# Baccalaureate Nursing Education: Has It Delivered? A Retrospective Critique

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**Abstract**

Despite political support for the baccalaureate degree as entry to practice, historical concerns over nursing education – the value of education versus service, professional versus vocational identity and theoretical versus practical knowledge – persist. The authors challenge the notion of a "two-tiered" nursing system and call for a nationwide curriculum review to help the profession adapt to the changing needs of the Canadian healthcare system.

**With the passing of** legendary nursing leader Dr. Helen Mussallem in Ottawa on November 9, 2012 at the age of 97, it seems fitting to pause and reflect on the changes she and other nursing leaders of her day envisioned and accomplished, with an eye to what these changes mean for the future of nursing. On the strength of past leaders' vision for baccalaureate education for all nurses, the current generation of Canadian nurses has witnessed dramatic changes in nursing education – the most remarkable of which is the comprehensive shift from hospital-based

training to university-based liberal arts education, and from primarily acute care–centred curricula to community health–focused curricula. And yet, not all nurses and students view these shifts as positive. Today, some nurses and students express a longing for the "good old days" of hospital-based schools, where students learned "real" nursing skills and could "hit the ground running" when they graduated. Others disparage community health content within existing curricula, preferring instead more acute care content to align with the predominant structure of healthcare in Canada.

**Tensions between Service and Learning Interests: From Hospitals to Universities**

The move from hospital schools of nursing to universities traces back to tensions between service and educational needs that surfaced in hospital training schools in the 1920s and 1930s. From the opening of the first Canadian hospital-based diploma school in 1874 (Kirkwood 2005) through the 1930s, when Canada boasted 330 hospital training schools (Paul and Ross-Kerr 2011), the structure and function of nurses' training remained virtually unchanged: hospital schools used an apprenticeship model of on-the-job training (Bonin 1977; Hermann 2001). In exchange for room and board, uniforms, training and a small stipend, students provided the primary means of staffing hospitals (Saarinen 2008). Hospitals desired low-cost service, and young women desired low-cost education; hospital training provided both.

Amid growing concern about the quality of student training, the Canadian Nurses Association (CNA) and the Canadian Medical Association jointly funded a nationwide study on nursing education. The resultant Survey of Nursing Education in Canada (Weir 1932; also called the "Weir Report") revealed a lack of high-quality education, including insufficient classroom instruction and lack of variety in clinical experience, and expressed grave concern about the ethics of charging sick patients for the education of nurses. This report recommended that nurse preparation be transferred from hospital schools into the general education system of each province, and funded in a fashion similar to other educational programs. Weir advised that nurses receive adequate liberal arts, as well as technical, education at the degree level.

Despite these recommendations, by the 1960s, 95% of Canadian nurses were still being trained in hospitals (Romyn 1990). During this time, the CNA, sparked by an interest in accreditation, sponsored a second nationwide survey of nursing education. Conducted by Dr. Helen Mussallem, the resultant Spotlight on Nursing Education revealed that only 16% of schools met the criteria for accreditation, indicating ongoing quality problems at hospital schools of nursing. Mussallem (1960) recommended that the CNA focus on upgrading nursing education programs, leading to a report entitled A Path to Quality (Mussallem 1964), which

was intended to prepare a plan for the re-development of basic nursing education programs within the higher education system. The concurrent Royal Commission on Health Services (Hall et al. 1965) also underlined the need to overhaul nursing education.

All three of these reports failed to produce timely changes in nursing education. The reason for this failure has yet to be analyzed. It is plausible that the failed uptake was due to the fragmented delivery of nursing education across hundreds of disconnected hospitals that may have been more concerned about their staffing needs than about the education of nurses, or due to lack of collective political will among nurses and governing bodies. While college preparation for registered nurses eventually became the norm in Canada, the realization of the baccalaureate degree as the requirement for entry to practice (BETP), initiated in 1957 and taken up in the 1980s, was not fully realized until 2007.

The impetus behind this mandate was the pursuit of professional legitimacy and the desire to better prepare new nurses for practice in an increasingly complex healthcare system (Kirkwood 2005; McIntyre et al. 2006). The BETP mandate effectively collapsed three existing educational pathways into one single route for becoming a registered nurse (RN) in Canada. Two- and three-year hospital- and college-based diploma programs were closed or folded into existing four-year university-based degree programs. Seen by some as a victory for professional nursing and an affirmation of the value and complexity of nursing knowledge, the establishment of BETP nonetheless left others wondering whether the move to universities signified a privileging of theoretical knowledge over practical skills. Having universities as the de facto site for nursing education exacerbated concerns that higher education prepares nurses for something other than the role in which most nurses are actually employed: as caregivers to sick and injured individuals in hospital settings.

**Tensions between Professional and Vocational Identity: The Rise of the BSN**

One impetus for discussions of a baccalaureate degree as entry to practice was a belief that its absence acted as a barrier to the establishment of nursing as a profession (Kergin 1970). Higher standards of education were thought to increase the social legitimacy of nursing (Baumgart and Kirkwood 1990; Hermann 2001; McPherson and Stuart 1994; Saarinen 2008). As separate, service-oriented institutions based on assumptions of the feminine propensity to care and serve, hospital schools of nursing lacked parity with other professional programs such as engineering, medicine and education. Without educational parity, it was feared, the profession would never be taken seriously, develop its own body of knowledge, have control over its own preparation or advance to being an equal partner in the healthcare system (Kirkwood 2005). Many nursing leaders believed that to realize

its full potential the profession would need to be less focused on "training" and more on "educating" nurses – that is, to exchange the traditional apprenticeship model for a curriculum that placed greater emphasis on the humanities and social sciences (Hermann 2001; Paul and Ross-Kerr 2011).

Integrating liberal arts with traditional (technical) and emerging (theoretical) nursing knowledge promised to foster critical thinking, situate nursing within a humanistic perspective, support personal and professional development of the student, promote social consciousness for citizenship and social reform, promote the acquisition of general knowledge and prepare students for complex healthcare environments that were constantly changing (Hagerty and Early 1992; Hermann 2001; Priest 1970).

While Mussallem and the Royal Commission on Health Services (Hall et al. 1965) proposed a two-tiered system with baccalaureate-prepared leaders and diploma-prepared bedside nurses, in actuality the realization of BETP threatened to eliminate the second tier. In the absence of diploma graduates traditionally trained for hospital-based care, it became unclear as to who would be best prepared to provide bedside care. Baccalaureate-prepared nurses may have been expected to step into the gap, but baccalaureate nursing programs in the 1990s and beyond reflected the widely held belief that healthcare was (and is) moving from acute care into the community (CNA 2008; ICN 2003; WHO 2008). In anticipation of a new era in healthcare in which greater emphasis would be placed on health promotion and illness/injury prevention at the population level (Cohen and Gregory 2009), baccalaureate nursing programs continued to emphasize a community health perspective that had, in previous years, distinguished baccalaureate education from diploma education.

Not all nurses were in favour of BETP (Brooks and Rafferty 2010). To some, the occupational culture produced by the apprenticeship model of hospital training schools seemed to prepare students better "for the real world they faced than the professionalization campaigns of an elite minority of nurses" (Strong-Boag 1991: 238). Nursing unions also largely opposed the baccalaureate policy, most likely because their focus was on member remuneration, working conditions and defending job security and upward mobility for diploma-prepared nurses (Rhéaume 2003). Some nurses and nursing leaders were concerned that baccalaureate-prepared graduates would be less competent and lack the level of skill and knowledge of a hospital-trained, diploma-level nurse (Bonin 1977; Crowe 1991; Kergin 1970). Today there is little evidence that the primary healthcare ideals so strongly represented in Canadian baccalaureate nursing curricula have actually come to fruition at the system level. If baccalaureate education was originally intended to prepare nurses for roles beyond bedside nursing (and within

an as-yet-unrealized primary healthcare model), it should not be surprising that the question continues regarding whether baccalaureate education adequately prepares nurses for acute care roles.

### Tensions between Theoretical and Practical Knowledge: The Case of Practical Nurses

Although Mussallem and the Royal Commission on Health Services (Hall et al. 1965) identified two tiers of registered nurse preparation – a baccalaureate level for leadership and complex care, and a diploma level for bedside care – there has long been a third class of nurses: practical or vocational nurses (and even a fourth class, if one considers care aides). Largely relegated to the margins of nursing history, education and practice, practical nurses have nonetheless been a relatively inexpensive staple of the Canadian healthcare system since the Second World War. Intended as a temporary solution to the wartime shortage and as assistants to registered nurses, the utilization of practical nurses allowed RNs to focus on increasingly specialized and complex nursing care needs (Ford 1965; Paul and Ross-Kerr 2011; Saarinen 2008). When RN shortages continued after the war, so did the market for practical nurses. The shorter training period and lower wages made the schooling and hiring of practical nurses economically desirable (Saarinen 2008) – a trend that continues to this day, with senior licensed/registered practical nurses (LPNs/RPNs) earning 14–20% less than newly graduated baccalaureate-prepared registered nurses (BCNU 2013; UNA 2012). Practical nurses were never intended to replace registered nurses, yet RNs have long expressed fear that practical nurses might do just that (Ford 1965; Saarinen 2008). And in the post-BETP world of Canadian nursing, it seems apparent that this is exactly what is happening: it is LPNs/RPNs who now occupy the second tier of nursing practice previously held by diploma nurses – albeit with a less standardized (and, some would argue, less rigorous) system for education, licensing and registration. In this sense, Mussallem's vision of two tiers of nurses has been realized, with baccalaureate-prepared nurses and practical nurses occupying essential positions in the nursing staff mix (CNA 2005).

### Nursing Education: Emerging from the Past and into the Future

According to the CNA's A Nursing Call to Action (National Expert Commission 2012), nursing continues to value community care that focuses on health promotion and that acts on the determinants of health. The National Expert Commission continues the as-yet-unrealized transformation of "our out-of-date, hospital- and illness-focused system into one that looks at the whole patient through the lens of the social and economic determinants of health, and provides care to people that reflects how they live in their community" (National Expert Commission 2012: 30). Nurses, other professionals and the public across Canada favour an acceleration of the transition from acute care to community care,

better service integration, greater health promotion at the population level and addressing the root causes of poorer health (National Expert Commission 2012); however, lack of commitment at all levels of government makes realizing these aspirations unlikely, at least in the near future.

Despite political support for the baccalaureate degree as entry to practice, historical concerns about the value of education versus service, professional versus vocational identity and theoretical versus practical knowledge continue to inform nursing discourse today. While it is clear that a two-tiered system of education and practice exists, what remains unclear is whether baccalaureate education is, or was ever, intended to fill the second tier – the one focused on direct bedside care, primarily in acute care settings. Until or unless the Canadian healthcare system shifts more resources to primary healthcare (prevention and health promotion), the need for bedside nurses will remain a key driver for economic decisions regarding nursing education and practice. The question remains: How do we best prepare nurses – baccalaureate and practical – for the realities of a healthcare system that requires, and deserves, excellence in bedside nursing? The historical tendency to stratify nursing in Canada into two tiers – with differentiated roles, status and pay – continues to influence Canadian education and practice today. We urge nursing leaders to consider what it means to nursing to allow this stratification and the assumptions underlying it to continue unchallenged. While nursing leaders recognize that baccalaureate-prepared nurses are needed across the healthcare system, we suggest that until we challenge the uncritical acceptance of a two-tiered (or more) nursing system – or unless we are willing to critically examine how "status," historically embedded in the different tiers, influences decisions about education and practice – we will not resolve the question of what the role of baccalaureate nurses should be in healthcare today.

What is needed, then, is a continued effort at all levels of Canadian nursing to be proactive in the radical transformation of nursing education (Benner et al. 2010), nursing practice (Browne et al. 2012; Gottlieb et al. 2012; Villeneuve 2006) and healthcare organization and funding (National Expert Commission 2012). It is timely, also, for a review of nursing education in Canada, given that a comprehensive national review of nursing education has not been completed since Mussallem's (1960) report. Nurse leaders are also calling for such a review – one that will provide curricular direction that will help nursing education adapt to the changing needs of Canadians and the changing healthcare system (Eggertson 2013; MacMillan 2013; MacMillan and Gurnham 2013). Surely the ideal of a well-educated professional nurse remains. But without clarity regarding what we are preparing nurses for, or clarity regarding how a historically informed resistance to baccalaureate-prepared nurses at the bedside influences messages about the relative importance of bedside excellence, the two-tier approach to nursing education and practice that assigns less status to bedside nursing will continue unchallenged.

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