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OUR CONVICTIONS THE DNA OF OUR ACTIONS

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REGROUPEMENT DES FIQ

OUR CONVICTIONS THE DNA OF OUR ACTIONS

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THEME DOCUMENT

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INTRODUCTION

During the democratic life cycle of organizations such as the FIQ and the FIQP, the Convention represents a unique moment to reflect upon who we are and what we do. This is a challenging but necessary exercise in order to plan for the future and stake out an advantageous position moving forward.

Therefore, the FIQ and FIQP Convention remains the decision-making authority where our organizations' key guiding principles are imagined, discussed and determined. The Convention provides the best space to ask and answer questions of the utmost importance regarding the Federations' future and especially regarding our ability to fulfil our primary mission, improving the working and living conditions of healthcare professionals.

It is important to note that if this democratic exercise has always had an important strategic value for our organization, this year's Convention is even more so in the current context marked by COVID-19. The pandemic did not only cause numerous human tragedies, it also revealed the fragility of our public health network whose minimum level of operations is partially maintained by gouging the women who work in it. Alarm bells denouncing the inhumane working conditions healthcare professionals face have been blaring and warning us for decades now. Quebecers sympathize and passively support us. For the last 30 years, the political class across all parties salutes our "heroism" and our commitment but it hasn't taken any concrete steps to stop the unacceptable, beyond making pious promises and campaign slogans.

Yet the challenge of attracting and retaining healthcare professionals is not complex or unattainable. There are several well-documented solutions that have been brought forward in various symposiums and publications over the last few decades. The province of Québec is rich in resources, so we have the means to serve our ambitions. The only thing missing is, without question, the political will.

As such, we have explored different approaches. We have provided conclusive data and have supported our arguments with scientific literature. We have called upon the population for their support. We embraced a proposal-driven unionism and the development of new care models. We appealed to the rationality and the good will of employers who just pretend to be listening to us. We have operated within the boundaries of the legal framework and filed tens of thousands of grievances in order to defend the rights of healthcare professionals.

We have come to realize that being committed and reasonable is not enough to create the obligation to act. Complying with the legal framework is not enough to stop elected officials from taking us for granted and making them feel that they have to listen and act. It is thus time that we step out of our Crocs to join ranks and drive change now, and not wait for the next reform.

A HEALTH NETWORK ADRIFT

Let's set the record straight first: anyone who believes that unions should focus on "working conditions" and do not concern themselves with political matters **is not concerned about our wellbeing**. In fact, this type of individual seeks to strip healthcare professionals, and all civil servants for that matter, from the possibility of taking action against the very source of their everyday work problems. It is therefore impossible to comprehend the chronic, endemic work overload healthcare professionals have without tracing it back to the political decisions that created this situation in the first place. Furthermore, our success in improving the lot of healthcare professionals can only be determined by our ability to drive, even force, policy makers to take decisions that serve our interests and not theirs.

We must thus ask ourselves why someone would not have a vested interest in ensuring access to quality healthcare services and that this access is facilitated? Or why someone would not want a decrease in absenteeism-related costs because of higher employee well-being and satisfaction? Of course, there isn't a single politician that will say that they aren't on our side. It isn't in their interest to say otherwise because everyone likes caregivers. However, are these same politicians ready to free up the funding that is required to increase the salaries of public sector employees? Do they have an interest in making lasting improvements for public sector employees by passing a law that sets safe ratios? Do they have an interest in strengthening the Government's ability to offer quality services? This is where it gets complicated...

The deterioration of working conditions for healthcare professionals is **intrinsically and directly** linked to the will of the political class over the last 30 years, regardless of the political affiliation, to reduce Government participation by reducing public funding and transferring responsibilities to the private sector and modifying the fundamentals that govern public services by applying a private sector methodology. This results in public services no longer being planned, funded and offered on a needs basis, but rather on achieving budgetary targets.

How was this downward spiral orchestrated?

Although this approach was gradually rolled out, it was only in the mid 1990s that it was implemented in its crudest form. Raising the spectre of the downgraded credit rating issued by Moody's as a result of the province's allegedly disproportionate public debt, Lucien Bouchard's government sat down with employers and unions in 1996 to get their consensus on the importance of reaching a zero deficit within four years or Québec would be plunged into a financial crisis. In 1999, the government reached its goal one year earlier than expected following significant budget cuts and the semblance of a consensus. Between 1996 and 1999, Lucien Bouchard's government slashed public spending by $4.2B, $2.45B of which in healthcare alone and more than $1B in education. During this three-year period alone, the health network was suddenly deprived of 10% of its workforce. In short, more than 30,000 civil servants (of the 15,000 anticipated workers) opted for the early retirement program which would have detrimental effects on the services offered to the public (Québec, 2000; Boivin, 2009 and Lessard, 2010).

Then, further budget cuts were made by the governments under Charest, Marois and Couillard. For six years, from 2010 to 2015, Quebecers were asked to make a $20B plus effort[1], $13.8B of which in budget cuts. This translated in additional cutbacks of $2.3B to each annual budget for six years (Beaulne, 2018). It is therefore clear that public service underfunding is the underlying reason behind the deterioration of public services and the deplorable working conditions public servants face.

It is important to note that these budget cuts were not and never were because Québec was at risk of falling into a financial black hole. Québec's debt was never out of control and it was always proportional to our wealth. In fact, Québec's debt fared well when compared to other wealthy western countries. These budget cuts were therefore not a demonstration of political courage in light of an unsustainable situation. If these budget cuts were presented as so, it was to get the public to accept choices that would have otherwise been highly unpopular. This was very much a political choice which sought to reduce government participation and increase that of the private sector. It is always about choices in politics.

Doing more with less

These budget cuts would clearly have significant consequences, even if we were long assured that it was simply to "trim the fat without impacting services". In a perspective of minimizing operating costs as much as possible, they sought to apply private sector "best practices" through the implementation of a New Public Management (NPM). While Bill 82, the Public Administration Act, was adopted in 2000 and enshrines the implementation of the NPM to the entire government body, it was through public health network reform (included in Bill 25) and its subsequent strengthening in 2005 that the NPM will be consolidated in health (Grenier and Bourque, 2014, 13;97). Moreover, when Minister Bolduc ordered Québec health institutions in 2008 to perform at least three Lean Management projects per year, the message was clear and it officially kicked off the eradication of mismanaged time, material and human resources.

This is how civil servants were gradually subjected to New Public Management (NPM) principles, the administrative branch of a neoliberal state. This management model, based on the 3 Es: economy, efficiency and effectiveness, and used to limit government spending, is what is responsible for the issues the membership has been facing and reporting for several years now.

We have to admit that these projects seemed attractive at the start, garnering the participation of a high number of employees in the reorganization of tasks that were supposed to be beneficial to all. Thus, LEAN champions claimed that this method would improve working conditions and job satisfaction for caregivers, while offering cost benefits and greater efficiency for employers and better services for patients.

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[1] Includes budget cuts and taxes.

However, we quickly saw through the sugar-coated veneer. In the end, the application of LEAN Management in healthcare is simply a way of implementing a cost-cutting, assembly line approach to a field where humanism and caregiving predominate.

By imposing the LEAN model, it changed the very essence of the commitment undertaken by health network employees. Trained to offer professional and humane care, our members experience an important conflict of values because managers do not see the value in this type of care. What they want and value is faster performances with less resources. Every fact and gesture is justified by countless forms that need to be completed, using time that could be spent with patients. The goal is to measure, calculate and eliminate actions that cannot be computed into an accounting-based approach.

This desire to apply at all costs a market-based approach also lies at the heart of the current issue of adequate staffing of care teams. Based on the catechism of Just-in-Time, employers fear above anything else the hypothetical surplus of personnel, a synonym of mismanagement of resources in their eyes. After all, optimizing the assembly line requires the full and absolute use of all production inputs.

Applying Just-In-Time methodology to the healthcare sector does not have the same implications as in a canning factory. Scheduling the strict minimum of staff places caregivers in a precarious situation and with an excessive workload should there be the slightest fluctuation in the number of patients. For employers, resorting to mandatory overtime or to private employment agencies are easy ways of adjusting supply and demand. The mental and physical toll on caregivers and patients as a result of this industrial management approach is not, however, part of the equation.

We therefore mean no disrespect to those championing for the sound management of public funds and the diminished participation of government, but this new public management approach is pushing the network and its workers to the brink, while not offering the level of services to patients the model presumably seeks to offer, all in the name of economic efficiency whose results are, at best, mixed.

Shaping the network, one reform at a time

In order to adapt the system to the desired approach, each government rolled out successive reforms which completely disrupted the organization of care. While some of these reforms seemed to be founded on the best of intentions, the need to apply budget cuts undermined any potential beneficial effect.

This is notably the case of the Rochon reform and the notorious ambulatory shift in the mid 1990s. Initially, one of the objectives of the reform was to integrate modern medical advances to the network, such as one-day surgeries, which freed up hospital beds faster since hospitalized and minor surgery patients could be discharged earlier. However, it also substantially increased the CLSCs' workload since they had to increase the offering of home-based care services. This resulted, as we all know too well, in patients being sent home without the necessary budget or home-based care services in place. By reallocating the money freed up to pay off the debt, we are still struggling to make up the shortfall in home care services, while needs only increase.

Then, under Jean Charest's government, the then Health Minister Philippe Couillard, introduced Bill 25, another healthcare reform. The purpose of this bill was to merge various health institutions under the CSSS in order to facilitate the adoption of a population-based approach and group different stakeholders and centres. Rather than creating a synergy among the various network stakeholders, this reform gave rise to hospital centrism and the centralization of decision taking by individuals who were far from the field. This reform also consolidated the private sector as an integral player in the provision of healthcare services within the healthcare system. Lastly, the reform also granted greater workforce mobility which allowed managers to reassign workers wherever there was a need.

This new workforce mobility provided by Bill 25 is directly aligned with the New Public Management principles which have the idea that there may be an extra employee on a shift. By having greater flexibility, managers believe they can assign employees with the highest degree of accuracy based on demand. When they can't do that, they resort to private employment agency personnel or mandatory overtime (MOT). It is important to remember that the use of private employment agencies and mandatory overtime are not only last-resort resources resulting from a shortage of healthcare professionals. They are also the result of political choices, made in fear of having a costly, overly healthy workforce, and that prefer to have a bare-bones workforce whose "circumstantial" shortages can be offset by the use these two management tools.

In the same vein, the reform Gaétan Barrette introduced in 2015 radically exacerbated the centralization of decision-taking within the public health network. By merging the former CSSSs into massive structures, that are the CISSSs and the CIUSSSs, and which sometimes cover hundreds of kilometres, employers have greater flexibility in terms of workforce management. Service contracts attached to tendering opportunities are therefore much more lucrative and that much more interesting to private sector players. In addition, the Health Minister gained important powers and was ensured unwavering loyalty and blind obedience to ministerial instructions since they can easily summon PEDs who report directly to them.

As many critics predicted, the creation of these mega structures resulted in a form of chaos that was rare for the public health network. The disconnect between what goes on in the field and decision-makers led to the creation of an inflexible structure that is ill-adapted to the reality of choices made. In addition to spawning despair and discouragement among caregivers, it is ultimately patients who pay the price of a management model that is incapable of quickly adapting to the evolving nature of a care setting which relies on the expertise of its healthcare professionals. The abolition of anti-establishment and participatory governance spaces quickly began to reduce accountability within the public health network. If we add the fact that this disconnection took place at the time when the budget was being slashed, especially in terms of the little administrative and clinical support that healthcare professionals could utilize, the worst-case scenario was well underway before COVID-19 hit.

A well-documented distress

The challenges linked to our difficult working conditions aren't new. There were countless reports, symposiums and press conferences, filled with good intentions, which address these challenges. From the outset, it should be noted that cardiorespiratory care professionals do not exactly have easy, carefree careers. These types of professions are demanding both psychologically and physically. These professions call for individuals to work daily with people in need with precarious health conditions. This means working alongside, day-in and day-out, suffering, solitude and illnesses that randomly choose its victims, often based on numerous injustices fuelled by economic system inequalities.

These are integral components of our professions. Our training prepares us for this, and our experience reinforces it. This is all counterbalanced by the fact that even though our professions are demanding, they are also extremely gratifying. This balance is delicately struck between curing the illness and caring for an individual. Being able to provide humane and professional care to a patient, it is without a doubt one of the most fulfilling jobs in this world. This is what prompts us to choose this career, other than satisfying personal material needs. It isn't the paycheck that drives our professional choices. Our purpose is fuelled by the humanity in each of our professional actions; it is what keeps us going during our studies and our first jobs. That is, until we are hit hard by the fact that our professions are slowly being stripped of this very humanity in favour of irresponsible accounting management practices.

It took us no time to take stock of the effects of the reforms levied since the 1990s, in particular the immediate effects of a heightened workload and the dehumanization of care. Furthermore, it is also around the same time we saw the feelings of belonging drop among members of care teams and institutions as a result of the greater flexibility demanded by workforce mobility.

Repetitive facts, continuous inaction

Since the turn of the century, there have been countless reports filed, sounding the alarm on the same diagnostic and posology. One of the first and most important reports was undoubtedly the report from the Forum national sur la planification de la main-d'œuvre infirmière (Forum on Nursing Workforce Planning) published in 2001. Healthcare representatives (ministry, managers, unions, professional associations and researchers) came together to form a work group and their mandate was to "propose recommendations and action plans to the Ministry based on a consensus regarding different issues, common visions and solutions". It was thought that the workforce shortage issue following the early retirement incentive this very government had offered 4,200 nurses could be curbed.

From the outset, the report (Québec, 2001, p. 20-21) references a report tabled by a similar group in 1998 calling out:

- the shortage of nurses and stability on basic care teams;
- the significant increase in the use of overtime to meet high volumes of work by public health institutions since 1997;

- the shortage of nurses, in particular to meet current work overloads which leads many institutions to force nurses to do overtime more and more; physical and psychological fatigue is on the rise among the nursing workforce.

Having concluded the continued and even the exacerbation of these factors three years later and considering the dramatic consequences stemming from the shortage of healthcare professionals, the sub-work group (employer, union and professional association representatives) proposed the following lines of actions to the Ministry, among others (op. cit, p. 62-63):

- Review and implement measures that facilitate work-personal-family life balance;
- Implement work time arrangement formulae that respect the will of the involved parties and personnel;
- Analyze the use of overtime and implement measures that reduce the use of this practice;
- Reduce nurses' workload by adopting appropriate measures;
- Ensure basic care teams are appropriately staffed;
- Foster continuity of care by increasing the number of permanent staff on basic care teams;
- Adopt a participatory management philosophy within each institution.

In 2003, the Forum research sub-work group on workforce planning published an extensive report that sought to "determine the factors that influence nurses' choices regarding employment status, identify factors and strategies to increase the number of available nurses, and specify what constitutes as career advancement and a rewarding career path for nurses" (Québec, 2003, p. 1).

What were the results of this research tabled in their report to the Minister of Health? (op. cit., p. 1)

- Nurses still love their profession and value patient contact;
- Overall, nurses denounce the work overload, lack of flexibility in work time arrangements, lack of autonomy they are granted, lack of listening and support from their managers, and financial conditions that do not reflect their level of responsibility nor the inconveniences tied to uninterrupted operation of institutions;
- If nurses' working conditions were improved, around 50% of permanent part-time (PPT) nurses and more than half of occasional part-time (OPT) nurses would agree to providing more availability. This would represent two additional days per every two-week period;
- Around two-thirds of nurses over 50 years of age would consider extending their career if their working conditions were improved.

Based on this report's conclusions, the research funded by the Ministry of Health recommended (op. cit., p. 3-7):

- Reducing the work overload;
- Improving the salary conditions of nurses to better reflect their level of responsibility;
- Continuing the review on how the organization of care and organization of work across all care settings;
- Stabilizing care teams by increasing the number of permanent positions (full-time and part-time), minimizing the number of occasional positions and stabilizing the number of positions in centres of activities and care units;
- Developing, in collaboration with personnel, creative and innovative working time arrangements while considering the impacts of uninterrupted operation (24 hours a day, 7 days a week) of health institutions on the personal lives of nurses while striking a balance between patient and employee needs;
- Disseminating work schedules and assignments earlier to ensure better work-personal life balance;
- Adopting a participation-based management model;
- Making available, in every institution, based on its specificities, various services for nurses for improving their quality of life at work and work-personal life balance, such as:
    - nurse-specific work areas, such as meeting, training and private rooms;
    - suitable break rooms;
    - warm meals 24/7;
    - access to health programs onsite or close by;
    - laundry service;
    - shuttle service for the night shift;
    - free or cost-share parking near the workplace;
    - onsite, at-home or other daycare services available day and night, 7 days a week, in particular in collaboration with childcare centres (CPE).

In the wake of the conclusions and potential solutions brought forward by the subcommittee, the Health Minister at the time, Philippe Couillard, created in 2007 the "(…) Table de concertation de main-d'œuvre en soins infirmiers afin de trouver des solutions concrètes pour pallier aux problèmes de pénurie de main-d'œuvre dans ce domaine (Québec Forum on Nursing Workforce Planning) whose mandate was to identify concrete solutions to curb the shortage problem. The Health Minister set out specific expectations regarding the use of mandatory overtime and private employment agency personnel in nursing" (Québec, 2008, p. 6).

Therefore, Ministry of Health officials, network managers, union and professional association representatives sat down again to find solutions to curb the shortage of healthcare professionals and the increase in overtime. Forum members, after sharing the same findings identified by previous forums in 1998, 2001 and 2003, reached identical solutions:

- Require strategic nursing staffing plans at the institutional, regional and provincial level for nurse clinicians, practitioners, assistants and any other job title;
- Stabilize work teams by adding support personal to care teams;
- Foster continuous training as a professional development strategy.

In addition, the Forum chair made the following personal recommendations:

- Require institution-specific personnel retention plans;
- Require institutions to provide strategic plans that seek to reduce the use of private agencies. Institutions that widely use private agencies must develop and immediately implement a plan to stop this practise within three years;
- Convert a percentage of overtime (OT) hours and mandatory overtime (MOT) hours worked into full-time positions;
- Abolish availability lists and convert the equivalence of hours worked into permanent positions.

In short, the underlying reason for the shortage of healthcare professionals that these different approaches and initiatives tried to identify and provide structuring solutions for is a simple question of supply and demand, a concept that managers and former company heads that govern us should easily understand. The basic and definitive solution to the issue of attraction and retention of healthcare professionals is improving their very working conditions and their compensation! However, notwithstanding the substantial amount of literature, evidence and provincial committee reports, Health Minister Christian Dubé announced on March 3, 2021 that "a working group would be set up to identify the challenges the nursing staff face in the field and provide targeted solutions"(MSSS, 2020). This initiative raises the following question: can this working group truly produce conclusions and solutions that are different from those produced in the last 30 years?

The COVID effect

The announcement of a working group whose mandate will be to "identify the issues nursing staff face and provide targeted solutions" would be almost funny if the situation wasn't as critical as it is today. As previously announced, the situation was already dire well before the pandemic hit and the cries and requests for help were widespread. COVID-19 only further exacerbated the unacceptable working conditions that had been tolerated for far too long between two symposiums and expert reports.

In general terms, the pandemic acted as a revealing indicator of how elected officials and managers view healthcare professionals. Their view is two-tiered, the first is to view healthcare professionals as saints whose values and generous hearts prompt them to self-sacrifice, and to be selfless and resilient. The second is that healthcare professionals are mere production inputs, resources that can be assigned, reassigned and exploited without any other purpose than having a well-oiled care production line.

These two views sit side-by-side and overlap, leaving healthcare professionals in constant conflict of values, without a sense of purpose and undervalued professionally and personally. Several protests took place during the pandemic calling out this deplorable situation, but the use of ministerial orders to uphold this type of management best illustrates the situation. While ignoring the regional disparities caused by COVID-19 and in blatant contempt of the most fundamental rights, healthcare professionals are assigned, reassigned, offloaded and forced to work based on their professional and human commitment to patients, their solidarity toward their colleagues with whom they shoulder this plight, and lastly under the endless threat of losing their permits to practice. Their rights to leaves, vacation days and a minimally stable work schedule that allows them to plan their lives have been removed. The government even went so far as to ignore scientific recommendations and refused the need to provide healthcare professionals with the necessary personal protective equipment so they could be better protected. By doing so, the government scoffed at the lives of healthcare professionals, of their loved ones, and of the patients they take care for. To this effect, the recent Administrative Labour Tribunal (TAT) ruling forced the government to provide N-95 masks to healthcare professionals and the ruling could not be any clearer on the matter. The ruling evinces that employers deliberately and wilfully chose to apply government directives and expose healthcare professionals and patients to the risks of contracting COVID-19 and suffering the consequences. The Federations acted in concert and brought this issue before the courts so this fundamental right could be recognized.

And speaking of consequences, we are only starting to assess the impact of COVID-19 and ministerial order-based management on the psychological impacts on healthcare professionals. To be used interchangeably and forced to work 16-hour shifts in a setting we do not know or on a shift that is not ours, constantly understaffed, and denied any type of work-family balance, and that without any recognition at all! This is enough to demoralize anyone. And if you add the fact of being in constant close contact with death, in questionable humane conditions and without having the time or space to process the countless COVID-19-related human tragedies, this cocktail would drive anyone to crack under the strain. The government's utter lack of consideration for overworked healthcare professionals has undeniably proven to be the straw that broke the camel's back. That being said, this is nothing new, nor surprising coming from a government that, even well before the pandemic, did not seem to care about the healthcare professionals' working conditions.

Faced with such contempt, the outcome was easy to predict. Between March and December 2020, nurse resignations rose by 43% (Duchaine, 2021). During this same period, about 4,000 healthcare professionals exited the network. Many left to take on jobs at private employment agencies, while others changed careers altogether or retired early.

In addition, 2020 ended with 7,668 healthcare professionals on paid leave for disability or work-related accidents, which represents a 28% increase if compared to 2019 (Ibid.). Faced with such havoc, any government who is committed to not only maintaining but also strengthening public services and its workforce would be working hard to radically improve the working conditions and put a stop to this hemorrhaging. The last negotiations are, of course, a step in the right direction and the Federations made significant progress for healthcare professionals. However, this exercise alone is not enough to break the vicious cycle that sees healthcare professionals leaving the network to work for private employment agencies. Each departure further deteriorates the conditions of public healthcare professionals left behind.

A NECESSARY SELF-EXAMINATION, THE RFIQ ON WORKING CONDITION ISSUES

As mentioned above, the current situation we are facing is the predictable culmination of an understaffed public health network that hangs together by a thin thread composed of professional commitment, exploitation and manipulation. The pandemic must be what breaks the thread once and for all so that we no longer have to put up with the unacceptable.

In this regard, the FIQ, FIQP and affiliated unions are well aware of the root cause of our problems and the required solutions. A quick review of the various themes presented at our conventions since 2001 suffices to make a case in point. Even if each of these democratic events takes place in different contexts and each have their own particular flavour, they each deliver similar conclusions:

- The root cause behind the difficult conditions in the field is **political**.
- While the proposed solutions can vary based on the point in time, the common denominator is the will to **further politicize** the labour movement and membership and identify ways **to involve and mobilize** the membership in order to improve our balance of power.

The fact that these key elements are at the heart of our union projects proves that we know what it takes to build a movement that improves our balance of power. Meanwhile, the persistence of these problems demonstrates that much remains to be done before we can get there. This persistence also reflects a firmly ingrained union culture. A union culture that doesn't have much time for self-examination or to test alternative methods when it needs to manage high membership expectations, a phone that rings off the hook, employers who are constantly calling, and thousands of grievances that keep piling up. If you add this to our organization's cyclical events (raiding, provincial negotiations, public health network reforms every 10 years), the heavy workload local union representatives face does not allow them any time to stop and ask themselves the fundamental and existential question:

- Does my practice, or rather our practice, as labour activists truly have a tangible and substantial impact on the reality, the day-to-day, of the membership we represent?

This is exactly the purpose a convention serves in a democratic organization. Taking the time to stop and analyze our strategies and tactics and assess if they satisfy our initial objective is sometimes gruelling and fraught with obstacles, but nonetheless necessary. The objective here is not to judge practices individually, but rather collectively, and decide on the next steps together.

Choosing to consider the collective standpoint rather than the individual standpoint forces us to challenge our daily personal efforts and possible wins, regardless of the tier, and look at the bigger picture. In this regard, after having examined the contexts and themes of each convention since 2001, we have concluded that the working conditions of healthcare professionals are not improving, quite the contrary.

For this reason, it is important to note that this is not just a "RFIQ problem". This is an observation that all Québec labour organizations have made as well a our CFNU healthcare professional union colleagues across Canada have made. This is an observation that Public Services International and Global Nurses United, our union partners have made. Everywhere across Québec and across the world, healthcare and more generally, public service workers are slapped with new waves of austerity, privatization and performance-based management measures because decision takers and their patrons share a common vision of the what the government's role is in terms of public services, be it at the international, national, provincial, regional and local level.

The key issue that we are experiencing is that if we are up against a political issue, if the improvement of working conditions for healthcare professionals depends on our ability to drive the development of policies that are in our favour, what are we doing collectively and on a daily basis to make this happen? What is our organizational strategy to bring about a new policy era that is in line with the public's needs and the membership's hopes? Despite past conventions and for the reasons mentioned before, our union activities continue to be based on the following three areas:

- Labour relations/legal component: almost exclusively performed at the local level and seeks the application of applicable laws and collective agreements to ensure good working conditions. Hold a growing number of meetings with employers to convince them to abide by our interpretation of the texts. In the event of a dispute, grievances and legal actions are the tools of choice;

- Influence component: consists of meeting and influencing elected officials or influential figures by calling on their good will, and presenting well-founded arguments and convincing facts, and on the advocacy-lobbying skills of RFIQ representatives;

- Communication component: consists of disseminating advertising campaigns to raise awareness among the public regarding our conditions and demonstrate to the membership that we are denouncing the situation.

These of course are generalizations. The RFIQ, the Federation and affiliated unions do sometimes employ other tactics and modes of action. The cornerstone of our union practice remains the legal, influence and communication prongs which take up most of our efforts and resources. Since it is widely acknowledged that the working conditions of healthcare professionals continue to deteriorate, the next question we need to ask ourselves is:

- Is it feasible to think that by maintaining our union activities centred on legal, influence and communications, we will one day obtain results that are different from those over the last 30 years?

Albert Einstein would probably answer this question by telling us that "insanity is doing the same thing over and over again and expecting different results." Our efforts did give way to some wins, such as getting an impervious government to make certain concessions or obtaining a happy outcome in an individual member's file. However, our efforts were not enough to put an end to the deterioration of healthcare professionals' working conditions which is our primary mission.

To use another quote, it is not a question of "throwing out the baby with the bathwater". Using legal tools is still necessary. Keeping an open line of communication with elected government officials is still useful. Using powerful communications must be maintained. What we must not do is limit ourselves to these activities and ensure **we have a pre-established balance of power**. In any labour organization, the balance of power is built thanks to its main resource of power, which is surprisingly underutilized: its ability to bring together workers who once mobilized have the power to force employers into adopting positions they did not initially want.

This doesn't mean we are no longer filing grievances or sitting down with employers. We have obligations in this regard. However, we must bear in mind that it can take up to three years to settle a grievance, and more often than not the outcome is not entirely favourable, despite the considerable efforts and breadth of legal expertise at our disposal. We must also bear in mind that when we sit down with employers, they do not really fear us because they don't really believe anything will change between now and the next meeting. So, meeting after meeting, we meet and often discuss the same agenda items without the employer doing any follow ups. Or they come back asking for additional explanations or claiming to have forgotten a point. Or they'll change their position and that means we are back at square one. In short, they often make us waste our time. And all the time we spend in meetings with them, getting prepared, repeating ourselves and holding debriefs is not spent meeting members, building trust, understanding their issues and identifying people of influence on individual care units.

In the same vein, we invest a great deal of energy and resources trying to convince politicians who do not share our interests and values. The three main political parties that have been in power since the 1990s in Québec have repeatedly demonstrated that they only want to offer setbacks, budget cuts and get more done with less. No political party, once in power, showed the will to reinvest significantly in public service workers. No party had the courage to find the money necessary to improve the working conditions of the women who are very publicly fleeing toward the private sector.

We must therefore conclude that the difficulties we face in influencing the political class to support us is not linked to their lack of understanding of the issue or of our rhetoric. Maybe the answer is simply that the ruling political class is not interested in investing massively in public services and it does not feel pressured to do so against their will. All of this is due to the fact that there is no balance of power. Because at the end of an unproductive meeting, we do not have strategies or the means to inflict a costly political consequence on those who do not take us seriously. And to be effective and taken seriously, this political consequence must be delivered by the 76,000 members that make up the FIQ and FIQP.

A CONVENTION THAT REFLECTS WHO WE WANT TO BE, ROOTED IN THE DNA OF OUR CONVICTIONS

What the Provincial Executive Committee is proposing for this edition of the Convention is a return to the very essence that constitutes our DNA as a labour organization. If female healthcare professionals made the choice to join ranks and establish organizations that would come together under the FIQ and FIQP, it is because they believed that by joining forces, they would be better positioned to defend their interests. Because when a sole healthcare professional is before an employer, they will be subject to an employer's arbitrary power. But when 50 healthcare professionals from a care unit, or 3,000 CISSS healthcare professionals, or even 76,000 at the provincial level take a stand together, it is then that they hold a power employers cannot ignore. And, if these healthcare professionals are supported by members of their community, by the patients they care for and by organizations that share their values, the possibilities are endless. Because even before laws were enacted to protect workers and governments elected by the people, the history of humankind is filled with examples of individuals who achieved the unachievable by joining ranks and standing together.

Choosing this path is no small task. It requires resources and energy to understand the balances of power that are causing our working conditions to deteriorate. Bolstering this awareness can only further support and anchor the need to galvanize the 76,000 FIQ and FIQP healthcare professional members into action by ensuring that every single member recognizes themselves and has a place in the collective action. After all, reclaiming our DNA is what it means to be progressive women, women of action, and women who are against all forms of discrimination.

PROGRESSIVE WOMEN

The political nature of the challenges healthcare professionals face on a daily basis leaves no doubt. We have demonstrated in the previous section how political decisions and choices are at the core of why working conditions have deteriorated (work overload, shortages, use of private employment agencies, mandatory overtime, replacing care with cure, generalized dehumanization of healthcare services, etc.). What is more, the extreme centralization brought on by Bill 10 further limits the flexibility of institutions that are accountable to the government. Now more than ever, our working conditions are determined by the government. Our salaries are determined by the government. An act on safe ratios will be adopted by the government. Our retirement is determined by the government. The solution therefore lies with the government!

We also briefly touched upon the fact that if governments in the last 30 years have brazenly deteriorated our working conditions, it is largely because they did not share and still do not share our values and beliefs. Being aware of this fact is important because it determines which strategy we need to adopt since our opponent does not share the same register as us.

We have therefore seen how improving the working conditions of healthcare professionals or passing a law on safe ratios goes against what the men who have governed us for the last 30 years want. As mentioned above, leaders have access to a wide range of expert studies and recommendations to help them act, but they don't. Because this would mean heavily investing in public services. This would mean identifying tax solutions to finance these investments. This would mean possibly shutting down private employment agencies. Because this would certainly increase the pressure to improve the precarious working conditions of other female professionals employed by the government.

Furthermore, our commitment as healthcare professionals to look after the health of the people in our care is embedded in our DNA. Therefore, our practice conditions are directly impacted by any public policy that affects people's health. For this reason, we are trained on the impacts of social determinants of health. As socio-economic inequalities increase and the rich get richer at the expense of the rest of society, the population will have more health issues and they will need us. By choosing to offer deplorable working conditions to teachers and collectively accepting that our children grow up in overcrowded classes and borderline clean facilities, we cannot deny that this will have detrimental consequences on the population's health and on CLSCs, for example. By underestimating the urgency of acting on climate change, it is proven that this will have potentially catastrophic effects on the population's health. By allowing unrestrained construction of condos in cities rather than investing in affordable housing, it is irrefutable that this will impact the health of the population we care for.

All these issues do not only affect us as healthcare professionals. They affect us as women, mothers and citizens. These choices are not made without knowing their effect. The wealthiest members of society are those that benefit from the rise of socio-economic inequalities. Government austerity measures prevent the identification of revenue sources (among the wealthy) and lead to investments being made in multinationals in the name of employment only for these jobs to be cut some years after. Government spending cutbacks lead to the creation of business opportunities for the private sector (for the wealthy). Not acting on climate change allows businesses to pay out dividends to their shareholders instead of using this money to fund their green transition. Not investing in affordable housing means cutting back on government spending but creating business opportunities for real estate developers.

In short, if those who govern us take detrimental decisions on our behalf as professionals, workers, women, mothers and citizens, it is not because they don't have the full picture. It is because they aren't interested in acting any other way. It is because the interests they defend aren't ours. Who campaigns for adequate public service funding? We do! Who believes that healthcare is a right and not a commodity? We do! Who seeks the improvement of social determinants of health of the population we care for? We do! And that is what makes us progressive. And the individuals who take decisions that affect our working conditions and our lives? They are not progressive.

Working to disseminate and enhance how professional issues, working conditions and political issues are interconnected is key and then can be used to cement the will to act. To make these connections, there are two particularly important files, the social determinants of health and safe ratios. These two issues clearly depict the reality healthcare professionals face and how this reality is linked to political issues.

Politicizing the entire FIQ and FIQP membership is an ongoing goal for the Federations because it is a Herculean feat and much remains to be done. Our goal is to get all 76,000 members to explain to their brothers-in-law and their neighbours how our political choices have a decisive impact on their work and health. For this reason, we must ramp up our efforts.

To that effect, the Provincial Executive Committee recommends that:

1. The social determinants of health and adoption of safe ratios are the cornerstone of our efforts to politicize the Federation's 76,000 members;

2. Political issues be taken into account in all files the Federations and affiliated unions process;

3. The Federations support affiliated unions in efforts to politicize the 76,000 members, by training the local politicization ambassadors.

WOMEN OF ACTION

We previously mentioned that understanding the balance of power causing the deterioration of working and living conditions of healthcare professionals is key in implementing a union strategy that can break the vicious circle we have been caught in for the last 30 years. It helps us understand why, despite the immeasurable efforts we deploy everyday to defend our members, results are mixed and certainly not enough to put a stop to the trend.

It is important to note that while the results have not proven forthcoming, it is not for lack of effort. Many of us give it our all and the toll it takes is substantiated in part by the high turnover rate we see among union reps on the union teams. It is a never-ending Herculean undertaking and efforts are rarely acknowledged. It is a thankless job, and it is easy to get discouraged when the disintegration of the public health network is not far off.

However, this situation is not set in stone. In fact, this state of affairs hinges on the need to adapt our strategy to the reality of the challenges we face. If we want to reembark on the path toward victory, we must adopt a strategy that is centred on the fact that the source of our challenges is **political**.

For example, one of the tasks that monopolizes our time and advocacy efforts is the grievance and management of grievances. The grievance is basically a legal instrument that is based on a statuary enactment and used to denounce an alleged violation by an employer. We then use the grievance as leverage to change an employer's decision. If it fails, we bring the grievance before a court of competent jurisdiction to settle the matter.

In that respect, the grievance remains pertinent. Using applicable laws to defend rights, especially the rights of individuals, is a tool we cannot do without. However, the grievance as such has very little impact on the political dimension causing the issues healthcare professionals face. While a favourable court ruling (which is rather rare) can bring about important changes, grievances alone have proven to be insufficient in reversing the ongoing deterioration of working conditions. It is important to remember that it can take up to three years for grievances to be settled in court, which is enough to quell any desire an aggrieved party or parties may have to get involved or rally. Lastly, the other downside of overusing grievances is that we dedicate a lot of time and energy to the same individuals, time that we do not spend with the rest of the membership who does not file grievances.

Furthermore, a significant part of our time and efforts is taken up by the numerous employer meetings we have. As representatives of the membership, it is our duty to be present at each meeting and assert the interests of healthcare professionals. An empty seat has never been popular at the FIQ and FIQP. And that is because we are an important cog in the chain of care, it is because we are supported by conclusive data and case law, it is because we build a robust and convincing case with the help from experts, and that is why we believe we can convince the individuals sitting opposite us of the legitimacy of our cases. If our work as professionals is valued by all, how can these employers insult us by ignoring our pleas?

The answer is simple, and we'll say it again: it is because the source of the challenges healthcare professionals face every day is political! The managers of health institutions with whom we establish labour relationships have to answer to their boss in Quebec City. They must make do with the budget that they are given and follow ministerial directives that are dispatched. In this respect, Bill 10 further centralized the chain of command in such a way that any misstep or expression of disagreement with the party line is punishable.

Local managers do obviously have a certain degree of latitude and the directives given by Quebec City are therefore not uniformly implemented in institutions across the province. However, when these managers can't counter our arguments, they often tell us that their hands are tied and that we need to take it up with the government.

As a result, we have extensively seen how elected government officials do not share our progressive values or our vision. They will always be respectful and courteous towards us. They will be understanding, attentive and even compassionate. But when we take stock of the last 30 years, we realize that sitting in the empty seat does not seem to have had any substantial impact on the healthcare professionals' working conditions.

Lastly, the use of communication tools also proved to be an important milestone of our strategy in the last few years. In an information age, the way we communicate our message is of great importance. In a social media age, where each news story, advertising campaign or meme can go viral in a matter of minutes, the use of social media is a must. We use social media platforms to influence public opinion and garner public support. Public support is one way of getting unyielding elected officials to revisit their positions because they would not want to lose voters. We also use social media to create a sense of belonging among the members to show them that that their organization is actively on the frontline defending their interests.

However, it seems these platforms alone cannot reverse the deterioration of our working conditions. The public is well aware of the challenges we face and their support dates back to almost the inception of the FIQ. For example, a recent survey commissioned by the FIQ revealed that "94% of Quebecers did not feel comfortable receiving care from a professional who had been on the job for more than 16 consecutive hours, while 80% stated that they felt hospital workers were overworked" (QMI, 2017). The survey also revealed that 83% of respondents were in favour of establishing safe ratios.

Despite the public's unwavering support, it isn't enough to reverse the trend and effect real change that goes beyond empty words and broken promises. We live in an age where news travels at the speed of light on our social media feeds, and the public's outrage and support is fleeting and short-lived. Similarly, a FIQ and FIQP ad seen by healthcare professionals on the eve of their next MOT may be gratifying, but it remains a simple "Like" if it isn't translated into concrete actions and change over time. For a burnt-out member who has never had a face-to-face meeting with their union representatives, seeing a FIQ and FIQP ad on a highway billboard after clocking in another shift with 5 less staff on the floor does little to bridge the disconnection they feel exists between themselves and the institution that defends their interests.

In short, the focus of this Convention is on if our overall strategy is effective enough to counter the political challenges we face. We want to know if the measures we are deploying within the framework of our strategic vision are enough to create a new vitreous circle that will immediately bring about substantial and lasting improvements to our working conditions.

Another point that we need to discuss is the need to act on the elements we do control, our own levers of power. In that respect, we do not control the wording used in the laws that frame our union practices, nor do we control the positions of the judges asked to interpret these laws. We do not control who gets appointed to serve as health network managers, nor do we control their motivations or the amount of latitude they have. We also have no control over the ministerial directives that elected officials adopt based on their interests. We do not control the media's agenda, nor the incessant flux of news. What we do have control over is our strategy and the measures we deploy to drive change. We have control over our union agenda. We have the chance to return to the very DNA that makes up our beliefs and reclaim the most powerful leverage we have, the power to unite healthcare professionals who through their sheer strength in numbers can move mountains. We can choose to use this powerful tool to drive change and give clout to the improvements we need. And **then** we can empower this collective movement using grievances, legal remedies, employer meetings and communication campaigns. The other way round does not seem to be working.

It would be wrong to say we didn't try to mobilize the members. Each FIQ and FIQP affiliated union undertakes actions that—despite their best efforts—often result in assemblies with less than satisfactory turnouts. However, low turnout rates at local union assemblies and activities is not something we should compromise on. We can certainly partly blame the individualistic nature of our society for these low turnout rates. Of course, the extremely difficult working conditions our members face probably doesn't exactly encourage them to attend a session on the union's financial statements after two successive MOTs. The fact that the CISSSs and CIUSSSs sometimes cover hundreds of kilometres probably doesn't help either. We also need to ask ourselves if we aren't partly to blame for our own misfortune.

The concessions made to the labour movement following the Quiet Revolution proved to be a poisoned chalice of a sort since they were eventually institutionalized[2]. The labour movement accepted to play ball within a labour relations legal framework that had been put into place for that purpose, if the government acknowledged trade unions, their rights and their resources. If any actions were taken outside this delineated framework, unions and their members were severely punished as the FIQ experienced in 1989 and 1999.

[2] See Mona-Josée Gagnon (1990; 2020) among others.

As a result, the labour movement gradually became institutionalized. The resources we have at our disposal allow us to refer to subject matter experts so they can provide advice and defend us within the legal framework that is in place. This type of configuration bureaucratized union activities and created a clear distance between the grassroots and the leadership responsible for strategizing and deciding on measures. This is what led Jane McAlevey to state that unionized workers are no longer considered essential in their own emancipation (McAlevey, 2016, p. 19). This emancipation is now in the hands of local elected officials, union employees and the provincial government. The members are no longer considered to be an "active subject" and the fight for better working conditions is outsourced to the union apparatus, who, with its considerable resources and experts, inherits this arduous task.

The divide that exists between dues-paying members and the union apparatus is tacitly upheld by both parties. On one hand, the union apparatus considers a job well done when it can promptly deliver quality services and correctly fulfil its union representative role before an employer. In this approach, the members are not called upon and the ability to offer a better service or perform better is contingent on having access to resources and expert advice. On the other hand, the members don't see the need to take part in their own emancipation because they pay to be represented and have access to services.

If we want to mobilize the membership, we must therefore get rid of the divide that exists between dues-payment members and the union apparatus. This can be done by rebalancing our union activities and dedicating time and energy to reclaiming our main lever of power—our strength in numbers—to drive change now.

It's possible!

Firstly, let's set the record straight. There is a certain belief that a collective action-based union strategy is not feasible for a union representing healthcare professionals, and any attempt to do so is doomed to fail. One's sense of identity and attachment to their job will always be stronger than one's sense of attachment to a union, considered by some as a tool for less-qualified workers. They have an anti-union predisposition, valuing autonomy and much preferring a cooperation-based approach to a conflict-based approach (Krachler et al, 2020, p. 3-4).

From the outset, this notion is difficult to reconcile with the FIQ's history because the FIQ was responsible for spearheading two of the most important public services strikes in Québec in 1989 and 1999. Furthermore, Kachler et al. (ibid)) demonstrate how this reality is not grounded in this notion following a review of existing literature. In particular, Briskin (2011 and 2012) provides several examples from around the world to illustrate how healthcare professionals were able to achieve significant milestones by adopting combative and collective approaches.

Similarly, Krachler et al. (op. cit.) show that a successful collective action-based approach for a union of healthcare professionals is based on three factors:

- the will of leaders to embrace this approach;
- the efficient use of internal structures to facilitate membership participation and empowerment;
- the ability to build alliances with communities not part of the establishment.

McAlevey (McAlevey, 2014) also provides examples of health workers who achieved significant milestones through active participation and mobilization in her work based on her own personal experience as a healthcare labour activist in the United States. For example, McAlevey reveals how in a place like Las Vegas, which is one of the most hostile anti-union and legally adverse environments, where individualism reigns and the billion-dollar private companies at the helm of the hospitals actively lead intimidation campaigns against unions, her and her team managed to negotiate phenomenal collective agreements with several hospitals. In particular, by involving union members in employer meetings, union members presented their demands themselves to their employers on behalf of hospitals, where 90% of workers actively supported a strike (ibid).

For McAlevey, the key to success lies in any given organization's ability to raise a membership's expectations regarding working conditions improvement, by actively advocating that they can achieve this goal if they are front and centre of union activities and that there is a plan in place. One of the union's priorities at this time is to identify and implement the means required to put the membership back at the centre of union activities and therefore counter the too-real perception that the union is simply a broker between employers and workers. The union must become the space where workers unite to drive change and not the space where only a few individuals shoulder the heavy burden of working to improve working conditions on their own before an employer or judge. For McAlevey, the perspective of "radical change", such as we wish for the public health network, can only be obtained through collective action, which is only possible if the members is at the heart of that action.

To make this happen, we must first know our membership! But as previously mentioned, Bill 10 and the hundreds of kilometres that lie between facilities makes this challenging, all the more reason to double our efforts. Creating tools that help us identify each member on each unit and shift is a good start. The next step would be to map out the information on a chart. For example, identifying who is interested in union activities and who is not. Undertaking such an exercise is key.

It is especially important because it collects information on members who one would call natural leaders. We discussed this point during the 2017 Convention, and it remains key. We must dedicate time and energy to identifying the natural leaders among our ranks. As a reminder, natural leaders are not necessarily the individuals who show up at our assemblies or who show an interest in union activities. Natural leaders are individuals who exert influence on colleagues on their team or shift, the individuals people turn to when they need advice. They are usually hard workers who are appreciated by their peers. They aren't necessarily in favour of the union, quite on the contrary sometimes. However, these are the individuals the union

should concentrate its efforts and energy on. We need to convince them, recruit them and get them involved if we want to build a movement.

Identifying natural leaders is key because it opens the door to a plethora of possibilities. Even if it only helps us identify the primary concerns of a unit, facility, CISSS or CIUSSS. We would then be able to help the affected members work on a plan to tackle these concerns, a plan where they would have a leading role. To build out the rationale and facilitate their participation in employer meetings. To disseminate the fact that challenges are political and to prepare a list of contacts and connections who might help us in our power struggle.

This way, an issue of inadequate ratios in a CHSLD can, of course, result in a grievance being filed. First and foremost, we would meet the affected workers who would then prepare, develop and implement an action plan which could include a press conference or an employer meeting.

MOTs are on the rise in the obstetrics unit? Workers have had enough? Having a one-to-one meeting with the employer or filing twenty or so grievances can only go so far. The involvement of workers in the development of an action plan is key because it is more impactful and can lead employers to solve cases more promptly. Moreover, workers can be put in touch with local feminist groups who can actively support them in their quest for humane working conditions for the women working in a department and to ensure the availability of safe, quality obstetrical services.

Increasing this type of action will certainly have a ripple effect. Members from different units and shifts speak to each and would discover that their power to change things resides in their action. To illustrate the proposed change, the union office should progressively evolve from a call centre to a general headquarters from where actions and support for the members are coordinated. This would enable workers to become reacquainted with their union's DNA which seeks to unite workers and leverage their strength in numbers to counterbalance employers. The union's role would thus no longer be to supply legal expertise but to facilitate potential collective action. Union representatives would then be able to expand their activities to hospital cafeterias, CHSLD parking lots and CLSC hallways.

In the wake of what was presented in 2017, regional footholds remain important levers that need to be utilized and promoted. Relationships between healthcare professionals and their communities run deep because these professionals often work and live within the same communities. Direct relationships are thus in place and communities are usually quite supportive of healthcare professionals. In addition, our members are also part of the community and have community ties. Building a "who knows who" community influencer map can help build relationships and forge alliances to improve our balance of power.

In short, the union cultural change that we are proposing is significant. It is important to highlight that this is not an additional task we need to fulfil. We are well aware that our plates are full and we already have a hard time fulfilling our current duties. What we are proposing is to free up the space currently used to manage grievances and hold employer meetings so that the time and efforts they take up are redirected towards the development of an action plan that will transform our union action into a movement by leveraging our most valuable asset, collective action. This change will gradually take place, while respecting everyone's pace and circumstances, but always supported by the Federations.

We are convinced that when things get heated across all Québec health institutions, the employers will call their mandators in Québec City in distress, demanding solutions for health-care professionals who are active, mobilized and supported by their communities, only then, will government elected officials, who had been averse to our values and warnings, find the resources to improve the working conditions of professionals, workers, women and citizens who are fed up of being subjected to the unacceptable.

To that effect, the Provincial Executive Committee recommends that:

4. The Federations and affiliated unions undertake to deploy the necessary resources and efforts to rebalance union action so that a substantial part of this is dedicated to building a real balance of power based on collective strength, and that activities are closely linked to the strategic plan;
5. The Federations and affiliated unions undertake to deploy the necessary resources and efforts to restore control of union action to the members;
6. Meaningful support is given to affiliated unions so that they can implement the proposed shift;
7. An annual activity status report is presented to the delegation;
8. A consultation is conducted with the affiliated unions to identify team needs in the development and operation of a political action site, and present results to the Provincial Council in December 2021.

WOMEN FIGHTING AGAINST SYSTEMIC RACISM

"[...] if I fail to recognize them as other faces of myself, then I am contributing not only to each of the oppressions but also to my own, and the anger which stands between us then must be used for clarity and mutual empowerment, not for evasion by guilt or by further separation. I am not free while any woman is unfree even when her shackles are very different from my own. And I am not free as long as one person of Colour remains chained. Nor is anyone of you."

Audre Lorde
– From The Uses of Anger: Women Responding to Racism

The importance of remembering our battles: fighting violence at the FIQ and FIQP

The Federation declared during its founding Convention that: "The presence of a new female-based labour organization in Québec will be meaningful if we succeed in articulating an original public debate that reflects the concerns, approaches and issues that bring us together." The progress the Federation has made is a testament of its steadfast commitment to deploying actions that address the members' concerns and improve their daily lives. Therefore, joining the feminist movement and tackling feminist issues is of the utmost importance.

To this end, fighting against gender-based violence is a key priority for the Federation. Ever since the 1988 Convention, the Status of Women Sector has investigated on-the-job acts of violence committed against the members by colleagues and patients. It is also responsible for identifying solutions to bring the violence to an end. It was also around the same time that the Federation first consulted racialized nurses to discuss the racism they faced. The Federation began work focused on the circumstances and experience these female healthcare professionals faced in the health network. During the 1991 Convention, the Federation adopted the Statement of Principles where it firmly undertook to "recognize and promote the provisions set out in the Québec Charter of Human Rights and Freedoms". The Federation also undertook to develop a policy aimed at ending all forms of violence and harassment.

The Federation's actions prompted the delegation during a 1992 Federal Council to adopt a Policy to combat sexual and racial harassment in our institutions. This was an important stance on racism and the Federation and delegation took it one step further by making it a specific issue with a targeted policy. Since then, there is a clear consensus at the Federation that any type of racial harassment is unacceptable, and the Federation is fully committed to defending targeted members. In November 1996, the delegation amended the Policy to clearly indicate that the Federation has the responsibility to "fight against all forms of discrimination and violence, whether perpetrated against or by its members." This amendment came after a major

and courageous decision was taken in June of the same year in the fight against violence, whereby the Federation and its affiliated unions "must have a favourable bias toward the injured employee except as provided by the Policy to combat sexual and racial harassment." The Federation's message couldn't be clearer or louder on the fact that it has zero tolerance for any type of violence in general or racism specifically.

At the 2001 Convention, the Federation unanimously adopted the General Policy against workplace violence and undertook to address racial violence more specifically. This commitment and the actions that followed led to the implementation in 2003 of the action plan Cultural Diversity: Creating a work environment of solidarity, which includes a section on racial discrimination.

This action plan resulted in the deployment of actions, including awareness and education campaigns and initiatives, and the implementation of healthcare professional workplace violence prevention policies in collaboration with employers. We updated our workplace violence policy based on recent research and information. The latest version was published in 2014 and is called Workplace Violence Prevention Policy: Working Towards Workplace Wellbeing.

The health and safety of the members the Federations represent has never been negotiable! It is also why we are presenting the issue of the fight against systemic racism to you.

On one hand we have to periodically remind ourselves of the feminist battles the Federations have fought and on the other, we have to evolve our line of thinking and adopt positions based on more recently studied realities and contemporary issues. The Convention is the best place to do so.

Context

Our fight against racial harassment and discrimination is based on a partial understanding of the racist issues and acts the racialized membership reports and faces every day and defending individual member victims.

We fight against presumed racists and place the burden of denouncing racist behaviours on racialized individuals with the risk it could impact their work, if they are healthcare professionals, or at the expense of their health or the services they are entitled to as beneficiaries of the care.

Yet it is clear that racism cannot be fought on a case-by-case basis. The fact is that even though the Federation was founded almost 35 years ago, racism is just as present and toxic as ever in Québec and Canada and the world.

In more recent times, the Federations have been witnesses to unprecedented movements denouncing violence against Indigenous and racialized people. There were numerous public demonstrations that swept across the province in June 2020 to denounce systemic racism, such as Black Lives Matter or Idle No More.

The Federations have also seen the publication of several commissions and reports:

- Truth and Reconciliation Commission (2007 to 2015);
- Public Inquiry Commission on Relations between Indigenous Peoples and Certain Public Services (Viens report tabled in 2019);
- National Inquiry into Missing and Murdered Indigenous Girls and Women (2016 to 2019),
- Report on Racial Bias in Police Stops (2019);
- Public Consultation on systemic racism and discrimination within the jurisdiction of the City of Montréal (*Office de la consultation publique* – June 2020);
- Public consultation on the SPVM's policy on street checks (2020);
- RCMP acknowledgement that it has enforced racist policies and laws (2021);
- Etc.

The Federations also witnessed several events in Québec that led to often heated debates on systemic racism: 9/11 and the rise of Islamophobia across the world, including in Québec; the debate concerning reasonable accommodations and the Québec Charter of Values, defended by the Parti Québécois; the Islamophobic racist attack against a mosque in Québec City in January 2017; the election of Donald Trump as president of the United States and whose racist rhetoric made its way all the way here, primarily encouraging white supremacist groups to proudly assert their racist values, and the media's numerous misdemeanours on the matter, namely commentators who used the divide and provocation to make a buck; the rise in race-based hate crimes in Québec, Canada, etc.. More recently, hate crimes against Asians and the arrest of Mamadi III Fara Camara brought to light the most violent face of racism in our society.

These non-exhaustive lists illustrate how important this issue is and how difficult it is to address and understand all its facets and its impact on the social fabric and the importance of its manifestations. Moreover, the reports, inquiries and commissions clearly illustrate that civil stakeholders can no look at racism as evil individual actions; they must broaden their horizons and see racism as a collective phenomenon.

The stance on systemic racism

To prepare for the theme of this year's Convention, we studied and assessed healthcare professionals' working conditions and concluded that the deterioration of these working conditions stems from a systematized economic vision. We concluded that it is not enough to stand up for our membership as individual victims of this system to end the ongoing deterioration of working and living standards. The Federations must tackle the source and the system that creates, maintains and exacerbates this deterioration. The same applies to racism if we really want to drive change.

It is our duty as a union standard bearer of progressive values of solidarity and justice to be proactive and reject all forms of discrimination. Beyond individual expressions, the key lies in our determination to fight against a system that allows, protects and perpetuates racism.

To find out more on how we developed and established our position and recommendations , we strongly encourage you to read **The Stance on Systemic Racism.** The purpose of this document is twofold: it provides a historical overview of the issues and gives concrete examples; and it illustrates how the current government is playing a game of semantics. In fact, this government is trying to create a diversion by manipulating words and concepts to better justify why they are not deploying specific actions to put an end to racism in our society.

If racism affects us as women and citizens, it also affects us as workers, professionals and labour activists. Burying one's head in the sand is not an option in this matter. We have seen numerous recent events that underpin the importance of acting.

Impacts of systemic racism on the health of racialized patients

On September 28, 2020, we were all appalled by the troubling circumstances that led to the death of Joyce Echaquan, a 37-year-old Atikamekw woman and mother to seven children. We were stunned at the disparaging slurs and disdainful behaviours the nurse and beneficiary attendant were caught on camera saying to Joyce Echaquan as she lay dying, calling for help. These unmistakable racist and demeaning statements reminded us (if we needed any further proof) that racism is very much present in our health network. If the case of Joyce Echaquan opened our eyes, we must consider the tolerated, milder expressions of racism that exist in health care. We must see it as the visible culmination of abuses against the rights of users "to receive, with continuity and in a personalized and safe manner, health services and social services which are scientifically, humanly and socially appropriate" (OHS Act, 2020, sect. 5).

As explored in The Stance on Systemic Racism (hereinafter the Stance on racism), racism is a structural social determinant of health inequalities. For example, racism influences the systems that our healthcare system forms part of. The healthcare system influences the degree of fairness in terms of healthcare and wellbeing at the individual level because it can facilitate, or not, equitable access to care. According to the WHO, equity refers to "fair opportunity for everyone to attain their full health potential regardless of demographic, social, economic or geographic strata." Simple variations or differences in health become social health inequalities that are "systemic, socially construed (and thus transformable) and unfair" (Shaheen-Hussain, p. 105).

It is important to note that regardless of what the intermediate social determinants are (material conditions, behaviours and biological factors, psycho-social factors and healthcare system), if "interventions often result in mitigating the consequences of living in poverty, growing up in an overcrowded apartment or in a dangerous neighbourhood, having a precarious job, being a smoker" (Ibid). They are inadequate because they "do not search for the origin of the causes advocated by the CSDH [the Commission on Social Determinants of Health (CSDH, 2008)]" (Ibid.).

"When racial minorities are in poor health, it is often because they are poor. However, this first level analysis calls for an immediate second analysis: if minorities are poor, it is often because they are victims of racism. If we do not go beyond the first-level analysis, which is unfortunately often the case, we disregard the primary role racism plays in the poor health of racial minorities" (Carde, p. 23).

The information and statistics presented in the Stance on racism on the realities racialized and Indigenous people live also reflect how these are also direct attacks on their health. The data, beyond the figures, demonstrates how racialized and Indigenous people, **specifically** are poorer, often live in inadequate housing (when they are not denied housing altogether), are more often victims of hate crimes (which affects their physical and mental integrity, among others), are stopped by the police more often and unfairly treated in the justice system; see their children taken away by social services (with all that trauma implies) to name but a few examples. This is the true face of systemic racism. A series of injustices that lead us to accept that in our society we tolerate that some people's lives are harder, simply because they are Indigenous, Black, Muslim, Asian, or Hispanic.

In addition, stereotypes impact patient diagnosis and result in reduced access to services (geographically or linguistically, for example), less personalized care based on cultural generalizations of patients, shorter appointments, more frequent medical interventions without consent, and therapeutic alternatives less often suggested, etc.

Of course, "all these manifestations of racism are included in the gamut of inequality social reports that exist in our society: reports on race, but also on class, gender, etc. Thus, individuals are not just members of this or that racial minority or majority, they are also men or women, rich or poor, immigrants or not, etc. These statuses together constitute a combination, unique to each, in which interactions are close. We can therefore not mechanically deduce from someone's racial status the index of racism that impacts their health: each of these statuses either exposes or protects it, depending on the other statuses" (Ibid.).

The Federations must send a clear message to the public that we have a zero-tolerance policy regarding any type of racist behaviour perpetrated against patients and beneficiaries. The health and physical and psychological integrity of patients is part of our DNA as healthcare professionals. We have the dual responsibility as Federations to improve the working conditions of healthcare professionals to improve the care to which the public is entitled. It represents the very protection of the Québec public health system that wants to and must remain a universal service, accessible to and safe for all, regardless of one's skin colour, ethnic background or religion. The health of racialized individuals and Indigenous people depends on the level of trust they have in the public institutions that serve them.

Racism is and must be more than ever a public health concern (CPHA, 2018) one which we must all undertake to fight at all levels. The correlation between social determinants and racism is evident. "We know this is to be true as demonstrated by several studies and ignoring these facts constitutes itself as systemic racism. Public policies are important drivers of this systemization and much more so than racist intentions [...] A public policy approach based on the interdependence of rights would play an important role in preventing problems from being isolated and confining racism to a small circle of prejudice shared by a small minority" (Lamarche, p. 120).

How racism impacts the racialized members

> **"I don't trust you anymore, you keep saying 'Go slow'."**
>
> Nina Simone

The Federations must be humble enough to acknowledge that they cannot gauge the impact of racism on any empirical data to truly understand the impact it has on racialized and Indigenous people when delivering services and interacting with colleagues and patients.

It would be easy to say that apart from a few isolated or high-profile cases, racism does not affect our racialized members. It would be even easier to blame this lack of information on the fact that racialized members don't report cases of racism which proves that they are not subject to any racism. This is obliviously far from the truth.

The FIIQ took a courageous stance when, like other feminist groups in the late 1980s, it began addressing the workplace violence healthcare professionals faced. In fact, even though they did not have much data on the matter, they knew that where there was smoke, there was fire. They knew they had to tackle the issue that impacted the dignity and integrity of its members and that it could not be postponed or left to chance. This is the approach the Federations are committed to in fighting any type of violence our racialized members so often bear in silence. We can fight against systemic racism, and like any other occupational health and safety issue, it can be substantiated with facts. Today, the Federations are fully aware of and not oblivious to this issue.

The Federations are sending a clear message to our racialized and Indigenous members: we will stand with you and defend you against any racist act, and we will fight to achieve true equality. We will not tolerate that anyone because of their skin colour, their ethnic background or their religion cannot benefit from a safe work environment and cannot lead a fulfilling healthcare profession. And it doesn't matter if the violence is perpetuated by a patient, a colleague or an employer.

The Federation's mandate to represent extends to all members and they are the voice of the entire membership. The labour movement needs every single member, and we must each ask ourselves what we can do to help racialized individuals, but above all what place we need to grant them in our ranks. While we are aware that changing mentalities and structures can take time and doesn't happen on the turn of a dime, we must set the example and lead the way.

Joyce's Principle

The circumstances leading to Joyce Echaquan's death will forever be engraved in our memories, insomuch as the sheer violence of the racist slurs she endured. The idea that a nurse and a beneficiary attendant, whose jobs are to provide care, could so blatantly disrespect the dignity of a sick and vulnerable individual is greatly upsetting. The reports and inquiries on the realities of Indigenous peoples keep rolling in (and say the same things), but we still witness racism within our public institutions.

How can we bring this cycle of violence to an end? How can we substantially change the violence that is perpetuated against Indigenous people and incessantly reported and documented? Do we need another video of an Atikamekw woman in such agony to acknowledge the issue and work to put in place a long-term, comprehensive solution? How many Joyce Echaquan's did we not believe and how many healthcare professional behaviours did we excuse or downplay because there was no solid proof of the abuse on video?

There have been other events since the death of Joyce Echaquan that have brought to light the behaviours of healthcare professionals that, although not as violent and racist, do elicit the need to understand and holistically tackle the problem.

The Legault government, by its refusal to acknowledge systemic racism, wants us to believe that the racism that exists in our public institutions and perpetuated by the words and actions of employees can be addressed through the use of disciplinary measures and dismissals. **Let's be clear, under no circumstances do we excuse or will ever excuse racist remarks, attitudes and behaviours**, even if and definitely if it involves the members we represent. Our Zero Tolerance Policy is loud and clear on the matter.

Furthermore, what we are saying is that we refuse to accept that individuals, even those who have perpetuated the most wrongful and abhorrent actions and remarks, be used as scapegoats by the government to quell a much larger problem that extends beyond the individual self, the presence of systemic racism in Québec and its public institutions. Placing the blame of racism solely on the shoulders of individuals is not only counterproductive and inadequate, but it also illustrates the lack of understanding and the absolute refusal to deploy the necessary measures to put an end to it.

The responsibility of maintaining a violence-free work environment and of offering safe social services to the public remains the responsibility of the institutions that make up our public services, and it is in this respect we need to act.

Dismissing members for racist conducts is not enough to fight the problem, if the government and health network employers do not acknowledge that systemic racism exists. We also need structured measures to be deployed to effectively combat racism. Let us reiterate that nothing that is requested herein can be interpreted as downplaying acts of racism.

In November 2020, following the death of Joyce Echaquan, the Atikamekw Council of Manawan (CDAM) and the Council of the Atikamekw Nation (CNA) presented Joyce's Principle in a brief to the governments of Canada and Québec (CDAM and CAN, 2020). "This principle is a call to action and a commitment from governments to end an intolerable and unacceptable situation". The adoption of Joyce's Principle by the governments of Québec and Canada "aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health."

In Joyce's Principle, the CDAM and CNA state that they intend to "continue to gather feedback from all stakeholders and decision makers in the health and social services field in order to ensure deep and lasting change." The Federations believe that it is essential we respond to this call-to-action by promoting and supporting the adoption of Joyce's Principle. We occupy an important role in the health and social services field and as such, we must lead the fight against systemic racism in Québec. Joyce's Principle calls upon the Government of Québec to adopt the following measures, among others:

- Establish an Ombudsman office for Indigenous health;
- Appoint an Indigenous member on all decision-making bodies affected by Joyce's Principle;
- Put measures in place that facilitate the mobility of human resources providing health and social services to Indigenous communities;
- Financially support the Indigenous authorities that set up awareness-raising and education campaigns about the realities of Indigenous life;
- Encourage social leaders to prevent, denounce and condemn any manifestation of racism against Indigenous people.

Joyce's Principle also calls on teaching institutions in the fields of health and social services to adopt a series of measures which aim to educate students on the realities of Indigenous life and decolonize course content and teaching methods across its entire curriculum, including continuing education.

They are also calling on the government to amend the Professional Code so that it includes recurrent and mandatory training courses on Joyce's Principle. The brief calls on professional associations in the health and social services field to appoint an Indigenous person to their board of directors.

Lastly, the brief calls on health and social services organizations to offer continuing education on Joyce's Principle, implement the necessary measures to ensure the cultural safety of Indigenous people, and denounce and condemn any manifestation of racism against Indigenous people.

Recognizing systemic racism and adopting Joyce's Principle will, on one hand, equip health network employers with the necessary resources to take on this issue. It is not just a question of having the necessary funding but also the specialized resources to help them understand how to tackle such a broad issue. We have to move away from a rhetoric that targets "bad apples" to a rhetoric that calls for the public to engage in a genuine joint mobilization against a common enemy, systemic racism. The adoption of Joyce's Principle is an important step in the right direction.

On the other hand, recognizing the sources, the scope of the problem and the joint efforts required to put a stop to systemic racism will also lead to the acceptance that it is not only racists (therefore bad people) who make racist remarks and behaviours, and individuals can have embedded racist biases without even realizing it. If Caucasians accept that you can be a good person and still make racist remarks, this will open a space for collective self-examination and awareness which is necessary to better understand our racial biases, our prejudices and stereotypes.

Under these conditions, in terms of health network labour relations, employers will have access to an array of tools to help raise awareness and help employees identify what they need to work on. Individuals will be able to engage in open discussions about race and societal stakeholders (including the media) will be less likely to prejudge facts, and department heads will have enough hindsight, legitimacy and credibility to undertake measures other than employee dismissals. Legitimacy and credibility are gained if systemic racism is truly and comprehensively tackled.

It is only if society, as a whole, undertakes to battle systemic racism will racialized and Indigenous people be able to renew their trust in our institutions.

We have always believed that prevention is the best tool to tackle workplace violence and hazards, and this type of violence is no exception. It is not realistic to think that by changing the way we think it will automatically eradicate racist behaviours, nor is it realistic to think that systemic racism will disappear once racists disappear (Murray Sinclair in Shaheen-Hussain: p. 134).

Unions and employers have the power, the duty and the responsibility to tackle the systematic racism that prevails in the health network. The Federations can no longer be a spectator and in honour of its feminist values, they must act. We may not always be responsible at a personal and individual level, but we have a collective duty to put an end to it.

To that effect, the Provincial Executive Committee recommends that:

9. The Federations adopt a clear and strong stance on the existence of systemic racism and our commitment to eradicating it;

10. The RFIQ is an organization that fights against all forms of racism and racial discrimination is added to its Statement of Principles;

11. The necessary adaptations to the RFIQ Policy to combat violence are made to include and characterize all forms of racial discrimination and racism as unequivocal forms of violence;

12. Alliances are created with other civil society stakeholders to build unity and a common vision on systemic racism and how to tackle it;

13. The Federations support Joyce's Principle;

14. An *ad hoc* committee, composed of one volunteer political officer, two union consultants, 6 union representatives, 4 of whom are racialized individuals, be created to:

    - Research, assess and make recommendations to the Provincial Executive Committee on the representativeness of racialized members in the delegation;

    - Identify cases of racial discrimination and racism reported by the members in order to understand why they manifest and identify solutions;

    - Identify information channels and actions in order convert each member into racism eradication champions and establish race issues as transversal in our organization;

15. Collective introspective exercises on racial issues are fostered and programed at all levels of the Federations, by providing frequent spaces for this to take place.

CONCLUSION

The considerations we have set out herein, and within the framework of the Convention and approaches, are rooted in our Statement of Principles' dual mission: the RFIQ is a labour organization whose aim is to improve the working and living conditions of its members and to act as a social change agent for the well-being of the public we provide care to every day. This Convention is thus a unique moment to hit pause and courageously and humbly review our current practices to achieve our objectives to the best of our ability.

To do so, we must first recall the DNA of our actions to forge a strategy that makes it possible to renew, embody and uphold these values. Since the dawn of time, women and men have chosen to join ranks to counterbalance power that binds, corrupts and discriminates in favour of its own interests. Since the dawn of time, these same women and men defeated seemingly unwavering forces thanks to their determination, cohesion and will. The conscious and deliberate use of collective power, capable of dispelling the worst despots, is the weapon we hold to overturn the most deeply rooted ideologies and the most oppressive systems. It is up to us to acknowledge this power and make good use of it.

The visionary healthcare professionals who paved the way before us built our organization so that we could reach this ultimate goal. They made it possible for us to read these lines with the same conviction they had when they began to fight our battles. These healthcare professionals were fully aware that strength through unity was necessary so that we could become more than big-hearted nurses and they believed we would become what we are today: professionals, workers, women and citizens who are determined to take matters into their own hands. We are healthcare professionals who are fully aware that a union was necessary to stymie a male power which is the root cause of salary inequity and the lack of consideration for our specific challenges. This is the very basis of the foundation and essence of the group of Federations we are, staunchly independent and feminist and staunchly guided by the values of social justice.

Today, we recognize that we are up against a powerful opponent. An opponent who holds all the levers of executive, legislative and judicial power to establish a vision of society that is not ours. To this end, this authority will only be convinced if we force it to be. An opponent who seeks to divide us in order to better rule and who has a range of tools to impose its vision of how it thinks society should be. It is just too bad if the majority considers this vision to be unreasonable, unrealistic and idealistic. This authority has been using the same methods for the last 30 years despite the disastrous results we have inherited: a public health network falling to pieces; healthcare professionals who jump ship to save their necks; socio-economic inequalities that threaten our social cohesion and our health, the ongoing superficial treatment of women issues and a threatened environment, condemning future generations.

To take on such an opponent, we cannot afford to not use our most powerful lever and we must stop breaking our backs "shovelling sand with a pick" (McAlevey, 2014, p. 93). Our beliefs must imperatively be supported by our purpose: uniting and using our collective strength to improve our working and living conditions, and the well-being of the public we care for.

The fight against gender-based discrimination is also one of the building blocks of the DNA of our convictions. As feminists, we know all too well that the ongoing inequalities between men and women is the result of its systemic nature, and full equality can only be achieved by changing the system that prevents this very change. In this respect, the fight against systematic racism shares the same challenges and should thus be organically embodied in the DNA that makes up our convictions. As feminists, we must use this experience to fight alongside racialized and Indigenous people and remember that our battles share the same objective: achieving social justice.

The changes the Provincial Executive Committee proposes within the framework of this Convention are not free of obstacles and pitfalls. We will learn from our attempts and mistakes and keep on moving forward. We will also take the time to bring upon this concrete change. If this Convention does not offer any guarantee of success, it does offer a guarantee of means. The Provincial Executive Committee is convinced that the proposed shift is necessary and urgent. It will spare no resources and energy to support the affiliated unions in the creation of this cohesion and collective determination which will surely guide us towards hope and victory. A change of paradigm is necessary, and the Provincial Executive Committee is absolutely convinced that through the determination of its affiliated unions and members, our convictions, will represent more than ever, the DNA of our actions.

RECOMMENDATIONS

The Provincial Executive Committee recommends that:

Recommendation 1

The social determinants of health and adoption of safe ratios are the cornerstone of our efforts to politicize the Federations' 76,000 members.

Recommendation 2

Political issues are taken into account in all files the Federations and affiliated unions process.

Recommendation 3

The Federations support the affiliated unions in efforts to politicize the 76,000 members, by training the local politicization ambassadors.

Recommendation 4

The Federations and affiliated unions undertake to deploy the necessary resources and efforts to rebalance union action so that a considerable part of this is dedicated to building a real balance of power based on collective strength, and that activities are closely linked to the strategic plan.

Recommendation 5

The Federations and affiliated unions undertake to deploy the necessary resources and efforts to restore control of union action to the members.

Recommendation 6

Meaningful support is given to affiliated unions so that they can implement the proposed shift.

Recommendation 7

An annual activity status report is presented to the delegation.

Recommendation 8

A consultation is conducted with the affiliated to identify team needs in the development and operation of a political action site, and present results to the Provincial Council in December 2021.

Recommendation 9

The Federations adopt a clear and strong stance on the existence of systemic racism and our commitment to eradicating it.

Recommendation 10

The RFIQ is an organization that fights against all forms of racism and racial discrimination is added to its Statement of Principles.

Recommendation 11

The necessary adaptations to the RFIQ Policy to combat violence are made to include and characterize all forms of racial discrimination and racism as unequivocal forms of violence.

Recommendation 12

Alliances are created with other civil society stakeholders to build unity and a common vision on systemic racism and how to tackle it.

Recommendation 13

The Federations support Joyce's Principle.

Recommendation 14

An *ad hoc* committee is created composed of one volunteer political officer, two union consultants, 6 union representatives, 4 of whom are racialized individuals, whose aim is to:

- Research, assess and make recommendations to the Provincial Executive Committee on the representativeness of racialized members in the delegation;
- Identify cases of racial discrimination and racism reported by the members in order to understand why they manifest and identify solutions;
- identify information channels and actions in order convert each member into racism eradication champions and establish race issues as transversal in our organization.

Recommendation 15

Collective introspective exercises on racial issues be continued at all levels of the Federations, by providing frequent spaces for this to take place.

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