense of Canada as their home.

Nurses, Wives, and Mother

In contrast to the scholarly literature, which has pathologized "the black family", and to feminist characterizations of the family as a site of oppression, anti-racist feminists have insisted that the family has been a critical source of strength and protection. Addressing the importance of black families, Hazel Carby points out, "we need to recognize that during slavery, periods of colonialism and under the present authoritarian state the black family has been a site of political and cultural resistance to racism."[65] In a similar vein, this particular institution has special significance for Canadian born and Caribbean nurses. Yet, there is little Canadian scholarship examining how black women negotiate paid and unpaid labour or on their perspectives on parenting. The interviews completed for this research offer some insights into how Caribbean and Canadian-born nurses organized their own family relations.

The organization and structure of black nurses' families differed on many levels from those of middle-class white families during the 1940s and 1950s. Unlike their mothers whose identities as mother's and wives were paramount, the women in this study were in a much better position to exercise their own reproductive choices. Some of the nurses chose to limit the number of children. Others had none of their own, focusing

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[65] Hazel V. Carby, "White woman listen! Black Feminism and the boundaries of sisterhood" in Heidi Safia Mirza ed., Black British Feminism: A Reader, 46.

instead on adoption or taking an active role in assisting other family members with their children. Clearly some of the nurses responded to memories of their own mothers chafing under the heavy responsibilities of parenting and domestic labour. This probably subsequently influenced their choices about children, work and marriage. In addition, several of the nurses divorced their partners, which would have been unheard of during their parents' lifetime. Divorced nurses, however, chose not to expound upon these details for the interview. One of the most important differences between the experiences of black nurses and their mothers was the meaning and emphasis on paid work. While many young white women had some choice as to whether they would participate in waged labour this was never an issue for black women. Whether or not social conventions of the period dictated that they were expected to work, the nurses in this study did not imagine a life that would revolve primarily around childrearing and domestic work.

The reasons for working provided by the interviewees defy easy generalizations, yet, a few facts were abundantly clear. Most wanted to pursue careers in nursing, teaching, missionary work or, for one nurse, journalism. Taking the life lessons and experiences of their own families while growing up, these women drew on aspects of their parents lives while creating their own unique way of managing family and work. In describing their own work, marriages and families, they avoided mentioning conflicts or abuse of any kind just as they had avoided those subjects in their narratives of growing up.

When I asked the nurses whether they were expected to work, most often responded with this incredulous look on their faces as if to say, "you should already know the answer to such a question." When Travis married, there was never any question that she would work. "We were both career oriented and we wanted to make sure that we had the finances to ensure our daughters were educated past the school level," she maintained. Although there was a gender division of labour in her house, this did not mean that her husband was unable to "do domestic things." According to Travis, her husband supervised the children and assisted with their homework while she was at work. When her daughters were in high school, Travis and her husband was able to hire household help. This was a relief for Travis who wanted to continue her education while remaining active in the black community. Over the years, Travis realized that the requirements of school meant she was unable to keep all of her commitments with respect to community activism, so she had to choose carefully which activities she would participate in. Travis also mentioned that her husband's ill health meant that she had to shoulder more responsibilities at home leaving little time for leisure. It was the death of Travis's sister in 1991 that served as a catalyst for a leave of absence from work, the first time in her career. Traumatized and emotionally drained, Travis was unable to function to her full capacity. Outside of the social identities such as race, gender and class that are given prominence in the scholarly literature, children, marriage, and death are also important because they too can mark changes in terms of the identity process.

Like Travis, Tynes assumed she would work for pay. "I couldn't imagine spending all those years to get through nursing and training giving it up by not working," she stated. Even though Tynes sees nursing as a calling and felt she was an excellent nurse, her life was marred by illnesses and death. While racism was a reality in her growing up, Tynes maintained that the personal tragedy endured by her family made experiences of racism appear insignificant at times. The first tragedy struck when Tynes's sisters died, one at the age twenty-one and the other at thirty-seven. Although she was married for twenty-seven years, Tynes has been a widow for seventeen years. In discussing the impact of these deaths, Tynes was unable to maintain her composure. "Yes it has taken a heavy toll because there has been so much death in my family. Sadness has changed me because I'm basically a happy person, but you see me crying today over death. Yes, it has changed me, and it has had a negative affect on me in many ways." Despite her losses, Tynes pointed out that marriage and having a child also matured and transformed her because she examined the world from the perspective of a mother and parent. She remembered how her mother used to admonish her for taking life as a joke and warned that eventually she would be forced to see how serious life was. Besides dealing with the deaths of her husband and sisters, Tynes's only daughter underwent a number of surgeries--one for a brain tumour and two for hip replacements-the second as a result of complications developed from the first surgery. For four years, Tyne's daughter lived with her until she was well enough to live on her own. While Tynes has seen the seriousness of life, there are moments when despite her mother's warnings she "still

thinks that things are funny and can still laugh about things." Clearly, these painful experiences contributed to the continuing formulation of her sense of self within the confines of the family.

Steeles's situation was somewhat different than Travis and Tynes. When she graduated from nursing school, the agreement between her husband and Steeles was that she would work part-time because they were planning on having a family. Steeles worked several years part-time while taking care of her children. In 1970, Steeles divorced, a revolutionary decision during that period, and she was left with six children. With no credit card and very little finances, she decided to seek full-time employment. By this time, several of her children were teenagers and could assist with household chores. During the interview, Steeles asked whether I could imagine calling Sears to make a purchase only to be told that it has to be authorized by my husband. "Those were the positions women were in," she tells me, stressing how much more fortunate I was to be living in more progressive times.

Like their white Canadian counterparts, the option of not having to work was never an alternative for most Caribbean nurses. Barrett who has three children and has been married for thirty years did not engage in any discussions with her husband as to whether she would work or not. "I didn't think I should to go to school and just stay home ... I didn't ask [husband] because it was not important, I knew I was going to work," Barrett laughed. Unlike some mothers who felt guilty if trying to combine work and motherhood when either appears to take prominence, Barrett expresses no

culpability. "I believe it's the quality time you put in the home with your family," she continues, "when I go out and work and I come in, I give them my quality time, and to me that is more important than staying home all day and still haven't done much for them." Barrett maintained that her long-time commitment and involvement in a number of community activities meant that her husband had to participate equally in childrearing and household work.

A divorced mother with two boys, Heaven pointed that she has grown as a result of the divorce, "I became much more sure of myself. I became self-sufficient, it mattered less what or how people perceive me, not that it didn't matter, it just mattered less. I just went about what I had to do and did it," she explained. Despite the divorce, motherhood was partly fun because Heaven only wanted boys, much to her mother's dismay, Heaven remembered her mother asking "was growing up so terrible for you why you don't want any daughters?" To which she replied "Oh God No!," but explained that "life is too hard for women, it is too one-sided ...I didn't want to bring women into the world." While Heaven was unable to explain further what she meant, her lament that life is difficult for women is far from unusual. Feminist scholars and activists have been instrumental in demonstrating the inequalities that continue to affect women. They point out that despite the gains that women have made, they still lag behind men in terms of wages; women continue to be primarily responsible for childcare and domestic work and violence against women is an ongoing reality. Heaven's own failed marriage and childhood might have contributed to her insights about the role of women and girls in society.

Even though Heaven wanted boys, she did not anticipate all the challenges that parenting brought. Heaven found out that her children encountered racism especially within the schools, which meant that she had to work hard to foster a positive self-image in them. Lewis also verbalized similar sentiments regarding her three children who were born and raised in Canada. While raising her children, Lewis tried to instil in them a sense of belonging in Canada and warned her children that they "need to be prepared to make sure that if an opportunity presents itself [they] are ready to embrace it." Despite the fact that her children are first-generation Canadians, Lewis points out that they feel (especially her son) displaced.[66] Lewis recounted the following conversation with her son to demonstrate what she meant:

> My son he's really big and tall, and I asked him why he doesn't join the [police] force. He responded that the force is very corrupt and [racist] He recognizes that he wouldn't really be accepted, he wouldn't fit in. Right then and there you know he doesn't feel accepted. It's not that they really want to accept you, but it's to make themselves look good. They are recruiting just to have a proportion of us there.

Concerns about racism were not exclusive to Caribbean parents but were raised by black Canadian parents as well. Even though the mothers in this study enjoy middle-class status and are able to provide their children with certain privileges such as private lessons and schools, and assist their children with post-secondary education expenses, the persistence

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[66] Camille Hernazdez-Ramdwar raises some of the issues of belonging and displacement of growing up in Winnipeg. See "The Elusive and Illusionary: Identifying of Me, Not by Me" in Carl E. James and Adrienne Shadd ed., Talking About Identity: Encounters in Race, Ethnicity and Language (Toronto: Between The Lines, 2001), 115-121.

of racism in Canadian society caused anxieties that middle-class white Canadians do not face. Their main concern was how racism would affect their children's sense of self. All worked hard to ensure that their children were valued and supported. Their children's success, however, becomes the testimony to their success as mothers. As one-nurse states, "I have done my best to be a mother."

Even though she has no children, Gomez who is married had concerns not raised by the other women. Gomez found out that in her attempts to emulate western notions of how a household should be ran, which was rather different from what she was accustomed to she ran into difficulties. According to Gomez:

> I was brought up in the Caribbean where the mother-the matriarch is the head of the household, I changed to the western way, where [husband and wife's] responsibilities would be on par with each other, where the man is supposed to do everything.

Trying to establish a household that was egalitarian did not work for Gomez who explained that, "after the first year of my marriage, I realize there are things that are a part of one's make-up, beliefs and cultural norms. I do not want to fight it, I don't want society to predict my behaviour." This period of identity crisis was rather short-lived because Gomez decided to revert to running what she described as a matriarchal household. "In my household, I prepare the meals, I make sure my husband has clean clothes, I do most of the house work," while her husband, an outdoorsman prefers to fix things, she stated. While, Gomez is primarily responsible for running the household, she admits to giving her husband chores to complete on a regular basis. The current

arrangement works better for Gomez who was content with not having to focus on creating a household based on societal conventions, which would cause her discomfort.

Regardless of how individual nurses organized the distribution of labour and responsibility in their own households, most of the nurses interviewed for this research project had achieved a level of economic security greater than their parents. As a group, these nurses had been able to make choices about the size of their families, could support themselves as single women, supported their children's education, owned their own homes and other property, and (for some) were able to send money to relatives in the Caribbean. Black nurses thus achieved the economic stability that marked them as middle class. Equally important, however, they endorsed the social values of "respectability" usually attributed to the middle class, including the value of hard work, education, and moral responsibility. Their understanding of their middle class standing was firmly rooted in their status in the black community. Given that nursing was one of the few skilled occupations available to black women, and given that many black women in the post-war decades continued to rely on domestic labour to support themselves, black nurses were clearly defined as "professional" within their communities. In turn, interview participants believed they had a special obligation to support and "uplift" black Canadian/Caribbean communities. The fact that, today, there continue to be two nurses "on duty" at my church speaks to the continued importance accorded nurses in black communities.

In conclusion, Mary Chamberlain points that "... on the ground, migrant lives are also quite prosaic, concerned with the daily round of work, home and family, as well as

developing and adapting older and cultural patterns and social formations, creating a new syncretic Caribbean culture abroad."[67] These women's narratives provide a window into how diasporic identities and experiences are multi-layered and constituted within and by various institutions as well as larger political, social, and economic forces. These nurses' realities encompass a whole range of experiences that influenced how they not only saw themselves but also their families, and communities and place within Canadian society. Caribbean and black Canadian nurses share similar diasporic experiences based on their identification as black women. At the same time differences abound within the groups based on age, training, and how they are situated in Canada. Even though the black Canadian presence is virtually absent in mainstream discourse, the nurses articulate their own narrative that places them at the centre of Canadian history and development as opposed to on the margins. While Caribbean nurses struggle with belonging in Canada due to the hegemonic construction of Canada as white, they continue to build their own lives and define themselves in ways that can be considered counter hegemonic. Thus, the migration of black peoples to North America, albeit at different historical junctures did "tun history upside down," to use a phase from the Bennett's poem "Colonisation in Return."

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[67] Mary Chamberlain ed., Caribbean Migration: Globalized Identities (New York: Routledge, 1998), 8.

Chapter 3
Race, the Canadian State, and Caribbean Immigrant Nurses, 1950-1968

As part of the black diaspora, Caribbean and Canadian-born black nurses shared many common experiences of family, community, education and work. A key difference between the two groups lay in the migration process. This chapter explores how the Canadian state -- by which I mean governments and their diverse agencies that carry out public policy -- shaped the immigration of black Caribbean nurses. Relying primarily on archival correspondence from the National Archives between 1950-1963 coupled with international scholarship on ethnicity, race and gender in nursing, this chapter explores how the state's agenda conflicted with the agenda of other bodies such as hospitals and nursing organizations. My goal is to unravel the tensions that emerged between nursing organizations, hospitals, and immigration officials, tensions that subsequently shaped the terrain on which migrant nurses worked. More specifically, this chapter focuses on how race was employed and articulated by the different players involved in the migration of Caribbean nurses in order to reveal the flexibility and historicity of this category. Thus, this chapter contributes to the emerging scholarship on race, gender, ethnicity and nursing, immigration history and feminist scholarship on the state.

In her key work on Canada's immigration policy during the 1950s, Agnes Calliste argues that it was structured on class, race, and gender lines. According to Calliste, Caribbean trained nurses who first immigrated to Canada were a "reserve army of

labour"[1] and required parliamentary approval as "cases of exceptional merit."[2] These nurses, Calliste maintains, were viewed as inexpensive and expendable, needed to fill the urgent demand for cheap labour. The racist discrepancy in immigration policies were blatant in that white nurses were allowed to enter Canada as landed immigrants, while Caribbean nurses were admitted as "cases of exceptional merit." Calliste argues that to be considered for landed immigrant status Caribbean nurses were expected to have qualifications that exceeded those of their white counterparts.[3] Calliste's research stands as an excellent starting place for understanding how racist exclusionary policies aimed at people of colour influenced one particular group of working immigrants, nurses. But as this chapter will show, racial ideologies around race, and racial categorization as it pertained to Caribbean immigrant nurses, were complicated and complex involving more than just Immigration Canada as the only player.

Post-war Immigration Policy

The decades following the Second World War were turbulent ones for the Canadian health care system, and that turbulence was intensified by the shortage of nurses that persisted throughout the 1950s and 1960s. Federal funding for hospital construction and the proliferation of state-funded hospital insurance programs increased

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[1] Agnes Calliste, "Women of 'Exceptional Merit': Immigration of Caribbean Nurses to Canada," Canadian Journal of Women and the Law, no. 6 (1992): 87.

[2] Ibid.

[3] Ibid, 95.

the need for hospital staff nurses, at the same time that new employment opportunities for women drew many prospective recruits away from the occupation. Thus, throughout the post-war decades, nursing leaders and educators faced the daunting task of ensuring that there were enough nurses to meet labour demand while at the same time maintaining the standards of the occupation. Funds were allotted for bursaries to encourage high school girls to choose careers in nursing, and nursing organizations introduced short training course for subsidiary workers who required less training and education. Nursing associations attempted to reduce the turnover rate, bring 25,000 "unemployed" nurses (such as those who had stopped working to marry or have children) back into the workforce, decrease emigration and increase migration all to alleviate "the manpower problem in nursing."[4] Yet the arrival of immigrant nurses who were trained and had worked outside of North America produced a new set of challenges for health care administrators.

Efforts to recruit foreign-trained nurses were linked to changes in post-war immigration policy. Before the war and in the years immediately thereafter, Canada had very restrictive immigration rules. Prospective immigrants from "preferred" countries, such as Britain and the United States, were distinguished from those from "non-preferred" countries, who could not be as "readily assimilated." Up until 1962, Canada restricted the immigration of people of colour to Canada due to deep-seated fears that these newcomers would be unable to adapt to Canadian society. According to historian

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[4] Canadian Nurse, "Manpower Problem in Nursing," (August 1967): 26.

John Shultz, Immigration Branch Officials assumed the role of safeguarding Canada's racial purity by protecting it against the influx of undesirable immigrants, which they thought threatened to erode the country's national fibre. Schultz also revealed how Immigration and Citizenship Canada employed racist characterizations of black men as a justification for restricting the migration of black people generally: "the Negro, the common wisdom went, was unassailable. His loose habits, laziness, sexual appetites, lack of manliness and mental deficiencies would pollute the stream of Canadian morals."[5]

For southern and eastern Europeans, immigration regulations had become less restrictive in the early 1950s. Labour needs and public pressure from local and humanitarian groups led to changes in Canadian immigration policies for Europeans affected by the turmoil of the Second World War. Migrants included Polish war veterans, displaced persons from Eastern Europe, and immigrants from Holland, Germany, Italy, and Portugal, who worked primarily as farm workers, domestic workers, nurses, and nurses' aids.[6] In 1952, a new Immigration Act simplified immigration administration, investing a great deal of discretionary power in the hands of government officials. Like its predecessors, however, the 1952 bill continued to prohibit the migration of "coloured," and "partly coloured" persons to Canada. As Vic Satzewich points out, the federal government's category of "... 'partly coloured persons' was restricted to certain classes

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[5] John Schultz, "White Man's Country: Canada and the West Indian Immigrant, 1900-1965," American Review of Canadian Studies 21, no. 1 (1982): 53.

[6] K.W. Taylor, "Racism in Canadian Immigration Policy," Canadian Ethnic Studies 23, no. 1 (1991): 285.

of 'close relatives of Canadian citizens, and cases of exceptional merit...[of] immigrant[s] who will contribute to the social, economic, an cultural life of Canada.'"[7] As well, the Canadian government allowed a small number of domestic workers from the Caribbean to enter on a quota basis in 1955. Despite these minor concessions, however, immigration officials continued to limit the migration of Caribbean migrants based on their supposed inability to assimilate to Canadian culture and climate. People of colour comprised only 5 percent of immigrants up until 1957, with just a 3 percent increase between 1958 and 1962.[8]

In the early 1950s, immigration officials, in conjunction with the Department of Labour, developed a number of initiatives to meet the nation's labour shortages and assist those affected by the war. One of the strategies adopted by Canadian officials was a group movement migration scheme, the purpose of which was two fold: 1) to demonstrate the government's humanitarian response to the situation in Europe and 2) to alleviate the labour shortage in Canada. Nurses' aides and domestic workers from countries like Greece and Germany were encouraged to migrate to Canada. In 1952, the Chief of Operations in Ottawa issued a circular that stressed the need for Greek and German nurses, nurses' aides, and domestics. The circular emphasized that these groups of workers were "in demand and were a continuing need and may be sent in large

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[7] Vic Satzewich, "The Canadian State and Racialization of Caribbean Migrant Farm Labour, 1947-1966," Ethnic and Racial Studies 11, no. 3 (1988): 289.

[8] Taylor, "Racism in Canadian Immigration Policy," 285.

numbers as we can obtain until further notice." [9] Likewise, the Department of the Citizenship and Immigration advised "the German authorities that [they] were anxious to recruit 8,500 agricultural farm workers and 5000 domestics, nurses and nurses aides..."[10] Nurses from Britain, Switzerland, Belgium, and Scandinavia were also welcomed by Immigration Canada "because they had the best schools."[11]

Immigration officials, employment agencies, nursing associations, and individual nursing directors concurred on the necessity of increasing immigration to alleviate the nursing shortage, as well as to support humanitarian relief. A major problem, however, was whether it would be the Department of Citizenship and Immigration or the various provincial nursing associations who would determine whether immigrant nurses had the necessary qualifications to meet Canada's provincially based standard credentials for nursing. Even though Immigration Canada made serious attempts to include nursing, the agendas and protocols of these various bodies were often in conflict. Prior to even considering the Caribbean as a source for nurses, Immigration Canada had to first sort out how it would deal with the migration of European nurses.

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[9] PAC RG 76 vol 626 file 960711, pt 2, reel C-10442, to Chief, Operations Division, Ottawa; fr: C.G.I.M., Karlsuhe, Germany, "Movement of domestics, nurses and nurses aids," 30 October, 1952.

[10] Ibid.

[11] PAC RG 76 vol 626 file 960711, pt 3, to: Eastern District Superintendent, fr: A. Reintam, Placement Officer, "Interview with Dr. Williams Storrar, A/ Superintendent of the Montreal General Hospital," 2 February, 1953.

Federal Policy and European Immigrant Nurses

There was no question about the Canadian Nurses' Association (CNA) and provincial associations' commitment to assisting their European sisters find employment in Canada. As early as 1947, the Registered Nurses Association of Ontario told the province's Minister of Labour that it would accept displaced European nurses.[12] Despite this support, nurses' associations had concerns about whether immigrant practitioners would meet North American standards given the varied meaning behind the term "nurse" in Europe. They worried about the "reported relaxation of laws which would permit the persons calling themselves nursing assistants or nursing aids to be automatically admitted to Canada subject only to the usual health, character and passport requirement."[13] In wanting to "safe guard standards and protect the Canadian people against unqualified practitioners,"[14] the CNA developed a number of guidelines to help immigrant officials assess the new migrant nurses. They also established protocols to help nurses upgrade called the Rehabilitation Plan. A CNA report of 1950 also urged immigration to inform prospective "migrants that once accepted in the rehabilitation plan of the Canadian Nurses Association, [they] are required to spend one year as nursing aides in hospitals."[15]

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[12] PAC RG 76 vol 626 file 960711 pt, 3, reel C-10442, to: Labour for Ontario; fr; the Registered Nurses Association of Ontario, 25 October, 1950.

[13] Ibid.

[14] PAC RG 76 vol 626 file 960711 pt 2, reel C-10442, Canadian Nurses Association Report, circa, 1950.

[15] Ibid.

It explained that "this year of service as nursing aides is a period of orientation to the Canadian nursing way of life, to hospital routine, methods of patient care and language."[16] Once the year had been completed, the Association explained, the immigrant - if recommended by the Director of Nursing - would be classified as a "graduate intern pending exams and registration."[17] The CNA also highlighted the differences among the various provincial associations with respect to qualifications and training. For example, because nurses registered with the General Nursing Council of England and Wales did not have to have training in obstetrical nursing, the province of Manitoba would not grant those immigrant nurses immediate registration status.[18] By contrast, the nurses' registration act in Scandinavian countries allowed for reciprocity, so those immigrant nurses could claim RN status anywhere in Canada. Given regional and national differences in training and registration regulations, the CNA hoped that the 1950 guidelines would reduce the possibility of unqualified nurses entering the occupation.[19]

In spite of the CNA's efforts to guide Immigration Canada, a large number of untrained nurses were allowed to enter Canada. This served as a catalyst for the ensuing tensions between Immigration Canada and some nursing associations around qualification assessment. Quebec's provincial nurses association (QPNA) was one of the

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[16] Ibid.

[17] Ibid.

[18] Ibid.

[19] Ibid.

most vocal critics of federal policy, offering an indictment of the over-seas immigration officials who did not adequately evaluate immigrant nurses. The QPNA, along with the secretary of the CNA in Montreal, filed a complaint with the Eastern District Superintendent of Immigration about the "numerous new arrivals who seek employment as nurses but who were found unqualified to practice."[20] The QPNA explained "that many of these [women] declared that they were issued visas on the strength of their nursing ability and qualifications, and they were disappointed and bewildered when refused employment."[21]

To solve the problem of unqualified immigrants entering the country, the QPNA suggested that, instead of immigrant nurses going through the Department of Citizenship and Immigration, prospective immigrant nurses should correspond directly with the secretary of the nurses' association in the province of intended residence, so the nursing association would then ascertain whether the nurses met the necessary qualifications. The QPNA noted that a similar and satisfactory procedure was in place for nurses migrating from the British Isles and that the results had been satisfactory. From the QPNA's perspective, having applicants contact the association directly would be more effective in determining qualifications. It would also help nursing to retain control over the standards

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[20] PAC RG 76, vol 626, pt 2, reel C-10422, Director, Ottawa: fr: Eastern District Superintendent, "Complaints-Immigrants coming forward as nurses," 9 October, 1951.

[21] Ibid.

of the occupation. [22] Once apprised of the situation, the Immigration Canada's Eastern District Superintendent recommended that "it be drawn to the attention of all visa officers overseas to advise persons desiring entry into Canada to refer to the Secretary of the Nurses' Association in the province of intended residence."[23]

His recommendation was not endorsed. Rather, in 1951 Department of Citizenship and Immigration officials crafted a manual to improve how immigration officials adjudicated immigrant nurses' credentials. Reflecting the CNA's concern, the manual re-articulated how immigration officers should proceed as they assessed the immigrant nurse qualifications. First immigration officials had to "insist upon the production of satisfactory evidence of professional qualifications...."[24] The officers were reminded that, despite the shortage of qualified nurses in Canada, "much disappointment is caused to persons who come in the hope of being able to practice as nurses but who are found to lack some of the professional training required." Furthermore, the manual reiterated the importance of the "utterly misleading title of 'nurse' as it is used in certain countries of Europe" and its connotations in Canada. [25]

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[22] PAC RG 76, vol 626 file 960711, pt 2, reel C-10422, Director, Ottawa; fr: Eastern District Superintendent, "Complaints-Immigrants coming forwards as nurses," 9 October, 1951.

[23] Ibid.

[24] PAC RG 76 vol 626 file 960711,pt 3, to: All Post Abroad (excluding Hong Kong), fr: Chief of Operations, 25 October, 1951.

[25] Ibid.

With these instructions, immigration officers assumed discretionary powers to evaluate the qualifications, experience and training of future nurses. Thus, partially trained nurses who had less than 2 years of training would be granted a visa on the condition that they accept employment as nurses' aides. As such, the chief of immigration pointed out that "examining officers must leave no doubt in the minds of fully qualified nurses that they must expect for a time to be employed in a capacity slightly lower than their professional qualifications warrant at home."[26] Equally important, immigrant nurses were expected to have adequate knowledge of either one of Canada's official languages. Immigration officers were also expected to show some sensitivity to nurses who might react unfavourably to the guidelines. It was incumbent upon officers to assure prospective immigrant nurses that being relegated to a subsidiary position in nursing once they arrived in Canada was not a case of discrimination. In addition to the memorandum, information was provided as to "the [rehabilitation] plan and working conditions in Canada."[27] Even with these clearly delineated guidelines, immigration officers were not always able to assess accurately the qualifications of European nurses. These errors were revealed when individual migrants arrived in Canada

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[26] Ibid.

[27] Ibid.

only to learn that what they believed to be "nursing" was, by Canadian standards, more akin to domestic work.[28]

Immigration Canada's inability to assess professional credentials was most clearly manifest in their group movement schemes. In conjunction with the Department of Labour and other organizations, the Department of Citizenship and Immigration initiated a number of group movements that included Greek nurses, nurses' aides and domestic workers. Initially the Intergovernmental Committee for European Migration (ICEM) set a target of 50 nurses' aides to be identified during its trip to Athens in 1958, but it was able to recruit only 8 nurses' aides. The ICEM assured Immigration Canada that those recruited had excellent qualifications, the "girls would be of superior education and background and will be fully qualified as nurses' aides in accordance with the criteria to be laid down by the province in which they were destined."[29] Of those migrants claiming RN status, the ICEM declared, "in view of the rather superior quality of these [Greek] migrants...[we] will continue to seek applications from them that would satisfy the

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[28] Ibid. For example, the QPNA reported that a German Immigrant named Miss Jasper claimed she was granted a Visa for Canada based on her skills as a nurse and the fact that there was a nursing shortage in Canada. It turned out, however, that Jasper had trained for a few months in Germany as sick children's nurse, a category that did not exist in Canada.

[29] PAC RG 76 vol 847 553-110, pt 2, Report from: Intergovernmental Committee for European Migration (ICEM), to: Helen Washington, Acting Chief, Department of Operations and Transport, "Group movements of Nurses Aides," 10 December 1958.

Registered Nurses Associations."[30] Despite such accolades, Greek nurses had a difficult time integrating in Canadian nursing.

The government's scheme to assist displaced Greek women failed miserably. No sooner had the newcomers begun working in Canadian hospitals than the issues of professional and language qualification came to the surface. A significant number of Greek nurses and nurses' aides could not speak either of Canada's official languages, and that placed them in a precarious position. Miss McLeod, Director of Nursing Services pointed out that speaking English and French were essential l for dealing with human lives and, in a not too subtle criticism of the Canadian immigration effort, remarked that "a British subject would, of course, have no difficulty in this matter."[31] The language barriers had a tremendous effect on the Greek nurses and aides. Of the 26 Greek women recruited in 1961, only 2 advanced from certified nurses' aides to non-registered nurses, while another 2 advanced from nursing aide to certified nursing aide. Commenting on how language skills disadvantaged Greek nurses, an immigration official concluded that while Greek nurses were reliable and well-trained, "the language barriers makes [their] advancement slow."[32] He continued that "few have advanced beyond the level at which

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[30] Ibid.

[31] PAC RG 76 vol 626 file 960711, pt 2, reel C-10442, Department of Citizenship and Immigration, "nursing assistants," 19 December, 1952.

[32] PAC RG 76 vol 847 file 555-110, pt 2, Department of Citizenship and Immigration, Movement of nurses, nurses aides, and household workers from Greece," 6 October, 1961.

they are placed as they are unable to obtain registration, certification, or licensing without demonstrating (their) facility in the use of English."[33] Despite attempts at language training, most Greek nurses were still unable to meet the language requirements advocated by the nursing organizations. As a result, the majority were demoted to domestic workers or were "placed as nurses aides and ward maids as their English was insufficient to ensure they could accept and give instructions accurately."[34]

Frustrated with the difficulty of finding them jobs, the National Employment Services told the Chief of the Settlement Division that Greek nurses almost always entered employment as nurses' aides because of language difficulties. He stated, "until each can demonstrate that she has good understanding of the English language and can take and give instructions in that language, none of the provincial nurses' associations will permit her to practice as a registered nurse."[35] The many difficulties Greek health workers faced led the group recruitment program to be shut down in 1961.[36] Henceforth

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[33] Ibid.

[34] PAC RG 76 vol 847 file 555-110, pt 2, Department of Citizenship and Immigration, "Movement of nurses, nurses aides and household workers from Greece," 6 October, 1961.

[35] PAC RG 76 vol 846 file 555-110, pt 2, to, Mr. L.M. Hunter, Chief of Settlement Division; fr: K.E. Marsh, Assistant Director of Employment, 16 October, 1962.

[36] W.R. Bakersville, Director of Immigration, admitted that "in view of the relatively little success we have achieved with this group, we have decided to dismantle the program as a special movement." PAC RG 76 vol 847 file 555-110, pt 2, to, E. Thompson, Director of Employment Service, fr; W.R. Bakersville, Director of Immigration, "Greek Nurses," 6 July, 1961.

Greek nurse and nurses' aides, like migrants from other European nations, would be dealt with individually and had to go through the same channels as regular immigrants. They would also, where appropriate, complete the necessary language training.[37] Throughout the years the program was in operation, the Department of Immigration and its provincial counterparts downplayed or ignored the CNA guidelines. Indeed, as the example of Greek immigrant nurses show, the state maintained an almost complete jurisdiction over immigrant nurses' entrance into Canada.

As they sought to recruit highly trained nurses, immigration authorities were sensitive to how they were perceived by the governments of countries like Australia. In 1959, Brantford's Hospital Administrator, Mr. Brock Payne placed various advertisements in newspapers in New Zealand, Australia, Holland and Great Britain with the intent on attracting "fully qualified women in the profession."[38] When Payne received 60 applications from Australian nurses, the Australian government and several hospitals protested to Canadian diplomats about these "attempts to attract the Australian-trained nurses overseas."[39] The Australian nursing authorities expressed concern about the loss

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[37] PAC RG 76 vol 847 file 555-110, pt 2, to, E. Thompson, Director of Employment Service, fr; W.R. Bakersville, Director of Immigration, "Greek Nurses," 6 July, 1961.

[38] PAC RG 76 vol 553-107-512, to: Executive Assistant to the Director, fr: Officer in Charge-Hamilton, " Recruitment of Australian Nurses by Brantford Hospital," 23 December, 1959.

[39] PAC RG 76 vol 847, 553-107-512, to: The Under-Secretary of State For External Affairs, Ottawa, Canada, fr: Office of the High Commissioner in Australia, Canberra, A.C.T., "Ontario Hospital calls fro Australian Nurses," 2 December, 1959.

of nurses especially at a time when the country was experiencing its own nursing shortage. Notwithstanding, Brantford Hospital initiated its own recruitment drive in Australia. The Department of Immigration had to then smooth over what was developing as a volatile situation. Laval Fortier, wrote to T.H.E. Hayes, Secretary of the Department of Immigration in Australia, stating "as you know, we have always respected the unwritten understanding between our two countries which takes into account our mutual needs for skilled workers and recognize the futility of trying to attract workers from the another's territory."[40] Laval assured Hayes that "no inducements were being offered, not even the normal operation of our Assisted Passage Loan scheme."[41] Sensitive to the impact of a brain drain on the on the Australian economy, Canadian authorities were able to get Brantford Hospital to cancel their recruitment policy.

Federal Policy and Caribbean Immigrant Nurses

Canadian federal government policies regarding the recruitment of white nurses from western nations stand in stark contrast with its treatment of Caribbean migrant nurses. It was never mandatory- only preferred- for Greek, German and British immigrant nurses to find employment prior their arrival. Indeed, attempts were actually made by the state to help Greek and German nurses find employment prior to immigrating as a way of easing the difficulties associated with migration. The migration of these groups of nurses

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[40] PAC RG 76 vol 847, 553-107-512, to: T.H.E. Hayes, esq, Secretary, Department Of Immigration, Canberra, A.C.T. fr: Colonel Laval Fortier, Deputy Minister of Citizenship and Immigration, Ottawa, 21 December, 1959.

[41] Ibid.

was wholeheartedly supported by the state. The Immigration Department at one point actually made provisions by way of assisted passage, which would allow German and British nurses to finance their trip to Canada. Finally, Canadian plans to encourage, or discourage, migration of nurses were formulated out of Canadian concern for the local economies, which the nurses left. Comparable efforts were never made with respect to Caribbean nurses, most of whom were not considered white. Even after Orders-in-Councils were no longer necessary for Caribbean immigrants, the immigration of Caribbean nurses remained minimal. This was consistent with the exclusion of blacks generally. Finally, despite major language difficulties that affected how migrants integrated into Canadian society, immigration discourses included no question of Greek or German or nurses' admissibility. It was accepted that they would acculturate to Canadian lifestyle, and as result, they were rarely scrutinized in the same way as Caribbean nurses.

While the department of Citizenship and Immigration welcomed Greek nurses and other persons displaced by the war, it discouraged any suggestion that a similar scheme be established for Caribbean nurses, many of whom were struggling with equally uncertain economies. For example, on a trip to Barbados in 1963, a Canadian representative was approached by a Barbados government official about the possibility of allowing three hundred nurses to migrate to Canada to seek employment. In the guise of being concerned, the immigration official raised the issue of a "brain drain" and the disastrous effect this would have on Barbados. In response the Barbados official

explained that the island was experiencing high unemployment rates especially for young people and that migration for many was the only option to secure employment. He emphasized that if Canada could assist in this process it would help Barbados tremendously.

Despite their Commonwealth ties, the Barbadian government official was suspect because he was unable to legitimize the skills and experiences of the nurses in the eyes of the Canadian authorities. The Canadian officials felt that one of the goals of the Barbadian official was to initiate a nursing scheme similar to the Caribbean domestic scheme. Once the Canadian representative returned to Canada, he immediately alerted immigration officials and nursing administrators who were instantaneously suspicious about three hundred Barbadian nurses immigrating to Canada. The Barbadian official made it apparent that unemployment was the reason for proposing the mass migration, but this crucial point was ignored by Canadian immigration officials. Instead the Toronto District Superintendent raised questions about the nurses' qualifications and concluded that Barbados was taking advantage of Canada's immigration policy toward the British West Indies by encouraging the immigration of unqualified nurses who would lower the standards of nursing.[42] Compared to the "8,500 agricultural farm workers, 5,000

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[42] PAC RG 76 vol 553-110, pt 1, to: Central District Superintendent, fr: Chief, Settlement Division

domestics, nurses and nurses aides" that Immigration Canada attempted to recruit from Germany, the 300 Barbadian nurses was remarkably small number.[43]

Although all immigrant nurses potentially faced bureaucratic delays, issues of qualifications were frequently raised to slow down the migration of Caribbean nurses. Caribbean nurses were not the only group of nurses who were expected to meet specific provincial qualification requirements, but immigration officials dealt with each group differently. Take for example, the discussions around the qualifications of British nurses, the largest group of migrant nurses. Alice L. Wright, Executive Secretary for British the Columbia Nursing Association, endorsed the CNA policy that prospective nurse-migrants write directly to the provincial association with whom nurses sought to register. Wright acknowledged that in her experience "a fair percentage of British nurses qualify for registration without having to supplement their training or write tests. A considerable number, however cannot."[44] Winonah Lindsay of Quebec's Nursing Association was equally cautious with respect to British nurses, and reminded federal officials that "no British nurses can be registered under Quebec law without having had obstetrics, because it is written in the law as a required course."[45] Lindsay noted that "any British nurse who

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[43] Ibid.

[44] PAC RG 76 vol 626, file 960711, pt 3, to: Mr. R.M. Winter, Settlement Division, fr: Alice L. Wright, Executive Secretary, 5 February, 1953.

[45] PAC RG 76 vol 626, file 960711, pt 3, to: Mr. R.M. Winter, Settlement Division, fr: Winonah Lindsay, Secretary-Registrar, The Association of Nurses of the Province of Quebec, 9 February, 1953.

does not have the [obstetrics] experience and instruction can only obtain employment as a nurses aide equivalent to the British Nursing Assistants at a considerably reduced salary."[46] Based on this correspondence, it is obvious that British nurses did not always have the necessary qualifications and that nursing leaders recognized the potential problem. Yet, while immigration officials often referred to Caribbean nurses' lack of qualification as a rationale for limiting their migration, at no point does the archival evidence suggest that British nurses as a group were discouraged from migrating.

While immigration officials and members of parliament concurred that immigration was necessary for nation building, questions of race and "whiteness," was never absent from the discussion. Only immigrants who were believed to be able to assimilate were welcomed into Canada. The fact that only 286 nursing assistants from the Caribbean and only 982 graduate nurses gained landed immigrant status between 1954 and 1965 compared to a total of 15, 359 nurses[47] primarily from Britain (which would include some Caribbean nurses) speaks volumes about the ease with which British nurses entered Canada. In spite of the nursing shortage, and the changes to the immigration regulations in 1962 which stressed educational qualifications and skills instead of presumed "assimilability," the migration of Caribbean nurses to Canada was minimal. Such low figures are a clear indication that the state attempted to restrict the migration of Caribbean nurses in direct contradiction to the needs of hospital and nursing

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[46] Ibid

[47] 'Women of 'Exceptional Merit,' 98.

organizations who were interested in procuring the labour to meet the needs of the nursing shortage.

To actively curtail the migration of Caribbean nurses, Canadian immigration officials instituted a number of regulations that made citizenship status dependent on professional qualifications. There is no evidence that these regulations and policies applied to non-Caribbean immigrant nurses. Registered Nurses were issued temporary visas and were considered for landed status only if they upgraded -- meaning they took courses in obstetrics or paediatrics and subsequently passed their exams. Applicants seeking training as nursing assistants were granted entry – though not landed status - only if they could prove that Canadian schools would license or certify them upon graduation had accepted them. [48] This particular policy posed considerable difficulty because only four provinces -Ontario, Alberta, Manitoba and British Columbia - certified and licensed nursing assistants at all. Given this provincial disparity, the Department of Immigration officials reviewed this regulation on certification and concluded that it was ineffective, and abandoned it. Since there was a "continuing shortage of nurses aides in Canada," the department decided, "we no longer require candidates coming forward to schools which certify or license them upon graduation."[49] The change may have been an efficiency measure so that students studying to be nursing assistants did not have to go through a

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[48] PAC RG 76 vol 553-110, pt, 1, to: Acting Chief, Admissions Division, fr: Admissions "B", "Student Nurses Assistant from the British West Indies," 4 July, 1956.

[49] PAC RG 76 vol 553-110, pt, 2, to: Acting Director; fr: Admissions Division, 10, April, 1957.

prolonged immigration process during the time of nursing scarcity. These policies had economic benefits for health care employers because nurses' aides and nursing assistants as opposed to RN's worked for cheaper wages and did not need to be certified or licensed in order to work.

At the same time that immigration officials were anxious to limit the number of Caribbean nurses, the power invested in individual officers sometimes led to inconsistencies. The fact the individual officers were able to make decisions placed Caribbean nurses in a precarious position. In 1956, for example, the Acting Chief for the Immigration Admissions Division had sent a memo advising his colleagues to refuse entry to students and nursing assistants from the British West Indies unless they had been accepted to a program, which "led to a degree of Registered Nurse which could be acceptable to the Provincial Nursing Association."[50] Yet at the same time that this memo was issued, the Immigration Department issued temporary visas to two women who had been accepted for training as nursing assistants at Norfolk General Hospital in Simcoe, Ontario, on the grounds that "these were exceptions and must not be taken as precedents." As officials were granting these minor concessions to individuals, in the late 1950s there were an "increasing number of [Caribbean] nursing assistants who...were applying for landing."[51] Immigration officials' fear of an influx of black nurses often led

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[50] PAC RG 76 vol 553-110, pt 1, to: Acting Chief, Admissions Division, fr: Admissions "B", "Student Nurses Assistant from the British West Indies," 4 July, 1956.

[51] PAC RG 76 vol 553-110 pt 1, to: Deputy Minister, fr: Director of Immigration, "Negro Male Nurses and Nurses Assistants," 9 October, 1956.

to reactionary measures to minimize the number of Caribbean nurses applying for permanent status once they were in Canada. At the same time, the fact that the two nursing assistants were allowed temporary entry on an exceptional basis confirms the contradictory nature of Canadian Immigration as it dealt with the migration of Caribbean nurses and hospital demands for nursing labour. It comes then as no surprise that in 1960 an immigration official admitted that "our procedures for dealing with applications from the West Indies nurses seems to have just developed overtime through practice over the past few years without there having been any specific instruction on the subject."[52] The absence of concrete policies and regulations impacted upon Caribbean nurses in multiple ways ranging from outright refusals to delays in the processing of applications.

While the migration of students seeking training, as nursing assistants and nursing aides were limited, Caribbean nurses eligible for registration with the provincial associations had far less difficulty. Their migration was premised on fulfilling certain criteria set out by the Department, and the fact that federal authorities were aware of the Caribbean nurses' racial origin was clear. "It has been the Department's practice to authorize the landing of Negro nurses, who are eligible for registration if coming forward to assured employment and the prospective employer is aware of the racial origin."[53]

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[52] PAC RG 76 vol 553-110, pt, 2, Director of Immigration, Ottawa: Attention-Chief of Operations, for: Director, C.G.I.S., U.K. London, England, "West Indies Nurses," 29 September, 1960.

[53] PAC RG 76 vol 553-110, pt, 2, to: Mr. C.E.S., Assistant to the Deputy Minister; fr: Director, "Nurses Aides from the West Indies," 7 October, 1956.

Again, non-Caribbean nurses did not have to secure employment prior to their immigrating and they were not expected to inform hospitals of their racial origin. Once Caribbean nurses met the criteria set out by the nursing organizations they would be granted their RN status without necessarily having to upgrade. Given the relative ease with which fully trained RNs could meet immigration requirements, it is not suprising that by 1958 immigration officials reported that most of the Caribbean nurses in Toronto were RNs[54] Already trained, these nurses would meet the immediate demand for labour, unlike those who were entering Canada as students to train as nursing assistants.

As immigration officials vacillated around Caribbean migration, hospitals disadvantaged because of the labour shortage often expressed their frustrations with immigration restrictions directly to the Department of Citizenship and Immigration Canada. Dr. F.S. Lawson, Director of Psychiatric Services for Saskatchewan's Department of Health, complained that his hospital was "having difficulty maintaining their quota of nurses"[55] and asked the department to assist by encouraging the migration of Caribbean nurses. The long delays resulting from extensive investigations of prospective black immigrants led to at least one hospital to ignore federal policies and initiate its own employment procedures. In 1957, some British West Indian nurses applied to Canadian immigration offices in London, England for immigration clearance

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[54] PAC RG 76 vol 553-110 pt 2, to: Mr. C.E.S., Assistant to the Deputy Minister; fr: Director, "Nurses Aides from the West Indies," 7 October, 1958.

[55] PAC RG 76 vol 553-110, pt 1, to: Director; fr: A/Chief, Admissions Division, "Student Nurses- (Male)," 13 August, 1956.

so they could accept employment with Norfolk General Hospital in Simcoe, Ontario. When they learned of these applications, Canadian immigration officials were displeased and chastised Norfolk General Hospital for promising the women employment. Hospital authorities were reprimanded for "the manner in which they encouraged these applicants, who are not admissible without an Order-in-Council, to a course of action without first applying to this office."[56] Federal officials further maintained "that the authorization put out by the hospital is, as far as we can make out, indiscriminate without first having reviewed the applicants' qualifications."[57] According to immigration officials, the letters of acceptance issued by Norfolk General Hospital had "no value in effecting the applicants' admission to Canada," and created "unnecessary problems for their London officials."[58] The discrepancy between immigration policies and the hospital's need for labour is apparent. Although they must have been aware of Ottawa's jurisdictions in controlling the flow of migration, some hospitals issued letters of employment that contravened immigration policies.

The need for nurses and nurses' aides in the late 1950s was dire, and hospitals were explicit in their need for assistance. Hospital representatives in Melfort, North

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[56] PAC RG 76 vol 553-110, pt 1, to: P.T. Baldwin, Chief, Admissions Division, Ottawa; fr: Director, C.G.I.S. U.K. Northern General Hospital, Simcoe, Ont, 2 August, 1957.

[57] PAC RG 76 vol 553-110 pt 1, to: P.T. Baldwin, Chief of Admissions Division, Ottawa; fr: Director, C.G.I.S. U.K. Northern General Hospital, Simcoe, Ont, 2 August, 1957.

[58] PAC RG 76 vol 553-110 pt 1, to: P.T. Baldwin, Chief of Admissions Division, Ottawa; fr: Director, C.G.I.S. U.K. Northern General Hospital, Simcoe, Ont, 2 August, 1957.

Battleford, and St. Paul's Hospital in Saskatoon told immigration officials "that there is a good demand for nursing assistants and that there is actually a shortage of qualified trainees." [59] Immigration officials once again revealed their preoccupation with race, stating that even though the hospitals were never contacted about "the training of coloured nursing assistants all are prepared to make this training available."[60] Despite investigations that showed how Caribbean migrant nurses would benefit the occupation, immigration officials often ignored hospitals' requests, or found other ways to limit the migration of Caribbean nurses and students.

In the midst of these tensions between employers and state officials, provincial nursing associations and their leaders also vacillated in their support for the migration of Caribbean nurses. Efforts by government agencies to draw individual nurse leaders into engaging in racist behaviour further disadvantaged individual Caribbean nurses, but also the occupation as a whole. The solidarity that could have been established through the integration of black nurses in the occupation was tempered by the discretionary power held by the state.

In contrast to the blatant racism of the Department of Citizenship and Immigration, medical and nursing organizations sometimes displayed more liberal attitudes towards Caribbean nurses' migration. Although nursing schools refused to admit

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[59] PAC RG 76 553-110, pt 2, to: A/Western District Superintendent, Winnipeg, fr: Officer-in-Charge, Saskatoon, 22 June, 1960.

[60] Ibid.

black students before 1945, in the years after the war the profession endorsed a non-discriminatory policy: In 1951, the Canadian Nurses' Association publicly "reaffirm[ed] its policy to support the principle that there be no discrimination in the selection of students for enrolment into schools of nursing"[61] and informed the Department of Immigration that the profession did "not discriminate in anyway regarding coloured nurses."[62] The CNA was willing to include Caribbean nurses in the occupation not only because of the nursing shortage, but because of its involvement with nursing at the international level, which prompted a more egalitarian approach to Canada's domestic nursing culture, and a commitment to eradicate racial barriers. In the United States, entrenched racism historically forced African-American nurses to train in black hospitals and to create their own organizations until the American Nurses Association became racially integrated in 1948.[63]

During the late 1950s, individual immigration directors spent a great deal of time interviewing hospitals and individual nurses regarding Caribbean nurses' performance. These investigations suggest that immigration officials were attempting to find evidence to support their claims that Caribbean nurses are not "suitable" citizens and poor workers. They found out, instead, that some nursing leaders and hospital personnel were prepared

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[61]Kathryn McPherson, Bedside Matters: The Transformation in Canadian Nursing, 1900-1990 (Toronto: Oxford University Press, 1996), 211.

[62] Ibid.

[63] Darlene Clark Hine, Black Women in White: Racial Conflict and Cooperation in the Nursing Oppression, 1890-1950. Indianapolis: Indiana University Press, 1989.

to employ Caribbean nurses. Immigration officers interviewed Miss Lindsay, Secretary-Registrar in Montreal, regarding Caribbean nurses' involvement in the association and were told that "there is no question of their acceptance into the Association because of their colour, provided they have the necessary qualifications."[64] Lindsay also reminded the officers that the Association had "nurses registered from such countries such as Trinidad, British Guiana, Jamaica, and India."[65] She also noted that once Caribbean nurses passed their courses the possibility of employment existed because "there was a good demand for nurses."[66] The Jewish General Hospital was also willing to offer Caribbean nurses employment, "with the understanding to secure accommodation outside of said hospitals due to their Nurses Quarters being filled to capacity."[67] Miss G. Patterson, Director of Nursing Services at Toronto Western Hospital, told immigration officials that "the hospital was in a position to hire practically all the nurses who come to their hospital from outside of Canada."[68] There was no guarantee, however, that immigrant nurses could have immediate access to upgrading programs. These nurses

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[64] PAC RG 76 vol 553-110, pt2, To: Director of Immigration, Ottawa, for: Eastern District Superintendent, "Nurses from the British West Indies," 16 Feb, 1956.

[65] Ibid.

[66] Ibid.

[67] PAC RG 76 vol 553-110, pt 1, to: Director of Immigration, Ottawa; fr: Eastern District Superintendent, "Nurses from the British West Indies," 16 February, 1956.

[68] PAC RG 76 vol 847, File 553-110, to: Central District Superintendent, fr: Director, Immigration, 19 December, 1958.

would have to work as graduate nurses until spaces were available to take the additional obstetrics or paediatric courses necessary to obtain registration. Immigration officials stressed that the general response from interviews with nursing representatives from Nova Scotia, New Brunswick, and Newfoundland was that Caribbean "registered nurses have been employed at one time or another and their services were beyond reproach."[69]

As immigration officials inquired into Caribbean RNs, nurses' aides and nursing assistants' performance, nursing directors and hospital personnel often asked whether nurses' aides and assistants were available. Referring to the need for Caribbean nurses aides and assistants, Miss McIrwin, Regional Supervisor, Women's Division of the National Employment Services in Toronto, pointed out that she had no objection to the recruitment of nursing assistants and nursing aides. McIrwin maintained that the local employment agencies "have no hopes whatsoever of recruiting sufficient applicants to take the required 10 months course for training assistants to meet the overall demand."[70] Likewise, Mother Superior at St. Joseph's Hospital, Hamilton, stated that "if nurses aides had the necessary qualification and there were openings in the hospitals no other conditions would be required."[71] Edith R. Dick, Director of the Nursing Branch for the

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[69] PAC RG 76, 553-110, pt 2, to: Director-Attn: Admissions Division, Ottawa, fr: Atlantic District Superintendent, Halifax, 15 June, 1950.

[70] PAC RG 76 vol 553-110, pt 1, to: Acting Chief, Admissions Division, Ottawa; fr: Mr. Fox, Acting Central District Superintendent, 9 May, 1956.

[71] PAC RG 76 vol 553-110, pt 1, to: Acting Chief, Admissions Division, Ottawa; fr: Mr. Fox, Acting Central District Superintendent, 9 May, 1956.

Ontario Department of Health, contended that the nurses hired "were proving to be satisfactory and it was the consensus of opinion that if nurses' aides were available, consideration would be given to granting employment."[72] The Personnel Officer of Vancouver hospitals also informed immigration officials that "the nursing assistants whom they have employed from the West Indies have worked out very well, and as they are always looking for nurses, they would accept more if they were available...."[73] During this round of consultation by immigration officials regarding Caribbean nursing personnel, there was a general acceptance regarding the migration of Caribbean nurses by nursing organizations and associations displaying again the continued discrepancy between the needs of nursing and the desires of the state.

Despite expressing their opposition to discrimination against black nurses, Canadian nursing organizations' liberalism sometimes waned in the face of questions by Immigration Canada. The contradictory feelings towards the presence of black nurses in hospitals were exemplified in conversations regarding the need for and performance of Caribbean nurses. For example, Miss Weir, Director for Mount Sinai Hospital, first asserted "that there is no discrimination whatsoever, and if the person is acceptable she is

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[72] PAC RG 76 553-110, pt2, to: Mr. C.E.S. Smith, Assistant to the Deputy Minister, fr: Director, "Nurses Aides from the West Indies," 7 October, 1958.

[73] PAC RG 76 vol 553-110 pt 2, to: Chief, Admissions Division, Ottawa, fr: Pacific District Superintendent, Vancouver, B.C. "Coloured Nursing Assistants-The West Indies and Haiti," 14 June, 1960.

registered without regard to race or creed."[74] Weir maintained that if Caribbean nurses completed their upgrading program, they would have a "reasonable opportunity to obtain employment."[75] But at the same time, she downplayed the role Caribbean nurses would have in her hospital. According to Immigration Officials, "Miss Weir confidentially stated of the hospitals desire to maintain a considerable majority of white nurses on staff."[76] When immigration officials inquired about the supposed nursing shortage, Miss Weir contradicted statements made in the local newspaper about the demand for nurses, claiming there was no shortage.[77] She continued to emphasize that "there is no shortage of nurses...and the hospitals can make a selection from a number of Canadian applicants."[78]

Implicit in this response is the recognition of racial difference between white and black nurses, with the former by virtue of being white deserving the "rightful" place

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[74] PAC RG 76 553-110, pt 1, to: Central District Superintendent; fr: Acting Officer in Charge, "Nurses' from the British West Indies," 24 February, 1956.

[75] Ibid. PAC RG 76 vol 553-110, pt 1, to: Central District Superintendent; fr: Acting Officer in Charge, "Nurses from the British West Indies," 24 February, 1956.

[76] Ibid. PAC RG 76 vol 553-110, pt 1, to: Central District Superintendent; fr: Acting Officer in Charge, "Nurses from the British West Indies," 24 February, 1956.

[77] According to Weir, "the hospital had attempted to refute these statements with a letter to the editors of the newspaper in question, which apparently went astray and were never printed." PAC RG 76 vol 553-110, pt 1, to: Central District; fr: Acting Officer in Charge, "Nurses' from the British West Indies," 24 February, 1956.

[78] Ibid. PAC RG 76 vol 553-110, pt 1, to: Central District Superintendent; fr: Acting Officer in Charge, "Nurses from the British West Indies," 24 February, 1956.

within the occupation. Despite Weir's intention of portraying herself as progressive and the as hospital inclusive, her assurance to the immigration officials was that ultimately there would be a limit on the number of Caribbean nurses who would be allowed to work. Weir's statements were consistent with racist sentiments of the time that insisted on keeping Canada white. It is reasonable to presume that the power invested in immigration officials as representatives of the Canadian state might have influenced how Weir responded. Weir might have felt that the immigration officer was questioning Mount Sinai's decision to admit Caribbean nurses into their program and answered according to what she thought was acceptable to the immigration officer.

Although the CNA was committed to nursing free of discrimination, in practice individual nursing leaders' actions demonstrated otherwise. Mrs. Corbeau, Senior Instructor at a Nursing Assistant Centre expressed the difficulties she experienced with nursing assistants from the Caribbean. Corbeau informed immigration officials "in the strictest of confidence that, of the number of West Indians admitted to these courses very few complete their training...with the result that the majority had left to take other forms of employment."[79] Corbeau also articulated her disapproval with outsiders in the occupation who, in her mind, were replacing Canadian nurses. Immigration officials remarked that, "she was not too happy with the inclusion of these people from outside of

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[79] PAC 553-110 pt 2, to: Director, Attention Admissions Division, for: Central District Superintendent, "School of Practical Nursing," 8 February 1960.

Canada to take these courses when sufficient applicants were available in Canada."[80] Even though nursing assistants were at the bottom of the nursing hierarchy, and filled a particular need, Corbeau felt that Caribbean migration should be suspended in favour of white applicants.

While most provinces were willing to accept Caribbean RNs on the basis that they completed the three months obstetrics course, the Quebec Nursing Association in 1956 changed its policy from three months to a year. Although immigration authorities claimed they had not received any explanation for the policy change, it is obvious that this was a move to discourage black nurses from applying to work in Quebec. The QPNA clearly stated that "it was the desire of the Association to register only nurses who were suitable and adaptable to Canadian conditions in the nursing profession."[81] The opportunity to live up to the ideals purported by the CNA to have an occupation devoid of discrimination did not translate into practice especially when the state intervened through their extensive and ongoing inquiries.

The Case of Haitian Immigrant Nurses

Nursing leaders and organizations were often positive about immigrant nurses from British Commonwealth nations in the Caribbean, but were much less supportive about prospective nurses from Haiti. Canadian nursing administrators colluded with

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[80] Ibid. PAC Rg 76 vol 553-110 pt 2, to Director, Attention Admissions Division, for: Central District Superintendent, School of Practical Nursing, 8 February 1960.

[81] PAC RG 76 vol 553-110, pt 1, to the Director, fr: Acting Chief of Admissions Division, 7 June, 1956.

immigration officials to perpetuate negative images of "blackness" against Haitian nurses that demonstrated how colonial ideologies operate to produce subtle though important distinctions between Anglo and non-Anglo Caribbean nurses. There are no specific statistics on the number of Haitian nurses who migrated during the period under discussion, but what is apparent is that, as French speakers, the majority of Haitian nurses chose to live and work in Montreal and Quebec. The presence of Haitian nurses in Quebec provoked anti-Haitian sentiment that appeared to be initiated by immigration officials and subsequently supported by various nursing organizations. Together the state and the association collaborated to produce discourses around the undesirability of Haitians. Some of the ongoing colonial stereotypes of black people such as greed, aggression, indolence and irrationality were attributed to Haitian nurses. Hence Immigration Canada constructed Haitian nurses and students as "outsiders," a problem that needed to be controlled, while some nurses associations emphasized Haitian nurses "otherness" via their supposed inability to adapt to Canadian work and community life.

It is difficult to ascertain when the antagonistic attitude towards Haitian nurses began and the reasons for the attitude. Correspondence between immigration officials and nursing associations suggests that it was immigration officials who first raised the issue of Haitian nurses' desirability and issued a series of circulars requesting information about Haitian nurses. Once these circulars were issued, nurses associations and directors of nursing schools responded with statements of distrust toward their Haitian staff.

During interviews with immigration representatives, nursing officials confirmed their ambivalence about Haitian students as appropriate immigrants.

In 1958 a series of "discreet" and "confidential" investigations of Haitian nurses were conducted in an attempt to monitor the migrants' movement. In one case, Immigration Canada's Chief of Admissions asked for information about three students who were accepted at the Cooke Sanatorium Hospital in Montreal. He wanted "their names and full particulars about them, including a report from the hospital authorities respecting their conduct and attitude at the hospital, and whether or not the hospital authorities are completely satisfied with them."[82] Such investigations may have created an adverse effect on Haitian nurses. Their inquiries prompted the surveillance of Haitian nurses' work and whereabouts, and prompted several hospitals to claim they were experiencing problems with Haitian nurses. Some nursing directors reported that "a large portion of Haitian girls...who are nursing aides have proven themselves unsuitable and unreliable." Haitian nurses aides were described as..."lazy, negligent, and also lacking in hygiene."[83] Mrs. Bouquet, the director for the BCG Clinic in Quebec which treated infants whose mothers were affected with tuberculosis, informed immigration officials that her clinic had been unfortunate in the selection of Haitians, for "hygiene plays a

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[82] PAC RG 76 vol 553-110, pt 2, to: Chief, Admissions Division; fr: Officer-in-Charge, Trois-Rivieres, Que, "Miss Harriet Whiteman of Haiti," 20 January, 1958.

[83] PAC RG 76 vol 553-110, pt 2, to: Director of Immigration, Admissions Division, Ottawa; fr: A/Eastern District Superintendent, Montreal, Quebec, "Miss Gilda Charles-Proposed Entry," 26 February, 1958.

capital role and this apparently is something that most Haitian students, to date do not possess."[84]

Similarly, a Sister at the Ste. Justine Hospital in Montreal told immigration officials that she had received letters from 38 Haitian students who were interested in becoming nursing aides, but that of the 38 applicants "a few might receive favourable consideration, although it was stated that the hospital had not been too happy with the Haitian girls who were there in the past."[85] The reason for the hospital's discontent was framed around alleged issues of hygiene and laziness. The assumptions held by the sister and Bouquet that Haitian nurses lacked hygiene drew on colonial discourses that associated "blackness" with sin, dirt and filth.[86] The investigations into the performance of Haitians nurses implied that they would tarnish the image of nursing. Here cultural racism, whereby blacks are deemed by the colour of their skin to be lazy and unclean, seems to take on special significance when applied to Haitian nurses. Furthermore, nursing historically has been constructed on ideals of purity and cleanliness, which were in turn associated with the racial purity supposedly embodied by white middle-class nurses. The presence of Haitian nurses would certainly shatter this ideal.

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[84] PAC RG 76 vol 553-110, pt 2, to: Director of Immigration, Admissions Division, Ottawa; fr: A/Eastern District Superintendent, Montreal, Quebec, "Miss Gilda Charles-Proposed Entry," 26 February, 1958.

[85] PAC RG 76 553-110, pt 2, to: Director of Immigration, Ottawa, fr: Eastern District Superintendent, "Haitian Nurses Aids," 7 March, 1958.

[86] Anne McClintock, Imperial Leather: race, gender, and sexuality in the Colonial Contest (New York: Routledge, 1995).

This is not to suggest that similar racist characterizations were absent in reference to Anglo Caribbean nurses. Francophone nursing leaders, however, were much more blatant in their vilification of Haitian nurses, a reaction that might be explained by the climate of Quebec in the 1950s and 1960s. Quebec's marginalization vis-à-vis Anglo Canada meant it was intent on maintaining its distinct cultural heritage. The hegemony of Anglo Canada led to the "Quiet Revolution," signalling an era when Quebec attempted to take more control of its institutions and the economy, which was rapidly expanding and needed immigrant labour. At the same time, Quebecois were concerned about the declining birth rate and the influx of immigrants (while necessary) raised concerns about Quebec as a distinct society. It is no wonder that amidst this uncertainty most Quebec nursing leaders would respond to Haitian nurses with such disdain.

There were some people such as Sister Marie Clement, director of Montreal School of Nurses at the Cook Sanatorium Hospital, who did not view all Haitian nurses as a monolithic group. The Sister told immigration officials that one Haitian nurse was dismissed due to a "lack of competence and interest in the performance of duties," but that the other nurses "are doing very well."[87] She noted that "they all belong to good families, they are studious, have good manners and they accomplish their tasks to the entire satisfaction of the authorities."[88] The Sister further informed immigration officials

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[87] PAC RG 76, vol 553-110, pt 2, to: Chief, Admissions Division, fr: Officer-in-Charge, Trois Rivieres, Que, "Miss Harriet Whiteman of Haiti," 20 January, 1958.

[88] Ibid

"that before accepting students from Haiti at their school a complete report must be obtained from religious or laic[sic] authorities with regard to the education, character and background of the applicants." Fortunately for these nurses, religious authorities were able to speak on their behalf and might in some way positively influence how these nurses were viewed by nursing directors and immigration officials. Sister Marie Clement's remarks to immigration officials also reflect the ongoing power of religious institutions to challenge Quebec state authorities.

No hospitals or nursing associations defended Haitian nurses against these allegations, and by June 1958 the Director of Immigration declared that all hospitals "favoured some control over these persons." [89] Indeed nursing directors and hospitals corroborated the so-called findings of immigration authorities. The Superintendent of Immigration for the Eastern District in Montreal described Haitian nurses as the ethnic group that was the "greatest offender,"[90] in terms of using the profession as an excuse to gain entry to Canada. He said: "We have formed the opinion that their main purpose in coming forward under the pretext of being students is to gain entry to this country than to

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[89] PAC RG 76 vol 553-110, pt 2, to: Director of Immigration, Ottawa, Ontario, fr: Eastern District Superintendent, Montreal, Quebec, "Haitian Nurses Aides," 9 June, 1958.

[90] PAC RG 76 vol 553-110, pt 2, to: Director of Immigration, Ottawa, ON; fr: Eastern District Superintendent, Montreal, Quebec, "Students-10.83 Procedures and Follow-up," 27th March, 1958.

extend their academic education or learn a trade."[91] Similarly, in another memorandum, immigration officials observed that several hospitals expressed doubts as to whether Haitian nurses really wanted training. They too concluded "that...Haitian nationals appear not to be interested in the course itself but are rather interested in coming forward to Canada and finding all sorts of excuses to remain in this country once in."[92] One immigration officer decided to refuse entry to a Haitian applicant because "in view of the difficulties encountered by this office with the Haitian girls who came forward to Canada to undertake this course, we feel that the subject may also prove to be a problem once in Canada."[93] Canadian immigration officials worried that Haitian nurses denied entry to Canada would subsequently find other means of entering the country. They worried that once Haitian students or nurses aides were aware "that our consulate in Port au Prince were refusing visas, those persons will no doubt come forward to Canada via the United States."[94]

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[91] Ibid. PAC RG 76 vol 553-110, pt 2, to: Director of Immigration, Ottawa, ON; fr: Eastern District Superintendent, Montreal, Quebec, "Students-10.83 Procedures and Follow-up," 27 March, 1958.

[92] PAC RG 76 vol 553-110, pt 2, to: Director of Immigration, Operations Division, Ottawa; fr: Eastern District Superintendent, Montreal, Quebec, 9 June, 1958.

[93] PAC RG 76 vol 553-110, pt 2, to: Director of Immigration, Operations Division, fr: Eastern District Superintendent, Montreal, Quebec, "Haitian Nurses Aids," 8 April, 1958.

[94] PAC RG 76 553-110, pt 2, to: Director of Immigration, Ottawa, Ontario, for: Eastern District Superintendent, Montreal, Quebec, 9 June 1958.

The high turnover rate among Haitian nurses in Canada was also used as evidence to justify racist sentiments. One nursing representative told immigration officials that many nursing students change hospitals and clinics "for no apparent reason, and most without warning."[95] Using the BCG Clinic to make the point, immigration officials commented that "of the 21 Haitian girls, who had proceeded to the clinic, 17 had left the institution after their arrival, 2 had not presented themselves at all, and only 2 were in attendance."[96] In a letter to Canada's Ambassador to Haiti, the Director of Immigration concluded that "...in view of the difficulties encountered with the Haitian girls who have come forward to take the course at the [BCG] clinic, that no further applications should be accepted."[97] It is possible that the high turnover of Haitian nurses was a response to the racism in the Canadian hospitals. However, it should be noted that they were not alone in their mobility. Nursing historian, Kathryn McPherson pointed out that following World War II; "tremendous turn over rates frustrated administrators efforts at stable staffing...."[98] In this context, it is striking that the high turn over rates among Haitian nurses received specific comment.

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[95] PAC RG 76 vol 553-110, pt 2, to: Director of Immigration, Operations Division, Ottawa; fr: Eastern District Superintendent, Montreal Quebec, "Students-10.83 Procedure and Follow-up," 27 March 1958.

[96] PAC RG 76 vol 553-110, pt 2, to: Ambassade du Canada, Port-au-Prince, Haiti; fr: C.E.S. Director, 4 March 1958.

[97] Ibid. PAC RG 76 vol 553-110, pt 2, to, Director of Immigration; fr: Eastern District Superintendent, Montreal, Quebec, " Haitian Nurses Aids," 9 June, 1958.

[98] McPherson, Bedside Matters, 231.

Like their Anglo Caribbean counterparts, the question of qualifications also emerged as part of the discussions about Haitian nurses' suitability. Immigration officials noted that for Haitian nurses the quickest way to come to Canada "was under the guise of nurses assistants or students."[99] They pointed out that, for the most part, some of these students did not "have the necessary qualifications"[100] to begin training. If a student was found not to have the appropriate qualifications, she would be "informed by the school that they can no longer be permitted to continue the course..."[101] While nursing authorities assisted German women who, because of the misleading title of "nurse" or because of language difficulties had to find other employment, there is no evidence (beyond Sister Clement) of nursing leaders assisting or defending Haitian students or nurses. Unwilling to challenge immigration officials' suspicions about Haitian nurses, the hospitals in Quebec and Montreal and their nursing directors basically concurred with the racist sentiments of Immigration Canada.

Once the investigations of 1958 were completed, immigration officials advised hospitals who employed, or intended to employ, Haitian nurses to submit their applications to the office so they could conduct a full investigation to determine whether

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[99] Ibid

[100] Ibid

[101] Ibid

applicants were "deserving of favourable consideration."[102] This meant that the Department of Citizenship and Immigration would determine the qualifications of immigrant nurses -even though maintaining the standards of the profession was supposedly nursing's domain.

In 1960, immigration officials were still inquiring about Haitian nurses, and it appeared that the attitudes of Quebecois nursing representatives and hospitals remained the same, with a few exceptions. Representatives at Albert Provost Institute admitted that "they will take Haitian students without too much discussion, if they had been admitted to Canada."[103] Although the Albert Provost Institute was willing to accept Haitian students, the Department of Immigration and Citizenship could prevent Haitian nurses from migrating to Canada. Other hospitals claimed that based on the difficulties they encountered with Haitian nurses, they were only interested in Haitian students, if their qualifications were over and above average and that if there were enough Canadian applicants then Haitian applicants would be ignored.[104]

The responses of Quebec's nursing leaders served to reinforce, rather than challenge, the racist anxieties of immigration authorities. Immigration officials concluded that the "[Quebec]Association of nurses was not in favour of having coloured students in

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[102] PAC RG 76 vol 553-110, pt 2, to, Director of Immigration; fr: Eastern District Superintendent, Montreal, Quebec, " Haitian Nurses Aids," 9 June, 1958.

[103] PAC RG 76, vol 553-110, pt 2, to: Chief of Admissions Division, Ottawa, for: Eastern District Superintendent, "Coloured Nursing Assistants," 30 June, 1960.

[104] Ibid

nursing because it was claimed that these students have great difficulties adapting themselves to our ways and means in their particular field of action, even as students."[105] The Association emphasized that if students were allowed to train in Canada, it was on the premise that they would return to their home countries and practice the knowledge gained in Canada.[106] The Association was only willing to offer Haitian nurses backhanded compliments: "...if a coloured nurse or nursing assistant succeeds and graduates, she usually has outstanding qualifications which makes them very recommendable."[107]

Black Nurses and Activists Respond

The immigration records contain no indication that black organizations provided any support to Haitians, but black activists did challenge the exclusionary policies aimed at English Caribbean nurses. In 1956, Donald Moore, Director of the Negro Citizenship Association, wrote to the Chief of Admissions at the Department of Citizenship to object to the situation faced by prospective immigrants from Barbados whose applications had been delayed.[108] According to Moore, three hospitals, Jewish General of Montreal,

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[105] PAC RG 76 vol 553-110, vol 553-110, pt 2, to: Chief, Admissions Division, Ottawa, for: Eastern District Superintendent, "Coloured Nursing Assistants-your memo," 1 June 1960.

[106] Ibid

[107] Ibid

[108] PAC RG 76 vol 553-110, pt 1, P.T. Baldwin, Chief, Admissions, fr; Donald Moore, Negro Citizenship Association, 14 January, 1956.

Windsor General, and Toronto's Mount Sinai, offered positions to three nurses, all of whom had completed the three-year general course and had much practical experience.[109] Similarly, Owen de Vere Rowe, a representative of the British Caribbean Students Liaison Office in Canada wrote another immigration official listing the names of students who had been accepted for "for training by hospitals schools, [but] were not successful in obtaining student visas from the Immigration Department,"[110] due to prolonged bureaucratic investigations. The National Association for the Advancement of Coloured Peoples also wrote to Canadian Immigration and Citizenship advocating on behalf of Caribbean nurses. Despite limited success, these black organizations worked on behalf of nurses and Caribbean immigrants to challenge the state's exclusionary policies.

Some individuals also challenged the state when refused entry into Canada. Take the case of the two women granted temporary entry to train as nursing assistants at Norfolk General Hospital in 1956. Four women had applied and only two were issued visas; the other two were sent letters informing them that their request for entry into Canada was rejected. One woman wrote the immigration department for an explanation as to why her application was refused when the other two women had applied approximately two weeks after she did. In an internal memo, the Chief of Admissions admitted that "in all fairness to Miss Husbands and her friend, I think we should

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[109] Ibid

[110] PAC RG 76 vol 553-110 pt 1, to W.R. Bakersville, Chief of Admissions; fr: Owen de Vere Rowe, British Caribbean Students Liaison Officer in Canada, 17 January, 1957.

authorize temporary entry in their cases."[111] However, he added that any such decision should not be taken as a precedent. Again, the fact that the Chief of Admissions made the above recommendation exposed the incongruities in immigration regulations but also demonstrates how some of the federal government's own immigration officers were willing to re-evaluate their application policy. It is not known whether these women were actually granted temporary entry, but it is significant that they were not compliant and got at least one immigration officer to take their side.

In their suspicions about the legitimacy of black immigrant nurses, immigration authorities deployed a range of tactics such as delaying applications or outright refusing entry to black nurses. But by 1962, new immigration regulations aimed at deracializing Canada's immigration policy - emphasizing skills, education and training as the criteria for migration - were firmly in place. Thus, the 1950s CNA recommendations that prospective immigrants contact provincial associations directly regarding qualifications and registration, was institutionalized. The various provincial associations, and not federal authorities, were entirely responsible for entry into practice. Ironically, then, while it was the state that emerged as the culprit in the 1950s and early 1960s in terms of affecting whether Caribbean immigrants were able to work in Canada, after 1967 it was the provincial nurses associations (and in Ontario the College of Nurses) whose assessment affected how black nurses were situated in the occupation.

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[111] PAC RG 76 vol 553, pt 1, to: Acting Chief, Admissions Division, fr: Admissions "B", "Students Nurses Assistants from the British West Indies," 4 July, 1956.

For this reason, in their recollections about the migration process, the majority of Caribbean nurses maintained that Immigration Canada processed their applications in a timely and judicious manner. According to those nurses, the efficacy in which their applications were dealt with was a result of the nursing shortage. In contrast, the College of Nurses in Ontario (since most of the nurses interviewed live and worked in Ontario) emerged as the gatekeeper, policing foreign-trained nurses. Even though the majority of Caribbean nurses were required to do some form of upgrading and to obtain registration, specialized nurses and England's State Enrolled Nurses (SENs) had the most difficult time with the accreditation process.

Both Brenda Lewis[112] and Myrna Blackman[113] were specialized nurses who had training in mental health. Lewis trained in Trinidad and Blackman, a Registered Mental Nurse (RMN), trained in Britain. Both women migrated in the early 1970s and found that there was no Canadian equivalency to determine what their status was in the Canadian context. The College of Nurses informed both that in order to obtain their Registered Nurse (RN) status upgrading was necessary. Until she upgraded, the College determined that Blackman's qualifications equalled that of Registered Nursing Assistant. Although Lewis had training in mental health, her credentials were not accepted by the College of Nurses, instead she was told that she had to redo the entire nursing program. In the

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[112] Brenda Lewis, interview by author, Personal recording, Toronto, Ontario, 24 February 2000.

[113] Myrna Blackman, interview by author, Personal recording, Brampton, Ontario, 29 May 1995.

meantime, Lewis worked as a nurse's aide while she attended Ryerson Polytechnic Institute at nights. Blackman, on the other hand, refused to upgrade because she felt that her British training had already equipped her to work in Canada, and additional training would be futile.

British State Enrolled Nurses' experiences to some extent replicated that of specialized nurses with respect to how the College of Nurses dealt with the issue of credentials. When Elaine Mcleod[114] immigrated to Canada in 1969, she was told by the College of Nurses that she needed a further twenty-one hours of training to be considered a Registered Nursing Assistant. Ready to begin training, Mcleod was then told by the school administrator of the community college that she applied to that she needed to redo the entire program rather than the College's recommended twenty-one hours. Mcleod blamed the College of Nurses for its inability to interpret her British qualification. Black nurses' indignation at the College of Nurses became more pronounced once they actually started working, as the following chapters reveal.

For many of the women in Lewis's position being demoted to menial and "unskilled" work was very difficult when compared to the responsibilities they had in the Caribbean and Britain. Mcleod's reaction is typical of those nurses who were placed in subsidiary positions. She recalled:

> I wasn't doing a whole lot, and it was frustrating. You were coming from somewhere where you were accustomed to running a whole unit, to do all

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[114] Elaine Mcleod, interview by author, Personal recording, Markham, Ontario, May 1995.

> your orders, and to carry out all your assignments that doctors gave you, and coming here, you can't do nothing. You couldn't do dressing and you couldn't give meds. All you could do was make beds, feed and bathe patients.

Although the College of Nurses might not have deliberately set out to undermine black nurses' skills and qualifications, how it determined entry into nursing practice operated to reinforce class and race cleavages in the occupation. In the name of protecting the professional standards of nursing, the credentialing mechanisms that were in place worked against the forging of powerful bonds in a gendered occupation where nursing is already subordinated to the medical profession.

Throughout the 1950s and 1960s, immigration authorities and Canada's nursing leadership struggled to accept Caribbean nurses as "suitable" citizens and "qualified" workers. These same authorities welcomed Greek and German nurses both as workers and migrants despite questions raised by nursing associations about European women's professional qualifications. At the same time, racial meanings were always being contested. Immigration officials made some distinctions between black Caribbean nurses and Haitian nurses and some hospitals administrators, faced with a dire labour shortage, wanted to employ black nurses. Furthermore, individual nurses and black organizations lobbied immigration officials challenging how race was constituted by the Department of Citizenship and Immigration.

The failure of nurses' associations to challenge inequity is significant. Despite the nursing shortage, nursing directors contributed to the dialogue that limited the immigration of Haitian nurses, nurses' aides, and students. Despite the CNA's1951

statement against discrimination, nursing directors were all too willing to support the state's findings that black nurses were a problem. In spite of the need for labour, they allowed Anglo-Caribbean and especially Haitian nurses to be excluded from their occupation. Had nurses stayed true to their stated principle of non-discrimination, they might have helped to shape a non-discriminatory and inclusive Canadian immigration policy for all prospective migrants. Such a policy was not enacted until the 1960s, when new regulations emphasizing education, skills, and training-rather than country of origin-made it easier for Caribbean nurses to come to Canada. Even when the College of Nurses was responsible for assessing the qualifications of nurses trained elsewhere, their strategies precluded the development of solidarity among and between nurses regardless of training location. Instead, those Caribbean nurses disadvantaged by the College remained resentful. Equally important, the racist ideologies that shaped both the state policies and nurses' attitudes continue to exist, albeit in different ways.

Chapter 4
Never The Twain Shall Meet: Professionalization, Proletarianization and Black Nurses in Ontario Hospitals

Like feminist historical scholarship on women and work, nursing scholarship relies on gender and to a lesser extent class and ethnicity to explain and describe nursing work.[1] These works are extremely useful and have provided much needed insights into nurses' lives and work. One important contribution is the focus on the gender division of labour within the medical field and how patriarchal ideologies operate to sustain nurses' subordination. Less attention has been paid to how notions of race structure nursing, whether black women and other women of colour are present in significant numbers or not. Moreover, Agnes Calliste provides an invaluable analysis of how the state developed racist, sexist, and classist exclusionary polices to curtail the migration of Caribbean nurses. And in another study, she focuses on the resistance strategies employed by black women to deal with racism in nursing.[2] Similarly, Tania Das Gupta explores the impact of racism and sexism on the experiences of black women in nursing.[3] But beyond the

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[1]Kathryn McPherson, Bedside Matters: The Transformation in Canadian Nursing, 1900-1990 (Toronto: Oxford University Press, 1996); Patricia Armstrong, Jacqueline Choiniere, and Elaine Day eds., Vital Signs: Nursing in Transition, (Toronto: Garamound Press, 1993); Sarah Jane Growe: Who Cares?: The Crisis in Canadian Nursing (Toronto: McClelland & Stewart, 1991).

[2] Agnes Calliste, "Antiracism Organizing and Resistance in Nursing: African-Canadian Women," Canadian Review of Sociology and Anthropology 33 no. 3 (1996).

[3] Tania Das Gupta, Racism and Paid Work (Toronto: Garamound Press, 1996).

studies by Das Gupta and Calliste, nursing scholarship remains race blind despite ongoing acknowledgement that race, ethnicity, gender, sexuality, age and ability are also important elements in the organization of any work place, albeit in different ways, and should be integral to any study that focus on women's work lives.[4]

In the intense debates delineating the characteristics of what constitutes a profession, nursing is often defined as either a semi or full profession[5] based on its engagement with professionalization initiatives. The concept of professionalization is often used to capture such strategies as education and registration that an occupation adapts to maintain control over its work. In contrast, proletarianization involves the transformation of the labour process, which includes the fragmentation and intensification of work, workers' loss of control over the work process, and increased managerial control.[6] Some nursing scholars, in Canada, Kathryn McPherson and David Coburn, have probed the tensions between professionalization and proletarianization as they have shaped nursing.[7] Building on their work, this chapter locates black nurses' experience in the twin processes of proletarianization and professionalization to better

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[4] See for example, Janet Ross Kerr and Jannetta MacPhail, Canadian Nursing: Issues and Perspectives, 3rd ed. (Toronto: Mosby, 1996).

[5] See for example, Mary Kinnear, Insubordination: Professional Women, 1870-1970 (Montreal and Kingston: McGill-Queens University Press 1995).

[6] David Coburn, "Professionalization and Proletarianization: Medicine, Nursing and Chiropractic in Historical Perspective," Labour/Le Travail 24 (Fall 1994).

[7] McPherson, Bedside Matters; Coburn, "Professionalization and Proletarianization," 140.

understand how those nurses were structured in a workplace where the position of health care workers was not always clear.

In this chapter, I am interested in the multiple identities that Canadian born blacks and Caribbean immigrant nurses expressed, and the different ways (materially and psychically) they responded to their experiences as nurses. I demonstrate that professionalization and proletarianization are not mutually exclusive or universal, and affected nurses in a myriad of ways with the differential impact felt not only between white and black nurses, but among black nurses as well. Using the nurses' oral testimonies, I begin with a brief look at the development of Canadian hospitals and Canadian born black women's recollections of their training. From there, I introduce the beginning of professionalization and proletarianization and the differential impacts these two processes had on black Canadian and Caribbean women. In the second half of the chapter, I examine how both groups of nurses respond to the introduction of technology, and the impact of government cutbacks on nurses' work. Finally, I conclude with a discussion on how unions and nurses' organizations are included in the goal of professionalization and Canadian born black and Caribbean immigrant practitioners' reaction to these various bodies. While race and racism were never absent from the world of work, the women interviewed responded in "professional" or occupational terms, defining their experiences with the work process in terms of their identity as nurses, rather than as "black nurses." Racism and work will be discussed in the next chapter.

The Development of Hospitals and the Institutionalization of Nursing

To provide social security for Canadians following World War II, the government initiated a number of programs that led to state-funded hospitals, hospital insurance programs and, by 1968, medicare. Pat and Hugh Armstrong maintain that health care not only stimulated economic growth due to investments but also created employment for a variety of people within institutions.[8] As hospital employment became the norm for the majority of nurses, private duty nursing that had dominated nursing work until the 1940s declined. Nurses opted to work in hospitals because institutions provided the benefits of a guaranteed wage, as opposed to the uncertainties of the private market. Nursing historians view this transition from the exploitive apprenticeship period to the hospital setting as the beginning of the quest for professionalization whereby nurses broke the dependency that had been created by hospitals need for nursing labour. Scholars argue that it was at this juncture that nurse leaders took their first step towards professional autonomy and control over the occupation's educational process.[9]

Despite the security that hospital employment offered, once in the hospitals nurses were embroiled in the struggle towards rationalization, which is similar to proletarianization when examined from the perspective of "the differentiation within a

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[8] Pat and Hugh Armstrong, Wasting Away: The Undermining of Canadian Health Care (Toronto: Oxford University Press, 1996), 121.

[9] Ibid.

division of labour."[10] Referring to the United States during the early twentieth century, Susan Reverby noted that the main characteristic of rationalization is efficiency and involves:

> The systematic analysis and timing of steps in a work process; the search for standards and the best way to perform each tasks, the separation of mental from manual labour to perform tasks; and ultimately, managerial control over planning and execution of work.11

A comparable quest for "efficiency" was also occurring in Canadian hospitals. The introduction of new drugs and procedures during and the after the Second World War, led to the reallocation of certain duties from doctors to nurses.[12] Registered Nurses (RN) were now expected to administer and understand the principles of newly developed drugs like penicillin, streptomycin, sulphonamides, and pituitrin.[13] RNs were also responsible for taking blood pressure and starting intravenous drips. While nurses were taking on some duties that were once the purview of the doctors, subsidiary workers including ward aides, practical nurses and nursing assistants "were introduced to take on the responsibility for the many technological aspects of patient care that RNs had previously

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[10] Cobourn, "Professionalization and Proletarianization," 139.

[11] Susan Reverby, Ordered to Care: The Dilemma in American Nursing 1850-1945 (New York: Cambridge University Press, 1987), 143.

[12] McPherson, Bedside Matters, 220.

[13] Ibid.

performed."[14] To ensure that a guaranteed supply of skilled personnel was available to deal with the changes taking place in medicine, the nursing elite introduced bacculerate programs and specialization certificates. In one sense a domino effect took place in the medical field as tasks were being apportioned among health care practioners and doctors. This led to a transformation in the organization of the workplace resulting in new divisions among rank and file nurses and nurse leaders, and also between hospital administrators and physicians. According to Coburn, "higher nurse supervisors were co-opted and absorbed into hospital management, the only avenue of upward mobility for nurses."[15] Upward mobility for senior nurses fractured the solidarity among nurses that had characterized the earlier years. Canadian born black nurses were absorbed into the changes taking place in nursing.

Black Canadian Nurses in Training

Regardless of training location, discipline, a rigid nursing hierarchy, long hours, and hard work were characteristic of the environment in which nurses trained. Like their Caribbean counterparts, black Canadian born nurses trained in hospitals or religious-based schools. Agnes Ellesworth[16] began her training with another black nurse at Windsor's Hotel Dieu Hospital in 1950. A typical day, she stated, began around 6:00am

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[14] McPherson, Bedside Matters, 6.

[15] Coburn, "Professionalization and Proletarianization," 153.

[16] Agnes Ellesworth, interview by author, Tape recording, Windsor, Ontario, 5 June, 2001.

with prayers followed by breakfast. Once breakfast was completed, the trainees proceeded to the wards. Ellesworth pointed out:

> We worked very hard. We had to do a lot of the menial work, we did bedpans; we were really hands on. We were doing a lot of the work that nurses do not do today. We had to cook and serve the breakfast. We made the beds and serve the medications. We were trained quite well.

Laura Tynes[17] began training in the 1950s at the Isaac Wilton Killam Hospital in Halifax. She too emphasized how demanding the training was, especially in the first two years where it seemed as if cleaning was as much a priority as the theoretical part of their education. Tynes's day began around the same time as Ellesworth's with prayers and breakfast. Once breakfast was completed, nurses began their twelve-hour shift, which included preparing meals, feeding and bathing children. Moreover, they would spend two to three hours in class and then return to the wards. Once they were back on the floor, Tynes pointed out:

> We had to clean the hospital. We would spend a block of time in one area according to the schedule and move to another area. We had to scrub the walls in the operating room from top to bottom everyday, if it was an infected case, then we had to clean it, everything had to be scrubbed after each case. We had to clean the tables and the equipments; it was our job. We also had to take the garbage out.

Tynes recognized the contributions of student nurses' unpaid labour to the smooth functioning and maintenance of the hospitals where she did her training, but noted that the rigidity, strictness, and the lack of remuneration, "didn't do us any harm, it made us

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[17] Laura Tynes, interview by author, Tape recording, Mississauga, Ontario, 6 December 1999.

into strong women." The nurses acknowledged that once the probationer stage was completed their training became far more technical and theoretical; they were also given additional responsibilities such as being in charge if the head nurse was unavailable.

Professionalization and Proletarianization and Black Canadian Nurses

One of the features that provoked the tensions between professionalization and proletarianization in Canadian hospitals was the introduction of subsidiary workers. The purpose of this move, according to McPherson, was not only to reduce nurses' workload but also "because personal care tasks, traditionally part of nurses repertoire of skills were being defined as inappropriate for highly trained professionals."[18] Instead of bedside care being the purview of RNs, they enjoyed an elevated status where they were now responsible for administrative duties. Professionalization also led to the introduction of more complex surgical and medical technologies, which opened up opportunities for some nurses in certain areas while opening leadership positions for others. Although professionalization provided benefits for RNs, ongoing proletarianization led "to a new degree of formal stratification"[19] between nurses in leadership ranks and those in various ancillary positions. McPherson opined that "this hierarchy created fixed relations of subordination and dominance between nurses and among hospital caregivers that were new to an occupation that had heretofore been characterized by an equality of

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[18] McPherson, Bedside Matters, 222.

[19] McPherson, Bedside Matters, 219.

practitioners."[20] Proletarianziation also meant that hospitals were continuously searching for new ways to be cost effective which meant that nurses had to perform multiple duties within a rapidly changing environment. As supervisors, several black Canadian nurses were the beneficiaries of the professionalization impulse, at the same time, they experienced the outcome of proletarianization.

After Marlene Watson[21] completed her training at Victoria General Hospital in Halifax in the late 1950s, she found employment at Toronto Western Hospital where she worked in the psychiatry unit. Watson soon moved to the recovery unit, a position she enjoyed because it reminded her of a mini-Intensive Care Unit (ICU). After working at Toronto Western for a number of years, Watson successfully applied for a charge nurse position at York Finch Hospital in the Intensive Care Unit (ICU). A year and a half later, Watson was told by the administration that instead of having two supervisors for the recovery and intensive care unit, they only needed one supervisor to manage both units. Watson and the supervisor for the recovery unit were each asked to submit a proposal to management outlining how they would supervise both units if either one got the position. Management accepted Watson's proposal and she was appointed to supervise the two units. Shortly thereafter, she was asked by the nursing director to take on an additional unit. According to the nursing director, "the head nurses were always coming and going

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[20] McPherson, Bedside Matters, 220.

[21] Marlene Watson, interview by author, Tape recording, North York, Ontario,18 January 2000.

and the department needed some stability." Assuming that the position was temporary, Watson agreed to manage the third unit. After two months, Watson inquired about the possibility of her replacement and was told by management that the nurses she worked with wanted her to stay on. Watson remembered saying to herself, "oh Father, I don't really need 3 units." Clearly as a method to improve efficiency and cut costs, the hospital amalgamated the cardiac unit to include coronary care, post-coronary care, endocrinology, and gastroenterology. Watson served as the supervisor in these three units until she became pregnant with her daughter. When Watson returned a year later, there were no supervisory positions left at York Finch General Hospital.

Frieda Steeles[22] graduated from Windsor's Hotel Dieu Hospital in 1954. Except for two special assignments that took her to Detroit, Michigan where she worked for a short period of time she remained at Hotel Dieu until her retirement. In 1960, Steeles took on a temporary supervisor position for a nurse who was on maternity leave. The position, according to Steeles, proved satisfactory because "it was a short time, and because I had a young family, that was good for me." Later, Steeles was asked whether she would like the position full-time. She declined and worked instead as a relief with a head nurse (supervisor) status. In 1968 when the supervisor retired, Steeles became part-time supervisor of admitting and in 1970 she began working full-time co-supervising with another head nurse. In terms of the division of labour, the supervisor was responsible for scheduling while Steeles did the statistics and the remaining duties were

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[22] Frieda Steeles, interview by author, Tape recording, Windsor, Ontario, 9 June 2001.

allocated between both supervisors. When the supervisor left, Steeles remembered being told that "I would not be replaced, and would be the sole one responsible" for running the department. Concerned about remuneration, Steeles maintained that "I asked lots of questions about methods of compensation, and we worked it out amicably." In the late 1980s, with new titles were being instituted in nursing, Steeles was no longer supervisor but the Director of Patient Registration.

While black Canadian nurses Watson and Steeles participated in and enjoyed the advantages of professionalization in relation to the leadership roles they assumed, Virgina Travis's[23] career epitomized how professionalization on an individual level translates into practice. Travis graduated from Chatham General Public Hospital in 1954. From there, she worked as a staff nurse in the surgical and operating units; two years later she was promoted to assistant head nurse in the operating room. Travis was also a nursing instructor; she eventually became the supervisor of the operating room. Throughout her career, Travis held a number of leadership positions and was actively involved with the College of Nurses and the Registered Nurses Association for 40 years.

An examination of Watson, Steeles and Travis's experience reveals the contradictions inherent in proletarianization and professionalization. On the one hand, they enjoyed the benefits and privilege of being in supervisory positions where they were responsible for overseeing other RNs and subsidiary workers. These positions demanded excellent communication, superior management skills and flexibility, which allowed

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[23] Virginia Travis, interview by author, Tape recording, Windsor, Ontario, 5 June 2001

these nurses to perform their obligations as expected. Conversely, the reality of professionalization with its emphasis on productivity and efficiency resulted in supervisors being given multiple positions, which increased their responsibilities. Watson was responsible for three units, while Steeles was the only supervisor for a position that originally required two people. Trained in Canada, black Canadian nurses' credentials were never questioned or held up to scrutiny like some of their Caribbean counterparts.

Professionalization, Proletarianization and Caribbean Immigrant Nurses

While black Canadian nurses participated in the process of professional advancement, and other nurses were taking on less skilled tasks, Caribbean immigrants' engagement with this process was much more complicated, especially during their early migrant experiences. In their reminiscences, Caribbean nurses trained in Britain and the Caribbean emphasized how their skills were utilized once they migrated. Upon migration, the responsibilities they were assigned in Canada were not commensurate with what they were accustomed to in Britain and Caribbean. The immense stratification, a by-product of the proletarianization that nursing was undergoing, coupled with how their qualifications were assessed resulted in some nurses working as graduate nurses while others worked in "unprofessional" categories.

The process of having their qualifications assessed placed immigrant nurses in one of four sets of experiences. First, there were Registered Nurses (RNs). These nurses were graduates of a three-year program either in the Caribbean or Britain who met the provincial licensing standards as Registered Nurses, which included education in

obstetrical nursing. For example, Orphelia Bennett[24] immigrated to Canada in 1955 from Jamaica. Bennett trained at the University of the West Indies as a general nurse; she also obtained a midwifery certificate and her qualifications were accepted. Likewise, Vera Cudjoe[25] trained in Britain, later returned to Trinidad, and subsequently immigrated to Canada in 1960. Because she had midwifery training she too was granted her RN status. Neither Bennett nor Cudjoe had to take additional courses. A second group upgraded on their arrival in Canada in order to obtain their RN status. Because the "British system" (on which Caribbean nursing education and licensing was based) defined obstetrical and paediatric training as separate qualifications not included in the regular RN stream, some British or Caribbean-educated migrants lacked this crucial component necessary for Canadian licensure. When June Heaven[26] immigrated to British Columbia from Jamaica in 1967, she did not need additional courses to obtain her registration. But when Heaven left for Ontario seven months later, she was required to take the three months obstetrics course to obtain her registration. As Heaven's experiences reveal, there were differences in terms of how provincial nurses associations adjudicated immigrant nurses credentials. Both Monica Mitchell[27] and Inez Mackenzie[28] immigrated to Canada in the 1960s and

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[24] Orphelia Bennett [psued.], interview by author, Tape recording, North York, Ontario, 14 October, 2000.

[25] Vera Cudjoe, interview by author, Tape recording, Toronto, Ontario, 5 January1995.

[26] June Heaven, interview by author, Tape recording, Rexdale, Ontario, 11 November 1999.

[27] Monica Mitchell, interview by author, Tape recording, Toronto, Ontario, 7 April 2000.

worked as graduate nurses until they were able to obtain their registration, even though like Cudjoe and Bennett, they too had midwifery training. Some of the nurses had not taken formal obstetrics courses, but read the materials and then wrote the exams.

A third group refused to undertake extra training or examination, or failed in their efforts, and remained in a subsidiary category of health care worker. For example, Mryna Blackman[29] was a Registered Mental Nurse (RMN) in Britain who immigrated to Canada in 1971. Blackman felt that she should have been granted her RN status without having to take additional courses, and refused to upgrade. Finally, there were specific groups of immigrant nurses whose qualifications were not accepted at all and who would have had to complete a full Registered Nurse or Registered Nursing Assistant (RNA) programme or remain working in "unprofessional" categories of nursing work, such as nurses aide or health care aides. For example, Britain's State Enrolled Nurses (SEN) had no equivalent in Canada. When Elaine Mcleod[30] immigrated in 1969, she was told by the College of Nurses that she did not have enough paediatric background and she only needed a further twenty one hours in training to be considered an RNA. Mcleod then inquired at the school where the course was being offered and was told by the administrators that she had to complete the entire program – well beyond the twenty-one hours determined by

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[28] Inez Mackenzie, interview by author, Tape recording, Markham, Ontario, October 13 1999.

[29] Myrna Blackman, interview by author, Tape recording, Brampton, Ontario, 29 May 1995.

[30] Elaine Mcleod, interview by author, Tape recording, Unionville, Ontario, May 1995.

the College of Nurses. The idea of having to repeat a program that she had already completed in Britain incensed Mcleod who blamed the College of Nurses for its inability to interpret her British qualifications. In making reference to the College of Nurses Mcleod contended, "they didn't think it was up to their standard having done two years [in England] when theirs [in Canada] is just a ten month program." Similarly, Brenda Lewis,[31] a RN in Trinidad with training in psychiatry, immigrated to Canada in 1970 and was told by the College of Nurses that she had to redo the entire program. Lewis worked as a nurse's aide while attending Ryerson Polytechnic Institute at nights. Despite the similarity in training (in mental health) with Blackman, Lewis was unable to work as a registered nursing assistant.

The pursuit of professionalization through improved education was a mechanism used to ensure that nurses were equipped with the knowledge and skills required in the ever-changing world of nursing. High professional standards also benefited nursing in terms of its legitimacy in the medical profession overall. Yet in maintaining strict standards, professionalism also produced adverse effects as seen in the cases of some of the nurses in this study who were affected by how their credentials were adjudicated. Darlene Barnes[32], a black Canadian born nurse who trained and worked in Britain, Canada and the United States pointed out that part of the problem with how credentials

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[31] Brenda Lewis, interview by author, Tape recording, Toronto, Ontario, 22 February 2000.

[32] Darlene Barnes, interview by author, Tape recording, Toronto, Ontario, 22 October 1999.

are adjudicated was the inability of North Americans to recognize the possibility that quality education and training could be obtained elsewhere. This, Barnes maintains, is the reason why people trained elsewhere experience difficulty getting their qualifications accepted. "I find that if you are trained elsewhere that the assumption is that you were not properly trained. One thing about Americans/Canadians is they like pieces of paper." Whether, as Barnes suggests, nursing associations believed that nurses trained elsewhere are poorly educated and relied on this rationale for how some Caribbean nurses were assessed is not clear. What remains obvious is that the credentialing process affected how some Caribbean nurses were situated within Canadian hospitals and the duties they were assigned.

The intensification and routinization of work affected the allocation of duties among nurses. While professionalization resulted in gains for some workers, in terms of skill and control, proletarianization, which takes the form of de-skilling and fragmentation of work,[33] affected other nurses. These processes occur unevenly and have a differential impact on workers because some nurses gain status while others lose. As white and black RNs vacated bedside nursing to take on more leadership roles, some British trained black nurses, especially SENs, were delegated to assume those "personal care tasks,"[34] and domestic duties. These nurses experienced deskilling because they were unable to fully utilize their skills.

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[33] Coburn, "Professionalization and Proletarianization," 143.

[34] Ibid.

In the American context, Evelyn Nakanno Glenn has argued, immigrant women of colour who worked as assistants, health care aids, and nursing assistants "constituted the hands that performed routine work that was directed by others."[35] It was in these inferior positions that Caribbean nurses whose credentials were not recognized were concentrated. The autonomy that Caribbean SENs and other specialized nurses were accustomed to in England and the Caribbean was replaced in Canada with repetitious and monotonous duties subject to the authority of the predominantly white nurse-mangers. Lewis had previously worked as an RN in Trinidad upon migration. After migrating she worked as a nurse's aide in a nursing home, a move she stated that was rather demoralizing. Making reference to her responsibilities as a RN in Trinidad, she stated:

> As a RN, you had more responsibilities and being in charge. Here [I] was doing baths, changing patients, really back breaking work...I wasn't used to that sort of thing, being under somebody and having to do this kind of work. And then you were working with people who never had any skills at all in regards to nursing. They just hire them because they needed somebody.

Lewis delineated the hierarchy that nursing engendered. Leadership and responsibility were reserved primarily for white RNs, while menial duties now associated with bedside nursing were for the unskilled and required very little or no nursing training. Thus

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[35] Evelyn Nakano Glenn, "From Servitude to Service Work: Historical Continuities in the Racial Division of Paid Reproductive Labour," in Vicki L. Ruiz and Ellen Carol Dubois eds., 2nd Ed, Unequal Sisters: A Multi-cultural Reader in U.S. Women's History (New York: Routledge, 1994), 427.

professionalization with its emphasis on education can be used as the rationale, to mask how racism can define how black nurses were situated in the occupation.

"Degrading" and "non-educational", or lacking in theoretical support, were terms the nurses used to describe their responsibilities. Elaborating on her first job at the Toronto Western Hospital, Mcleod also remembered:

> I wasn't doing a whole lot, and it was frustrating. You were coming from somewhere where you were accustomed to running a whole unit, to do all your orders, and to carry out all your assignments that the doctors gave you, and having come here, you can't do nothing. You couldn't do dressing and you couldn't give meds. All you could do was make beds, feed and bathe patients.

Despite the fact that over time her responsibilities increased, this did not prevent Dorothy Jones[36] from commenting that:

> I found at the time that it was degrading for me. I was just like a second class; I was more like an assistant to the RN. I just grin and bear it, did what I had to do. As time went on, they started giving you little things like doing the G-feeds, and you were able to turn on the oxygen, and all these sorts of things that was nothing for me.

Commenting on the introduction of subsidiary workers in nursing and the impact of this on the division of labour, McPherson points out that "the ideological and formal divestment of those tasks that had bordered on the domestic and personal constituted a crucial line of demarcation between "professional" graduate nurses and "non-

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[36] Dorothy Jones [psued], interview by author, Tape recording, Rexdale, Ontario, 29 February 2000.

professional" subsidiary workers." [37] Thus professionalization operated to promote some nurses, while proletarianization placed some Caribbean nurses in an inferior position. Given the hierarchical structure of nursing, lack of adequate credentials rather than racism could be used to justify how Caribbean nurses were located in the occupation.

To deal with the disappointment associated with the accreditation process and the fact that they had to work in subsidiary positions, Caribbean nurses responded in several ways. Blackman refused to upgrade and chose to work instead as an RNA, because she felt that additional Canadian training would still be limited compared to her training in England. The other nurses upgraded by taking additional courses immediately or when it was convenient. Even as they were disadvantaged by the credentialing process, which is intricately linked to professionalization strategies, Caribbean nurses emphasized how much better trained they were than their Canadian counterparts as a way of understanding and dealing with the process of deskilling.

Caribbean immigrant nurses' perceptions of Canadian nurses' relationship with the medical profession revealed the contradictory nature of professionalization. Before the era of registration and control over the education process, nurses were classified as the "physicians hands," a discourse of subservience that reflected the care/cure dichotomy. This perspective emphasized the notion that nurses naturally possessed qualities that make them caring, while doctors learn the curing tasks that involve saving

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[37] McPherson, Bedside Matters, 223.

patients lives. Nurses' subordination "structures the nurse-doctor relationship,"[38] which reflects, according to Ema Garminkov the archetypal family: the doctor as father, the nurse as mother, while the patients are children. Garminkov argues the very structure of nursing replicates the wife's role in the patriarchal family. As such the role of the nurse is that of "nurturer," and the physical work is closely identified with domestic work, which has no value in the medical hierarchy because nurses are completing functions that are "naturally" within their sphere. As a result, a paternalistic relationship often exists between doctors and nurses.[39] Improved education and transformations in nursing meant that RN duties were expanded thus eliminating the idea of nurse as the "physician's hand" and nurses were then seen as equally vital in curing as well as caring. For example, after World War II nurses began "charting on permanent records, administering medications, taking blood pressures and inserting catheters."[40] As nurses' duties expanded, they took on responsibilities that the professional elite viewed as improving nurses' status.

Yet Caribbean immigrant nurses continuously made reference to the omnipresence of doctors in medicine. British and Caribbean trained RNs argued that

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[38] Ema Gamarnikov, "Sexual Division of Labour: the Case of the Nursing," in Annette Kuhn and AnneMarie Wolpe eds., Feminism and Materialism: Women and Modes of Production (Boston: Routledge, 1978), 97.

[39] See for example, Jo Anne Ashley, Hospitals, Paternalism, and the Role of the Nurse (New York: Teachers College Press, 1976): Mariann C. Lovell, "Daddy's Little Girl: the lethal effects of paternalism in nursing," in Janet Muff ed., Women's Issues in Nursing: Socialization, Sexism and Stereotyping (Illinois: Waveland Press Inc, 1988).

[40] McPherson, Bedside Matters, 222.

duties they were traditionally responsible for in Britain and the Caribbean were still primarily in the hands of doctors in Canada thus limiting Canadian nurses' roles. Mackenzie who worked at the University of the West Indies Hospital in Jamaica before immigrating to Canada expressed criticisms about the role of nurses and doctors in Canada similar to those of British trained Caribbean nurses. Mackenzie maintained that in Jamaica:

> The doctor would leave you to make a bit more decisions. If a patient has a headache, we give the patient the medication, and tell the doctor when they come. [In Canada], they take away a lot of the responsibility that you use to carry. I don't know if it's because they have more doctors. You have to go to them for everything.

For Blackman, doctors' control over the medical process disadvantaged Canadian nurses, whose expertise and knowledge was defined as secondary to that of doctors, an issue that was not as prevalent in England. In England, Blackman lamented:

> ...You were a nurse, you learn everything, whereas here you learn some things, and the things you do learn, you cannot really work with it, because the doctors do most of it. That's what nursing here is all about. You are not really a nurse.

Just as some Caribbean nurses experienced deskilling due to the way that they were positioned in the nursing hierarchy, and others criticized the way Canadians "do nursing," practicing midwives were further deskilled due to the legal prohibition against midwifery generally in Canada. Many trained midwives and nurses felt that this lack of crucial education placed their Canadian counterparts in a subordinate position vis-à-vis medical doctors who exercised authority in an area the British and Caribbean-trained

nurses saw as women's rightful sphere. In Canada, the virtual elimination of midwives is a part of the story that dominates nursing scholarship and is seen as reflecting the unequal relationship that has existed between medical authorities and women.[41] Writing about midwifery in the nineteenth and twentieth century, Diane Dodd asserts that the medicalization of childbirth with the emphasis on "physician-controlled and eventually hospital birthing"[42] was part of the outcome of male practitioners' dominance over the traditional mothering role. Doctors' hegemony over the birthing process continued well into the twentieth century with practicing midwives virtually eliminated in most provinces. By contrast, midwives continued to play a central role and were recognized in the Caribbean and Britain. In fact, many RNs went on to do extensive obstetrical nursing training and to license as midwives. Caribbean and British trained midwives viewed Canadian nurses as lacking in autonomy particularly around childbirth and argued vehemently that childbirth ought to be nurses' domain.

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[41] For a discussion on how medical men in the U.S. in the 20th century took control, authority, and ability to earn a living away from midwives to ensure the institutionalization of scientific medicine and that the medical field would be male dominated see Barbara Ehrenreich and Diedre English describe in "Exorcising the Midwives" in For Her Own Good: 150 Years of the Experts' Advice to Women (New York: Anchor Press, 1978).

[42] Dianne Dodd, "Helen MacMurchy, Popular Midwifery and Maternity Services for Canadian Pioneer Women," in Dianne Dodd and Deborah Gorman eds., Caring and Curing: Historical Perspectives on Women and Healing in Canada (Ottawa: University of Ottawa Press, 1994), 135.

The experience of British trained Nancy Ward[43] who immigrated to Canada in 1970s affirms some of the challenges licensed midwives faced. Ward had difficulty finding employment because, according to the Ontario College of Nurses, she lacked "Canadian experience." "When I came here, they said I needed Canadian experience. Every hospital you went to it was Canadian experience. I went back to the College of Nurses; they said they would send me to a place. It was a thousand miles away from Toronto," Ward recalled. Family commitment prevented Ward from relocating so she worked part-time in Toronto until she procured full-time employment. A trained midwife, Ward highlighted her own experience as a pregnant mother to illustrate a number of points ranging from the lack of information presented to pregnant women, how limited Canadian nursing education was with respect to childbirth, and how doctors dominated obstetrics. Ward who currently works at Bay Crest Hospital remembered:

> When I was pregnant, no one told me anything. I didn't tell them that I was a nurse. I didn't go to the doctor until I was six months. I knew I was having a good pregnancy, no complications. I had the child and still no one told me what to do. If I were a new mother, I wouldn't know what to do.

Ward further explicated the difference between the doctor's role in childbirth in England and Canada:

> Over here, most of the doctors do the delivery. I took that to mean that the nurses really had nothing to do in terms of examining the baby. In England when you do midwifery, you have to know everything about labour. The nurse is there, even if it's a student nurse [she] examines you. You were

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[43] Nancy Ward [psued.], interview by author, Tape recording, Scarborough, Ontario, 6 June 2000.

> told everything about the pregnancy and what to look for. You don't have to be a midwife to know that.

According to Ward, student nurses in Britain were expected to check for abnormalities once a pregnant patient entered the hospital, a procedure that was absent in Canada. Getting acquainted and accustomed to the Canadian system would have been more difficult for Ward had she not been employed in a hospital with a number of white British and Caribbean trained nurses.

Lilli Johnson[44] who is now currently retired had an extensive career in England and Scotland as a midwife before migrating in Canada in 1960. Johnson concurred with Ward regarding the gender and racial division of labour that existed in Canada and succinctly captured how patriarchy defines the relationship between doctors and nurses:

> They give you no responsibility. The doctor has to order everything. Although it seems to be getting better, it seems all they [doctors] want is a 'handmaiden.' There are so many British trained nurses who have their midwifery training, but none of them are accredited for it here.

Johnson's criticisms regarding medical authority over the birthing process demonstrates a keen understanding of how gender and race informs the relationship between doctors and nurses. Instead of working on a ward and watching doctors deliver babies, Johnson chose to pursue additional studies that would enable her to work as a public health nurse.

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[44] Lillli Johnson, interview by author, Tape recording, Scarborough, Ontario, 9 August 1999.

Eileen Jacobson[45] another British trained midwife who worked on the paediatrics floor when she immigrated to Canada in 1960 echoed Johnson's criticisms. She explained how doctors continued to enjoy a monopoly on certain procedures, which undermined nurses' roles. Currently retired, Jacobson hopes that doctors in Canada will eventually see the value in sharing power and privilege, a stance, which she sees as beneficial to the health care field as a whole. Laughing, Jacobson recounted a popular story she heard during her tenure as a nurse. According to the story, the doctors coveted thermometers when they were first introduced in the hospital, "they walked around as if it was a precious thing," Jacobson explained. "In time" she added, "[doctors] too will learn that they will have to give up procedures to nurses and accept it."

The above examples reveal how different groups of Caribbean nurses personally experienced deskilling. The inability of the College of Nurses to decipher some of the practitioners' qualifications led to some nurses working in 'non- professional' categories. Caribbean and British trained midwives were further disadvantaged because childbirth was 'safely' in the hands of doctors in Canada. Whereas some nurses perceived it was an unfair system, they in turn emphasized their own sense of professionalism as good nurses who were well trained – a self-perception which helped to shape their identity as immigrant nurses working within a different system.

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[45] Eileen Jacobson, interview by author, Tape recording, Burlington, Ontario, January 1995.

Organizational changes in hospitals coupled with proletarianization also affected how Caribbean and British trained RNs understood and explained their commitment to patient care. With the introduction of subsidiary staff, bedside care was supposed to be the purview of nursing assistants, and other non-professional workers rather than RNs. In 1957 for example, Christine Livingston, President of the Ontario Registered Nurses Association outlined in a letter to the Premier of Ontario some of the problems facing nursing. Livingston maintained that even though medical science made tremendous strides nursing was not keeping pace. Livingston urged the premier to make resources available to aid in the professionalization of nursing. She also made the distinction between the regular RNs, "those who have spent less time in her preparation than the grad of the university school of nursing,"[46] and stressed the need for university prepared nurses. These nurses would have a broad background in the Humanities and Sciences enabled them to give skilled nursing care, but to also assume administrative and teaching responsibilities.[47] RNs would no longer be responsible for the "practical work", an improvement in the professional standing of the graduate nurse advocated by nursing leaders, [48] such as Livingston. Referring to this change, McPherson noted:

> As they relegated certain tasks to those subsidiary workers personnel, RNs divested themselves of the labour-intensive personnel care domestic tasks

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[46] Ontario Provincial Archives, RG 10-106-92-1, "Letter to the Premier," fr: Christine Livingston, President, Registered Nurses Association of Ontario, 21 Jan, 1957.

[47] Ibid.

[48] McPherson, Bedside Matters, 226.

> that traditionally had blurred the boundaries between maternal and 'womanly' care and the specific skills offered by trained nurses.[49]

These subsidiary workers, Livingston maintained, would be responsible for, "those simple duties essential to the comfort of the patients."[50] Still, there was disagreement among nurses as to which group of nurses should really be at the bedside caring for patients. These discussions, which began after World War II, continued well into the 1960s leading to tensions as nursing leaders struggled to define the responsibilities of "professional" nurses versus "unprofessional" staff.

Thus, in addition to immigrant nurses whose credentials were not recognized in Canada and the nurse-midwives who were not permitted to use their obstetrical skills in Canada, RNs experienced deskilling in a third way when they faced restructuring of nursing tasks. RNs were taking on more leadership and administrative roles while doing fewer personal patient care duties, which the nursing leadership lauded as an indication of professionalism. Conversely, British trained RNs felt that the fragmentation of work that some Canadian nurses were celebrating actually deskilled the job of caring. For example, Cudjoe pointed out that patient care was the essence of "real" skill that Canadian nurses lacked. In making reference to patient care in England, Cudjoe commented:

> The job of nursing a patient was different in England. We used to have spend time for instance with the patients. It meant a lot. Psychologically

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[49] Ibid.

[50] Ontario Provincial Archives, RG 10-106-91-1, "letter to the Premier," fr; Christine Livingston, President, Ontario, Registered Nurses Association of Ontario, 21 Jan, 1957.

> that was very good medicine and we knew that to be true. Our whole training when it was given to us we understood that it was very personal that kind of psychological treatment that was good for the patients, sometimes they needed that more than the medicine.

V.V. Murray's 1960 study on nursing in Ontario explicated the difficulties practitioners had in trying to decide how the position of RN should be defined,[51] along with additional problems facing nursing. Murray, for example, concurred with Cudjoe that the psychological aspect of caring for a patient was absent from the Canadian system. He maintained that this area was underdeveloped but that hospital administrators and nurses recognized the importance of providing psychological care. Murray cited inadequate resources among other reasons for not including this as a vital part of nurses' training. Murray noted that, "in the case of increased psychological care, we found most of the directors of nursing were sensitive to this, yet were rather discouraged with the possibility of implementing change."[52] Hospital administrators hoped that "improvements would come about as their hospital hired new graduates whose training had included the subject."[53]

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[51] Murray's work is a comprehensive study of nursing and nurses, including a critical review of nursing activity, working conditions, supply and demand, and issues of education. Murray concludes his analysis by recapitulating the various problems within nursing, and offered recommendations and approaches to resolving these issues. Nursing In Ontario: A Study For the Committee The Healing Arts (Toronto: 1970), 39

[52] Murray, Nursing in Ontario, 39.

[53] Ibid.

Proletarianization affected how bedside care was administered as nurses in the name of efficiency worked to get their tasks completed in the allotted time, which undoubtedly affected the quality of care that patients received. The Canadian Nursing Association (CNA) submission to The Royal Commission On Health Service not only highlighted the problem of the nursing shortage but also addressed how the trend to shorter working hours, transformations in science and technology were affecting nurses and nursing.[54] For Cudjoe the business-like way in which healthcare was being practiced in Canada was disturbing. An incident with a head nurse who criticized her for speaking to a patient, coupled with the reorganization taking place in the hospital, contributed to Cudjoe leaving her vocation. She explained:

> I actually fell into destitution because of that attitude in trying to do this to the patient. It was cut and dry, when 4 o'clock came and people looked at their watches, and dropped what they were doing and left. I felt that this was horrible business. There was little sensitivity, I began to feel frustrated, feel that something is wrong, something is radically wrong things were not right. I never really settled into nursing here. I remember loving nursing; it was a nice thing to nurse a patient as a student or whether you were in charge.

The problems that Cudjoe included as her rationale for leaving nursing in the early 1960s would continue to plague nursing twenty years later. Many British trained Caribbean nurses also echoed Cudjoe's frustration with what she perceived was the devaluation of bedside nursing care. For example, Jones claimed that:

> I knew I had the bedside training, I had [it] from scratch. They

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[54] Canadian Nurses' Association, Submission to The Royal Commission on Health Services (Ontario; 1962), ii.

> [Canadian trained nurses] went to school into a college, and the only time they had the practical training was only two days a week…But in England, when you're a nurse and in training you do those things, because you are the very person that is working on the floor with the patients.

Other British-trained Caribbean nurses also reiterated Jones's claims that the British system was superior to the Canadian one because bedside care was seen as intrinsic to patient care. The introduction of technology into nursing would transform how patient care was provided but also accelerated the impact of proletarianization on some nurses' work in the form of deskilling.

Technology and Deskilling

Deskilling is often defined as the consequence of technological advancement introduced into workplaces, which has grave implications for how workers perform their duties. The argument is that with the introduction of machines into the workplace, workers faced increased managerial control, loss of autonomy and control of the labour process, a separation of the mental from manual, and increase alienation. Harry Braverman addressed these themes in his influential book, Labor and Monopoly Capitalism.[55] He argued that in the twentieth century, employers and managers employed scientific management principles to wrest control of the labour process from workers. With the reconfiguration of labour, workers found themselves carrying out simple tasks that require little or no training and were orchestrated by managers. Braverman

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[55] Harry Braverman, Labor and Monopoly Capitalism: The Degradation of Work in the Twentieth Century (New York: Monthly Review Press, 1974).

maintained that capitalists benefit from a deskilled workforce because deskilled workers are obviously cheaper and have less bargaining power. Although his emphasis was on how class relations – not gendered ones -- are constituted in the workplace, he did demonstrate the processes whereby clerical work (which is now a predominantly female occupation) became proletarianized. Once a highly skilled and well-paid position, the introduction of machinery led to the deskilling of clerical work.

The introduction of technology into nursing has substantially restructured the physical aspect of nursing has also affected how patient care is given. Within scholarly debates on the usefulness of technology, feminist scholars caution against a reductionist and positivist view of women's relationship to technology. Instead of accepting that technology automatically means progress, it is important to explore how it contributes to the creation of a sexual division of labour, but also how this division of labour is dismantled and re-established through individual and collective efforts[56]. It is also important to keep in mind that technology is the outcome of social processes, which are constantly shifting and changing. In nursing, technology is intricately tied to professionalization because additional education is often required when nurses operate these new devices. While these very same nurses are able to operate new technologies the argument is that it actually deskills them because it takes away the caring aspect of nursing which is fundamental to the occupation. Furthermore, in the long run the

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[56] See for example, Juliet Webster, Shaping Women's Work: Gender, Employment and Information Technology (New York: Longman Sociology Press, 1996).

technology drains the skill requirements usually demanding semi-skilled rather than skilled workers. Moreover, as Ruth Minard points out, "technology is not confined to the introduction of machines, but includes changes at the site of production, in the transfer of production between the workstations, and in the coordination of the two."[57] Rinard sees the increase in the numbers and types and use of drugs used by nurses and the introduction of machines in manufacturing as similar.[58] She also compares the development of specialized care and critical care information systems units to batch processing and automated manufacturing respectively.[59] While Minards and other scholarly critiques are legitimate, nurses' insights into how technology transforms the social organization of the workplace and their own individual and collective responses to these changes are also important.

Because they trained in Canada, Watson and other Canadian born nurses who began their training in the 1950s were able to provide sensitive thoughts into the advantages and disadvantages of technology in nursing. These nurses tend to advocate and applaud the use of technology if patient care is not compromised and if there are actual improvements in bedside and patient care. Drawing on her extensive career as a nurse, Watson pointed out that, in many respects, "technology has been great, and I think

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[57] Ruth G. Minard, "Technology, Deskilling and Nurses: The impact of the Technologically Changing Environment," Advances in Nursing Science, 18 no 4 (1996): 62.

[58] Ibid.

[59] Ibid.

it offers a whole lot more of nurses 'interpretation of patients' wellness... It's been a big improvement." To support her point, Watson used the example of a patient who underwent open-heart surgery. In a situation such as this, Watson maintained, a highly experienced and skilled nurse would look after the patient. This nurse, according to Watson, would be able to examine the monitor the patient is hooked up to "see if they are going to fibulate...You could be forewarned because you have a nurse sitting there responsible [for] checking those monitors as they go along."

For Steeles, technology is only useful insofar as it is used as an efficiency saving mechanism. According to Steeles, "we can get reports right away; we don't have to rely on invasive surgery for answers. It [technology] is fast and efficient." References, for example, were made to how specimen tests produced more accurate results and are done at a much faster pace than the older method. The use of certain technology prevents, for example, the over-crowding of certain departments, which has benefited not only the patients but also nurses. Using again the example of the patient who had post surgery operation, Watson pointed out, "we whip them into the recovery room, and most recovery rooms can take a respirator," which leaves enough space so that nurses can do their job. Watson continued that, "in the critical care units where nurses are well trained to operate those machines they can look after those patients even more intelligently than they could if it was a hit and guess." The common consensus is the patients are the biggest beneficiaries of technology. Thinking about what nursing was like prior to the introduction of technology Watson explained:

> We don't have patients biting thermometers and cracking them in their mouths, because we had oral thermometers. Now we get a needle, we can just stick them in the ear, and in two seconds like the temperature is taken. It [technology] has taken the danger aspect away as well.

The majority of nurses were not critical of technology, which is not surprising given that the authoritative discourse equates technology with progress. Watson, for example, argued that once nurses are trained to operate a particular technology it is easier to make more intelligent decisions with respect to patient care. Yet she did not acknowledge that sitting in a room for eight hours monitoring a machine does not encompass all that a nurse is trained to do. Furthermore, in a situation where a nurse is monitoring a patient from a different location it is difficult to simultaneously use technology and provide patient care. Nurses who monitor devices are being deskilled because this work is monotonous, unchallenging and renders obsolete other abilities that are central to nursing.

In discussing nurses' response to technology, Rita Maloney, paraphrasing Marie Campbell, maintains that, "technology continually transforms the context and ideas people use to think about it, making it difficult for nurses or anyone else to stand back and judge its impact. But nurses must stand back and judge."[60] Even when RNs praised the use of technology in nursing, a few nurses were cognizant of its disadvantages particularly as it relates to patient care. While they are unable to change what has become

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[60] Rita Maloney, 'Technological Issues," in Alice J. Baumgart and Jenniece Larsen, Canadian Nursing Face The Future 2nd Edition (Toronto: Mosby Year Book, 1991), 295.

inevitable in nursing, they have not been passive recipients of these devices. For example, Heavens argued that the debate about technology and the impact on patient care needs contextualization which means examining how the wider society sees and values the role of caring. Heavens acknowledged the benefits of changes in nursing education and the concomitant skills that nurses have acquired but pointed out that it is the working conditions coupled with society's attitude and perception about caring that has affected patient care. "Definitely without a doubt, nurses have required more skills with high tech procedures. You have better educated nurses to handle more high tech procedures," she remarked. But speaking to the impact on bedside care, Heaven pointed out that the working conditions such as the patient/nurse ratio is a lot higher now than in previous years which affects not only nurses' well being but how patient care is delivered. According to Heaven, we currently live in a society, which is indifferent and sees technological advancement as contributing to this process as nurses come to depend on machines and caring will no longer be essential to nursing. For Heaven, patient care cannot be understood in isolation from the changes taking place in society. Thus, her conceptualization echoes Reverby's stance that "nursing is a form of labour shaped by the order to care in a society that refuses to value caring."[61]

For Jones the way in which technology appears to be replacing traditional nurses' knowledge, especially among newer nursing graduates, is a concern.

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[61] Susan Reverby, Ordered to Care: The Dilemma of American Nursing 1850-1945, (New York: Cambridge of University, 1987), 1.

Missing from nursing is a system whereby older experienced nurses can act as mentors for younger nurses and pass on their knowledge as opposed to giving computers precedence over nurses' experience. Thus the older nurses are "just holding on, doing the best that they could, they are waiting to get out" Jones declared. Speaking about younger nursing graduates, she continued:

> The younger people are just graduating and coming in, they don't have the older nurses to prime them, you know, to pass on their experience. But with the new technology, they do everything by the computer, but the basic hard working experience that the older nurses had, you wouldn't find that among the new nurses coming in. So in that way it's more or less left for computers and machines....

Nurses however have a different reaction to computers in nursing than they do with other forms of technology.

While these nurses generally view the introduction of electronics machinery such as the respirator and specialized care units as contributing to good patient service, the introduction of computerized systems is seen as more of a nuisance because it is time consuming. There is definitely a generational difference in terms of how computer technology is viewed and employed. For the most part, those nurses who began working in the 1950s and 1960s displayed more discomfort with the use of computers in the hospitals and also see it taking away in a major way from bedside care. It appears from observation, one interviewee lamented, "that nurses spend more time putting things in the computer, and trying to work this computer." The use of computerized systems in the hospitals is often followed by new management protocols as a way to manage the

workplace. Speaking about the computerized and the patient classification system, nursing researcher Jacqueline Choniere argues that:

> Management, in an effort to rationalize the workplace, had created a new work organization to enhance the new technology. More specifically, management had found a technology which they believed would help them to rationalize the workplace. The new technology supports the new organization, and the resulting changes in the nature of work exert pressure on the worker, in an attempt to prevent her from functioning as before.[62]

Marie Campbell further contends that the reason the patient classification system was implemented in hospitals was so that management could have some control over nurses' labour placing differential value on aspects of their work. Campbell explains, "once the work was captured 'abstractly' (as classifications, units, and levels of care), hospitals could reconfigure the financial allocation to nursing labour and thus by creating a scarcity, require nurses to pick up their pace of work."[63] The elimination of nursing staff and with fewer nurses working the computer is far from the efficient equipment that it was purported to be. In terms of her own work, Watson pointed out:

> I don't even bother with the computer...By the time I type in I.D.'s and all that stuff, I could have done another I.V. By the time I get done with this information input and then I have to do my charting afterward, I find that

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[62] Choiniere, "A Case Study Examination of Nurses and Patient Information Technology," in Pat Armstrong, Jacqueline Choiniere and Elaine Day, eds., Vital Signs (Toronto: Garamound Press, 1993), 66.

[63] Marie Campbell, "Knowledge, Gendered Subjectivity, and the Restructuring of Health Care: The Case of the Disappearing Nurse," in Sheila M. Neysmith ed., Restructuring Caring Labour: Discourse, State Practice, and Everyday Life, (Toronto: Oxford University Press), 190.

> for me it does not save me any time. If I had my own way, I would probably do away with computers.

Clearly, Watson and her counterparts recognize the ineffectiveness of some of the technology instituted in the workplace and did not always use it in the way it was intended.

In her study of nursing, Choiniere also noted that even after the implementation of computerized systems nurses avoided using the computers and continued to use the telephone to communicate around issues like dietary changes or lab results. Thus management's initial intent in terms of how computers would be incorporated into the workplace did not always translate into practice with the nurses. As Choiniere points out, "in spite of management's intent, and the technology itself, many nurses were refusing to change their work practices. Nurses were exercising some resistance by refusing to use the computer some of the time."[64] But in order to meet the predetermined time frame demanded by the patient classification system, the nurses' workload was increased. Lewis cogently pointed out that there is really no time available for bedside care:

> You don't have time to do that now. You have got to do your paper work and you have so many patients to look after, before you had less, and you could really do bedside nursing for your patients. But now it's a matter of survival, of getting the workload done. So you cut corners to survive.

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[64] Choiniere, "Nurses and Patient Information Technology," 67.

While Steeles for example recognizes the importance of technology in terms of its efficiency, she worries about its effect on nurses' skills - skills that are intrinsic to how nurses care for their patients. Steeles, now retired, sees the situation in the following way:

> I think that the observation skills of nurses have been downgraded. I feel that the nurses don't have time, and doctors don't seem to listen or rely on them like they used to. The machines are not able to tell us, for example that, Mrs. Jones is worried about a sick child at home, or that she is worried about leaving her ailing mother at home.

Some nurses in this study agreed with the analysis that nurses' skills improved with the introduction of technology but they do not see technology as superior to their experience. Nurses lament that an important attribute such as caring that entails duties like comforting patients is being subverted in favour of administrative duties all in the name of good organization.

To expand our analysis of technology, one question that Rinard proposes we ask is how "as the technological changes are introduced into nursing, are the social relations of a capitalistic society maintained?" Nurses such as Barrett do recognize how some technology instituted in nursing is profitable for management because managers are able to eliminate nursing staff in the process. Barrett used the following example to illustrate her point:

> When you have to take a temperature you had to stand there and wait for the thermometer to reach its level. Now in seconds, you can do the temperature. Because the technology wasn't there you had more time then to spend with the patient. They have cut the staff in nursing because they [management] are saying it's taking less time to do the things you used to do. The patient interaction is no longer there like it used to be.

Barrett sees management as deliberately engaging in the centralization of work plans to control the labour process at the expense of workers and to save money.

The use of new technology has not only reorganized the daily routine of nurses' work but it has also impacted upon the relationship between nurses and their supervisors. Indeed, nurse managers are often in a conflictual position as those responsible for ensuring that the new technologies and management systems are being carried out. Nursing scholars Alice Baumgart and Jenniece Larsen argue that "nurses who occupy middle-management positions are often laden with budget, staffing and related functions as a result of decentralization and frequently have very little time to provide necessary 'support work' to ensure that nurses feel valued [or] will take risks to find out creative solutions to workplace problems."[65] Thompson's insight into how management has changed in the last twenty years reaffirms Baumgart and Larsen's analysis. According to Thompson, management show very little interest in the welfare of workers and her frustration is evident in the following quote:

> Managers used to care about you. You are not well, just go home. People would care and you would get your vacation. Now I can't even get a vacation this year because we don't have enough staff, and they can't grant you vacation, if they don't have any staff. Nurses are caught in a catch twenty-two because we work in the health care field and caring for people whose lives are in your hand, you can't take a vacation because there is no staff.

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[65] Alice J. Baumgart and Jenniece Larsen eds., Canadian Nurses Faces The Future, 2nd Edition, (Toronto: Mosby Year Book, 1992), 233-4.

Like their white counterparts, these transformations in nursing have led black nurses to question the very philosophy and foundation on which nursing has been constructed. In the midst of cutbacks, short staffing, and minimal wages, the ability and desire to "care" has certainly been eroded. Another interviewee illuminated her feelings:

> Hospitals run like businesses and nurses are at the bottom of the totem pole. They know that nurses will work anyway, because you can't walk off a unit and abandon your patients. They cash in the whole philosophy off what a nurse does, the caring, nurturing, so you are going to continue nursing. We are held hostage to that.

Cost containment measures proposed in the 1970s and 1980s have left most nurses who are currently working disillusioned, and those who are retired satisfied with their contributions to nursing, but also concerned about the occupations' future.

Cutbacks and Nursing

The quality of health care service that health care workers provide is contingent on the political economy. As employees of a publicly funded system, nurses' work is affected by whether funding is reduced, expanded or withdrawn, and in an era of rising health care expenditures decreased government funding to health care is putting pressure on hospitals to control costs. Although the question of providing adequate patient care has plagued nursing since World War II, the late twentieth century has seen a new shift in how nurses perform their work. In the 1950s and 1960s, the debate about patient care centered on which group of nurses would be responsible for bedside care. In the 1970s and 1980s the emphasis on efficiency and cost control led to structural changes in hospitals and the reorganization of nurses' work. Speaking about nursing in the late

twentieth century, sociologist Pat Armstrong points out: "Nursing work is again being transformed and jobs are being eliminated or made insecure. For the first time in many years, nurses are being laid off, and those who remain work harder, under worsening conditions, with less and less opportunity to provide the skills and care they have the skills to provide."[66] In addition to patient care being compromised, nurses' morale and commitment to work is also affected. Nurses on the floor, according to Dorette Thompson[67], "have lost a lot of pride in their work because of the way hospitals have treated nurses. There is no loyalty, and there is a lot less of that patient caring. There is no time to care, the nurses on the floor tell you."

For Lewis the cutbacks in health care in the 1980s created an environment where the co-operation visible in the 1970s was replaced by hostility in nursing:

> Nursing has changed quite a bit; there was a more supportive environment especially for new grads going into the profession. Now in 99% of the cases, it is such a hostile environment. It's survival of the fittest, you know, and again, it is all because of the restructuring, and the cutbacks. Nurses are very stressed; nurses are very disillusioned; they are disappointed with what's happening within the profession.

This particular sentiment is not unique to Lewis and was expressed by other interviewees who lamented the changes the occupation has undergone since they began their careers. Once viewed as a respectable occupation when they were girls, a few nurses who are still

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[66] Armstrong, Choinire, and Day, Vital Signs, 12.

[67] Dorrette Thompson [psued], interview by author, Tape recording, Mississauga, Ontario, 17 August 2000.

employed insisted that they would dissuade their daughters from becoming nurses. Unable to handle the cut backs, layoffs, or loss of seniority some nurses opt for early retirement, others, who are near retirement, work on the registry, or have left institutional work altogether. Nursing scholar Alice Baumgart maintains that the situation in nursing is "further compounded when service provided to patients is subverted by understaffing, inadequate supplies, and equipment -and by according priority to the execution of medical treatments over other aspects of nursing care."[68] Amidst all the transformations taking place within the occupation, the nursing elite continues to be preoccupied with how to improve nursing's status.

Professionalization and Education

Sarah Jane Growe's argues that, "nursing has been trying to, and failing, to define itself as profession since the turn of the century." [69] Her conclusion that "no single quality sets apart a profession more than the level of training and education necessary to gain access"[70] has been reiterated by other nursing scholars with respect to general nursing education. This emphasis on improved education has divided university-trained nurses with degrees from hospital-based trained nurses with diplomas. As I have demonstrated in the beginning of this chapter, professionalization not only provides some nurses with status, control and power, but it also operates to create a hierarchy within the occupation

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[68] Baumgart and Larsen, Canadian Nursing Faces The Future, 12.

[69] Jane Growe, Who Cares, 157.

[70] Ibid.

that fosters tensions among nurses. And while there are already divisions based on race, age, skill, experience, and knowledge, education intersect with these same differences to create a climate of hostility among nurses. Lewis's insight on the divisions within the nursing hierarchy serves as an illustration:

> Some nurses' figure that they are way up there, and the others, such as the RPNs [Registered Practical Nurses] are down below, and never the twain shall meet. It puts a division between the RNs and the RPNs, and right now there is a lot of conflict. The RNs figure that they do x,y,z and RPNs are down here and they should only do x,y,z. Now the RPNs are saying that [they] have the skill and knowledge to do a little bit more, but it seems as though they have to get permission from the RN to do that.

These differences also play out in terms of who is responsible for bedside care and those responsible for administrative duties. Watson claimed

> There has been some thinking of the higher ups that unless you have a degree your nursing is missing something. Bedside nursing is bedside nursing, and that means that nurse who has the experience far outweigh the nurse who walks in with her big fat degree and can sit behind the desk and do administrative as well. I figure a degree helps you to improve your skills as far as leadership and things are concerned. But they certainly can never replace the work that the bedside nurse can do.

The idea that nurses' identity and skills are linked to their ability to provide bedside care for patients was reiterated several times throughout the interviews. These nurses feel very strongly that if they are unable to care for patients in a way that is beneficial to them, then they are not nursing.

Watson is not the only nurse decrying how the emphasis on education as an indication of the profession's status has affected social relations among nurses.

Growe points out that "more than 80 per cent of registered nurses working in Canada today have graduated with diplomas, either from a hospital based-school or community college,"[71] but noted that the thrust towards university educated nurses has left the majority of nurses feeling insecure. The CNA proposal that nurses should have degrees will obviously impact diploma nurses especially as Growe notes, "hiring practices have already been influenced by the national lobby for entry to practice. After 1982, hospitals, despite union contracts, started to hire and promote degree nurses first."[72] These steps are a sure way of contributing to further demarcations in nursing fracturing the potential of any affinity between nurses. Even though individual black nurses have sought improved education to be able to gain improved professional credentials, some nurses are critical of how education is being utilized in the occupation. Although most nurses in this study are retired, they have witnessed the shift from hospital-based training to colleges and universities. Still, they could also be responding to the decision by the CNA to institute the "entry to practice policy," whereby nurses in the latter part of the 20th century will be expected to have a BScN degree.

Caribbean Nurses and Professionalization Pursuits

Scholarly discussions about professionalization usually focus on specific policies and strategies that nursing bodies deploy especially around credentialism, registration and education to advance the occupation. Less attention has been paid to how individual

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[71] Growe, Who Cares, 158

[72] Growe, Who Cares, 159

nurses respond to or participate in professionalization efforts. Because I have already focused on black Canadian nurses in supervisory positions, at this juncture in the chapter, I want to focus on Caribbean nurses and their engagement with professionalization strategies. Their insights are different from their Canadian born counterparts who did not face the credentialing process demanded by immigration.

Caribbean-born nurses' decisions to accept or decline supervisory positions or pursue additional training and education were influenced by family commitments, racism, climate of the workplace, and ongoing structural changes in nursing. When British-trained Thompson arrived in Canada 1968 she worked at the Toronto Western Hospital and within six months was promoted to assistant head nurse. Even though Toronto Western had on staff a number of Caribbean nurses most were working as auxiliary workers under the supervision of white nurses. Given the racial composition at Toronto Western, and the fact that she was new to Canadian nursing, Thompson felt that obtaining a supervisory position was quite an accomplishment. While she enjoyed the position immensely, Thompson often found it difficult being in a position of authority and supervising her peers, many of whom shared her same cultural background. She also found the multiple roles of "wearing many hats" at times quite daunting. Thompson's experience echoed those of Canadian born nurse Watson, cited at the beginning of the chapter, who was expected in the name of efficiency to perform multiple tasks. Here, Thompson described how being an assistant head nurse was played out on the ward:

> When the head nurse was not there, you were in charge. When she is there, you had to do the work of a staff nurse. You also had to sit on

> committee, and on some days it would be difficult. For example, you had an appointment looking after a patient, and there would be a committee meeting and you would not be able to attend.

Thompson described her tenure as head nurse as a tug-of- war and while she enjoyed the challenges the position also had its drawbacks. Thompson often missed important meetings because she was wearing the staff nurse "hat" which she found disturbing because it precluded her from providing input into important decisions being made. Looking back, Thompson remembered:

> Today you were a staff nurse and tomorrow you would be in charge. But then you were younger and you enjoyed it as part of your professional development. The head nurse trusted me a lot and we relied on each other.

It was the relationship based on cooperation and support with the head nurse that made the position bearable. Nevertheless, this position fostered Thompson's interest in the administrative aspect of nursing. Throughout her career, Thompson did extensive upgrading to obtain the skills and education needed for future leadership positions.

Unlike Thompson, whose experience with assuming leadership roles was seen by her as a natural part of her growth in nursing, Johnson felt otherwise. Although she clearly stood out among the Caribbean nurses interviewed who embodied the ideals of professionalization, and despite her own admission that she was a success story, her experiences working in Canada were fraught with various obstacles that left Johnson disillusioned about how she was treated. Johnson attributed the obstacles she faced throughout her working years to racism, coupled with organizational and structural changes in nursing, which will be discussed at length in the next chapter.

When Johnson arrived in Canada in 1960, she worked at a hospital in Toronto, an experience she would prefer to forget. In less than a year, Johnson left to work at the Hospital for Sick Children where "things started looking up." Even though Johnson enjoyed working at the Hospital for Sick Children she stayed for only one year, because according to her, "I'm not a hospital girl." Johnson applied to the University of Toronto to pursue a diploma in public health in nursing. Once she finished the diploma, she joined the Victoria Order of Nurses (VON) to work in public health nursing. Johnson subsequently found employment with York Region Health Unit because she wanted to be in the community. "I do not believe in treatment, I believe in prevention, I believe that a lot of things can be prevented," she emphatically stated. After spending ten years as a public health nurse, Johnson then went to Humber Community College where she was in charge of the post-diploma program teaching maternal and child health care. During this period, Johnson also obtained her Bachelors in Science Degree (BScn), though she noted that her wages were not commensurate with her extensive experience and education.

Johnson stayed with the Ministry of Health for five years but with the cutbacks to health care in the beginning of the 1980s she was terminated, which devastated her. Johnson insisted that with her work experience, there was no justification for how she was treated by the Ministry. She pointed out that, "They were asking that the position be filled with someone who was doing a PhD." Of the individual chosen, Johnson stated, "it was embarrassing, she didn't know anything." Despite the emotional trauma, Johnson applied for a position as the Director of Nursing for Leeds Grenville District Health Unit,

in Brockville and worked there until she retired. Johnson emphasized that her accomplishments were not easily gained, even though she had managed to reach the highest level in her profession. She had been a midwife in England and Scotland where she had managed her own district and assisted in the training of student midwives and resident doctors. In Scotland, Johnson knew her experiences were validated. In contrast, Johnson felt that when working in Canada she was always being "watched," and had to consistently prove herself to her peers, whereas in Britain and Scotland, "I only had to prove myself in the interview and the job was mine." Given Johnson's position in Scotland it is not surprising that the negative experiences she encountered resonated so profoundly in her reminiscences.

Obtaining positions as a nurse educator is also a hallmark of professionalization. Three of the women were nurse educators in this study, two taught on a temporary basis and the other full-time until retirement. The decision to teach for Caribbean nurses was not conscious or planned but when the opportunity presented itself they decided to grasp it placing them in the elite among their peers. When Heaven was accepted at McGill University to complete her Bachelors in Science Degree (BScn) she opted to work instead, a decision she later regretted. Heaven worked part-time for several years at a number of hospitals in Ontario before she finally found a teaching position at Humber College. She stayed at Humber until she retired several years ago. Paradoxically, Heaven's mother wanted her to follow in her footsteps and be a teacher, but Heaven wanted to be a nurse. In the end, Heaven was pleased that she was able to combine both

careers. Mitchell, on the other hand, taught at the Oshawa General Hospital for a short period as a temporary fill-in. Outside of a couple students who claimed they were unable to understand her because of her accent Mitchell enjoyed the position. Even though it was tempting to pursue teaching, Mitchell decided against it because she preferred bedside nursing.

While some nurses accepted promotions willingly, others refused, especially in the volatile period of the 1980s. Some cited the stress and politics associated with being in a leadership role, while others emphasized family commitments. Racism was also cited as another reason some nurses were refused promotions. While working at Toronto Western Hospital, Ward was offered a position but refused. Here, Ward explains her reason for refusing several promotions:

> I really didn't want to be promoted. I've been called, but I didn't want it. After I came here, six months after I got married, I was pregnant. After that I miscarried, and then within two years, I had another baby. I don't like to be in charge. I will do it on the floor, but to be in a big position, I didn't want it.

Ward also pointed out that her own family influenced how she felt about being a mother and parent, and wanted to integrate a balance without either one taking precedence. She continued:

> I had a very happy childhood; I didn't want it to interfere with my children's happiness. I will, if I have to, but I do not want to be in charge. I've been in charge for months if someone is on vacation. That's one thing, I didn't want to do. I didn't want to sacrifice my children. I had them one after the other, and I didn't regret it.

Despite the many promotions offered, Ward chose to accept positions that would allow her the time needed to meet her family's needs. Like many women in society, nurses such as Ward had to figure out how to strike a delicate balance between work and family.

Guyanese born Jean Harry,[73] also a British trained nurse, refused promotions even though she was recognized by her peers and doctors to have great leadership skills. Often, Harry sat on hiring committees where her input was largely instrumental in decisions around staff appointments. Instead of accepting management positions, Harry opted instead to train assistant and head nurses and on other occasions she would informally act as a replacement for supervisors on vacations or maternity leaves. Despite extensive experience, Harry avoided supervisory positions because once nurses become a part of management they were no longer a part of the union. Explaining her decision, Harry declared:

> Because you are no longer in a union, they could just get up and fire you at will. I've seen it happen, where one morning you walk in, and then security comes up, take you to your desk and then escort you out. I didn't want that to happen to me.

Being a regular practitioner with protection from the union offered Harry some security that was not guaranteed once in management. As black women in a gendered occupation that is dominated by white women in leadership positions and which appears to be constantly going through transformations, and where racism is never absent, the nurses in

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[73] Jean Harry, interview by author, Tape recording, Scarborough, Ontario, 8 August 2000.

this study have developed mechanisms to ensure that the job of caring for patients remained paramount.

Conflicts, Cooperation and Surviving on the Ward

Nurses' work and skills are affected and shaped by modernization, reorganization of the hospital and technology. Depending on age, race, and education the above changes were experienced differently by individual nurses. While doctors' hegemony in medicine means that they have the ultimate decision making authority with respect to patients' diagnosis, nurses are crucial to this process. But what has become increasingly clear is that nursing has become an occupation that demands multi-tasking in order to effectively ensure that the wards operate smoothly which means the full cooperation of all medical personnel. This means nurses developing strategies to ensure the successful daily operation of the ward.

Getting accustomed to working in Canadian hospitals took time for British trained Caribbean nurses. Before they completely adapted to the Canadian way of doing nursing, British trained black and white nurses organized the ward the "British way," to make the transition of working in a new hospital culture easier. While Working at the Toronto General Hospital Prince pointed out:

> Most of the nurses on the floor were black, West Indian and English [white] nurses. They were all English trained. They were Scottish, three English Jamaicans and me. The head nurse was Canadian, and so was the relief staff. So we ran it like a ward in England.

Similarly, Ward continued to use her British training while working at Bay Crest Hospital working alongside other British trained nurses who had assimilated into Canadian nursing. British trained nurses wanted, according to Ward, to use their British training but many refrained from doing so and eventually a lack of practice made them forget. Ward recalled: "When I came here, some of the girls would say, you can tell us some of the things we forgot. They had forgotten some of the things they learned." Ward noted that since they were all trained in England, "we had something in common. We always kept together, and it didn't matter what floor you were on." As newly arrived immigrants, these nurses used their British skills and experience to create some sense of solidarity and familiarity on the ward.

Even though their attempts to work cooperatively were interrupted by the exigencies of nursing or conflicts among and between nurses, black and Caribbean nurses accentuated how important it was for nurses to work cooperatively on the wards. Once she completed her training at Ryerson Polytechnic Institute, Lewis was able to put her days working as a health care aide behind her. She found employment as a regular staff nurse at the Queen Street Mental Health Centre. Lewis described herself as a "people person" who prides herself on the ability to build successful relationships working with others. When asked to talk about her work experience at Queen Street Mental Health Centre, Lewis emphatically stated:

> Oh, that was great, I fitted in. I built a really good rapport with the staff. Being a staff nurse at this point, you know, I was in charge, but the people really liked working with me, because you know, I'm really a people person.

One aspect of the work ethic that Lewis relied on while working at Queen Street Mental Health was making sure that all the nurses regardless of status felt validated because she believed satisfaction enhanced their productivity. One way Lewis accomplished this was with respect to breaks and she applied this precept regardless of whether she was in a supervisory role which she did take on periodically, or not. Lewis explained:

> When it was time to take a break, you take your break and I will cover for you. And the thing about me is…yes, I was a staff nurse, but it wasn't beneath me to do some of the work the RPNs or the health care aides had to do. I'll do everything on top of what I had to do. So because of this they [other nurses] kind of really liked the way I operated.

Lewis enjoyed working at the Queen Street Mental Health Centre because she was able to work in area that was more in line with what she had been doing in Trinidad. Being finally able to do what she was trained to improved her morale, Lewis stated, "I felt so much better about myself."

In any workplace, conflicts are inevitable and nursing is no exception. "[Nurses] they don't always like one another," Canadian born Tynes acknowledged. As a supervisor, she had her own strategy to deal with disagreements when they surfaced. Because of her propensity to resolve conflicts, Tynes felt she was respected and admired by her colleagues. In the event of a confrontation Tynes said:

> I would talk with that one and I would talk to the other one, and then talk to them together. I would say 'look we have a job to do here, we have people to look after, and I don't care what you do after you get off the ward, you are a team, you work together. If you can't do that, then you're going somewhere else.' It always worked. I have never lost a nurse over something like that.

Black nurses were for the most part conscious that racist stereotypes about blacks permeated their work environment, from which they were not always able to escape. For some of these nurses validation by white doctors and nurses served as an affirmation of how successful they were. Harry's overall experience working at Toronto East General Hospital was positive due to her conflict resolution skills and the relationships she developed with other staff. Similar to Tynes, Harry had her own set of techniques, which she mastered over the years for dealing with friction on the ward. If a conflict could not be resolved between nurses, Harry would call one nurse for assistance, even if the assistance was not necessary, to remove the nurse from what could be a volatile situation. Another informal method was to give the nurses "the eye" a look which basically meant that the nurses had to immediately resolve whatever issue was taking place. Harry recalled that in a meeting, the nurses were asked to mark the characteristics that best described each other, she remarked that, "80% of the nurses chose peacemaker, they say, 'if anything goes wrong, Harry fixes it.' They say, 'Harry keeps us out trouble.'" These skills earned her the respect of the doctors and her colleagues alike. Harry's longevity at the hospital, and dedication to creating a peaceful work environment was reflected in the retirement party held in her honour. She remembered:

> It was a surprise party and the best retirement party at Toronto East General it was beautiful. Everyone bought their different dishes, and everyone turned out. Three doctors closed their doors that day. The Chief Plastic Surgeon brought red roses, and the Chief of Thoracic Surgery spoke. Everyone was shocked, because he's a man of few words.

Harry enjoyed a rewarding and fulfilling career as a nurse, which influenced her decision to retire early. Harry also pointed out that as long as she had her health and strength, she wanted to enjoy life with her husband. Nurses such as Tynes and Harry viewed any type of conflict as disruptive to team work and the provision of quality care which was also tied to their notions of professionalism.

Due to their migration experiences, cultural affinity, and racism Caribbean nurses tended to emphasize their congeniality towards each other. Mitchell explained that Caribbean nurses tended to "gravitate towards each other," when working together. This, "natural" affinity was seen by many nurses as essential to their survival and as a result disagreements among Caribbean nurses were downplayed or dismissed altogether. The fact there were so few black nurses in nursing could account for this "imagined" solidarity. As a result, expressions such as, "we have to solve these problems among ourselves," and the belief that "airing one's dirty laundry in public" is proof to white society that blacks cannot get along, served to preclude any real disclosure of conflicts among Caribbean nurses. Even though she had had some unpleasant "instances with [her] own people" Ward concluded that overall "it's been very good" working with other black nurses. At Bay Crest, Ward maintained:

> ...We can talk with each other; we bond with each other then with other people. Some of them I didn't know at all, and we became good friends and we support each other. The groups I work with, if you are an RN, health care aide; we tend to bond with each other. If the health care aide doesn't know something we help them. We have encouraged a lot of them. We'll tell them 'you are doing a good job, why don't you do the RPN and from there you can go on further.'

Unlike elite supervisors whose professionalization pursuits have been geared towards making the distinction between RNs and other subsidiary workers, black nurses refused to make those distinctions. Even though there were differences between Caribbean nurses based on education, experience, training and skills, RNs downplayed the divergences between themselves and nurses' aides to maintain a strong support system. For example Caribbean RNs such as Ward recognize that there were benefits to being in the upper echelon of nursing and encouraged other black nurses aides and nursing assistants to consider further training. Those nurses who encouraged black nurses to move out of subsidiary positions were practicing a form of "race uplift." They recognized that there is a preponderance of black women in these non-professional categories and that most of these women have the potential to do more than clean bedpans and bathe patients.

Caribbean nurses' attempts to forge cohesive bonds with each other were not always successful, which reveals the fluidity in terms of a racial identity. Some black nurses in positions of authority experienced apprehension when supervising other Caribbean nurses. One RN in particular noted how difficult it was to supervise Caribbean auxiliary staff because they sometimes disregarded her role as a supervisor based on the fact they were all black. The assumption was that they shared a commonality in experiences. She maintained that outside of the routine responsibilities of being in a supervisory role, the non-professional staff brought external problems into the workplace often seeking her advice. The supervisor recalled how on one occasion there was a disagreement between a black and white nurses' aide. The black aide told her husband

about the dispute and he subsequently called the supervisor advising her to reprimand the nurse who was "bothering his wife." The supervisor felt that had she been white, the husband would not have felt as comfortable to call her on his wife's behalf. Even though there were moments when she was clearly frustrated, the supervisor tried to understand how these nurses were situated within the health care field by focusing on their material and social realities as a way of understanding their behaviors. "They were non-professional staff, who were poorly paid, they were not well educated. It was hard work," she contended. That these black women were also concentrated in long term care with very little room for advancement was another issue to be considered. In the final analysis, the head nurse appreciated these subsidiary workers because despite the low pay and limited room for upward mobility they were excellent caregivers.

Other tensions emerged between black nurses based on location of training. In her reminiscences Carmencita Gomez[74] recalled being shunned by a Jamaican nurse who was in charge of her orientation the first day at the Poison Information Centre. Gomez who trained in Britain maintained that Caribbean students who were educated and trained in Canada used their training to belittle nurses trained elsewhere. According to Gomez the Canadian-educated nurses believed:

> You were not brought up in the system. You didn't go to George Brown or to one of the colleges. The whole system [they] have here, we did not have it in England, so you are considered like your training is different. You are an outsider.

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[74] Carmencita Gomez, interview by author, Tape recording, North York, Ontario, 14 October 1999.

While Caribbean nurses were reluctant to discuss their differences, Canadian born Watson was more candid about her relationship with Caribbean born nurses. Caribbean nurses, according to Watson displayed certain attitudes which implied they were superior to black Canadian nurses. Although she worked with nurses from diverse backgrounds, Canadian-born Watson contended that, "I had my time with black West Indian nurses who come here either from the West Indies or from the States." There were so few black Canadian nurses and there was a sense that Watson needed to prove herself. "I hold myself at a certain standard. I don't deter from that or apologize for it," she stated. Watson worked at Toronto Western Hospital, which had a disproportionate number of Caribbean women on their staff. Watson's relationship with her Caribbean counterparts was strained at first, but they managed to eventually work out the differences that arose. Watson also recognized that she was a "good nurse" and did not necessarily have to prove that to her Caribbean counterparts.

One of the outcomes of professionalization is the development of professional associations and unions with the aim of improving nurses' lives and the occupation itself. The Ontario Nurses Association (ONA) is the union that represents nurses in collective bargaining and other contract issues; the Registered Nurses Association is the professional association that represents nurses at inter-provincial and national levels and lobbies on behalf of nurses; and the Ontario College of Nurses is responsible for licensing, registration, setting and maintaining the criteria for nursing education and practice, and carrying out disciplinary measures. Nursing associations also act in a human

relations capacity to ensure that nurses are seen and respected as professionals. Over the years, nursing organizations have worked hard to mobilize the support of rank and file practitioners to support major goals within the occupation including that of unionization. Nursing unions have worked to improve working conditions, wages, and to allow nurses some control over their work. The effort to unionize has not been a successful or easy one given the ideologies of "care" on which nursing has been constructed. The belief that striking goes against the fundamental core of the occupation coupled with the underlying patriarchal ideologies about women's work contributed to the struggles around unionization.[75] For women, there are benefits to being part of a union as Julie White points out, as unionized women tend to earn more than their counterparts who are not unionized.[76] The right to collective bargaining led to better working conditions and better wages, which is important for black nurses who might otherwise be subjected to differential salaries based on race. Nursing unions struggle to obtain economic and social rewards in a society where women's work is often invalidated. Furthermore, for the last two decades nurses have witnessed the impact of restructuring, rationalization and cutbacks to health care in tandem with an anti-union climate which makes it all the more crucial for them to support their unions.

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[75] See for example, Day, "The Unionization of Nurses," in Vital Signs ; McPherson, Bedside Matters, Chapter 6.

[76] Julie White, Women and Unions (Ottawa: Canadian Advisory Council on the Status of Women, 1980).

While some attention has been paid to the exclusionary practices of labour unions towards men of colour, less thought has been paid to their female counterparts.[77] In nursing scholarship, any discussion about unions or any other organizational activity tends to be race-neutral. As a disproportionately female dominated occupation, issues that nurses confront are viewed and dealt with from the perspective of gender. Oral testimonies provide an opportunity to delve into black nurses' consciousness of themselves as workers and their perceptions about unions and other professional organizations. This particular information is vital because black women's perspective is often missing from labour and working class histories. What then do black nurses have to say about organizational nursing generally? And more specifically how do these organizations deal with the issue of racism in the workplace?

The majority of nurses conceded that with respect to wages and working conditions that nursing unions have made substantial changes. They were, however, critical of individual representatives and the unions and professional nurses' associations in terms of how they assist nurses in crisis and their effectiveness in dealing with racial discrimination. Although Jones has never had

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[77] See Gillian Creese, "Organizing Against Racism in the Workplace: Chinese Workers in Vancouver Before the Second World War." Canadian Ethnic Studies, vol. 19. no 3 (1987; Gillian Creese, "Exclusion or Solidarity "? Vancouver Workers Confront the 'Oriental Problem'" in Laurel Sefton MacDowell and Ian Radforth eds., Canadian Working Class History (Toronto: Canadian Scholars Press, 1992).

any difficulties with management and has never needed to secure the union's assistance, she still appreciates its presence. "Once you are in the union, they [management] can't just take advantage of you and dismiss you like that...for harassment and all those sorts of things, you could bring the union and they could really fight for you." For Jones the union' s ability to protect the interests of nurses who are vulnerable to various forms of discrimination is enough reason to have it. At the same time she stressed that the Registered Nurses Association of Ontario could be more helpful when dealing with the unfairness or crisis that comes with being a nurse. Several Caribbean nurses were adamant that the unions and professional associations were ineffective. Mitchell feels that the nurses union is being co-opted by hospital administrations, and noted that at Toronto Western Hospital the "union was in bed with the administration," making it difficult to distinguish between the two. Janet Barrett[78] claimed that, "most of the times the unions don't work for you...Unless you go to them with a problem that everyone can see, they don't back down, they work for you."

Black Canadian-born nurses were less critical of the unions and professional organizations, which may be explained by the fact that most of them are in management positions and therefore not unionized. Steeles pointed out, "I do believe in collective bargaining, as a member of the RNAO, I voted for collective bargaining. The objective of the organization was to protect the rights of workers." She also recognizes the

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[78] Janet Barrett, interview by author, Tape recording, Toronto, Ontario, 5 June 2000.

contradictory position nurses are in as "the largest group of health care workers in the province", because linking gender to biology the ideas is that nurses possess inherent characteristics such as compassion which prevents them from "doing [certain things] because of their nature." Steeles maintained that nurses are not a monolithic group and that there will be disagreements on certain issues but she is pleased with the nursing leadership which is "taking a stand on professional issues," and presenting these issues to the appropriate government bodies.

Tynes on the other hand expressed some dissatisfaction with the union because she sees the nurses' representatives as being self-serving. "The little bit that I had to do with the union I found the same people stayed in year after year because nobody else wanted it, so they were more interested in their own aspects of a situation [as opposed] to what the nurses need," she stressed. The only occasion Tynes recalled where the collective interests of nurses took precedence over the individual agenda was when a black friend of hers was in charge of the union at Toronto General Hospital. According to Tynes, "she fought for the nurses, and seems to take their best interest at heart, but not all union representatives are like that." Tynes was the only nurse who mentioned a black union official at the hospital where she worked. A number of nurses were pleased with their individual white union representative and felt they made an effort to support them.

The inability of nurses' unions and organizations to address and successfully deal with racism is a key concern for nurses regardless of whether they are currently working or retired. Although the issue of racism and nurses organizations will be discussed in the

next chapter, it is worth addressing here because the nurses' view the elimination of racism in nursing as a professionalization goal. Commenting on the College of Nurses' inactive approach to addressing racism, one of the interviewees in a leadership position stated:

> Based on what I've read and heard, they [black nurses] are having a difficult time. They are kept down, no opportunities for upward mobility they are squeezed out of it. There is a lot of racism in the workplace based on the reports, complaints we've heard. I see a lot of what white nurses get away with a lot of black nurses wouldn't get away with it. There is racism and there has been real evidence of it. I don't know what we are going to do about it.

The lack of adequate procedures by the College adds to the frustration that nurses who are victimized encounter. Because neither the nursing union nor the College has dealt effectively with complaints about racism, nurses have had to turn to the Ontario Human Rights Association to fight their cases using the Charter of Human Rights and Freedoms. Black and Caribbean nurses in particular point out that in addition to the backlog of cases, the Human Rights Association's procedures are long and drawn out. Nurses advocated that it should be nurses' own unions and organizations that deal with issues of racism rather than the Ontario Human Rights Association. They maintain that if nurses have to turn to the Association to adjudicate discrimination cases the message the nurses unions and organization are sending to their employees is that addressing racism is not important. One administrator argued that there need to be a stronger commitment by the union and the College of Nurses to eradicate racism and all forms of discrimination in the workplace. She offered the following recommendations for it to consider:

> [There is] a disciplinary section at the College, and just as how they report somebody for abusing a patient, I think that option should be there for nurses who racially abused other nurses. Going through the Human Rights takes a long time. There are also needs to be anti-racist education that would help the nurses understand the different ethnic groups of nurses.

Heaven, a nurse educator felt that the union that she belonged to while at Humber College was more progressive in terms of dealing with issues of racism compared to the nurses union. Heaven stated:

> If you take an issue to them that they perceive as racially motivated, they will address it as just that- a racially motivated issue. And we had set up guidelines for how people can complain or whatever, and I'm not sure the nurses union has that. That's the impression I get from listening to the nurses. Neither are they addressing it [racism] or prepared to address it.

Although Mackenzie did not have problems with the College of Nurses, it is yet to earn her respect. The College, according to Mackenzie is merely a moneymaking organization, which does not adequately represent nurses' interests, support or empower them. "What are they really doing for you?" Mackenzie queried:

> They claim they are there in times of need. And although it hasn't happened to me, I've heard of nurses in lawsuit. They said the College is there to help them. The impression is that you are always guilty and the College has not been there. In certain cases, nurses are guilty before they are proven innocent. There is some support but it's not enough.

Instead of depending on the College, ONA or the RNAO to adequately address black nurses' interest, Johnson advocated a Black Nurses Association, claiming that nursing organizations "are prejudiced." She pointed out that often in cases of racism it is the individual who has to come to their own aid as opposed to the nurses' organizations, which should not be the case.

Unlike some of the nurses who feel that the College avoids dealing with issues of racism, Tynes's personal experience revealed otherwise. In 1985, Tynes was fired from Toronto General Hospital a move she stated was to "get rid of the senior nurses," especially black women. Management reported Tynes to the College of Nurses and attempted to have her license revoked. Several months later, Tynes attended a hearing and was subsequently cleared by the College who recognized her as an intelligent and experienced nurse and was unable to understand the rationale behind her firing. Even with all the accolades the College expended on Tynes's behalf after twenty-six years of service to Toronto General Hospital she was not reinstated. Tynes's experience demonstrates the weakness of the College of Nurses and the union.

While these nurses have been critical of the unions and professional organizations, less than a quarter of the nurses interviewed had been actively involved in them. During the interviews the majority of Caribbean nurses acknowledged that they needed to be more politically active in these various bodies in order to have their interests represented. It is important that black nurses working and living in a white-dominated workplace and society be involved, Mackenzie emphasized. "You have more black nurses who are becoming representatives in the union. So I think one of these days, things will change. We'll be well represented." Mackenzie also pointed out that it is not just black nurses who need to more politically astute and that nurses, as a group should be involved especially on hospital board of directors. She maintained that, "...half the time the boards would be making changes, or the supervisors making these changes, and they

don't know how it affects nurses or patients." On the other hand, Ward pointed out that nurses need more solidarity among them as a group. "I find that nurses are too divided among within ourselves and it can be difficult," she stated. In order to deal with racism Ward pointed out that nurses have to come together to recognize how divisive racism is to the profession as a whole.

In the mid-1980s, Barnes applied to be in charge of the bargaining unit at the hospital where she was employed but was denied the position. Explaining why she was rejected, Barnes pointed out, "I was a radical and they just didn't want me in that position and being in charge." Barnes decided to fight the case but lost in arbitration and she recalled, "I was angry, and then I thought, there is more than one way to skin a cat, I don't have to be in charge, I could be the president of the union and be even worse and that's what I have done." Today, Barnes remains active in her nurses' union and has been outspoken about issues of racism in nursing.

Conclusion

Overall, the nurses in this study envisioned organizations and unions that take a more proactive approach to understanding racism and attend to the ways that racism produces differential treatment in the workplace. One nurse noted that for example, when unions advocate for better working conditions, they should also include workplaces that are free from racism. Thus, eradicating racism should be intricately connected to the pursuit of professionalization.

In many ways professionalization goals have contributed to nursing's legitimacy as a profession. Unfortunately, in the quest for professionalization some nurses experience the simultaneous effect of proletarianization. With respect to the black nurses in this study, these processes occurred unevenly and as a result did not affect all of them in similar ways. While some black and white RNs assumed administrative tasks, which stood as a measure of professional status, Caribbean nurses (some trained in Britain and the Caribbean) whose qualifications were not accepted experienced deskilling because they had to work as nursing assistants and nurses aids.

The introduction of technology and increased education have brought enormous benefits to nursing but have also affected nurses' autonomy over their work and their ability to provide quality care. While technology offered nurses options and reinforced their claims to professionalism as skilled and knowledgeable workers, the cutbacks beginning in the late 1970s and culminating in the late 1980s have fundamentally transformed nurses' work and their sense of purpose in the occupation. Black nurses argue that hospital administrators and management need to pay attention to how technological interventions affect nurses' ability to care and the deskilling that accompanies these changes. Moreover, the majority of Caribbean nurses insists that unions and nurses organizations need more effective resolutions to address issues of racism and nurses overall security, black nurses maintain that these initiatives have to be more than token gestures to quiet the disgruntled few.

Finally, black nurses have incredible insights into nursing and the changes it has undergone. They have not acquiesced to these transformations but have developed multiple strategies, from refusing to use the computers, forging bonds throughout the course of their careers to deal with the various exigencies that arise from being black women in nursing. In black nurses' articulation about their work, their identity as nurses and as workers takes precedence. These women have dreams for the occupation and hope that the ability to care will continue to be central to it.

Chapter 5
Racism and Resistance

In her book, Understanding Everyday Racism, Philomena Essed posits that "general knowledge about racism presupposes insight into...the following aspects: a) the ability to explain individual experiences in terms of group experiences, b) acknowledgement of the historical experiences of the group, c) explanation of (historical and contemporary) group experiences in terms of racial and ethnic domination, d) acknowledgement of continuity in the relation between personal experience and the group experience, and e) personal responsibility in the process of change."[1] In addition, Essed explains that an understanding of racist events is contingent upon "the availability of general knowledge about racism...."[2] I would also add that one of the challenges people face naming and identifying acts of racism is that they often feel that there are other possible explanations that are equally plausible.

Essed's framework is useful in exploring how the black nurses in this research understood, explained and interpreted their experiences with race and racism in nursing. This means paying attention to how their recollections are influenced and shaped by the ethos of care on which nursing as a profession is established, the political economy of nursing and larger historical, political and social forces. The first section of the chapter

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[1] Philomena Essed, Understanding Everyday Racism: An Interdisciplinary Theory (Sage: London, 1991), 76.

[2] Ibid.

will focus on instances that Caribbean women identified as having racist implications and their responses to the inequalities they faced in the workplace or in other public places. The second section of the chapter will highlight the multiple resistance strategies, both formal and informal, that black nurses have developed, which defy the portrayal of them as long suffering victims.

Tania Das Gupta's work on racism in contemporary nursing and Agnes Calliste's study on the state's contribution to the subordination of Caribbean immigrant nurses call attention to the differential position black women occupy in nursing. Yet there are no historical studies that analyze the role of race and racism in structuring the social relations between black women and other nurses. This neglect is not surprising given the ways nursing has been constructed on specific gendered ideals, especially around qualities such as caring. The assumption is that women, specifically middle class white women, "naturally" possess traits that automatically make them "good nurses." Focusing then on the "natural" and "innate" skills of women in a profession where caring is central makes it difficult to focus on racism because of the idea is that nurses who care and cure cannot be racist. Evelyn Barbee, in discussing racism and nursing in the United States, contends that "the contradictions between caring, a principle part of the identity of nursing, and racism make it difficult for nurses to acknowledge racial prejudice in the

profession."[3] This statement by Barbee resonates within Canadian nursing despite the variations in terms of the context in which race and racism emerged in Canadian society.

Despite the commitment of Canadian nursing to eliminate discrimination in the profession, the number of Canadian born black nurses remained relatively small in the post-World War II decades. Thus, the black Canadian nurses interviewed for this project were in fact trailblazers and articulated their experiences within that context. Similarly, Caribbean nurses, especially those who migrated to Canada during the 1950s and 1960s, entered Canada and nursing where there were few other black practitioners. As a result, their narratives about migration (demonstrated in Chapter 2) and nursing reflected this reality. The presence of black nurses in an occupation that since its inception had been predominantly white reshaped workplace dynamics.

Black nurses' interpretations of racism within nursing revolve around four interrelated themes. Some nurses explained that, due to the small number of blacks in nursing, their experiences of racism during training or on the ward were limited. Nurses who immigrated during the early 1950s or 1960s or who established themselves in remote areas fell into this category. A second group downplayed incidences of racism. They were reluctant to tarnish the occupation's reputation and worried about the implications of having colleagues and friends read their narratives. When nurses in this group provided examples that could be construed as having racist dimensions, they found equally compelling alternative rationales for these incidences. Others, less inclined to

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[3] Evelyn L. Barbee, "Racism in Nursing," Medical Anthropology Quarterly 7(4), 346.

discuss racism between themselves and white nurses, were able to discuss racism directed towards them from, for example, Filipina nurses. Finally, there were those who acknowledge that racism existed (and exists) within the occupation and have developed survival strategies to ensure that racism's impact on their working lives has been minimal. This group include those nurses who immigrated in the 1970s and 1980s (and those who are currently working) and who are aware of ongoing discussions about racism occurring in the public and political arena. The majority of the nurses had no difficulty discussing patient-nurse racism, or racism within mainstream Canadian society. Indeed, the experiences of black nurses in this study reveal the difficulty and complexities professional women face naming racism in an occupation like nursing.

Nurses Who Felt Welcomed

Many of the women who migrated during the 1950s and 1960s insisted that race and racism did not negatively affect their nursing careers and that they were treated well by their white counterparts. They attributed their positive experiences to the nursing shortage in Canada and the small population of blacks in Canada as tempering racism. For these nurses, incidents that could be interpreted as racist only appear to have racial overtones when viewed from today's perspective.

Monica Mitchell[4] immigrated to Canada from Jamaica in 1960 and summarized what living and working in Canada was like during the early years of her migration:

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[4] Monica Mitchell, interview by author, Tape recording, Toronto, Ontario, 7 April 2000.

> I often said to people that when I came to Canada the first time, I was so comfortable. I never heard all this black-white thing, and my feeling is that my group did not represent a threat to white people. Now I think my group represents a threat.

Mitchell worked at the Oshawa General Hospital and for her it was the camaraderie among nurses that made the experience enjoyable. She recounted with fond memories the two years spent at the hospital:

> Everyone was very nice to me. There were tea parties; there were country clubs, oh yeah. We would go to that man, the founder of General Motors, Canada. He left his residence to the Oshawa General Hospital. He literally owned the whole town. So I went to his house, I was treated well. I have no complaints.

Trained in Britain, Vera Cudjoe returned to Trinidad once she completed her studies, and subsequently migrated to Canada in 1960. She expressed similar sentiments:

> The issue of racism was not evident and apparent at that time as it is now. There were so few of us here that they [whites] had not begun to panic, to feel afraid or intimidated to by our presence…On the other hand, in the hospital we were a minority, and we were just concerned about doing our work. They seemed to want us more than anything else.

For these nurses, racism in Canada was tempered by the need for nurses, and the fact that the black presence in Canada was kept minimal.

Nurses who traveled to remote areas in Canada to accept nursing employment maintained that they were exoticized because it was the first time that people in the communities they worked in had come in contact with blacks. June Heaven who left Jamaica in 1967 for Trail, British Columbia recalled, "in B.C. I was a novelty; a lot of people had never seen anyone black where I was in Trail. Some days it was fun, some

days it was annoying." For Heaven and her friend, having fun meant observing the stares and reactions of people, who could not hide their curiosity. Constant questions about their background, together with the feeling of being constantly on display eventually irritated the two women and they left for Toronto. Carmencita Gomez who immigrated from Britain to The Pas, Manitoba in 1975 remembered being treated extremely well because people were sympathetic to the fact that she had left her family to work in The Pas. Gomez recalled that her supervisor at the hospital where she worked invited Gomez and another Guyanese nurse to Christmas dinner each year. Gomez was surprised at how friendly and kind her supervisor was and thought to herself, "if that's the way they treat people in Canada, I think I'm going to stay in the country." She continued "...wherever we went, we felt a part of society, I never felt like this in Britain...I didn't feel different being a black person."

Thinking about her job at the Oshawa General Hospital, Mackenzie was unsure as to whether she actually had experienced any racism because of her own understanding of what it meant to be identified as black before she immigrated to Canada. Describing her experiences around race and reflecting on being black at her very first place of employment, Mackenzie pointed out:

> It was 1960, and at the time there were not too many black nurses, and it was okay. You know, I realized that I was new, that the colour of my skin was new, they were very polite. It was very funny how children did not see too many black nurses. I remember this little 3 year old that looked at me and say's 'oh you are burnt,' and I just smiled and I said, 'poor little thing, you have never seen a black nurse.'

Writing about Jamaica, Mackenzie's birthplace, Stuart Hall maintained that up until he left the island in the 1950s, he had never heard anyone call or refer to anyone else as black. Hall pointed out that there were many ways of identifying people ranging from the different shades of brown, quality of hair, the type of family they came from and even the street on which they lived. Hall asserts that it was not until the 1970s "for the first time that black people recognized themselves as black. It was the most profound cultural revolution in the Caribbean, much greater than they ever had."[5] Those nurses who immigrated to Canada would have missed this process of self-identification around issues of being black that was taking place in the Caribbean.

Even though she lived in Britain for almost five years, Cudjoe did not automatically define Canada as a white settler colony that practices racial inequality. Thus, it took Cudjoe sometime before she understood the impact of racism. Describing the early years of her migration, Cudjoe recalled:

> I was not aware of racism at the time, but in hindsight, I think there was because there were times when people were being unfair and you didn't know why. You never thought it was because of me being black. You were more concerned with the actual victimization of what's being done to you and trying to work it out and resolve it rather than point fingers at somebody and call them a racist.

For those nurses who immigrated during the 1950s and 1960s, their attention was on, in the words of one nurse, "learning the ropes" of being in a new country. Understanding

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[5] Stuart Hall, "Old And New Identities, Old and New Ethnicities" in Les Back and John Solomos ed., Theories of Race and Racism: A Reader, (New York: Routledge, 2000), 150.

how racism operated on the systemic, ideological, and individual level would for some nurses emerge with the politicized discussions that took place in the 1970s and 1980s.

Other Explanations for Racism: Professional and Social Hierarchies

David Goldberg maintains that in dialogues about race, "the paradoxical struggle over the social site of 'race' is fuelled by a deeper more difficult complex of concerns we call racism."[6] For nurses, the "paradoxical struggle" to name racism was complicated by the professional hierarchy in which they worked. In discussing tensions between themselves and white nurses, black nurses were often reluctant to attribute racism as the sole cause of tension, even if black nurses suspected that racism might have played a role. Elaine Mcleod[7] moved to Canada from Britain where, as a State Enrolled Nurse, she had enjoyed more autonomy and authority. In Canada, Mcleod found her position as a non-registered nursing assistant unbearable. As a result she considered white nurses, who had higher levels of responsibility, to be domineering, and described her relationship with them as "strained and stressful." According to Mcleod, "everything was dictated to you, it was almost as if you had no mind of your own." She also added that "it was not just me, there was a lot of us [black nurses] who had come from Britain and could work. All the non-registered nursing assistants who had migrated to Canada were doing that, they were all black women." In discussing the race and gender construction of reproductive labour

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[6] David Theo Goldberg, ed., Anatomy of Racism (Minnesota: University of Minnesota Press, 1990), xi.

[7] Elaine Mcleod, interview by author, Tape recording, Markham, Ontario, May 1995.

in American nursing, Evelyn Nakano Glenn argues that "within the new bureaucratic structures, race and gender ordering is inherent in the job definitions. The nurse's aide job is defined as unskilled and menial; hence, the women who do are, too."[8] She also pointed out that in the racial pyramid, it is women of colour who are disproportionately nurses' aides and "constitute the 'hands' that perform routine work directed by others."[9]

Political scientist Marion Young asserts that "social rules about what work is, who does what for whom, how work is compensated and the social processes by which the results of work are appropriated operate to enact relations of power and inequality."[10] The structure of nursing whereby white nurses dominate in leadership and supervisory roles can operate to mask racist practices because their actions can be explained by seniority, status and educational differences. If race and racism are not considered as integral to how relations of power and inequality structure nursing, then white nurses' predominance in supervisory and leadership positions is deemed "normal" and their treatment of other nurses explained as a function of their job. Mcleod clearly recognized the stratification that existed between nurses in leadership positions and pointed to the "indifference" white nurses displayed towards black practitioners. Yet, she attributed

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[8] Evelyn Nakano Glenn, "From Servitude to Service Work: Historical Continuities in the Racial Division of Paid Labour" in Vicki L. Ruiz and Ellen Carol Dubois eds., Unequal Sisters: A Multicultural Readers in U.S. Women's History 2nd ed. (New York: Routledge 1994), 423.

[9] Evelyn Nakano Glenn, "From Servitude to Service Work," 419.

[10] Iris Marion Young, Justice and the Politics of Difference (New Jersey: Princeton University Press, 1990), 50.

white nurses' behaviour to their seniority and education, as opposed to racism, and thereby seemed to justify the actions of her superiors.

A similar occurrence took place between Jamaican born Inez Mackenzie[11] and a white head nurse that echoed Mcleod's experience after she transferred to the Operating Room (OR) at St. Michael's hospital. Prior to working in the OR, Mackenzie recalled, she heard different stories about the organization of the surgical department. "I heard all the rumours...that the nurses in the OR tended to act like surgeons-they run the show. That they didn't want any blacks there (in the OR) that there were only a few of us [blacks] there." From the moment Mackenzie entered the OR her relationship with the head nurse was contentious. Regardless of how well she performed, Mackenzie's work was judged unsatisfactory by the head nurse. According to Mackenzie, she felt like a complete failure. It was not until after her three-month evaluation that it became abundantly clear to Mackenzie that staying in the OR was not an option if the head nurse remained as her supervisor. Mackenzie recounted her experience with the head nurse in the OR as follows:

> I must say she took set on [me]. To me, it's like you could never do anything right. So when the evaluations came, and it was coming from the upper one, I realized then that everything I did was wrong...I went back to the nursing office that particular Friday evening, and I said, 'I will not go back there on Monday. I prefer to resign this minute. If I'm to spend another day there. I am positive that I'm going to have nervous breakdown or a heart attack.'

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[11] Inez Mackenzie, interview by author, Tape recording, Markham, Ontario, 13 October 1999.

Mackenzie's apparent frustration led the administrator to grant her request to transfer immediately back to the department where she was previously working. Fortunately for Mackenzie, there was still an opening and the following Monday, according to her, " I was back into my glory again."

Black nurses sometimes left hospitals, departments or wards in order to avoid confronting co-workers who might be racist. For example, in 1955, Orphelia Bennett[12] a trained RN and midwife immigrated to Canada. Bennett applied to the Toronto General Hospital, but her tenure there was short-lived. Three weeks later, Bennett left, because according to her:

> One little gal [white] that just finished nursing started bossing me around, she had no orientation. She was just finished and wasn't even registered yet. We were just going around, she kept telling me that I have to move this patient, to do this and to do that. It was on a Sunday, I didn't return.

Bennett recognized that even though her qualifications superseded that of the newly trained white nurse, the white nurse felt superior to her. Yet she refrained from characterizing the incident as racist.

To understand Bennett and Mackenzie's unwillingness to identify and name racism even in the most obvious of circumstances, Essed's framework is again useful. Essed differentiates between historical actors' narratives of events that conform to our understanding of wider patterns of racism and those actors' own "knowledge and

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[12] Orphelia Bennett, interview by author, Tape recording, North York, Ontario, 14 October, 2000.

comprehension of racism."[13] The nurses interviewed demonstrated some understanding of group racism, but less about how it operated at the individual level between themselves and the white nurses in question. When asked whether racism might have been a factor in how she was evaluated Mackenzie emphatically replied, "no, no, because it affected everybody. But I think in my own self, I just felt like it's nothing I could do right. I don't want to term it as racism." For Mackenzie, racism cannot be used as an explanation for how she was treated by the white nurse due to the structure and nature of the OR. The clinical setting was challenging hence all the students were evaluated on an equal basis. But in the same sentence, Mackenzie pointed out that, "most of the time it was the black student nurses, (there were a few whites), but most of the times it was the black students who were doing OR courses who could never succeed." While Mackenzie was cognizant that black nurses were at a disadvantage because they dominated the group often repeating tests, she was unable to link her individual experience to what was happening to black nurses as a whole. Instead, she pointed to her own inadequacies, while pointing out that the inequalities in the OR "affected everybody."

In the 1950s and 1960s, when these incidents occurred, there was little public discussion about the realties of racism, and it thus was understandable that the nurses did not make any connection to racism. Yet, whether they understood how racism shaped institutional practice and every day interactions or not, neither nurse accepted the situation. It was patently clear to Mackenzie and Bennett that the treatment meted out

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[13] Essed, Understanding Everyday Racism, 77.

towards them by their white counterparts was unacceptable. Hence, Bennett left the hospital and Mackenzie quit the OR. Because in such situations where there was no institutionalized support for challenging racism, individual action was all that was possible.

Relations Among Women of Colour

In her study of black women's anti-racist organizing and resistance, Agnes Calliste discovered that "...many of the oppressors of black nurses are white (and a few Filipino nurses who collaborate with management in harassing black women."[14] When asked to highlight incidences of racism in their careers, some black nurses were more explicit and candid when it involved other women of colour, especially nurses of East Asian descent. To explain this tension some participants pointed out that nurses of colour participated in reproducing racist ideologies about them. Others maintained that the disagreements between the two groups were based on cultural misunderstanding.

Filipina nurses were the group most frequently described as participating in the victimization of black nurses, and for many black nurses they were viewed as "traitors." One nurse, who preferred not be identified, described herself as a people person with the ability to build good relationships with her staff. By and large, she characterized her work environment as a positive one even working with a diverse group of nurses. When

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[14] Agnes Calliste, "Antiracism Organizing and Resistance in Nursing: African Canadian Women," Canadian Review of Sociology and Anthropology, vol 33:3 (1996), 363.

frictions did arise, she observed, it was primarily between black and Filipina nurses. The nurse explained:

> The blacks and Filipina had their little bit of problems. The Filipina nurses-you can't really trust them because they would rat on you at the drop of a hat. They would go up and suck up to the head nurse, which is usually a white nurse.

In an occupation such as nursing where divisions based on education, training, or seniority defined the environment, Filipina nurses had, according to black nurses, a tendency to "suck up to management" that was seen as a betrayal to nurses' solidarity.

Prince maintained that relationships with her colleagues were, for the most part, harmonious, except for one altercation that involved her and a Filipina head nurse. Prince maintained that the head nurse treated the subsidiary workers on the ward badly. She recalled:

> It used to bother me, because I'd seen it. It had nothing to do with me, but I was aware of what was going on. They were grown women, some of them grandmothers; they worked hard, looked after the patients, and cleaned the wet beds that sort of thing. She used to come around and talk to them as if they were dirt, and they used to grumble but they didn't do anything about it.

One evening while on shift, Prince returned to the station to find out that the doctor had made his rounds and changed one of her patient's medication to one with which she was unfamiliar. Prince then asked the head nurse about the drug but was dissatisfied with her response. Sensing Prince's scepticism, the head nurse responded, "if you don't believe me, you can look it up yourself." Prince's decision to look up the drug offended the head nurse, which resulted in an unpleasant exchange between the two. Disturbed by Prince's

outburst the head nurse reported her to the nursing director. The following day when Prince reported to work she was immediately summoned to see the nursing director. Prince admitted getting angry, but also recounted the head nurses' shabby treatment of subsidiary workers:

> I said, 'she is asking for it.' I said, 'you should come up the backstairs one day and listen to how she speaks to the staff. She is a racist, she yells at them, and calls them names.'

Prince justified her reaction towards the head nurse by drawing on her reputation as an excellent nurse, whose employment record revealed no evidence of antagonism. The nursing director must have believed Prince because she refrained from reprimanding her and subsequently consulted with the ward aides about the head nurses' behaviour. The head nurse was either terminated or transferred. Prince remembered, "I came on duty the next morning and they [wards and nurses aides] were jubilant."

In these and other stories, black nurses were able to attribute unacceptable behaviour directly to racism but also to draw upon their sense of professionalism to insist that racism at work should not be tolerated. When Jamaican-born and British trained Lilli Johnson[15] immigrated to Canada in 1960, she maintained that her first experience with racism was from a Japanese-Canadian RN who was a head nurse. Having had extensive training in Scotland and Britain, and university experience in Canada, Johnson felt that the Japanese-Canadian nurse was unable to recognize or acknowledge her as a qualified

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[15] Lilli Johnson, interview by author, Tape recording, Scarborough, Ontario, 9 August 1999.

professional. In reference to this nurse, Johnson stated, "she was prejudiced. She was suppose to orient me, but she looked down upon me like I was an ignorant." For Johnson the Japanese-Canadian nurse's treatment of her transgressed professional responsibilities.

Other black nurses interpreted Filipina nurses' behaviour in terms of cultural difference.[16] For example, they concluded that Filipina nurses gifts to white nurses in supervisory positions was a method of winning and gaining approval. Jean Harry[17] remembered how a Filipina nurse she worked with would bring food to management hoping that it would influence them to give her the days off that she requested. According to Harry, the gesture worked because the nurse did get the entire weekend off. Harry took it upon herself to question the nurse. The nurse did not realize that there were consequences for refusing to work weekends and, in Harry's telling of the story, the nurse thanked Harry for bringing this breech of professional etiquette to her attention. In this narrative Harry situated herself as the arbiter of professional standards, identifying and correcting the error produced by cultural difference.

Black nurses who had complaints about Filipina nurses generally viewed the latters' actions as divisive and as further reinforcing some white nurses' negative perceptions of blacks. How then do we explain the ease with which some black nurses explicitly spoke of incidents or tensions with other nurses of colour while demonstrating

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[16] For example, Prince acknowledged that bringing gifts and food could actually be an aspect of Filipina culture.

[17] Jean Harry, interview by author, Tape recording, Scarborough, Ontario, 8 August 2000.

their reluctance to do the same with white nurses? And, are these tensions really indicative of racism?

While it is likely that black practitioners' views of Filipina nurses' relationship with white nurses were partially based on cultural misunderstandings, it is apparent from the interviews that the relationship some Filipina nurses developed with white supervisors resulted in the marginalization of black nurses. Black nurses suggested that white nurses viewed Filipina workers more positively. To understand black nurses' response to Filipina and other nurses of colour means exploring how these groups have been situated vis-à-vis each other from an historical perspective. One of the lasting effects of colonialism has been to create and shape perceptions of people, which transcended that of the colonizer/colonized, but also influenced relations between different groups of the colonized. The end result was that some groups were viewed as more "civilized" and less "primitive" than others. Subsequently these perceptions and images are reproduced over time and continue to affect interactions and encounters between peoples. This process of racialization produced understandings that the image of some people were more acceptable and less threatening than others.[18] Stereotypes of Asian women as "docile" stand in contrast to those of black nurses who are often seen as more "aggressive" and together may have also contributed to how each group was

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[18] See for example, Ani Loomba, Colonialism/Post Colonialism (New York: Routledge, 1998).

viewed by white nurses. Black nurses' view of Filipina nurses is indicative of how notions of race and racism are played out at a specific site.

Naming Racism

In their influential book, Racial Formations, Michael Omi and Howard Winant emphasize the shifting meanings and instability of the category race. They argue that "racial categories and the meaning of race are given concrete expression by the specific social relations and historical context in which they are embedded."[19] Omi and Winant further point out that, as the "organizing principle of social relationships", race operates at both the micro and macro levels of society. At the micro-level or individual level, daily social activities and relations with others shape one's understanding of self but also contribute to identity formation among groups. At the macro-level or institutional level, "race is a matter of collectivity, of the formation of social structures: economic, political and cultural/ideological."[20]

By the 1970s and 1980s racism was a public topic that Canadians, especially those living in large metropolitan areas with racialized minorities, could no longer disregard. In 1973, the United Nations introduced a decade of action to combat racism. A number of widely publicized racist incidences that included vandalism, boycott, name-calling

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[19] Michael Omi and Howard Winant, Racial Formation in the United States from the 1960s to the 1980s (London: Routledge, 1986), 66.

[20] Omi and Winant, Racial Formation, 66-67.

beatings, and in some cases death, took place in various cities across Canada.[21] According to Daniel Hill, these occurrences led the federal government in 1983 "to appoint a special House of Commons Committee to seek ways of 'ameliorating relations...between visible minorities and other Canadians."[22] During this period allegations of racism had began to surface in various hospitals, which led to the formation of a number of organizations to deal with racism against nurses of colour. Moreover, the militancy among people of colour who were protesting against inequality in Canadian society also helped to push racism to the fore. In addition, numerous reports documenting systemic and institutionalized racism against blacks and other people of colour in the areas of employment, education, housing and social services led to an increased dialogue about race and racism. The politicization of racism in Canadian society thus gave some of the nurses in this study a language to identify, name and challenge racism in nursing. They could identify the ways race structured social relations in hospitals to create a power imbalance between white and nurses of colour, the division of labour in the occupation, and the over-representation of black nurses in specific departments. The development by black nurses of a critical analysis about racial discrimination was also influenced by their participation in anti-racist organizing in various segments of the black

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[21] Daniel G. Hill, Human Rights in Canada: A Focus on Racism, (Ottawa: Canadian Labour Congress, 1984), 5.

[22] Ibid.

community. In addition, conversations among black nurses also helped to raise each other's consciousness about racial discrimination in the occupation.

To discuss the perniciousness of racism in nursing during the 1970s and 1980s means also placing the discussions within the political economy of nursing, and how transformations in health care placed nurses generally, but more specifically black nurses and especially outspoken ones, in a fragile position. Mitchell, who considered her early career in Canada devoid of racial discrimination, pointed out that she "ran into problems" while working at Toronto Western Hospital in the early 1980s. She maintained that disagreements stemmed from the fact that she dared to object to some of the policies and procedures implemented by the administration and individual nurses in management. As she neared retirement in the mid 1990s, Mitchell observed that racial tensions began to peak between some black and white nurses. While other nurses chose to remain silent, Mitchell did not hesitate to address issues that she felt were detrimental to nursing and nurses. Confident in the knowledge gleaned from the University of the West Indies where she had studied contract law and issues around bargaining, together with the experience she gained from working for the Jamaican government, Mitchell was able to articulate some of her concerns to the administrators and nursing supervisors at Toronto Western Hospital. She provided the following example to illustrate her point:

> One of the things that stand [sic] out in my mind was this instructor teaching [nurses] how to complete an incident report. The point she made among other things was that if a nurse was operating a dysfunctional stretcher and something happened to the patient, when she wrote the incident report...she should not implicate the hospital. And I thought, 'what a piece of nonsense...the hospital is a corporation, it's a statutory

> body, it was opened by the government. It all has all the protections. Here is this poor nurse who has no protection. She might be the sole breadwinner for herself and her family, and this woman is telling the nurses that they should implicate themselves and not the hospital.'

While Mitchell acknowledged that gendered racism was indeed a factor--that is as a black woman she was expected to be silent—the institutional hierarchical structure in nursing operated to exacerbate disagreements between nurses. According to Mitchell, the lines in nursing were very rigid, and "the lower ones should not question the one above." On being a black woman questioning authority, Mitchell added "so as a little staff nurse, how dare me, question the authority of a [supervisor]. Second, I was black. I also had knowledge of how personnel should be treated." The disagreement between Mitchell and the supervisor was irresolvable and eventually she sought employment elsewhere.

Cheryl Gilkes argues that, "Black women's assertiveness and their use of every expression of racism to launch multiple assaults against the entire fabric of inequality have been a consistent, multifaceted threat to the status quo. As punishment, Black women have been assaulted with a variety of negative images."[23] Stereotypes of black women as 'mammies,' matriarchs, and welfare recipients, while indicative of the African-American experience, have some resonance in Canada albeit to a lesser degree than in the United States. In nursing, black women who challenge the status quo are often labelled as

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[23] Cheryl Towsend Gilkes, "From Slavery to Social Welfare: Racism and the Control of Black Women," in Amy Swerdlow and Hanna Lessinger, Class, Race, and Sex: The Dynamics of Control (Boston: G.K.Hall, 1983), 288-300.

"trouble-makers." Dorette Thompson[24] pointed out that it was Jamaican nurses in particular who were marked as agitators because "we spoke up about things, [we] would stand up for what [we] believed in." Thus, Gilkes's argument that assertive black women are often punished is corroborated by black nurses who contend that when and if they "spoke out" or questioned their superiors they were more likely to be penalized than their white counterparts.

Carmencita Gomez remembered working on a floor where the nurse manager made a decision to move nurses from other areas of the ward to care for a sick child whose parents were wealthy. Gomez questioned this decision, noting that other patients would be left unattended. Perturbed that Gomez had questioned her decision, the nurse manager asked Gomez to leave because she did not want anyone telling her how to run her ward. Gomez was placed on another ward and forbidden to return to the previous floor for a year. She states: "I was not allowed to go upstairs where all the others were, there were just the two of us downstairs." Although Gomez believed that the nurse manager's actions were racially motivated, she experienced some satisfaction based on her assertiveness, because the head nurse did address her concern regarding the lack of available nurses on the ward that evening. Gomez continued, "despite the fact that she put me down, whatever I said she knew it was [the truth] and at least there was extra coverage and that [child] wasn't getting just two nurses and the rest of the ward was

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[24] Dorette Thompson [psued], interview by author, Mississauga, Ontario, Tape recording, 17 August 1999.

suffering." Even though Gomez realized that as a black nurse she was being reprimanded for challenging the head nurse's decision and that she was isolated from her peers, she minimized the impact of the incident by focusing instead on what she gained by working on the new ward. For Gomez, the independence coupled with the fact she did not have to work with or interact with the head nurse was viewed as a blessing.

Gomez's and Mitchell's experiences are not isolated, but capture an important dimension of black nurses' lives. Both Das Gupta and Calliste demonstrate how black nurses are racialized within nursing. Racialization is the process whereby certain meanings are attached to black women, which subsequently influence how their white counterparts view and interact with them. Thus, according to Das Gupta, the response to Gomez and Mitchell by white managers provides a:

> Glimpse of what can happen in a racist, sexist culture where Black women workers with high levels of skill and leadership qualities challenge the status quo. Individuals who have much to gain from the status quo i.e. those with relative power, White in most instances, struggle to put Black women back in their 'ascribed' place. [25]

Dorothy Jones[26] also concurred with Gomez and other nurses that black nurses who spoke out were often stereotyped in negative ways. Despite the stereotypes and labels that accompany black women who choose to challenge the social order of nursing, there were

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[25] Das Gupta, "Racism in Nursing," 76.

[26] Dorothy Jones [psued], interview by author, Tape recording, Rexdale, Ontario, 29 February 2000.

some nurses who refused to let the negative images deter them from speaking out. Jones, for example, pointed out she admired this one nurse who she worked with because:

> ...She wouldn't back down and she didn't care if you were white, black pink or blue. If you offended her, she would fight for her rights. She would go to whoever she had to get her satisfaction. [She] was branded a troublemaker because she was able to stand up to them, and of course they didn't like this girl at all. But you know she didn't care. She would get it fixed, whatever was wrong, [even] if she had to take it to the union or whatever. She did it.

While some black nurses who were aware of the implications if they objected to or defied nurse supervisors, they did not acquiesce because they feared losing their jobs. Some willingly took the risk

Since the perception of racism is that it is intangible and hence difficult to prove, the majority of nurses at one time or another during their interviews wondered whether the various incidences they encountered could be characterized as racist. Because social structures perpetuate race, gender, class and other inequalities, there is no reason to suspect that all these nurses' stories are merely a figment of their imaginations. The treatment of black nurses by their white supervisors certainly disrupts the tendency to associate nursing and nurses with essentialized female qualities such as caring. Even though there is only one nurse who believed that racism played a (minimal) role in her termination, some of the nurses in this study were acquainted with, or knew of at least one black nurse who was fired, demoted, or penalized in some way for questioning their superiors.

Unlike some Caribbean nurses who were ambivalent about identifying racism, Canadian born Darlene Barnes[27] was most explicit in her discussions about racism in nursing and Canadian society generally. Barnes credits her father for leaving a legacy of activism – he was a strong unionist in the Brotherhood of Sleeping Car Porters -- for her ongoing commitment to address issues of racism and other inequalities in nursing. When Barnes returned from Britain in 1975, she worked at an agency as a part-time graduate nurse as well as in the office doing administrative work. While working at the agency, Barnes found out that the people who managed the registry were indicating the race of certain nurses. Barnes recalled:

> They were putting down 'B' for black or 'W' for West Indian and 'C' for Chinese. If a family called and said they wanted a nurse, and they didn't want a black or Chinese nurse, then they could look on their list and see who was black, Chinese and so forth. And that's how they assigned their staff.

This practice, according to Barnes, was rationalized as acceptable customer service because clients should be able to make their preferences known when requesting a nurse. Barnes also pointed out the customers assumed she was white and at one point she began asking why, for example, "they didn't want a black nurse?" When she inquired as to whether putting people into categories for employment was legal and whether the government was aware of what was taking place, the people who owned the registry removed her from the office. Eventually, Barnes left the agency. Barnes acquired her

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[27] Darlene Barnes, interview by author, Tape recording, Toronto, Ontario, 22 October 1999.

knowledge about racism from growing up in segregated Canada and knowing about her father's commitment to racial justice and was able to name racism when she saw it at work.

In examining some of the broader issues of racial inequality with respect to Caribbean migrants in Toronto, Frances Henry focused on employment, housing and education. Henry pointed out that besides racial harassment and name-calling, the respondents she interviewed also reported, "being passed over for promotions despite having qualifications similar to, or better than those of successful employees."[28] Some black nurses who believed they were more qualified than their white counterparts but were overlooked for promotions expressed similar sentiments. Even if racist discrimination did not emerge as the main reason black nurses were refused certain promotions, concerns were raised regarding the decision-making process, which they argued was biased and unfair.

As indicated in the previous chapter, some black nurses chose to avoid pursuing promotions or in some cases were refused them. There were also some nurses who felt that racist practices fused with other factors to determine who got promoted. Mackenzie applied for a position in the gynaecology outpatient department even though she was confident that the position would be given to someone else. She recalled:

> I applied, but at the time we had a union and of course it [the position] had to be publicized. The person who was running [the department] knew who

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[28] Frances Henry, The Caribbean Diaspora in Toronto: Learning to Live with Racism (Toronto: University of Toronto Press, 1994), 107.

> they wanted. I had an idea too, but I thought 'well, I'm going to apply because if you don't try, you'll never know.' So I applied, I went for the interview; of course I didn't get it. That same person who I thought was going to get it got it.

Mackenzie had deduced that a white nurse would be chosen for the position and was correct in her supposition. While Mackenzie believed racism was a factor in the decision, she argued that it was not the sole reason. According to Mackenzie, the nurse who received the promotion, was a friend of the unit manager and they interacted socially on a regular basis. The friendship of the two women, Mackenzie contended, most likely played a role in the decision-making process. Because she did not have this kind of rapport with the unit manager, Mackenzie maintained that she just accepted the decision as "the way things are." For Mackenzie, the devastating experience in the OR coupled with the loss of the promotion led her to develop a new attitude towards life and nursing. She made a decision to "enjoy life from there on ...and make myself quite happy in my surrounding life." To maintain her sanity, Mackenzie made a decision to forego applying for other promotions.

For about five years, Canadian born Marlene Watson[29] filled in for a supervisor at Toronto Western Hospital. When the supervisor left, Watson assumed that based on the experience she had acquired in the position and her other leadership that management would have talked with her about replacing the supervisor. Watson later learned that the position, which had not been advertised, was given to a younger white nurse with much

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[29] Marlene Watson, interview by author, Tape recording, North York, 18 January 2000.

less experience. When the position was announced, Watson and her colleagues were surprised at the decision. Commenting on the administration's decision, Watson stated, "she certainly wasn't a better nurse and she will never be. I'm not saying that I think I've got big broad shoulders...but I've seen that girl do things [in the recovery room] and I would say 'oh God', you must not...." Watson also added that they were a number of procedures that only she was able to perform in the recovery room, and that on several occasions she had to assist the same nurse who got the position. Although she had a difficult time understanding why the younger, inexperienced nurse was given the position, Watson was hesitant to concede that racism played a role in the decision. She explained that it was her refusal to provide management with information about a colleague why she was overlooked for promotion. When her disappointment became known, Watson was offered another head nurse position but she declined. She explained:

> I said no, send her [the nurse who got the position] so she can learn. I said, 'I'll stay in the recovery room'. Then I said, 'no I'm resigning' and that's what I did. But they offered me another head nurse's job, but I didn't want [it] because if this girl had been in any way even on my level, equal with me, it wouldn't have bothered me at all.

True to her word, Watson left Toronto Western for York Finch Hospital where her skills and experience were legitimized. She applied for a supervisory position and got it.

Eileen Jacobson[30] who immigrated to Canada in 1960 felt that having worked for several years at Brantford Hospital she should have been promoted or moved to another

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[30] Eileen Jacobson, interview by author, Tape recording, Burlington, Ontario, January 1995.

department. Jacobson was unable to identify whether systemic racism might have contributed to the difficulty faced by some black nurses when it comes to promotion. Jacobson felt that it was primarily her own responsibility that she remained in the same position. "I think I should have been aggressive" was how Jacobson explained the fact she was never promoted. In an afterthought, Jacobson added that in her entire nursing career, she had yet to meet a black nurse in a leadership role -- that is in the position of a head nurse. She then wondered adding, "I heard of a black head nurse somewhere, I'm not saying there wasn't, maybe in the city." Thus, Jacobson hesitated to make a strong connection between her experience and that of other black nurses.

Structural Changes and Racism in Nursing

Structural changes in nursing that begun in the late 1970s and culminated in the early 1990s coupled with cutbacks in health care have also had an adverse effect on black nurses. Das Gupta rightly points out:

> Most of the studies on the healthcare crisis and on patient care and on labour relations have the limitation of being race-blind. It is assumed that the impact of reorganization and increased surveillance of nurses is uniform to all nurses.[31]

A number of nurses reiterated how the reorganization of the hospitals affected the few black women who held leadership positions. Some of these nurses accepted early retirement packages and others were demoted. A few older black nurses were replaced

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[31] Das Gupta, Racism in Nursing, 76.

by white nurses who were judged to have more knowledge -- that is they were university trained nurses and were more in tune with the transformations in nursing.

Sandra Ward[32] remembered this one black nurse who worked for over twenty years at Bay Crest Hospital that the administration wanted to replace:

> They tried to get her out; they were new people who wanted to get her out. There were new people who wanted to take her place. She was going home crying, saying, 'she doesn't know what was happening to these people.' Surprising, there was this particular Jewish doctor who said, 'that's wrong'. He went to the top and told them that she had been the right hand for them. He told them that when she is ready to leave, she would leave. And that was so good.

The intervention by the doctor seems a rather extraordinary act, and more the exception than the norm. For the most part, nurses in these positions regardless of colour were often left to fend for themselves illustrated by the nurses' testimonies in Chapter 4. In this case, the doctor was able to speak on behalf of this woman and her forced retirement was revoked. The fact, however, that a white woman was in line for this position disturbed Ward because the administration made it appear that "the position was too good for a black woman." Black nurses were not the only nurses in positions of power that were affected by the cut backs as Pat Armstrong's study of the crisis in Canadian health care reveals. With the introduction of new ways to manage health care, many head nurses were replaced by men with business degrees whose main responsibility was to cut costs.[33]

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[32] Sandra Ward, interview by author, Tape recording, Toronto, Ontario, 5 January 2000.

[33] See for example, Pat Armstrong et al., Taking Care: Warning Signals for Canada's Health Care System (Toronto: Garamond Press, 1994).

These cuts profoundly impact on how nursing care is delivered. Unfortunately, with the very small number of black women in leadership roles compared to white women, it appeared to some of the nurses that they were often the first to be eliminated from these positions.

Canadian born Laura Tynes[34] experienced first hand the impact of the cuts in the 1980s while working at Toronto Western Hospital. Tynes, who held a senior management position, worked at the hospital for twenty-seven years until she was terminated in 1985. She realized that problems were about to begin when a new white supervisor approached her and talked about some changes taking place in the hospital. According to Tynes, the supervisor said "I could trust her...and then they moved me out of my office, the same office they had built for me, into this crummy little old office thinking I would leave. But I wouldn't." Approximately three months later, Tynes was told that her services were no longer needed and she was asked to sign a piece of paper. She refused. Tynes then proceeded to ask for an explanation. The only response Tynes was given as to why she was being terminated was "a lot of things." She pointed out that the decision to get rid of senior nurses was a strategic move on the part of management to avoid paying benefits to nurses in her position. Tynes believed that given her long service to the hospital she needed a more concrete explanation. The following is a synopsis of the conversation that took place between Tynes and the administrator:

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[34] Laura Tynes, interview by author, Tape recording, Mississauga, Ontario, 6 December 1999.

> Why weren't these lots of things pointed out to me: I've had excellent evaluations always, what is the problem? Why I haven't been told that what I'm doing is wrong? [Sic] My nurses didn't seem to think it's wrong; have you had any complaints from my staff? No, but there are things and they didn't choose to tell me.

Tynes was reported to the College of Nurses who attempted to revoke her license but once she met with them and the complaint was reviewed the College found that the allegations the hospital made could not be substantiated and cleared her. According to Tynes, the representative for the College pointed out that, "they had never seen such an intelligent and well informed person that had been dumped for the reasons the hospital said, which was, 'that I wasn't doing my job properly.'" How Tynes described her situation reflects how racism is often linked to other factors and needs to be placed within specific contexts. Tynes argued that cut backs to health care in the 1980s precipitated the elimination of mostly black women in senior position compared to their white counterparts. In reflecting on what took place, Tynes maintained, "I got the feeling that it was definitely racially motivated. But, it was the senior aspect as opposed to just the racial aspect, but they were getting rid of their black head nurses faster than they were anybody else." Although white nurses were not immune to the transformations taking place, Tynes's testimony revealed her sense of the precarious position of black nurses in senior positions. In the end, Tynes refused to be a victim and successfully sued Toronto Western and eight years later she was awarded a settlement.

This option of suing is not always available to nurses who have been wrongfully dismissed because of the financial and emotional costs associated with lawsuits. Tynes

also had the support of a majority of the nurses she worked with. Laughing, Tynes recalled how emotional it was when her colleagues visited her at home. "All my nurses all came here and sat around my living room and cried and carried on. I told them 'don't cry just find me a good lawyer-- I need a good lawyer, crying is not going to do anything,'" she recalled. Fortunately, one of the nurses Tynes worked with suggested a lawyer by the name of Tim Danson who felt Tynes had an excellent case. Despite the fact that Tynes did not have the financial means to pay him he took the case telling her, "When you get paid, I will get paid." As a black Canadian nurse whose experiences of racism began as a child living in Kentville, Nova Scotia, Tynes was able to understand her experience as being linked to a broader pattern of unequal treatment against black nurses. At the same time, Tynes also understood that her situation emerged within the specific context of the cutbacks, which intensified black nurses' vulnerability.

Outside of the systemic and institutionalized forms of racism in nursing, black nurses also had to contend with everyday and individual acts of racism on the ward. Henry describes these as "the many and sometimes small ways in which racism is experienced by people of colour in their interactions with the dominant group. It expresses itself in glances, gestures, forms of speech and physical movements."[35] According, to Essed, "every day racism is also infused into familiar practices, it involves

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[35] Frances Henry etal., The Colour of Democracy: Racism in Canadian Society, 2nd ed. (Toronto: Harcourt Brace Canada Ltd, 2000), 55.

socialized attitudes and behaviour."[36] Black nurses' experience with everyday forms of racism included among others things, name-calling from patients and their peers' alike, differential treatment with respect to vacations, shifts and the units they were concentrated in.

The racial epithets and jokes made by white colleagues who, according to black nurses "should know better," was what most nurses felt comfortable challenging. Dorette Thompson[37], for example, explained her reaction to racial jokes: "I would tell them plain that I didn't think it was appropriate." At one point racial jokes were so commonplace that Thompson brought the issue to the director who concurred with her that this type of behaviour was tasteless. With the director speaking out, Thompson noted that, "in the end they stopped, they would not do it front of me anymore, because they knew how I felt...I'm not going to sit [with them] if there were going to tell racial jokes." These overt forms of racism were easier to acknowledge and addressed than systemic and institutionalized racism, which was harder to identify. The latter form of racism is embedded within the structures, policies and practices (whether intentional or not) of the health care field that it seemed normal thus making it difficult to prove charges of racist practices.

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[36] Essed, Everyday Racism, 3.

[37] Dorette Thompson [psued], interview by author, Tape recording, Mississauga, Ontario, 17 August 1999.

While individual black nurses were quick to challenge their white colleagues who participated in racist name-calling and jokes, they found in their observations that management was reluctant to seriously engage with staff members who perpetrated these acts. For Jones, the lackadaisical manner in which incidences were dealt with when it was brought to the management's attention was difficult to fathom at times. She explained: "it always get resolved...without blaming the white ones, but with just enough softness so they would kind of calm down." There were moments when individual white nurses and supervisors recognized that black nurses' complaints about racism were indeed warranted and they spoke out. Yet, such instances were infrequent. For the most part, white nurses were rarely penalized for their racist behaviour. When translated by black nurses this suggested to them they were hardly valued. The inattention to issues of racism by management contributes to why some black nurses remained silent in the face of racist adversity beyond name-calling, but also reinforced the idea that racist incidences are isolated and the exception. Essed, for example, argues that "neglect as a form of racism is particularly important in contexts where whites are motivated to maintain a non-discriminatory self-concept and, therefore, try to avoid Blacks and more generally, racial issues altogether. The underlying thought is that, if one does not 'do' anything, one cannot be accused of having 'done' anything discriminatory."[38] Management's indifference in tackling issues of racism in the workplace supported and permitted ongoing discrimination against blacks and other nurses of colour.

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[38] Essed, Everyday Racism, 134.

Besides dealing with racism from their colleagues, black nurses also faced racism from their patients. Overall, black nurses found it much easier to identify and challenge overt patient-nurse racism than they were able to with administrators, supervisors, or other nurses. Black nurses' responses to racism from their patients varied depending on who the patients were. Black nurses tended to dismiss or ignore racist statements made by elderly patients and children. With respect to elderly patients, one nurse stated, "they are old, so you forgive, they don't really know what they are saying." Highlighting one of the many examples of racist encounters with patients, Jones recalled, "they would call me black bastard, or they would say, 'go back to Jamaica or Africa'." In response, Jones retorted, "it's a good thing I came here to look after you." She would then point to the number of nurses on the floor, while telling the patients that they are, "6 staff on, and 4 were black nurses, and 2 would be in charge, and the 4 [black nurses] would be the ones doing the [rounds]." On other occasions, Jones stated, "I would shrug it off [the racist remarks] because of their age, they were senile and they don't really know."

Another way in which patients' racist behaviour was rationalized by nurses was to focus on how elderly patients were socialized as children in what nurses considered a much more racist society. By placing the patients' behaviours in the context of a society where various institutions including the family reproduced race, gender, and class inequalities, black nurses viewed elderly patients' racist behaviour as inevitable. In dealing with elderly patients, another nurse claims, "I never take these things to heart because they would tell you these things and later they would call on you." In other

words, at the same time that patients were spewing out abusive racist remarks, they would in the next instance, be seeking the assistance of the very same nurses they were racist towards.

Calliste, Das Gupta and Dionne Brand concur that classist, sexist, and racist ideologies intersect to influence not only perceptions of black nurses, but where they are concentrated in the health care system. The nurses I interviewed who worked at institutions like the Toronto Western Hospital noted that at the beginning of their careers they were concentrated on the psychiatry floor. Calliste's research also showed this. In other hospitals, black nurses predominated in chronic and geriatric care units where heavy lifting and other physical tasks were common elements of daily work.

When she migrated from England in 1960, Lilli Johnson[39] worked on the psychiatric ward in a position she found unbearable. Johnson was given a six-month temporary visa with the stipulation that she should complete the courses needed to obtain her registration. Johnson's work schedule, however, made it difficult. As a result, she was unable to find the time to study. Johnson felt that the hospital's decision to place her on a laborious ward was a way of discouraging her from completing the course she needed, but also that the practice of black nurses being concentrated in specific areas was systemic. Johnson explained that there were only two other black nurses at that hospital, both working on the labour intensive psychiatric ward. Speaking about the floor she was

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[39] Lilli Johnson, interview by author, Tape recording, Scarborough, Ontario, 9 August 2000.

working on, Johnson pointed out that "it was a difficult floor, anytime there is a difficult floor that is where they pushed black people." Even more ominous for Johnson were those patients who had to be placed in "stiff jackets," with the assistance of the police. In discussing her own experience, Johnson noted that:

> I would be on the afternoon shift, and they had me on ten days straight, and then I would have one day, and I would be on at nights. At that time, I was supposed to be going to school to take refresher course to get certification. They never sent me or allowed me to sit my Ontario certification, which I had to have in six months.

After failing the test twice, Johnson relocated to the Hospital for Sick Children where they provided the support she needed to pursue her studies and subsequently earned her RN status. Because of her experience at this hospital, Johnson refused to put it on her resume and asked that I not name the hospital in my research.

Black nurses were also cognizant of the increased patient load they were assigned over their careers. While working on the Urology floor, Prince observed that a pattern developed with respect to the patients she was assigned. At the beginning of the week, she would begin with a heavy patient load, which lightened as the week progressed. Prince found that when she returned to work, she would be given new post-operative patients. "The lighter patients would be given to white Canadian nurses." On one particular occasion, Prince challenged her supervisor's decision to rotate her patients in a way that ensured she had a disproportionate number of "heavier" ones. Prince recounted:

> When I looked at the assignment, I said, 'why have you given away my patients, and why did you give them to so and so? I said, 'I've looked after these patients for a whole week, they are lighter, I'm looking forward to

> having a couple of light days. I don't mind one fresh post-op, but not a whole bunch of fresh post-ops.'

To justify why the white nurse received lighter patients, the supervisor told Prince that the white nurse was often late for her shift and she "didn't manage as well." The supervisor further explained that Prince was given the heavier and more disadvantaged patients because she was a more effective nurse and could manage the patients. In response, Prince pointed out that she was in fact making the same amount of money as the tardy nurse and felt that the supervisor's decision was unfair. Together, she and a colleague agreed not to take the new patients. In rendering her decision to refuse the patients, Prince explained:

> I don't think that it's fair. I've worked with those patients all week, and I was determined not to do it. I told her frankly, 'I'm not doing it. I said, 'if you don't give me back my assignment I'm going home.' So, she did, and she said an interesting thing. She [supervisor] said, 'you know we were discussing this last week at a meeting of head nurses, and it came up. The consensus was that people who were competent and work hard get more work.'

When confronted, the supervisor admitted that there was differential treatment in terms of the distribution of labour. Yet the rationale behind Prince being given the heavier workload was explained in terms of competence as opposed to the idea that black women are inherently suited to do these kinds of work. While in this particular case, proficiency, and hard work constituted a plausible reason for the supervisor's decision, Prince and other black nurses' interpretation of the division of labour in the hospitals was that it was racialized. Another issue that Prince raised was that the white nurse was never penalized

for showing up late. Prince was certain she would have incurred disciplinary measures if she had been perpetually late.

It is true that some nurses never viewed their place in the health care system as disadvantaged, even when they were concentrated in units where the patient load was heavy, or the work was considered difficult. Thompson immigrated to Canada from Britain in the 1970s, and having worked for some time on the medical floor doing menial work, welcomed the opportunity to work in the emergency department. Prior to this move, Thompson felt disillusioned about nursing, and was having second thoughts about staying in the occupation, "I hated it, I got bored working on the floor you know cleaning bedpans, and the rest of the work. I got a transfer to ER which was a brand new unit," she explained. Thompson emphasized that her request for a transfer was repeatedly ignored, but once the transfer was obtained knew that the move to the new unit would be a major improvement over the domestic like work she was doing. Thompson worked in the Emergency department for eight years and explained the experience as follows:

> We were working in a situation, where you all have to work together. You meet the odd person who didn't want to work together, but as a rule, there was a group of people who you work well with and who support each other.

Despite the tumultuous nature of the new unit, Thompson claimed that she benefited from being there.

Daphne Bailey[40] was trained in Britain and was recruited by Brantford Hospital. She immigrated to Canada in 1960. Unlike her other Caribbean counterparts, Bailey had the unique experience of living in a nursing residence upon migration. Working daily with the nurses with whom she shared a home made her experience delightful. Bailey stated, "I got along well with everyone. I worked on the Intensive Care Unit [ICU] and that was challenging as much as the job in Britain, so it was not too bad." Nurses such as Bailey who were placed in positions comparable to those held in England or the Caribbean tend to speak positively of their experiences, even if their work was onerous.

Das Gupta found in her study that "in general, black nurses are also treated differentially and adversely when it comes to good shifts, lunch breaks, and vacations." Black nurses, especially those who are currently working, supported Das Gupta's findings. For example, holiday policies stipulated that nurses had to work only one statutory holiday. Some black nurses found that these policies were often ignored, and as a result, they often ended up working on statutory holidays. Jones recalled an incident that involved a black nurse who was required to work on Christmas and New Years Eve, while her white counterpart had the holidays off. The black nurse, Jones maintained, refused to work one of the holidays, but she had to endure the repercussions that came with her part-time status. According to Jones, "they were not booking her any shifts because they were punishing her. So when you stand up for yourself, this is the way they get to you, in a subtle sort of way."

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[40] Daphne Bailey, interview by author, Tape recording, Toronto, Ontario, 29 May 1995.

The ambiguity and sometimes reluctance with which black nurses often spoke about racism in nursing was absent in their discussions of racism within the larger society. This requires some analysis. Unless the racism was overt, nurses had a difficult time discussing racism especially when it involved other nurses, supervisors or the administrator. There was a deep-seated fear on the part of black nurses regarding the ramifications of speaking out. Here, Thompson identifies what is probably the main reason why black nurses are unlikely to talk about racism: "We are not going to look for it, because if you do, you are going to lose your job, let not kid ourselves. You know, but what are you going to do? You have to eat...Many of us are not willing to lose our bread and butter. What if you get blacklisted and can't work anywhere?" She continues to explain that only in cases, such as with Northwestern Hospital[41], where evidence has been amassed over a period of time were black nurses complaints of racism given any credence. Thus, black nurses felt constrained in speaking up about racism in the nursing profession. It comes as no surprise that they would be more comfortable providing examples of discrimination outside of nursing.

One of the most common complaints of racism faced by Caribbean migrants regardless of the period they migrated was related to housing. After repeatedly being refused by property mangers to lease her an apartment, one nurse decided to place an

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[41] See for example the conference report from, "End The Silence In Health Care: Building a Movement Against Discrimination, Harassment and Reprisals,": A Conference For Black Nurses and Other Health Care Workers," May 25-26, 1995. O.I.S.E., Toronto, Ontario.

advertisement, stating, "coloured couple require apartment." This particular move, the nurse explained, was to protect herself against further unpleasantness. Bennett who immigrated to Canada in 1955, from Jamaica stressed that it was the ongoing racism that she faced when attempting to rent rooms that compelled her to purchase her own home. Bennett remarked:

> After being here for two years, I bought a house. You think they had apartments then? You had to rent out rooms. And when you come they would slam the door in your face because you are black. And when you call, they say 'yes,' but when you came they said it [the room] was gone. And even if they had a kitchen, you had to use a hot plate in your bedroom.

Bennett added that she was the first Caribbean person to own her home, which she used to entertain other Caribbean migrants. As a respected member of the emerging Caribbean-Canadian community, Bennett eventually became known as the nurse who held the best parties. On the other hand, Mcleod lived in Ontario Housing, a government subsidized unit that catered to low income families and, according to Mcleod, included a number of black and other immigrant families. Mcleod pointed to the lack of maintenance as an indication of how the government viewed the people who lived in the area. She argued that for the most part the buildings were "run down," and "unkempt." They were definitely "low class buildings," she added. Besides the fact that there was a sense of community among newly arrived migrants living in Ontario Housing, for many it was the only alternative until they were able to afford more suitable accommodations.

While Mitchell recalled that in general her experience in Oshawa was positive, the most unpleasant experience she faced was trying to rent an apartment and being refused. Mitchell described the experience:

> The first place I went to...these people were just nasty people...I don't think it was but...it could have been prejudice, but they were nasty. They didn't treat me nicely. But I went to live with another lady-a white lady, a Canadian lady-her husband had passed away. Mrs. Gibson was her name...and she was ever so nice to me. I hardly cooked. Every night she would invite me to come and have supper with her. When she is going to the supermarket, she wants to know if I'd like her to buy anything. She really treated me nicely.

While she expressed some doubts regarding whether racism played a role in the above encounter, Mitchell's experience was a common one, as validated by other black nurses in this study. For example, several years ago, Canadian born Virginia Travis[42] purchased some land on which to build their current home. Travis remembered being asked by the contractor "to go elsewhere." Growing up in Canada had prepared Travis for dealing with racial inequities, and as result, she was not surprised. Consequently, Travis and her husband refused to be deterred and proceeded to have their house built.

In their discussions of racism, Canadian-born women in this study talked about a period in Canadian history that mirrored the segregation of the American South. This is an era that most white Canadians -- not subjected to racism themselves and untrained to see its systemic nature or their own privilege -- do not have to acknowledge. Barnes

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[42] Virginia Travis, interview by author, Tape recording, Windsor, Ontario, November 11 2002.

explained that her father prepared her for dealing with racism by making ongoing comparisons between Canada and the United States. She remembered:

> He would talk about Canada as though Canada was no better than the United States and it wasn't. They had the same 'Whites only' restaurants, 'Whites only' drinking fountains. Blacks were expected to go to the back of the bus. Canada truly wants the world to believe that racism did not exist here that it was American thing. But guess what? It was blatant as hell in this country.

From Canadian born nurses, we get a glimpse of what it was like growing up black in Canada where covert and overt racism was a daily reality. These nurses recounted how blacks were excluded from entering certain public spaces and described the lack of jobs and opportunities available to them.

Still, some nurses claimed that they did not experience any form of racism, and despite the contradictory elements of many of these accounts, this remained their experience and view of the world. While Canadian born Tynes was accustomed to racism in Nova Scotia, she found that her colleagues in training "were not prejudiced," and "treated me like I was of one them-that was nice-being treated like one of them." Even after being sick and entering a class of new students, Tynes did not experience any kind of racism, and boasts that "I'm still in touch with all of them and we still have reunions every 5 years."

Resistance and Survival Strategies

Before I proceed to specify the ways black nurses developed resistance strategies, it is important to provide some background as to how some black nurses understood and explained racism in Canadian society. Racism in Canada was often measured against

their experiences of racism in Britain and the United States. For some nurses who worked and traveled in the United States, racism in Canada paled in comparison. Elucidating the differences in these societies is not to downplay racism in Canada, but to acknowledge that living in the United States could be worse. Mitchell who traveled extensively in the U.S. during and after the Civil Rights movement discussed the intensity of racism that black Americans faced:

> I traveled through Maryland, Florida, and Virginia and visited all these hospitals. I was horrified by what I saw. I thought with Civil Right some of it [racism] had changed. But I was there in the 80s and I couldn't stand it. I identified with black people even though I lived on the north side. I was still a black person and found it very, very painful.

The degree of racism in the United States prompted Mitchell to return to Canada and find employment. She found the racism in Canada more bearable.

Darlene Barnes went to England in 1971 to train as a nurse. Prior to leaving, Barnes's father warned her that that she would never experience "true," racism until she lived in England. Although Barnes recognized how racism manifests itself in Canadian society having been raised here, she felt that racial discrimination was more endemic in England. Barnes also compared England with her experience of travelling in the United States. In describing her experience in England, she pointed out:

> Every single day I experienced [some] blatant racism in England. Having been to the United States as a child, I could handle overt racism because you expect it, you know what to do; you know how to handle it. But when it's subtle, the way it was there sometimes, it was harder to call people on it. But when it was blatant, I called them on it. I mean I wasn't going to sit there and let them think they were cute and get away with it.

Of course, there is no monolithic description of how racism manifests itself in Canada, England and the United States. Some nurses argue that Canadian racism is difficult to define and name due to its subtle nature, especially when accustomed to more overt forms of racism in other places. Mcleod for example, made the distinction between England and Canada by comparing patients in both countries. She said:

> In Britain, people would say they didn't want any black hands to touch me, but here [Canada] they wouldn't say that, but you know they are not accepting of you. They [patients] might ask for some one else, or might ask, 'what happened to the person I had yesterday.' It was indirect, not direct like you would expect it elsewhere.

Conversely, Ellesworth emphasizes that it was due to Canadian racism that blacks were not recognized even though they were educated. In the United States, she maintained that "it didn't matter your colour, it was your education, and we were promoted to better jobs." In Windsor on the other hand, "we have this background and foundation and I think we were a bit overlooked." Ellesworth sought opportunities in the United States, which she believed were unattainable in Canada. At the time, she sought a position lucrative enough that she could raise her four children. Because her skills were recognized and rewarded, her outlook on racism in the United States is different from some of the other nurses who emphasize the blatant racism that exists there.

To illuminate the divergences in racial inequality in the various countries is important, because it demonstrates that racism and racial inequality are not fixed or unchanging phenomena. Furthermore, making distinctions regarding racism in the United States, Britain and Canada could, for the nurses, provide some rationale for the choices

they ultimately made in terms of where they chose to live and work. Focusing on racism primarily as an American or British occurrence, served to shroud the reality of racism in Canada. At the same time, given the history of racism in the United States, it is possible that for some nurses Canada was, at the time, indeed a better place to work.

Patricia Hill Collins argues: "Social science has ignored Black women's actions in both the struggle for group survival and institutional transformation. In part this neglect stems from the exclusion of Black women as a subject of serious study from both traditional scholarship and its Afrocentric feminists' critique."[43] Collins further ascertains that, "white male conceptualizations of the political process produce definitions of power, activism, and resistance...[that] fail to capture the meaning of these concepts in Black women's lives."[44] In other words, the research tends to focus on formal resistance strategies concentrated in the public as opposed to those that are informal and even invisible. Throughout this chapter, I have alluded to some of the ways black nurses resisted everyday racism. They developed direct and indirect strategies to deal with the inequality they faced primarily as individuals. For example, Tynes's friends not only supported her emotionally during the ordeal of being fired but also were able to recommend a good lawyer. Several of the women demonstrated the important role of black Canadian parents in preparing them as children to deal with racism by being honest

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[43] Patricia Hill Collins, Black Feminist Thought: Knowledge, Consciousness and The Politics of Empowerment. (New York: Routledge, 1991) 140.

[44] Ibid.

and open about how it would affect them. As a result, as adults these women were able to identify and challenge racism. I would like to highlight some more specific ways in which various forms of resistance were employed.

The parents of black Canadian nurses worked consistently to provide their children with a sense of pride about being black in a society where their skin colour was often associated with a lack of intelligence. These parents reiterated to their children that they were just as good as their white counterparts and emphasized the significance of education and achievement. Watson's mother, a domestic worker, repeatedly told her children while growing up that she had high expectations of them as adults. Speaking about her mother, Watson pointed out, "my mom's greatest expectation of us [was that] we would grow up to be law-abiding, educated children, to be able to make our mark on the world and be responsible citizens." Watson added that her mother did not want any of her children to replicate the life she led; she wanted more for her children and Watson remembered saying to herself, "you will never catch me scrubbing a white woman's floor! I made up my mind a long time ago." In referring to her mother, Tynes pointed out that "my mother always seemed to find money to buy books and so on to get us doing educational things. [She] was always in the background, attempting to teach us and make ways for us to achieve whatever we wanted to achieve." These nurses extracted lessons about hard work, survival, and the importance of education and incorporated these tenets into their adult lives.

In From Stumbling Blocks to Stepping Stones: The Life Experiences of Fifty Professional African-American Women, authors, Kathleen F. Selvin and C. Ray Wingrove point out that for black girls growing up in a racially divided America a good education was seen as the "passport" to a better life. This emphasis on acquiring a formal education is not exclusively a black American phenomenon, but is applicable to those who live in other diasporic communities, especially those from poor and working class backgrounds. This value on education is exemplified in most of the nurses' decisions to upgrade by taking additional courses, and pursuing degrees. These actions remained significant resistance strategies throughout the careers of the women in this study.

The importance of pursuing education as a way of resisting devaluation is reflected in the experiences of those nurses whose qualifications were not recognized by Canadian nursing authories. Even though the majority of nurses felt that their education, skills and training from Britain and the Caribbean prepared them to work in Canada, in order to be full-fledged professionals in terms of Canadian standards most nurses took the required courses needed to obtain their registration. These migrant nurses made conscious choices about how to deal with the accreditation process.

Coupled with obtaining the necessary education, Caribbean nurses expressed a profound sense of confidence in their training, skills and experience, which they felt superseded that of their white Canadian counterparts. Belief in one's ability "to be the best" is an adage these nurses relied on in an environment where they faced de-skilling and their training was not always respected and valued. Caribbean and British trained

nurses knew they exemplified the epitome of professionalism and repeatedly referred to this in their interviews. Prince summed up what the majority of nurses knew to be true about their abilities. She stated: "The assumption was that British trained nurses didn't have the theory but we got them both together." Prince maintained that even though Canadian nurses might have passed their exams, they were not good nurses." She continued, "it was rare to find a good nurse because a) they were not used to looking after more than two patients and b) they were not used to being on their own." Thus resistance is embodied in rejecting the subordination associated with being deskilled or being trained elsewhere. While some of these nurses discussed the frustrations they felt with being temporally relegated to the bottom of the nursing hierarchy, they often relied on their own knowledge about their abilities to do nursing. In order to cope with working as graduate nurses (before they received their registrations) Caribbean nurses drew on their own notions of professionalism by highlighting and comparing their experience and skills to those of white Canadian nurses, which they explained were superior.

In dealing with racism in nursing, black nurses developed a number of strategies ranging from finding other explanations for the way in which they were treated, "speaking out", remaining silent, or relying on more formal mechanisms such as the union, and, in the case of Tynes, filing a formal lawsuit. Due to the difficulty faced when trying to ascertain whether certain situations had racist overtones, many nurses found other plausible explanations for their victimization. This allowed some black nurses to perform their tasks without the stress associated with believing that racism permeates

every aspect of nursing. Thus as Cudjoe put it, "we were just concerned with doing our work." Such nurses' abilities meant they refused to allow racist and sexist oppression as the only factor determining their existence.

Some nurses focused on their achievement and success within nursing or asserted their professional identities as nurses, rather than emphasizing other identities, to minimize the realities of racism. These nurses, at times, assumed a "race-less persona,"[45] (talking about themselves as nurses) while affirming the support they received from whites. Even though, she faced the threat of losing her job, and felt that race might have been an issue, Travis insisted that:

> My patients come first, not my personal issues, I didn't make issues of racial discrimination; I knew that it existed; I didn't go searching for it. I have always done well. I was well respected, I had reaffirming experiences that I could take on a leadership role, I had a lot of authority, and I had support from management. I was elected by my peers to the College of Nurses. In addition to being on the council, I was on the disciplinary committee...the fact that they asked me promoted me for the Council of the College, that was an affirming situation.

Throughout her career, Travis was active in a number of capacities on different nursing boards "trying to make a difference." Examining her career accomplishments, the point she seems to suggest is that she was able to transcend the crippling effects of racism that allowed her to enjoy a successful career.

British trained nurses, such as Jones summed up how she felt being relegated to an inferior position in the nursing hierarchy:

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[45] Beverly Daniel Tatum, "Why Are All the Black Kids Sitting Together in the Cafeteria?"And Other Conversations About Race, (New York: Basic Books, 1997), 86.

> What came across with Canadian nurses, the RNs here, is they feel that when you are an RNA that you weren't good enough to be a RN. You couldn't become a RN, so you have to stay RNA, and your opinions don't count in anything at all. You would see things and you would tell them, and they would say, 'I'm the RN, you don't tell me what to do.' It was up to them. It was like you [had] to sit, and shut up, and let them find it out. ...But as times go by you learn to realize, well this is the way they operate and you just had to let it go. Deep down you know how you were feeling, but you just went with the flow.

Over the years, according to Jones, some white nurses "mellowed," because British trained black nurses asserted themselves on the ward. She pointed out that such black nurses came to realize that professionally they knew more than white nurses or were on similar ground. Jones pointed out that, "[black nurses] put their foot down, and wouldn't let [white nurses] treat them as if they are nobodies, and things like that." As a result, some white RNs were able to accept black nurses as full-fledged professionals on par with them; there were some who would listen and support black nurses. Thompson felt that there was a sense of mistrust on the part of some white nurses who had a difficult time accepting black nurses not only as their equals but also as "good" nurses. Her "motto was to prove them wrong;" Thompson continued...If you think I'm stupid, I'm going to prove to you that I'm not stupid, I'm going to do this job well. In the long run, they [white nurses] began to decide, 'oh my God' you're a good nurse.' So I prove their theory wrong so that people who come after me can reap the benefits of knowing that because I'm black, I'm not stupid. That's how I survived." In other words, Thompson performed the good nurse role. Black nurses also maintained it was during times of crisis when their assistance was vital that they were able to prove themselves to white nurses.

Another survival strategy employed by some nurses, whether they named it as such or not, was being cognizant of limits. This is illustrated in the number of nurses who frequently changed hospitals or floors because of incidents with white nurses or administrators, or with the case of nurses being placed on difficult floors. Even though these nurses did not always construe these incidents as being racist, and sometimes characterized tensions in terms of personality differences, education, or experience, these incidences nonetheless created tensions on the ward. Bennett left Toronto General Hospital after three weeks of being bossed around by a white nurse with fewer qualifications. Likewise, Johnson's tenure at her first job was brief because, as she recalled, "it was the most difficult floor. Anytime there is a difficult floor that is where they would push black people." While formal acts of resistance would involve strategies like registering complaints with the appropriate bodies in nursing, these nurses did not choose this avenue. Unfortunately, this approach individualizes potential racist incidences, which hides the larger systemic problems in the occupation.

Nurses who immigrated or who are still working in the later decades when racism was more politicized developed their own methods of dealing and coping with the differential treatment they faced. Having seen or heard of black nurses being fired, offered retirement packages because of cut backs in health care, or demoted, some nurses preferred to ignore or deny racism than deal with the consequences of speaking out. Those nurses who chose to speak out frequently did so because it was a question of

integrity. Others, such as Janet Barrett[46], who faced racism from a doctor who had had four black nurses fired, relied on the union, a more formal mechanism to assist her. She recalled:

> I phoned the union, and they showed up...[this] doctor's name apparently rang a bell and I told him what happened. He told them, he said 'we're willing to go to court, if there isn't an apology.' So I got my apology.

Despite the fact that some black nurses express concerns about the union's ability to deal effectively with issues of racism (as discussed in Chapter 4), Barrett was able to attain the support of the union.

Some nurses chose to remain silent even when they recognized and admitted that racism is indeed a factor in their experience. Black nurses' silence can be interpreted in a number of ways but silence can also be recognized as an act of resistance. Some nurses chose to remain silent because they had to consider the repercussions in terms of family and other commitments. For many, speaking out would jeopardize their quality of life as the realities associated with material living outweighed taking a stand. As previously stated, some nurses remained silent due to the lack of seriousness with which racism had been dealt with previously by hospital administrators and nurse managers. Ignoring racism served to create a climate that is not only unhealthy for the victims but the perpetrators as well. Indeed, until racism is seen by those in power as an important issue that affects the quality of nursing and warrants attention, black nurses will continue to remain silent, even when they agree with other nurses' allegations of racism. Finally,

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[46] Janet Barrett, interview by author, Tape recording, Toronto, Ontario, 5 June 2000.

black nurses chose to remain silent because of other repercussions such as being ostracized and marginalized. Jones summed up the consequences of nurses' silence, "They fear that they [those in power] would retaliate against them-they would take it out on them and stuff like that." Conscious of the fact that the emotional investment in speaking out would eventually take a toll if she fought every battle that came up at work, Mitchell, for example, armed her colleagues with the necessary information so that they too could speak out. By getting other nurses involved Mitchell made sure she was not the lone voice speaking. The strategy sometimes worked, but in other cases nurses did not always want to speak out for fear of reprisals.

Some nurses accepted that racism in nursing was inevitable and did not let its impact on their lives affect their ability to perform their work or their mental health. Making a decision to remain silent in the face of oppression should not be construed as a sign of weakness, but as another form of resistance, of "choosing one's battles carefully." When black nurses experienced indignation or rage at particular injustices, they often relied on their friends and colleagues to listen and validate their experiences. Hill Collins reminds us that:

> While domination may be inevitable as a social fact, it is unlikely to be hegemonic as an ideology within that social space where black women can speak freely. This realm of relatively safe discourse, however narrow, is a necessary condition for black women's resistance. [47]

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[47] Hill Collins, Black Feminist Thought, 95.

Black nurses relied on public spaces, such as their churches and cultural organizations, as well as friendships they formed with other black nurses to talk about the inequalities they faced. Mcleod described her relationship with the women she worked with upon migration from Britain in the following way: "I could relate to them more, and they had a bit of understanding from where you were coming from, and what you were able to do, having to work here [Canada]." For Sandra Ward[48] working with her "own people," meant being healthy and feeling worthwhile: "It's been good, and we can talk with each more than with other people," she stated. The multiple experiences these nurses faced were then validated and legitimized in the confines of formal organizations or among friends.

In her study of black women's health activism in the United States, Susan Smith argued that "middle-class black women asserted that their class, as well as their gender, made them uniquely fitted to bring about the salvation of the race."[49] She also claimed, "Black middle-class women felt a personal stake in the 'improvement' of the poor because of the potential effects on their status."[50] This long tradition of 'lifting as you climb' was also revealed in black nurses' discussions about how fruitful it was to assist

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[48] Sandra Ward [psued] interview by author, Tape recording, Toronto, Ontario 5 January 2002.

[49] Susan L. Smith, Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890-1950 (Philadelphia: University of Pennsylvania Press, 1995), 18.

[50] Ibid.

other nurses and be assisted by other nurses to "learn the ropes." Black nurses often encouraged their sisters to advance their education. Even though there were differences in terms of training, experience, and pay, being black women served to homogenize these nurses, while sometimes reinforcing a singular identity based on race. Thus they overlooked or downplayed their differences in order to "get along" and support each other. Johnson described how she saw her role as an older more experienced nurse in relation to younger black nurses who were experiencing difficulties in the occupation. Johnson contends, "I wanted to elevate and improve their self-esteem because if you didn't feel good about yourself being black, you are not going anywhere." For black nurses the importance of assisting other black nurses is definitely related to their black American sisters' tradition of "uplifting the race." These women had a keen sense of responsibility towards their fellow nurses, especially those concentrated in the lower ranks in the occupation.

For these women, nursing was viewed as a type of calling, a way of helping others, and despite the racism or other inequalities that might have existed in the workplace, these nurses were fulfilling a dream, and they were often mindful of this reality when working. In referring to how she dealt with the racism that she was familiar with in nursing, Tynes stated that in order for her not to be bitter or vindictive, she chose to "let a lot of things go." Nursing was, she continued:

> Something I wanted to achieve. Therefore the prejudice-ness of what was going on, I just let it go because it [nursing] was something I wanted, and in order to get it, I had to turn a deaf ear and a blind eye to a lot of things that went on.

For the majority of nurses, their reason for choosing nursing as an occupation was what they focused on when issues of racial discrimination or any other crisis surfaced.

Religion was also instrumental in their interactions with other people. On many occasions, being a Christian helped the nurses to deal with peoples' racist behaviours by focusing on the belief that all human beings are God's children and one should "love thy neighbour as thy self." If nurses take the scriptures and lives accordingly then their goal as Christians should be to live in peace with their fellow human beings. Watson pointed out that her mother's teachings and her acceptance of Jesus convinced her "that there was a certain code of behaviour expected [of a] Christian person. God played a very very important part in my life because in my heart…I did not want to do anything that would bring disgrace or discredit Christ's name."

While the various forms of resistance employed by these nurses did not involve formal and explicit challenges to inequity, they are indeed significant because they worked. Black nurses, whether from the Caribbean or Canada faced similar struggles associated with "having black skin", as well as the additional struggles associated with being nurses. These women adopted multiple forms of resistance to deal with the reality of working in Canadian hospitals and the larger society.

In examining the relationship between and among women, authors Teresa Amott and Julie Matthaei point out in Race, Gender and Work: A Multi-cultural Economic History of the Women in the United States that:

> ...In a very real sense, the lives of any one group of women have been dependent upon the lives of others...Unfortunately, the ties which have joined us, have rarely been mutual, equal, or cooperative; instead, our interdependence has been characterized by domination and exploitation.[51]

The above quote speaks to a certain degree to the situation in nursing. Despite the fact that nursing is a gendered occupation issues of "race" at times serve to create conflicts between those in dominant positions (mainly white) and working nurses (where most women of colour were located.) These divisions are detrimental to the kind of solidarity needed to challenge cut backs to health care which has a fundamental impact on nursing and nurses' work. Despite the impact of discrimination within and outside of nursing, black nurses developed a number of survival strategies that helped them lead worthwhile careers. The majority of nurses expressed no regrets in choosing nursing as an occupation.

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[51] Teresa Amott and Julie Matthaei, Race, Gender, and Work: A Multi-cultural Economic History of Women in the United States, rev. ed. (Boston: South End Press, 1996), 3.

Chapter 6
Conclusion

The main objective of this research was to document the experiences of a group of middle-class black professional women, black nurses in Ontario. The intent was not to compare and contrast the experiences of black nurses with white nurses, even though I acknowledge that the experiences of these two groups are interdependent and have implications for how they are situated within nursing. Given the paucity of research on black professional women in Canada, I wanted to place black nurses center stage and make them visible, to examine what role race, class, gender, and professionalism have played as they interpret their work, family, ideas about education, community, and, for Caribbean-born nurses, immigration experiences. While archival research did produce some critical documentation pertaining to nurses' work lives, the oral histories completed for this research provided the most evocative information gleaned about these nurses. Relying on this indispensable source allowed me to give voice to these women whose experiences will otherwise be lost to historical obscurity.

From the onset, the women in this study were eager to be interviewed because they were cognizant of the absence of studies on black Canadian generally, and more specifically on women. Black Canadian nurses whose ancestors have contributed to the development of Canada emphasized how important the "nurses story" is. The information gleaned from the interviews about family, work, migration, and racism would not otherwise been possible without the use of oral history. The rich information provided by these nurses about various areas of their lives is a testament to how important oral history

as a methodology. While the framework, theories and analyses drawn from black diasporic studies, feminist theorizing about women and work, migration studies, and nursing history are useful to explain and interpret black nurses experience, the limitations and gaps in these various fields are also obvious. Furthermore, in a predominantly female occupation such as nursing where a gendered and to some extent class analysis has been the basis for analysis, it is easy for black women's specific realities to be obscured in these discussions. Similarly, discussions and theorizing about race often begin from the perspective of men without any consideration given to women. Overall, the importance of nursing to the interviewees is also a reminder to anti-racist scholars that gender also matters.

In nursing history, concepts of professionalization and proletarianization have proven useful tools to understand the changing nature of the health care system. The studies used in this research have shown how these processes operate simultaneously with the result that some nurses gained status while others lose. Given the labour shortage in the nursing following World War II, and the resulting efforts to recruit nurses from overseas, this study builds on existing scholarship to explore how proletarianzation and professionalization affected those nurses whose "foreign" credentials were questioned by the nursing elite. Similarly, this dissertation demonstrates how the presence of black nurses in a predominantly white profession complicated these processes. On the one hand, black Canadian and Caribbean nurses were beneficiaries of both the professionalization and proletarianization process. Trained in Canada, the former were in leadership and supervisory roles until they retired. Individually, they also participated in

the professionalization efforts via education, which they viewed as the key to upward mobility in the occupation. Professionalization and proletarianization impacted nurses trained in the Caribbean and Britain differently. Some of these nurses worked in subsidiary positions until they upgraded, and others were placed in leadership roles. Most were critical of Canadian ways of doing nursing especially with respect to patient care. The irony is that while the nursing elite embraced professionalization pursuits such as having RNs assume more administrative responsibilities, Caribbean-born nurses felt that these initiatives negatively impacted nurses' ability to provide adequate and quality care for patients. Through a close attention to the influence of race and through incorporating the voices of black women this dissertation calls for further studies of professional women that include race as a critical tool for analysis, which will in turn promote a rethinking of processes like professionalization.

While recent scholarship have examined the plight of domestic workers for example, less attention is devoted to black women in the professions in Canada. As one of the few occupations available to black women, being a nurse brought respectability, prestige and consistent wages. The emerging Caribbean community recognized the status of black nurses when they chose to invite them as opposed to Caribbean domestic workers to their social functions and community events. Whether married, divorced, or single, the majority of nurses in this study live a middle-class standard of living. Most own their own homes and others have cottages. Those who had their children were able to successfully educate them. Those who are retired engage in leisure activities, and others participate in various political and social organizations. As professional women,

black nurses shared with their white counterparts middle class status and identity. But while white Canadian women in the post-war era were just coming to terms with the reality of working for wages after marriage and during motherhood, black women expected they would always work throughout their adult lives. And while the conventions of the day suggested that child-care and domestic responsibilities were "women's work", black nurses insisted that their husbands assist with household duties and child rearing. In nursing shift work is the norm, and most of the nurses--especially during the early part of their careers-- were unable to hire domestic help or nanny, husbands and older children had to do their part to ensure the smooth functioning of the household. Thus, one of the most important contributions this study makes to the scholarship on women and work is black women's discussions about unpaid work.

How some black nurses used their mother's lives to influence theirs was also insightful. The nurses recognized how being a housewife placed their mothers in a precarious position and many nurses concluded that their mothers were unable to realize their own dreams because the family was often their only priority. Other than one nurse who had six children, the average nurse had two children, and several remained childless. Clearly, there is a link for some black nurses in this study between memories of how hard their mothers worked and their own decision to be parents. Measuring their own lives against that of their mothers is a testament to the nurses of their own success. The black Canadian and Caribbean-born nurses' articulation of identity speaks to the conclusions of theorists who posit that identity is multiple, fragmented, and fluid. These theorists challenge frameworks that emphasize the dominance of a singular identity: In black

studies this takes the form of a racial identity; in feminist scholarship, a gendered identity; and for political-economists (especially working class) identity and consciousness. The current scholarly trend towards thinking about identities as multiple and complex with specific histories always in the process of being reconstituted is exemplified in the daily-lived realities of black nurses. The nurses' experiences indicate that there is really no single black identity. Divisions based on by age, where they were born, location of training, and education were real and impacted relationship among and between nurses. Trained in the Caribbean, Canada, and Britain some nurses were RNs in leadership positions supervising other RNs and subsidiary workers. Most black nurses framed their accounts in terms of the discourse of patient care, and articulated an identity as professional workers, which was forged in their training as nurses, and subsequently their work at the bedside. Black Canadian nurses commitment to quality care was emphasized throughout the interviews. Whether it was Caribbean trained British nurses who criticized how Canadians did nursing during the early 1960s or those who witnessed the impact of the cutbacks to health care in the late 1970s and 1980s on patient care, what is obvious is that they often spoke as nurses. In these moments, their racial identity was often underemphasized.

The ability of Caribbean and black Canadian women to articulate their identity in terms of nurses as opposed to black nurses reveal is indicative of how people experience identities in different settings. Even though nurses their racial identity at work was not always foremost in their minds, which was evidenced in the discussions about professionalism and deskilling, race was never absent from the profession. My discussion

in Chapter 3 devoted to the contradictory responses of individual nursing directors and supervisors regarding the presence of black nurses in the occupation demonstrate their stark awareness of race. But, unlike their white counterparts, who had the privilege to refrain from thinking about their racialized status, black nurses did not always enjoy this luxury. Ideas and notions about blackness materialized at different times throughout their careers. The accumulation of racist experiences within the larger Canadian society led the nurses to articulate a racial identity. For Caribbean nurses, the idea of home is intricately tied up in discussions about identity. For some nurses their outsider status in Canadian society resulted in a yearning for the Caribbean home where a sense of belonging solidified their sense of themselves. For Canadian-born black nurses, Canada is "home". Thus, a black Canadian identity is evoked with pride to signify the contributions of their ancestors and themselves. Even if Canadian-ness is defined as white, individual nurses made claims to a Canadian identity, though perhaps in the form of a hyphenated Canadian identity. The black women consciousness of themselves as nurses was forged by migration, by being the first black nurses to enter the occupation, and cut backs to health care.

Black nurses did not allow themselves to be victimized by racism. As children, black Canadian families armed their children with tools to deal with racism that stayed with them throughout their lives. The mantra that they were "just as good as white people" was embedded in the psyche of black Canadian nurses from their childhoods. In addition, their conservative view of education was used as a response to white racism for both black and Caribbean nurses. Caribbean nurses claims that racism was virtually

absent from the nursing profession during the early 1960s—a result of the small number black nurses—is a clear indication not only of how exclusionary policies of the earlier decades affected the profession but that discussions of race needs to be contextualized. The manifestations and development of racist ideologies during the early 1960s was not the same in the 1980s. The politicization of racism in the 1980s, the influx of black and other women of colour in nursing, public discussions about racism in the occupation provide an avenue for black nurses who are currently working to explain their experiences of racism.

Nursing in the millennium is vastly different from when the first black Canadians entered training in the early 1950s. The various nursing organizations and unions have worked hard to carve a space for nursing in the medical field where the interests of male physicians have been paramount. The issues of professionalization, however is never complete, and the nursing elite continues to be preoccupied with nurses' status at the expense of dealing with other crucial issues affecting solidarity in the occupation. For example, in the mid 1990s, lawsuits by primarily black nurses--some of which are still pending-- against various hospitals in Ontario,[1] illustrates how much of an issue racism is. While racism in the medical field is hardly a new phenomenon, it was intensified in the cost containment period of the late 1980s and 1990s. In this period of economic insecurity, black nurses were more than likely to feel the brunt of these changes through,

[1] See for example the conference report from, "End The Silence In Health Care: Building a Movement Against Discrimination, Harassment and Reprisals,": A Conference For Black Nurses and Other Health Care Workers," May 25-26, 1995. O.I.S.E., Toronto, Ontario.

factors like lay-offs and increased patient care load. Furthering restructuring will continue to impact the occupation, rupturing the teamwork essential for nurses to perform the work of caring which is so central to nursing.

There is much research to be done on black professional women in higher education, law and other areas traditionally reserved for white males. At the same time, there is still much work to be done on not just black women in nursing but other women of colour. A comparative analysis that examines between the experiences of women of colour and their white counterparts would complicate our scholarly understanding of how relations of dominations operate within a female-dominated skilled profession. In the final analysis, I hope this research will be the starting point for further research.

Appendix

Brief biographical details of the women interviewed

Note: * Asterisk indicates use of pseudonyms

Daphne Bailey
Born: Jamaica, 1932
Age: 63 years old
Parents: mother, dressmaker; father, farmer
Trained in Britain as a Midwife/Nurse
Immigrated to Canada in1960
Worked from 1960 to mid 1990s
Retired at the time of interview
Interview date: May 29, 1995.

Darlene Barnes
Born: Winnipeg, Canada,
Age: 49years old
Parents: mother, chef; father, sky-cap
Trained in Britain in 1971; returned to Canada in 1975.
Divorced, 1 child
Working full-time at the time of interview
Interview date: October 22, 1999.

***Janet Barrett**
Born: Jamaica
Age: In her 60s
Parents: mother, post-mistress father: worked with the Parish Council (government)
Immigrated to Canada as a domestic worker in 1968, went to high school at nights.
Completed nurse training in 1974.
Married, 3 children
Working full-time at the time of interview
Interview date: June 5, 2000.

***Orphelia Bennett**
Born: Jamaica, 1915
Age: 85 years old
Parents: mother, housewife; father, farmer
Trained at the University of the West Indies as a Midwife/
General Nurse
Immigrated to Canada in 1955.
Widowed, 2 children

Worked from 1955-1989.
Retired at the time of interview
Interview date: October 14, 2000.

Myrna Blackman
Born: Grenada
Age: In her 70s
Trained in Britain in as a Registered Mental Nurse (RMN)
Immigrated to Canada in 1971, worked as a Registered Nursing Assistant (RNA)
Married, 2 children
Worked from 1971-1994
Interview date: May 29, 1995.

Vera Cudjoe
Born: Trinidad, 1928.
Age: 67 years old
Parents: Mother; teacher; father, cane farmer
Trained in Britain as State Registered Nurse (SRN)/Midwife
Immigrated to Canada in 1960
Never been married, no children
Disillusioned with nursing made a career change in1962 shortly after migration
Interview date: January 5, 1995.

Agnes Ellesworth
Born: Maidstone Township, Ontario, 1931
Age: 70 years old
Parents: Parents worked at odd jobs
Trained at Hotel Dieu, Windsor, worked there for 2 years, worked in Detroit, Michigan from 1958-1996
Married, 2 children
Retired at time of interview
Interview date: June 5, 2001.

***Carmencita Gomez**
Born: Trinidad
Parents: Mother, teacher; father, electrician
Age: late 40s
Parents: Mother, teacher/housewife; father, electrician
Trained in Britain as an SRN (State Registered Nurse); migrated to Canada in 1975.
Married, no children
Working full-time at time of interview
Interview date: October 14, 1999.

Jean Harry
Born: Guyana
Age: late 60s
Parents: Mother housewife; father, farmer.
Trained in Britain as State Registered Nurse (SRN)
Immigrated to Canada 1960
Married, 2 children
Worked from 1960 to the mid 1990s
Retired at the time of interview
Interview date: August 8, 2000.

June Heaven
Born, Jamaica, 1943
Parents: Mother, school principal; father, worked in the banana industry
Age: 55 years old
Trained at the University of the West Indies as a General Nurse
Immigrated to Canada in 1967
Divorced, 2 children
Worked as a nurse/nurse educator from 1967 to the mid 1990s
Retired at the time of interview
Interview date: November 11, 1999.

Eileen Jacobson
Born: Barbados, 1932
Age: 62 years old
Parents: Mother, housewife; father: overseer on the plantation
Married, 2 children
Trained as a State Registered Nurse (SRN)/Midwife
Immigrated to Canada in 1960
Worked from 1960 to mid 1990s
Retired at the time of interview
Interview date: January 1995.

Lilli Johnson
Born: Jamaica
Age: In her late 70s
Parents: Mother, schoolteacher; father, worked in the community
Trained in Britain as a Midwife/Nurse
Immigrated to Canada in 1960
Have never been married, no children

Worked 1960-1987
Retired at the time of interview
Interview date: August 9,1999.

***Dorothy Jones**
Born: Grenada, 1943
Age: 56 years old
Parents: Mother, worked in a nutmeg processing plant; father, tailor
Trained in Britain as a SEN (State Enrolled Nurse)
Immigrated to Canada in 1971
Married, 3 children
Worked from 1971-1999
Retired at the time of interview.
Interview date: February 29, 2000

Brenda Lewis
Born: Trinidad, 1945
Age: 55 years old
Parents: Mother, housewife; father, labourer
Trained in Trinidad, RN, specialized in Psychiatry
Immigrated to Canada in 1971
Married, 3 children
Currently working in management at the time of interview
Interview date: February 24, 2000.

Inez Mackenzie
Born: Jamaica, 1935
Age: 64
Parents: Mother, housewife; Father, supervisor for the Public Works Department
Trained: University of the West Indies
Immigrated to Canada in1960
Worked from1960-1998
Married, 2 children
Retired at the time of interview
Interview date: October 13, 1999.

Elaine Mcleod
Born: Jamaica, 1943
Age: 52 years old
Parents: Mother, domestic/childcare worker; father, worked in hotels
Trained in Britain as State Enrolled Nurse (SEN)
Immigrated to Canada in1969.
Divorced, 2 children

Working full-time at the time of interview
Interview date: May 1995.

Monica Mitchell
Born: Jamaica
Age: Mid 60s
Parents: Mother, housewife; father, subcontractor
Trained at the University of the West Indies as a general nurse
Immigrated to Canada in 1960
Never been married, 1 child
Working full-time at the time of the interview
Interview date: April 7, 2000.

Jeanette Prince
Born: Antigua, 1939
Age: 60 years old
Parents: Mother, housewife; father, police officer
Trained in Britain, returned to Antigua.
Immigrated to Canada 1960
Never been married, no children
Retired at the time of interview
Worked from 1960 to the mid 1990s
Interview date: October 8, 1999.

Edna Black Searles
Born: Canada, 1915
Age: 85
Trained in Ontario
Parents: Mother, housewife; father, Chef
Married twice, twins' from first marriage.
Worked from 1959-1965
Retired from nursing early
Interview date: September 4, 1999.

Frieda M. Steeles
Born: Windsor, Ontario
Age: 72 years old
Parents: Mother, teacher; father, Windsor's first black uniform officer
Trained: Hotel Dieu Windsor
Divorced, 6 children
Worked from 1950-1992
Retired at the time of interview
Interview date: June 9, 2001.

***Dorette Thompson**
Born: Jamaica
Age: In her 50s
Trained in Britain as a SRN (State Registered Nurse).
Parents: stepmother, self-employed; father worked.
Immigrated to Canada in 1968
Never married, no children
Working full-time at time of interview
Interview date: August 17, 1999.

Virginia Travis
Born: Dresden, Ontario
Age: 64 years old
Parents: Mother, worked part-time doing domestic work; father, labourer, factory worker;
Trained at the Public General Hospital, Chatham, Ontario.
Married, 2 children
Worked as a nurse/nurse educator from 1957-1991
Retired at time of interview
Interview date: June 5, 2001.

Laura Tynes
Born: Kentville, Nova Scotia
Age: In her late 60s
Parents, Mother, housewife, domestic worker; father, chimney sweep
Trained at the Children's Hospital, Halifax
Widowed, 2 children
Worked in nursing from 1954-1996.
Retired at the time of interview
Interview date: December 6, 1999.

***Nancy Ward**
Born: Dominica
Age: 52years old
Trained in England as a State Registered Nurse (SRN)/ Midwife
Immigrated to Canada in 1970.
Married, 4 children
Working full-time at time of interview
Interview date: January 5, 2000.

Marlene Watson
Born: Nova Scotia
Age: 61years old.
Parents: mother, teacher/housewife, domestic worker, father, quarry worker
Trained at Victoria General Hospital, Halifax'
Never been married, 1 child
Working full-time at time of interview
Interview date: January 18, 2000.

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