Dominant Discourses and Ideologies That Have Shaped the Education of Registered Nurses and Licensed Practical Nurses in Canada

by

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Abstract

Nurses, the largest health care provider group in Canada, are comprised of three regulated categories: Registered Nurses (RNs); Licensed Practical Nurses (LPNs, referred to as Registered Practical Nurses in Ontario); and Registered Psychiatric Nurses (RPNs). RPNs are educated, regulated, and employed in the four western provinces and although an important group to consider are not the focus of this paper. The purpose of this paper is to lay the groundwork for consideration of undergraduate intraprofessional RN-LPN education.

Health care reforms in Canada, influenced by the economic, social, and political forces of each successive generation, have historically had a profound impact on nursing education. A central feature of the most recent health care reform initiatives is interprofessional education (IPE). IPE assumes that bringing students from different health professions together will teach them the knowledge, skills, and attitudes required to be effective collaborative practitioners. Amazingly, the tremendous possibilities that undergraduate intraprofessional RN-LPN education could offer nursing and the health care system have been systematically overlooked.

As a way of understanding this surprising circumstance, I will use the context of health care reforms to critically examine how dominant discourses and ideologies embedded within economic, social and political forces have influenced the evolution of undergraduate RN and LPN education in Canada. I will state my beliefs and what I envision about the potential that undergraduate intraprofessional RN-LPN education can provide nursing and the health care system. I invite readers to reflect on and discuss the possibilities if opportunities for this form of nursing education were available.
My Area of Interest

Introduction and Background

Health care reforms have had a profound impact on the evolution of nursing education in Canada, thus they provide an appropriate context within which to critically examine the dominant discourses and ideologies that have shaped the economic, social and political forces that influenced decisions about undergraduate nursing education. The knowledge generated from such an examination helps us understand why undergraduate intraprofessional RN-LPN education has been overlooked and can serve as a resource for considering the educational directions and goals we envision for nursing’s future.

In the period from Confederation to the 1960’s, government allowed physicians, hospital administrators and hospital boards a leading role in determining what constituted nursing education (Bramadat & Chalmers, 1989; Kinnear, 1994; Kirkwood, 2005; Mansell & Dodd, 2005; McPherson, 2003). The economic benefits that student labour provided hospitals took precedence, and nurses had little say in their curriculum. University schools of nursing did not fare better; they were located under medical programs until the 1960’s (Mansell & Dodd).

In 1938, an anticipated shortage of RNs on the home front during World War II (WWII) led to the creation of the LPN category (Registered Practical Nurses Association of Ontario, RPNAO, n.d.). Intended as a temporary solution to the war time nursing shortage, LPNs were initially trained to assist RNs. Today, LPNs are autonomous practitioners who comprise the second largest nursing group in Canada.

By the 1970’s, hospitals no longer found it cost effective to educate nurses and asked their respective provincial governments to transfer this responsibility to Ministries of Education. For the first time, nurses had a major voice in determining their curriculum
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(McPherson, 2005). In 1982, Canada’s national RN association, the Canadian Nursing Association (CNA), announced its position that a baccalaureate degree should be the minimum entry to practice for RNs by the year 2000 (CNA, 2005a). This has yet to be accomplished in all provinces and territories. Practical Nurse Canada (PNC), our national LPN association, is currently working toward a national education standard for LPNs (PNC, 2007).

IPE is the latest health human resources education reform initiative in Canada (Health Canada, n.d.; Oandasan & Reeves, 2005). It is defined as “occasions when two or more professions learn from and about each other to improve collaboration and the quality of care” (Center for the Advancement of Interprofessional Education, as cited in Oandasan & Reeves, p. 24). A number of different terms are used interchangeably when referring to IPE. For example, the prefixes inter vs. intra vs. multi vs. trans, and the suffixes professional vs. disciplinary. Oandasan and Reeves explain their decision to use the term *interprofessional* education. It is the same term used by Health Canada and working groups created to develop IPE initiatives for collaborative patient-centred practice, and the term I will use in this paper.

*The Purpose of This Paper*

The purpose of my paper is to lay the groundwork for consideration of undergraduate intraprofessional RN-LPN education. My intent is to stimulate critical reflection and discussion among readers about the dominant discourses and ideologies that have enabled undergraduate intraprofessional RN-LPN education to be systematically overlooked in Canada. I invite readers to consider the possibilities for nursing if opportunities for undergraduate intraprofessional RN-LPN education were
available. To avoid confusion, I will not use an abbreviation to refer to intraprofessional education. IPE shall refer only to interprofessional education.

Impetus for the Paper

I am an RN and former Registered Practical Nursing Assistant, a past title given to LPNs in some provinces. I currently teach in both the undergraduate baccalaureate and practical nursing programs at Northern College, Ontario’s smallest community college. RN and LPN students frequently ask me about the course content of one another’s programs of study. Both groups have misconceptions about one another’s roles and responsibilities. Some RN students have remarked that LPNs are not “real” nurses, and many are surprised when they hear about LPN course content. Some LPN students have expressed the opinion that many RN students seem to believe LPN education focuses on preparing the LPN to work under the RN. Their remarks caused me to wonder whether undergraduate intraprofessional education would provide an opportunity for nursing students to learn together in selected theory classes and clinical work experiences. This could promote positive relationships through improved understanding, appreciation, trust and respect for one another’s knowledge base, roles, and scope of practice. I believe this would have a significant positive impact on nursing as a discipline and a profession.

What is Known about Undergraduate Intraprofessional RN-LPN Education

Researching the literature on undergraduate intraprofessional RN-LPN education produced no research studies on the topic. Two reports commissioned by Health Canada (Dutcher et al., 2005; Pringle, Green & Johnson, 2004) identified the need for integrated RN-LPN education. A third report (Villeneuve & MacDonald, 2006) commissioned by the CNA recommended consideration of RN-LPN education. On the same topic, Pringle (2005) identified the need for research on intraprofessional relationships in the workplace.
and Duddle & Boughton (2007) highlighted the negative aspects of intraprofessional relations among RNs.

In the final weeks of writing this paper, I was amazed to learn that for several years in the mid 1990’s to early 2000’s, Northern College offered a common first year for RNs and PNs. Students shared classrooms and clinical placements (S. Tremblay, personal communication, April 7, 2008). During the same period, Ontario’s Georgian and Sault Colleges also offered intraprofessional RN-LPN education. I was unable to determine the exact years the programs were offered, but they were phased out when Ontario adopted the baccalaureate degree as the entry to practice requirement for RNs. Although no research was carried out, the general consensus of those who were involved in the programs was that intraprofessional education did improve RN-LPN student relationships. Students were admitted either to the RN or LPN program, were together the first year, and then in separate classrooms for the remainder of their programs. LPN students who had the academic aptitude could transfer to the RN program at the end of the common year if they wished (S. Tremblay, personal communication, April 7, 2008; J. Carbonneau, personal communication, April 9, 2008; J. Stevens, personal communication April 15, 2008; A. Lee, personal communication, April 16, 2008; B. Warnock, personal communication, April 23, 2008).

RNs and LPNs represent the two largest regulated health care provider groups in Canada (Office of Nursing Policy, 2006). In many situations they work closely together, yet do not have a good understanding of one another’s education, roles, or scope of practice (Pringle, 2005). Given the possible benefits of combining at least some of the educational experiences of these nurses, I found the absence of research and serious consideration of the possibilities for undergraduate intraprofessional RN-LPN education
surprising. What was even more surprising was learning the CNA (2005) released a position statement in support of interprofessional *collaboration*, but to date has not developed position statements for either inter or intra professional education of health professionals.

*What is Known about IPE*

IPE is an outcome of the most recent round of health care reform initiatives which began in 2003 when the Prime Minister, Provincial Premiers, and Territorial Leaders met to discuss health care. The result was the First Ministers’ Accord on Health Care Renewal (2003 Accord). IPE is central to the 2003 Accord’s recommendations for health human resources educational reform (Health Canada, n.d.; Oandasan & Reeves, 2005). The goal of IPE is to teach students the knowledge, skills, and attitudes required to be effective collaborative practitioners (Oandasan & Reeves). The assumption is that IPE will result in better outcomes for patients, greater patient and health care provider satisfaction, and overall improved quality of the health care system (Canadian Interprofessional Health Collaborative, n.d). However, there is no evidence to support this assertion. Health Canada commissioned Oandasan et al. to conduct a comprehensive review of interprofessional literature as well as national and international approaches to interprofessional education and collaboration. They concluded, “There is no empirical evidence to date that interprofessional education can improve patient care outcomes” (Oandasan et al., 2004, ¶2). However, they found evidence that graduate level collaborative practice initiatives were beneficial. Another Health Canada commissioned report (Dutcher et al., 2005) determined, “there is currently a paucity of evidence that interprofessional education will generate effective collaborative practice” (p.17).
Despite the above findings, IPE has been embraced by health care reform decision makers as a means of improving collaborative practice among health care providers. The Health Council of Canada (HCC, 2006), comprised of government and non-government appointees who report to the public on the progress of the health reform initiatives identified in the 2003 Accord, recommended an “aggressive” focus on IPE (p. 2). The federal government is providing $90 million in funding for IPE initiatives over a five year period (Department of Finance, Canada, 2003). If federal and provincial governments believe IPE is worth funding so generously, why has undergraduate intraprofessional RN-LPN education not been considered?

**Approach to the Inquiry**

*The Influence of Discourses and Ideologies*

Discourse in this paper refers to the ways in which a society’s culturally produced patterns of language create and sustain common beliefs and understandings about what “should be” in society. Discourses establish a foundation for power over others by constructing expectations for behaviour (Francis, 2000). I will examine the dominant discourses that have influenced decisions about nursing education.

Ideologies are powerful, authoritative voices in society “that tell us who we are, what we are to think and how we are to behave” (Althusser, as cited in McDonald, 2006, p.336). Taken for granted ideologies can limit our possibilities for knowledge development (Doane & Varcoe, 2005). The ideologies of the born nurse and professionalization have profoundly influenced our own and others’ knowledge about nursing. They are examined in this paper.
Situated Myself

The understandings we construct about something are unique to self, guided by our values and beliefs and influenced by the situated context of our life experiences. My personal values and beliefs are congruent with critical social and feminist theories. Critical social theory considers language a significant influence in how we interpret context (Duchscher, 2000). It uncovers and critiques taken-for-granted assumptions about power, knowledge and truth, with the goal of emancipating people from hidden, dominating constraints in society. Critical social theory holds that truth as knowledge is socially constructed, thus subjectivity is central to knowledge generation (Duchscher).

I will use my critical social theory lens to examine the dominant discourses and ideologies embedded within the social, economic and political forces that have shaped the evolution of undergraduate RN and LPN education in Canada.

The overwhelming majority of nurses in Canadian patriarchal society are women. Examining nursing education through the feminist lens I hold puts into focus how nursing and utilization of power in Canada’s health care system are gendered experiences. Dunphy and Longo (2007) note:

Feminist theory considers gender “as a basic organizing principle that profoundly shapes and mediates the concrete conditions of our lives. Gender is viewed as central in the shaping of our ideas of the world, the skills we acquire, the institutions in which we reside and work, and the distribution of power and privilege” (p. 137)

A feminist lens helps me understand how nursing education in Canada has been shaped by societal assumptions about gender.
I wish to remind readers that I am situated as an RN who began my nursing career as a practical nurse. I have personally experienced the stigma and marginalization that has resulted from being viewed by some nurses and members of the public as not being a “real” nurse. These oppressive experiences have left an indelible impression and made me a strong advocate for LPNs. At the same time, I am a very proud RN and an active RN advocate. I am cognizant that my voice as an RN carries more weight and is more likely to be heard than an LPN voice in our society. I am no longer a practical nurse and do not presume to speak for LPNs. I have tried my best to consciously attend to RN-LPN power differences within my paper.

Use of the Literature

I will utilize literature drawn from scholarly nursing journals, interprofessional education and medical journals, nursing textbooks, nursing association and government fact sheets, reports, guidelines and position papers. I recognize that my choice of materials and what I find pertinent to my work are uniquely mine; this influences my understanding and the contents of my paper.

It is surprising how little research and published information in general there is on practical nursing in Canada. Very little is written about Canada’s LPNs in nursing literature. Sources of information about practical nurses in this paper consist primarily of government funded nursing studies, practical nursing association and college reports, and the work of non-nurses such as historian Kathryn McPherson.

Significance of This Project for Nursing and Contribution to Nursing

Canadian nurse researchers and educators have identified a need for intraprofessional nursing education (Dutcher et al., 2005; Pringle et al., 2004; Villeneuve & MacDonald, 2006). My personal teaching experience confirms this need, yet there is
no indication that this has ever been given serious consideration. A critical examination of the dominant discourses and ideologies that have shaped the evolution of undergraduate RN and LPN education in Canada can help nurses understand how undergraduate intraprofessional nursing education has been systematically overlooked. To my knowledge, this has not been done before. The critical reflection and dialogue this might generate among nurses can raise awareness and promote understanding about the foundational knowledge, roles, and scope of practice of RNs and LPNs. It can provide insight into the reasons why past decisions about nursing education were made, scrutinize the current context for nursing education, and envision new possibilities for nursing and our healthcare system if undergraduate intraprofessional nursing education was implemented. Critical reflection and dialogue can also foster increased respect and trust for one another and improved working relationships, which will ultimately benefit our clients. This can be an empowering process for nurses, not only in terms of gaining knowledge about the evolution of nursing education in Canada, but also as a result of the deeper understanding of self as nurse that will be gained.

*Dominant Discourses and Ideologies that Shaped the Evolution Of Undergraduate RN-LPN Education in Canada*

*A Critical Examination*

This paper is not an integrated literature review, nor is it simply an historical overview of undergraduate nursing education in Canada. My paper provides a critical examination of the dominant discourses and ideologies that have informed societal understandings of who nurses are and what constitutes nursing, and how this has shaped the evolution of undergraduate RN and LPN education in Canada.
It is not my intent to persuade readers to agree with or adopt my understandings about the evolution of undergraduate nursing education in Canada, or the possibilities undergraduate intraprofessional RN-LPN education might offer nursing. The interpretations and understandings presented are my own, based on the situated context of my life experience. I invite readers to formulate their own interpretations and understandings, and I encourage the dialogue and debate that might be generated after reading my paper.

To promote critical reflection and stimulate dialogue and debate, I have posed questions for readers in different sections of the paper. There are no best or right answers; readers will answer the questions according to their own unique lived experiences. The questions invite readers to critically reflect not only the “what was” and “what is”, but also consider the “what might have been” and “what could be” for nursing. I hope nurses who read my paper will gain awareness that what they understand and value about nursing has been shaped by discourses and ideologies that nurses have both participated in and been excluded from, and that have largely served to subjugate nurses. Finally I hope that considering the possibilities for nursing that undergraduate intraprofessional RN-LPN education can provide will stimulate readers to imagine new ways of being, thinking, and doing in nursing. This can be emancipating.

*Tracing Nursing’s Educational History is Necessary*

In order to gain a thorough understanding of why undergraduate intraprofessional RN-LPN education has been systematically overlooked in Canada, we need to trace nursing’s educational history from its origins to the present day. Although LPNs were not introduced in Canada until 1938 (RPNAO, n.d.), their educational history is directly linked to that of RNs. Thus, the dominant discourses and ideologies that influenced RN
education before LPNs were created had a direct impact on expectations for LPN practice and decisions about LPN education.

The process of beginning at nursing’s roots in Canada illuminates the dominant discourses and ideologies embedded within the economic, social and political forces that have always influenced societal understandings of who nurses are, what our work should entail, and what constitutes nursing. Some of these have been a continuous thread throughout the evolution of nursing education. Health reforms have historically had a profound impact on nursing education, thus they provide an appropriate context for tracing the evolution of nursing education in Canada.

1600-1874: Lay Nurses and Nuns and the Ideology of the Born Nurse

The history of nursing education in Canada predates European settlement in North America. The earliest nurses in Canada were lay Aboriginal women. They were taught how to identify, prepare and administer herbal medicines, and provide maternity and general health care for members of their community (Benoit & Carroll, 2005). The discovery of Canada’s lucrative fur trade and fisheries brought French and British men and eventually their wives and children to this “new” world; French and English settlements were established by the early 1600’s.

The French and British considered health care an individual, family, or church responsibility (Young & Rousseau, 2005). Responsibility for health fell primarily to the women in the colonies, reflective of the historical belief that caring for others is an innate quality of all women, and thus women’s work (McDonald, 2006). The ideology of the born nurse incorporates taken for granted notions that all women are born with “feminine” and “domestic” traits of caring and nurturing, and do not need to be educated to do “what comes naturally”. How does the ideology of the born nurse devalue women
and respect for the work nurses perform? How does it contribute to the invisibility of nurses’ relational and emotional work and nursing knowledge? How does the way in which society understands nurses and their work shape nursing education and practice? These are important questions to explore because the ideology of the born nurse persists to the present day.

Formal nursing education in Canada was first introduced in the mid 1600’s by Roman Catholic nursing orders of nuns who arrived in the “new” world and settled in the French colonies. Initially trained in France according to a formal apprenticeship program, they were highly skilled practitioners in nursing and pharmacy for their time; some also had excellent surgical skills (Violette, 2005). By the end of the 18th century, French Canadian Roman Catholic nursing orders of nuns had created a network of hospitals throughout Quebec and Ontario and were educating new nuns in the practice of nursing (Paul, 2005). Separated by their religious orders from the day to day functioning of society, these nurses enjoyed autonomous nursing practice.

In 1844, nursing orders of French Canadian nuns, in response to bishops’ directives, began expanding across Canada, establishing themselves in the settlements that were springing up across the west. They built, ran, and staffed hospitals. The nuns provided nursing education for their religious sisters and some lay women (Paul, 2005). Charged with saving souls through the charitable work of nursing, nuns provided urban, rural and remote parts of a young frontier country with highly skilled nursing services at no cost well into the early 1900’s.

*Late 19th Century Scientific Advances Mean an End to Lay Nurses*

Until the mid 1800’s, medical therapeutics relied heavily upon “bleeding, purging, vomiting, salivating, and blistering” (Godden & Helmstadter, 2004, p.160). Nurses were
not expected to have any substantial knowledge, and hospitals hired primarily lay nurses who spent the majority of their workday keeping the wards clean, picking up bandages discarded by physicians, and emptying basins. Physicians, predominately male, sought greater autonomy in their practice in several countries, including Canada, and launched a successful international public image campaign that promoted the discourse of physician as expert knower of humans’ health and healing needs. The germ theory of disease developed by French scientist Pasteur and German scientist Koch, the development of anesthetics, and British surgeon Lister’s work with antiseptic surgery, all of which occurred in the last decades of the 19th century, helped doctors advance their cause. Physicians were eventually successful in persuading society that they were the leading experts on health matters, and best qualified to perform surgical and medical procedures (Violette, 2005).

Physicians were given control of Canadian religious and secular hospitals, and under the discourse of medical expert, reorganized hospitals to suit medical practice. Hospitals of the time relied heavily on government and charitable funding, and administrators looked for innovative ways of keeping costs down (McPherson, 2005). Nurses represented the largest group of hospital workers, and there was an acknowledged need for formally trained nurses. However, administrators, in keeping with the ideology of the born nurse, were reluctant to pay a fair wage for work that was considered an extension of domestic services. Developments in nursing education in England toward the end of the 19th century provided a solution to the cost of nursing services in Canada.

*The Nightingale Model of Nursing Education*

England’s Florence Nightingale believed it was a Christian duty to help the sick and poor and developed a training school for RNs at St. Thomas Hospital in London,
England (Pfettscher, de Graf, Tomey, Mossman, & Slebodnik, 1998). Control of nursing education was shared between a board of directors, a nursing matron, and physicians (Bramadat & Chalmers, 1989). Funding was external to the hospital and Nightingale closely supervised the school’s operation (McPherson, 2005). The ideology of the born nurse was central to Nightingale’s nursing program. She believed nurses did what came naturally to all women (Nightingale, as cited in Evans, 2004). Nightingale stressed that a motherly nature was a key nursing attribute, and a nurse’s ladylike behaviour was a means of influencing the patient’s moral behaviour. England was a class based society. Women from the upper middle and upper classes were trained to assume nursing management positions, and were expected to be ladies of “character”. Lower or lower middle class women who attended Nightingale’s school provided direct patient care. Required attributes of “good” front line nurses included being “sober, honest, truthful, punctual, quiet, trustworthy and neat in person” (Seymer, as cited in Godden & Helmstadter, 2004, p. 162).

How did the Victorian values of Nightingale’s era, which Canada shared as a British colony, maintain societal discourses about nursing that discouraged men from considering nursing as a career choice? What has the legacy of this been for nursing and men who become nurses? How did Nightingale’s views about the “good” nurse serve to exert social control over nurses’ behaviour? How did beliefs about Christian duty to the ill and poor shape nurses’ work and wages? These questions are worth thinking about, given that Nightingale’s beliefs about nursing reinforced existing western societal understandings about nurses.
1874: The Nightingale Model is Adapted for Canada

Word of Nightingale’s hospital apprenticeship style of nurses’ training soon reached Canada. Realizing the economic potential of a cheap source of reliable nursing labour, hospital-based schools adapted the Nightingale model, with significant differences. The hospitals funded the schools, hospital administrators and physicians controlled nurses’ educational programs, and physicians determined what nurses could do in the clinical setting (McPherson, 2005). The primary goal was to supply a steady source of nurses who were socialized to think and act according to the wishes of their patriarchal superiors: well-disciplined, obedient, and able to follow orders. Higher learning was not a consideration (Bramadat & Chalmers; Kirkwood, 2005). Of note, the motto of Mack’s Training School, the first nursing school in Canada, was “I See and I Am Silent” (Kirkwood, p.184). The school was founded in 1874 by Dr. Theophilis Mack at St. Catherine’s Marine and General Hospital in Ontario (Kirkwood).

Within fifty years, the apprenticeship model of nurses’ training was established in more than 200 hospitals across Canada (Weir, as cited in Bramadat & Chalmers, 1989; Gibbon & Mathewson, as cited in McPherson, 2005). Rapid expansion led to a decline in admission standards, substandard curricula, a lack of standardization among schools, and insufficiently prepared instructors (Bramadat & Chalmers). The quality of education varied from hospital to hospital (Bramadat & Chalmers; Kirkwood, 2005). Some hospitals employed nursing instructors, while others relied on doctors’ lectures, often delivered at the end of a long clinical day (Kirkwood).

It is reasonable to expect that nursing education during this time was shaped by physicians’ values and beliefs about people in sickness and in health. How has the ideology of scientific medical knowledge influenced other forms of knowledge? How
has it influenced nurses’ understanding of human beings, expectations about the sick person, and health and healing?

*Educated and Underemployed*

The apprenticeship model of nursing education firmly established medical and hospital administrator domination over nurses (Northrup, Tchanz, Olynyk, Makaroff, Szabo, & Biasio, 2004). Based on service and self-sacrifice, duty, commitment, and subordination to male hospital administrators and physicians, the model resulted in poor pay and social status for nurses (Melchior, 2004). It did nothing to identify or develop a nursing knowledge base (Kirkwood, 2005). The apprenticeship model was the dominant means of staffing Canadian hospitals with nurses until the early 1960’s. Nursing students apprenticed over a two or three year period, during which time they provided most of the hospital’s nursing labour in exchange for room and board, a small stipend, and their education. Supervised by a few graduate nurses, they worked 12-14 hour days, often received one-half day off duty in a week, and commonly worked over-time (Ross-Kerr, 2003b).

It is apparent that hospital expansion across Canada depended on the free labour of student nurses. How did the discourses of insufficient funding, a Christian duty to care for the sick, and the ideology of the born nurse converge in a way that enabled hospitals to maintain this status quo? Having care provided by nursing students who received a haphazard education was not in the client’s best interests, so whose interests were best served? Answering these questions may cause us to reconsider the altruistic assertions of those involved in providing health care services. The answers also provide insight into the manner in which ideology and discourse is used to support economic and political influences in health care.
Graduation brought uncertainty and stress for nursing students. Very few could expect to find employment in hospital settings. By 1914, there were over 20,000 nurses in Canada, most of whom could not find regular nursing work (Keddy & Dodd, 2005). World War I (WWI, 1914-1918) provided temporary employment for many who became military nurses with Canada’s Armed Forces; however, only twelve permanent military nursing positions remained at the end of the war (Toman, 2005). Private duty nursing, which lacked job security and a good wage, offered one of the few employment options available to “respectable” women (Keddy & Dodd). Nurses were working hard to change society’s perception of nurse as an extension of domestic worker. Nevertheless, 1920’s society still commonly associated nursing with the innate “feminine” traits of caring and doing for others, and nurses employed in private duty were often expected to provide a mixture of domestic and nursing duties (Keddy & Dodd).

What expectations did society have for women in the workplace that enabled hospitals to treat nurses as disposable workers? Given the lack of regular employment opportunities after graduation, why did women continue to choose to study nursing? The ideology of the born nurse is apparent in the way nurses were treated. It devalues women and nurses because it diminishes their contributions to society and trivializes the knowledge required to perform nursing work. Thus, nurses are not paid for their work or are grudgingly or poorly paid.

1915: The Drive to Professionalize Nursing Begins

Like their counterparts in the United States, Canadian nurse leaders were not happy with the apprenticeship model of nursing education and sought to professionalize nursing through legislation, professional associations, and university level education. At the turn of the 20th century, nurse leaders began petitioning government for legislation to
regulate nursing practice (McPherson & Stuart, 1994). They wanted to obtain registration for trained nurses as a means of enabling the public to distinguish them from untrained nurses (Brunke, 2003). The public could expect that a nurse who was registered provided a standard of care, skill and knowledge legislated by government (Dick & Cragg, 2006).

Nurse leaders were successful in their initiative; by 1922, all provinces had passed legislation governing nursing (Ross-Kerr, 2003a). Early legislation addressed registration only; title protection was not yet achieved (Brunke, 2003; Ross-Kerr, 1996). Nevertheless, provincial nursing legislation promoted a national standard for nursing curriculum development across Canada, which was spearheaded by the CNA. This was badly needed given the unsatisfactory nursing education standards that many hospitals employed at the time (Wood, 2003). Legislation also effectively dissociated lay nurses from trained nurses.

At the turn of the 20th century, women were becoming aware that higher education was a means of reducing social inequities between men and women (Baumgart & Kirkwood, 1990). RN leaders also recognized that the higher standards of education obtained through a university education, particularly the scientific–technical education so esteemed by other professionals, would advance social legitimacy for nursing (McPherson & Stuart, 1994). However, societal discourses of nursing as domestic work was a significant barrier to implementing university level nursing courses. In 1906 for example, the University of Toronto approved a general course in household science but rejected a course for nursing hospital supervisors (Kirkwood, 1994). It is clear that universities reflected societal understandings of women’s roles and what they should study. Women who attended university were encouraged to enroll in programs such as
home economics, education, and psychology. These areas of study would help women become better wives and mothers, but did not threaten their domestic obligations to their family or men’s access to key leadership positions in society (Baumgart & Kirkwood).

1919: University Level Nursing Education is Introduced in Canada

RN contributions during WWI and the influenza epidemic in 1918-1919 helped advance the image of the nurse as a trained professional (Kinnear, 1994). RN leaders seized upon nurses’ accomplishments on these fronts to advance their goal of gaining autonomous nursing education in Canada’s universities. In 1919 the University of British Columbia (UBC) introduced a five year basic university degree nursing program (Thomas & Arseneault, 1993). The first program of its kind in the British Empire, it owed its birth to medical opinions that better educated nurses would provide more competent, cost effective and efficient provision of hospital and public health reforms (Kirkwood, 2005). Early university nursing programs like UBC’s shared nursing education with hospitals under the “sandwich” model (Dick & Cragg, 2003). Nursing students attended one year of general arts and science courses at the university, followed by two or three years of training at a hospital, during which time the hospital’s service needs took priority over the students’ educational needs. Students then returned to university for a final year of public health studies (Kirkwood). Hospitals did not require nursing students to apply their general education in clinical settings (Dick & Cragg). The practices hospitals engaged in demonstrate that their economic discourses continued to influence nursing education. Why would hospitals not encourage nursing students to engage in praxis? What were the implications of not engaging in praxis for nursing students’ knowledge development? What were the implications for their clients?
Exploring the answers to these questions helps us examine taken for granted assumptions about the purpose and role of hospitals in health care.

1932: Kathleen Russell’s Integrated University Nursing Program

Nurse leaders wanted autonomous nursing education. In 1932, Dr. Kathleen Russell, RN, Director of Public Health Nursing at the University of Toronto pioneered the integrated program, a new approach to university nursing education in Canada (Kirkwood, 2005). Unable to secure sufficient university or provincial funding, Russell received private funding from the United States’ Rockefeller Foundation to implement a 39 month university degree nursing program. An integrated program allowed nursing faculty full authority over both university nursing curriculum and clinical hospital practice; neither students nor faculty would be responsible for meeting the service needs of the hospital (Kirkwood, 1994). It meant the university could now ensure clinical practice was linked with general theory courses and clinical experiences met the students’ learning needs. Integrated programs also provided courses that were developed in accordance with educational principles (Dick & Cragg, 2003).

The Rockefeller Foundation made clear that it did not intend to further nursing education, but rather, to promote the best interests of public health programs and medical education. Nursing was considered an ancillary service and secondary to this objective (Baumgart & Kirkwood, 1990). The Rockefeller Foundation stipulated that the program must be university controlled and have the support of the medical faculty. As a result, nursing was located under the medical program, not beside it, and the medical faculty at the University of Toronto was given a strong voice in determining the direction of the nursing program (Baumgart & Kirkwood). The discourse of expert medical knowledge continued to shape nursing education. Nevertheless, in 1942, after nearly twenty years of
petitioning the university, Russell finally realized her dream of having the nursing
program granted degree status, along with senate representation and academic status for
nursing staff (Kirkwood, 1994). It would be another 20 years before a university, the
University of Montreal, realized Canadian nurse educators’ dreams of having a nursing
faculty that was autonomous from a medical faculty (Mansell & Dodd, 2005).

The Ideology of Professionalization

Professionalization is a product of the late 19th century. It was created by white,
middle-class men who wanted to secure existing and new occupations in society, and
obtain a monopoly on the services provided (Carr, 2003). The Flexner report, released in
the United States in 1910 by American educator Abraham Flexner, secured the dominant
role natural science research played in determining what constituted scientific knowledge,
and the importance of a university education for health practitioners (Northrup et al.,
2004). Flexner identified key characteristics of a profession based on his observations of
law, medicine, and theology. He determined that a profession is: intellectual; contains a
specialized body of knowledge that must be learned through a formal educational
discipline; is practical rather than theoretical; is well organized; and is motivated by
altruism (Ross-Kerr, 2003b). With the exception of altruism, patriarchal western
societies associate the characteristics outlined by Flexner with masculinity. In his
opinion, nursing did not meet the criteria for a profession because nurses did not possess
unique knowledge or have autonomous responsibilities (Ross-Kerr). It is worth noting
that Flexner chose powerful male occupations for his study and released his report during
a time when women in Canada were still considered the property of their male relatives;
they did not have the right to vote. How does Flexner’s gendered definition of
professionalism continue to influence Canadian society’s understanding of nursing?
Front-line nurses had little time to devote to the professionalization issues nurse leaders identified as important. They were continuously engaged in attempts to find sufficient paid work (Keddy, as cited in Kinnear, 1994). Nurses desired the regular work, increased pay, and eight hour work shifts that professionalization promised; however, they also wanted to protect their public image as caring, self-sacrificing individuals. At the dawn of the 20th century, prevailing societal discourses of men as intellectually superior and women as most fulfilled when performing domestic and mothering roles were not compatible with any woman’s desire to become more educated (Baumgart & Kirkwood, 1990). The ideology of professionalization created a dilemma for nurses. They could not risk being perceived as placing their own best interests ahead of the patient’s welfare (Kinnear). Nurse leaders faced the daunting challenge of promoting nursing as a profession that was caring and service oriented, but also required scientific knowledge.

**Physicians Oppose Nurses’ Professionalization**

Most doctors opposed the professionalization of nurses. In the late 1920’s for example, the Quebec College of Physicians and Surgeons sought legislation to “control the admission of women to the study and exercise of the profession of nursing” (Samuel, as cited in Kinnear, 1994, p.163). Quebec physicians were unsuccessful in their bid, but clearly believed they had the paternalistic right to control women’s entry to nursing schools. The medical faculty at the University of Toronto had also unsuccessfully petitioned to completely control nursing education programs (Kirkwood, 1994). One American doctor stated nurses did not require “excessive” training, and that nurses did not need to understand everything the doctor did (Kinnear). In his 1905 address to a graduating class of nurses, Dr. John Hunter, a Toronto physician, stressed that while
nurses did not need skill or knowledge, it was essential that they have good health and a pleasing personality (Hunter, as cited in Baumgart & Kirkwood, 1990). The patriarchal attitude of many doctors toward nurses is captured in the following statement made by an author who chose to remain anonymous. It appeared in an article in a 1927 edition of the Canadian Medical Association Journal (as cited in Kinnear), about a medical conference held in Montreal one year previously:

To be able to go into the kitchen, and, with all the fine touches of the culinary art, create an appetizing dish for her patient, was in the opinion of most speakers, a much greater asset than a knowledge of the distribution of the fifth nerve, or the functions of the pituitary body (p. 166).

Some doctors believed nurses were already overeducated, while others feared that if nursing education standards were raised, nurses could threaten their authoritative position in society (Kinnear). The ideology of the born nurse and echoes of economic and expert medical knowledge discourses are evident in such remarks.

1926: The Weir Report: A Call for Nursing Education Reform

Nursing leaders had long recognized the need to improve existing hospital schools of nursing (Mansell & Dodd, 2005). In 1922, the Government of Ontario appointed Alice Munn, RN, to the position of Director of the Department of Public Health and instructed her to investigate nursing schools in the province. Within the first year of her mandate, 51 schools were found inadequate and were closed (Mansell & Dodd). Four years later, the Canadian Medical Association (CMA) appointed a committee of doctors to study nursing conditions in Canada. Nurse leaders voiced their objections to a solely physician review, and in 1927, the CNA, in conjunction with the CMA, co-funded a study on nursing and nursing education. Mr. George Weir, a professor of education at the
University of British Columbia conducted the study and released the results in *The Survey on Nursing Education in Canada* (Weir Report) in 1930 (Kinnear, 1994; Kirkwood, 2005).

The Weir Report supported nursing leaders’ assertions that nursing education needed to be overhauled (Mansell & Dodd, 2005; Pringle et al., 2004). Among its findings were nursing students who had not completed primary school, nursing schools without any instructors, and a significant amount of nursing student time spent on “maid’s work” (Dick & Cragg, 2003, p.189). The Weir Report called for sweeping changes to nursing education, including abolishing hospital control, closing some schools entirely, and placing nursing education in general educational institutions such as universities (Kirkwood, 2005). Weir recommended three year programs of study, and stated hospitals with less than 50 beds should not be allowed to run nursing schools (Mansell & Dodd). The CNA established common standards of education based on Weir’s report, and some school closures occurred. However, his recommendations were not compulsory and many hospitals ignored them (Kirkwood). What factors enabled hospitals to ignore the Weir report? How might nursing education have evolved if the recommendations had been implemented?

1938: *The Birth of the LPN*

The Great Depression that swept the world from 1929-1933 compounded the difficulties Canadian nurses faced in finding paid employment, as fewer families were able to afford to pay for services (Keddy & Dodd, 2005). WWII (1939-1945) provided nurses with badly needed good paying, steady work. Over 4,000 RNs enlisted and served as military nurses in the Canadian Armed Forces during the war years (Toman, 2005).
Political discourses concerning an anticipated need for more nurses led to increased enrollment in nursing schools. From 1939-1946, the number of graduates grew by 45% (McPherson, 2003). Federal funding for nursing education was flowed through the CNA and was distributed to both university and hospital based programs (Ross-Kerr, 2003c). The Victorian Order of Nurses (VON), the Canadian Red Cross Society, and the W.K. Kellogg Foundation also offered scholarships and loans to university nursing students enrolled in baccalaureate and public health nursing programs during WWII (Ross-Kerr). It was not easy to attract women into nursing however, given the availability of other jobs that paid well during the war years. Despite best efforts to produce more graduates, a shortage of nurses persisted on the home front.

In 1938, a new category of nurse, the practical nurse, was created in Canada to offset the RN shortage (RPNAO, n.d.). Ontario was the first province to enact legislation authorizing the creation of practical nursing and the development of practical nursing education (Russell, as cited in Pringle et al., 2004). Originally referred to as nursing assistants or nursing aides, practical nurses in early Canadian programs received six months of basic training; upon graduation, they provided hospital and home nursing services under the supervision of RNs. The educational admission requirement for most of the early programs was a completed elementary school education (Pringle et al.).

Practical nursing programs were meant to provide a temporary political solution to the country’s war time RN shortage, and governments planned to disband them after the war, when RNs returned to civilian duties (RPNAO, n.d.). They survived over the long term however, because RN shortages continued after the war. It is also reasonable to expect that economic discourses supported the continuation of practical nursing programs. As compared to RN programs, practical nursing programs were less expensive
to fund and of a shorter duration. Practical nursing graduates were available to the workforce sooner, and they were paid a lower wage than RNs.

How did the ideology of the born nurse influence societal beliefs that it was acceptable for practical nursing applicants to have such low educational admission requirements? What has been the legacy for practical nurses of titles such as “nursing assistant” and “nursing aide”?

*RNs Are Given a Measure of Control over LPNs*

Records show that early practical nursing programs in Canada prepared graduates who were meant to assist the RN, not replace or supplement them (Russell, as cited in Pringle et al., 2004). This is reflected in early titles such as Certified Nursing Aide, Certified Nursing Assistant, and a later title of Registered Nursing Assistant, and in provincial governments giving RN associations some authority in making decisions about practical nursing, such as determining standards and controlling enrollment numbers (Pringle et al.). In Ontario for example, the Registered Nurses Association (RNAO) was charged with developing a curriculum for a demonstration school in London that operated from 1941 to 1945 (Russell, as cited in Pringle et al.).

There was a pervasive fear among RNs that practical nurses could replace them one day (Mussallem, as cited in Pringle et al., 2004). Whenever possible, RN leaders arranged for RN and practical nursing students to train in different hospitals, effectively preventing them from learning about one another’s education, scope of practice, and day-to-day responsibilities (Pringle et al.).

It is worth spending some time contemplating why RNs believed they could be replaced by LPNs because the same belief is present today. How do we, as nurses, define ourselves? What is our understanding about the purpose of our education and its
application in our practice? What are the RN and LPN scopes of practice, and are they interchangeable? How do societal understandings and expectations for nurses influence our beliefs about who we are and what constitutes the work we perform? How did the original intention that practical nurses would be temporary workers only affect RN-LPN relationships? If there had been opportunities to learn and work together as students from the beginning, what might it have meant for RN-LPN understandings of one another’s knowledge, scope of practice, and contribution to health care? What oppressive practices did RNs knowingly and unknowingly use against practical nurses? As difficult and painful as some of these questions are to reflect upon, I believe it is in nursing’s best interests for all nurses to earnestly try to answer them. It is also worth contemplating what nursing would “look like” today if opportunities for undergraduate intraprofessional RN-LPN education had been pursued when practical nurses were introduced in Canada.

1946-1950: Nurses Benefit from Military Service and Canada’s Baby Boom

RN leaders recognized the advantage military nursing service during WWII offered in advancing their goal of securing university nursing education in Canada. Leaders of university nursing programs had formed the Canadian Association of Schools of Nursing (CASN) in 1942 to advocate for university preparation for nurses and to develop and implement accreditation standards at the university level (Dick & Cragg, 2006). In the immediate post war years, RN leaders successfully asserted RNs’ rights to higher education on the basis of their contribution to the war effort (Wood, 2003). University nursing education programs were now firmly established in Canada.

The rapid rise in the Canadian birthrate in the years following WWII as men returned home from military services contributed to a need for more nurses, and the number of both RN and practical nursing schools expanded accordingly (Pringle et al.,
Practical nurses were particularly sought in the immediate post war years by the Federal Department of Veteran Affairs (DVA) to care for war veterans, and the DVA sponsored practical nursing education in several provinces until 1947 (Pringle et al., 2004).

**1947-1950’s: Hospital Health Insurance Plans Impact Nursing Education**

Canadians’ experiences with two world wars and the Great Depression produced societal discourses about the need for a social safety net. The federal and provincial governments responded by developing a social welfare system, which included hospital insurance (Storch & Meilicke, 1999). This had implications for nursing education.

In 1947 Saskatchewan’s Premier Tommy Douglas introduced a comprehensive and compulsory hospital insurance plan (Storch & Meilicke, 1999). Ten years later, the federal government implemented the *Hospital Insurance and Diagnostic Services Act*, which included a 50-50 cost sharing formula with the provinces for insured hospital services (Storch & Meilicke). Coverage of capital costs was included (McPherson, 2003). Societal and political discourses about receiving health care close to home led provinces to build hospitals in multiple towns and cities, equipped with the latest in medical equipment. Patient demand was strong. From 1950-1955, patient loads in Canadian hospitals increased by 40% and hospital operating expenses grew by 260% (McPherson). At the same time, advances in medical technology and knowledge resulted in decreased mortality rates and increased patient acuity. Social discourses about fair labour practices in the years following WWII led to the introduction of 40 hour workweeks in many sectors of the Canadian workforce, including nursing, which meant employers had to hire more staff. These combined factors resulted in secure employment opportunities for
Canadian nurses for the first time in our country’s history. The increased demand for nurses led to changes in nursing education (Strong-Boag, 1991).

**Hospitals’ Acute Care Focus Influences Nurses’ Scope of Practice**

Acute care management was the central focus of hospitals during WWII and in the post WWII years, and RNs possessed the skills required to manage acute patient care needs. The discovery of new drugs such as penicillin and other antibiotics during this time led to an increase in intramuscular and intravenous administration (McPherson, 2003). Public demand for these and other medical advances such as collecting and storing blood and new clinical procedures, required competent, knowledgeable practitioners.

Provincial governments recognized that one way of meeting public demand for improved access to medical care was through legislation that mandated nursing registration. (Ross-Kerr, 1996). Mandatory registration provides title protection (which had already been realized by Canadian nurses), requires a definition of nursing, and a clear description of scope of practice that is restricted to nursing members in good standing. Newfoundland passed the first mandatory nursing act in 1953 (Ross-Kerr). Across Canada, RN scope of practice was expanded to accommodate new skills that would otherwise occupy a significant portion of physicians’ time such as administering intravenous therapy, blood transfusions, and blood pressure monitoring (McPherson, 2003). LPNs’ scope of practice was adjusted to enable them to perform nursing duties that did not involve assisting a doctor or administering drugs, and they were expected to work under a nurse’s supervision. They were employed primarily in non-acute settings (McPherson).
It is interesting that consideration of physicians’ time management led to decisions that enabled RNs to perform duties they had previously been denied. What societal discourses enable this type of control over nursing? Scope of practice as described here is closely tied with clinical skills. LPNs had the knowledge, skill and judgment to perform basic nursing care, which all clients require. Why were they relegated primarily to chronic care wards? What is scope of practice? Why were they prevented from learning additional skills such as taking blood pressure? Assisting a physician often involves providing information about a client, assisting the doctor on rounds, handing over instruments or supplies, removing a dressing, or re-bandaging a wound after the doctor’s inspection. Why were LPNs not allowed to perform these types of functions? Although we must bear in mind the historical timeframe within which LPNs practiced here, it is worthwhile to consider the factors that constrained RNs and LPNs from making a greater contribution to health care. How did the delineation of RN and LPN work influence curriculum development for both nursing categories? How did this obscure consideration of the possibilities for undergraduate intraprofessional RN-LPN education? Although there are no straightforward answers to these questions, they can provide greater insight and understanding about our perceptions of one another as nurses.

1950’s: Practical Nursing as a Trade and Behavioural Models of RN Education

In 1951, in response to the changing needs of its hospitals, the Government of Ontario amended its existing Nurses’ Registration Act to give the RNAO responsibility for the registration of both registered nurses and practical nurses and the establishment of standards of admission to their respective educational programs (Government of Ontario, 2005). This provided an opportunity for government and nurse leaders to consider the
possibilities undergraduate intraprofessional RN-LPN education might offer nursing and health care, yet there is no indication that this occurred.

Practical nursing education was transferred to vocational training sectors in most provinces during the 1950’s (Pringle et al., 2004). In 1957 for example, Ontario’s Department of Education sponsored a practical nursing stream in Grades 11 and 12 at some secondary schools, a practice that continued until 1990 (RPNAO, n.d.). It is apparent that practical nursing was viewed as a trade, and treated accordingly. Ontario’s Department of Health retained jurisdiction over practical nurses in the province. It lengthened the educational program from a 6 month to 10 month certificate program in 1953, with a corresponding rise in the admission requirement to successful completion of Grade 10 (RPNAO). This provided another opportunity for nurse leaders and government to consider the benefits of RN-LPN intraprofessional education, but there is no evidence that this was done.

During this same period, university nursing programs began adopting behavioural models of education. University nursing curriculum development was shifting from a national standardized approach to an individual school based approach. Faculty established curriculum committees and began developing nursing courses. Behavioural objectives, popular in general education at the time, were unquestioningly incorporated into many nursing programs (Bramadat & Chalmers, 1989). Although nursing faculty sat on the curriculum committees, it should be remembered that university schools of nursing were located under medical schools and nursing faculty did not yet have autonomy over curriculum content.

Behavioural models of education involve developing planned learning outcomes (behavioural objectives) for every learning activity. They are inflexible and are most
appropriate for skill training and instruction (Bevis, 1989). Congruent with empiricism, behavioural models of education complimented traditional approaches to nursing education because they promoted conformity and control. Learning was seen to take place only if there was a demonstrable change in behaviour (Bevis). Nursing education’s focus on behavioural outcomes constricted knowledge development (Duchscher, 2000). Might a behavioural approach to nursing education also have constricted RN leaders’ ability to envision non-traditional approaches to nursing education, namely undergraduate intraprofessional RN-LPN education?

*The Creation of Ontario’s College of Nurses: A Missed Opportunity to Consider*

*Undergraduate Intraprofessional RN-LPN Education*

Perhaps Ontario, more than any other province, has had the greatest opportunity to consider implementing undergraduate intraprofessional RN-LPN education. It created the College of Nurses of Ontario (CNO) in 1963, a statutory body whose mission is to regulate both RNs and LPNs, and protect the public’s interests where nursing practice is concerned (Government of Ontario, 2005). The introduction of the CNO ended RN jurisdiction over LPNs in the province. In keeping with the requirement that all nurses must be registered, the CNO changed the title of Ontario’s practical nurses from Certified Nursing Assistant to Registered Nursing Assistant shortly after its inception (Government of Ontario). The CNO considers nursing one profession with two categories of care providers (CNO, 2005a). This position has always provided a golden opportunity for Ontario’s nurses and provincial government to consider the possibilities for intraprofessional nursing education. However, there is no indication that this occurred in 1963 or at any point thereafter, to the present time.
1964: Report of the Federal Royal Commission on Health Services (Hall Commission)

In 1960, Helen Mussallem, PhD, RN, president of the CNA, was concerned enough about the state of RN education in Canada that she asked for a federal review of nursing education (Pringle et al., 2004; Ross-Kerr, 2003c). In 1962, in response to Mussallem, the concerns of other health care provider groups about their levels of education, and hospital requests for others to assume responsibility for some nursing education programs, the federal government formed the Royal Commission on Health Services (Pringle et al.). Known as the Hall Commission, it was charged with conducting a review of health profession education programs and the state of health care services.

This was a prime opportunity for government and nurse leaders to seriously consider the benefits of undergraduate RN-LPN education for nursing and the health care system. However, there is no indication that anyone did so. In fact, in its submission to the Hall Commission, the CNA recommended assimilation of practical nursing programs within RN programs and the elimination of practical nurse positions (Mussallem, as cited in Pringle et al., 2004). This was driven in part by RNs’ discourse of fear that LPNs could one day replace them. It is also reasonable to expect that LPNs were less likely to be considered professionals, and thus were a threat to RNs’ goal of professionalization. Hospitals had become dependent on practical nursing services however (Pringle et al.), and in its 1964 report, the Hall Commission disregarded the CNA recommendation.

The Hall Commission did support other RN leader recommendations, including a number of changes to university level nursing education (Pringle et al., 2004; Wood, 2003). Changes consisted of the autonomous administration of university schools of nursing, an immediate addition of ten more university schools of nursing to prepare nurses to adequately meet society’s health care needs, and abolition of non-integrated
basic university nursing degree programs (Wood). This latter recommendation was
significant given that in 1964, admissions were 22 percent higher in non-integrated
university programs (Ross-Kerr, 2003c). All of these recommendations were soon
realized.

_The Hall Commission Recommends Removing some RN Education from Hospital Control_

The Hall Commission also recommended that RN programs of fewer than three
years be independent of hospital control (Ross-Kerr, 2003b). Hospital administrators had
approached the federal and provincial governments, using economic discourses to request
that responsibility for some RN programs be transferred elsewhere (Kirkwood, 2005).
Hospital based RN schools were funded through a combination of hospitals’ operating
costs and student nurses’ clinical hours of service (Registered Nurses Association of
British Columbia, as cited in Ross-Kerr). By 1960, the massive national hospital building
program that Canada embarked upon in the 1950’s resulted in an 88% increase in hospital
beds and increased numbers of RNs were needed to meet the acute care needs of the
patients who primarily occupied those beds (Pringle et al., 2004). The costs associated
with hiring RNs could be offset to some degree by relying on the work of senior RN
students, who had sufficient training to meet acute patient needs (Kirkwood, 2005).
Junior RN students did not possess the skill or knowledge to care for such patients, thus
no longer provided hospitals with a cheap source of labour. As the 1960’s progressed, it
became apparent that the cost of educating RN students now exceeded the economic
return they provided through their labour. With the support of the Hall Commission
recommendations, hospitals succeeded in being removed from responsibility for nursing
programs of less than three years’ duration.
Transfers of such nursing programs were already underway in many provinces prior to the Hall Commission. In the early 1960’s for example, independent RN schools were established in Ontario. They were funded by groups such as the Ontario Hospital Services Commission and the Catholic Hospital Conference of Ontario, and administered by independent boards of directors (Ross-Kerr, 2003b). In 1964, Toronto’s Ryerson Polytechnical Institute (which later became Ryerson University) established Canada’s first public educational institution-based RN school. Provincial RN associations built upon the CNA’s efforts to draw federal attention to nursing education by lobbying for legislative changes in their respective provinces. Their combined efforts helped persuade provincial governments to transfer responsibility for most RN education programs to Ministries of Education or Training by 1967. However, some hospital based programs persisted in Canada into the mid 1990’s (Dick & Cragg, 2003). Locating nursing programs outside of hospitals provided RN leaders and government an opportunity to conceive of new ways to educate nurses. However, there is no evidence that intraprofessional education was considered.

*The Internship Model of RN Education*

Hospital based schools of nursing were now three year programs. Administrators found the apprenticeship model of RN education in hospital based schools of nursing was no longer cost effective and replaced it with the nurse internship model (Kirkwood, 2005). As with the apprenticeship model, concern for nursing knowledge was not central to hospital administrators’ decision making process. RN students were provided with more classroom instruction during their first two years of schooling, followed by a senior year clinical internship (Kirkwood). This approach prepared junior students to care for acute patients in their senior year, during which time hospitals benefited from their free labour.
Furthermore, newly hired graduate RNs required minimal orientation, especially if hired by the hospital were they “trained”.

1970’s: Nursing Education Shifts from a Biomedical and Behavioural Focus to Humanism and a Curriculum Informed by Nursing Theory

Realizing the Hall Commission recommendation of transferring responsibility for most RN education programs in Canada from hospitals to community colleges in the 1970’s significantly reduced physician and hospital administrator control over nursing education. Whether this was an anticipated or unexpected outcome is not known, but it did benefit nurses. In Canadian universities, wide spread adoption of the integrated model of nursing programs, also recommended by the Hall Commission, had a similar effect. For the first time, nurse educators could determine nursing education standards and curricula, and they began turning away from the biomedical perspective that had long dominated nursing.

Physicians had long taught nurses in accordance with the biomedical perspective they favour. Nurses learned to view the human body metaphorically as a machine with separate systems that can be isolated and treated independently of one another. They were taught that human behavior is predictable, and objective assessments are the only valid data (Monti & Tingen, 1999). Also in keeping with physician beliefs, nurses were taught that health care providers are the expert knowers of client care and must take charge of their client’s health and healing needs. The biomedical perspective and university nursing programs’ adoption of behavioural models of education were not consistent with nursing’s holistic view of the person (Bramadat & Chalmers, 1989).

Nurse educators wanted nursing curriculum to reflect a holistic approach to nursing care, and human science offered a framework for achieving this. Human science
recognizes and validates the esthetic, personal, and ethical knowledge inherent in nursing (Monti & Tingen, 1999). By the late 1970’s, a humanistic, existentialist perspective rooted in interpretivism, was gaining influence in nursing education (Bevis, 1993; Chan, 2002).

A number of social discourses contributed to the movement away from biomedicine and toward human science based nursing education. Canadians were beginning to realize the influence social determinants had on health (Duchscher, 2000). There was also growing public knowledge about the impact technological improvements and knowledge development had in altering the course of disease trajectories. Successful management of some disease processes was shifting acute diagnoses to chronic diagnoses, and technical skill alone was no longer sufficient to meet client needs. Nurses were increasingly being called upon to act as educators and facilitators, helping people understand their health and learn how to manage their care needs in ways that were meaningful to them (Bevis, 1989).

Nurse educators valued the process of learning, and found that a human science based curriculum nurtured this process and invited and supported nursing knowledge development (Bevis, 1993; Duchscher, 2000). They developed a humanistic nursing curriculum, grounded in human science. Humanistic nursing education nurtures the relational practice embedded in nurses’ work, acknowledges the uniqueness of every human being, and emphasizes the centrality of the client in health care. The client is considered the expert knower of self, who enters into an interactive relationship with the nurse to find ways of meeting his or her self identified health and healing needs (Paterson & Zderad, 1976). It is evident that the humanistic perspective seeks ways of sharing power with clients. It could also be viewed as embodying socially ascribed feminine
traits of consideration, awareness of others’ feelings, understanding, and kindness (Weiten & Lloyd, 1997). It is not surprising then, that nurses, a predominately female group, found human science reflected their understanding of nursing.

The ideology of professionalization and nurses’ continued quest to achieve professional status also influenced nursing curriculum in the 1970’s. Nursing theory development was a means of developing a distinct body of nursing knowledge, and many nurse researchers focused on expanding nursing theory (Bramadat & Chambers, 1989). Many schools of nursing chose a nursing theory and organized curriculum around it (Bramadat & Chambers).

How has the dominance of biomedical thinking both frustrated and rewarded nurses? What role do gendered understandings about knowledge development in our society play in valuing different ways of knowing? How has autonomy over curriculum helped empower RNs? What is the significance for nursing when practice is informed by knowledge derived from nursing theory? Reflecting upon these questions helps us as nurses to better understand some of the factors that have constrained and facilitated nursing education and practice.

It is also worthwhile thinking about the possibilities that human science can offer, with regard to undergraduate intraprofessional RN-LPN education. How might a humanistic perspective, applied to RN-LPN relations, help create mutual respect, trust and acknowledgement of one another’s nursing knowledge and scope of practice? What possibilities for intraprofessional education might be generated if RNs and LPNs applied a humanistic perspective in their consideration of one another?
Baccalaureate as Entry to RN Practice Position

RN leaders had not abandoned their collective, long held dream of a university level education as the minimum requirement for nursing practice. Attaining this goal would help establish RNs as nursing professionals. In 1979, RNs in Alberta became the first in Canada to endorse a baccalaureate degree as the minimum entry to practice for their province’s new graduates (Pringle et al., 2004; Ross-Kerr & MacPhail, 1996). In 1982, the CNA supported Alberta’s position and urged all provinces and territories to make it their goal by the year 2000 (CNA, 2005a). Nurses increasingly needed well developed critical thinking and life-long learning skills to keep pace with ongoing advances in health technology and nursing science. An expanded education provided the time and support needed to develop the skills that promoted competent nursing practice (Wood, 2003). It is reasonable to expect that the drive to achieve a baccalaureate degree as entry to RN practice took precedence over any consideration of undergraduate intraprofessional RN-LPN education that might have occurred during this time.

The National Nursing Competencies Project of 1995-1997, undertaken to help determine whether educational programs were preparing nursing students appropriately, supported RN leaders’ assertion that a baccalaureate nursing education should be the minimum entry to practice requirement for RNs (Purkis & Nelson, 2006). This position was eventually endorsed by heads of professional RN bodies in all sectors of health care and by all regulatory RN bodies in Canada (CNA, 2005a; Pringle et al., 2004). However, provincial governments, not regulatory bodies, have the authority to create the legislative changes necessary to enable regulatory nursing bodies to enforce entry to practice requirements. The central focus of regulatory bodies of nursing is to ensure the public is protected by requiring nurses to demonstrate competency in maintaining a set standard of
Dominant Discourses and Ideologies

Care (McIntyre & McDonald, 2006). Regulatory nursing bodies make recommendations to their respective provincial government concerning legislative changes affecting nursing. It is curious that although Ontario’s professional RN association, the RNAO, endorsed the baccalaureate as entry to practice position in the early 1980’s, the province’s regulatory body, the CNO, did not do so until December 1998 (Pringle et al.).

In 1988, Prince Edward Island became the first province in Canada to legislate baccalaureate education as the minimum entry to practice for RNs (Pringle et al., 2004). All of the Atlantic provinces passed comparable legislation in 1998, and Saskatchewan followed suit in 2000 (CNA, 2005a). This was a pivotal moment in Canadian nursing history. However, the CNA’s goal of accomplishing the same result in all Canadian provinces and territories by the year 2000 fell short. British Columbia and Ontario achieved baccalaureate entry to practice in 2005. Quebec, Manitoba, Alberta, the Yukon, Nunavut, and the Northwest Territories have yet to realize baccalaureate entry to practice (CNA).

Opposition and Apathy about the Baccalaureate as Entry to RN Practice Position

The political discourses of provincial nursing unions have largely opposed the baccalaureate policy. This is not surprising, given that a union’s primary focus is member remuneration and working conditions (McIntyre & McDonald, 2006). Unions feared the loss of diploma prepared jobs, the ability of diploma prepared nurses to access senior nursing positions, and general restrictions in their work (Rheaume, 2003). Economic discourses about the additional costs associated with educating university prepared nurses, the potential for increased wage demands among more highly educated nurses, and the political discourse of a potentially less compliant nursing workforce, were
raised by some provincial governments, other health professionals, and also by some nurses (Dick & Cragg, 2003).

The apathy of some provincial governments to require university education as the minimum entry to practice for RNs, despite active provincial nursing association lobbying to encourage them to do so, suggests the ideology of the born nurse persists in our society. The public does not perceive higher education as necessary to the effective function of front line nurses. For example, when the Government of Manitoba agreed to eliminate college diploma RN programs in the late 1990’s, only to reverse its position shortly thereafter under the rationale of needing to quickly graduate nurses to meet a growing shortage, there was no significant public outcry. RN education in Saskatchewan faced a prospect similar to Manitoba’s experience but the united lobbying efforts of university nurse educators and their students, and the Saskatchewan Registered Nurses Association, convinced Saskatchewan’s government not to revoke its support for baccalaureate entry to practice (Dick & Cragg, 2003).

How do dominant discourses and ideologies in Canadian society contribute to the public image of nursing and subsequently, expectations about the minimum level of education nurses require? How has the invisibility of much of the work nurses perform helped sustain these dominant discourses and ideologies?

**Impact of the Baccalaureate as Entry to RN Practice Position on LPN Education**

The RN baccalaureate as entry-to-practice position had a direct impact on LPN education in several provinces. In Ontario for example, it was determined that there were varying expectations and assumptions about LPN knowledge and responsibilities, and employers were not allowing LPNs to utilize their full scope of practice (Pringle et al., 2004). This led the CNO to recommend a two year diploma program for LPNs in Ontario
by January 1, 2005, the same date that baccalaureate as entry-to-practice would take effect for new graduate RNs in the province. The CNO also recommended that the LPN program be offered only in community colleges, thus closing Ontario’s three remaining high school programs (Pringle et al.). These recommendations were implemented.

Today, LPN programs in Alberta and the Maritime Provinces are also two year diploma programs. The Northwest Territories, British Columbia, Saskatchewan, Manitoba and Quebec offer certificate programs of less than two years’ duration. Newfoundland and the territories of Nunavut and the Yukon do not presently offer practical nursing programs. Practical nursing education in Quebec is provided by local boards of education under the auspices of the provincial Ministry of Education. Private, for-profit colleges in British Columbia and Quebec also offer practical nursing education programs (Pringle et al., 2004). The remainder of Canada’s practical nursing programs are provided through community colleges. Some LPN programs have formed consortia to offer practical nursing education. For example, northeastern Ontario’s Northern College, where I teach nursing, is part of a consortium of seven Ontario community colleges.

LPN leaders across Canada have long been aware of the discrepancies in LPN education and practice among the provinces and territories. Pringle et al. (2004) found evidence that one practical nursing school requiring the least amount of theory and clinical practice hours in Canada provided less than half of that required by schools with the greatest requirement of theory and practice hours. Since 1984, LPN leaders have sought to address such differences (Pringle et al.). Practical Nurse Canada, the national association of LPNs, is working toward the long held goal of achieving a national standardized education program with the intent to establish a standardized scope of
practice for LPNs across Canada (Practical Nurse Canada, 2007). As with RN leaders’ focus on achieving a baccalaureate degree as entry to RN practice, it is reasonable to expect that LPN leaders’ preoccupation with achieving a national standardized education program and scope of practice for practical nurses has taken precedence over any consideration of undergraduate intraprofessional RN-LPN education.

1970-1990: Opportunities to Consider Intraprofessional Nursing Education

Although RNs and LPNs may have been preoccupied with advancing their own nursing categories for most of the final quarter of the last century, the available literature on LPNs in Canada reveals that there were opportunities to consider intraprofessional RN-LPN education. In the 1970’s, practical nursing graduates were required to pass an RN developed and CNA controlled national LPN exam, which was based on competencies common to all Canadian practical nursing graduates (Pringle et al., 2004). Preparing the examination must have raised awareness among CNA leaders about the core knowledge, values, and beliefs that both nursing categories shared. There is no evidence that this was acknowledged. LPN leaders found the exam did not adequately test new graduates’ knowledge and sought permission from the United States’ National Council of State Boards of Nursing to use their national LPN exam. This spurred action within Canada to work toward a more standardized national LPN curriculum with the goal of graduating students across the country with the same core knowledge, which would be captured by the national exam (Pringle et al.). This provided another opportunity to consider the merits of intraprofessional education. Why did RN and LPN nurse leaders not acknowledge the common core material that students from both nursing categories studied? Why did this not stimulate consideration about some undergraduate intraprofessional RN-LPN courses?
Circumstances in Ontario in 1981 and 1993 provided additional opportunities to consider undergraduate intraprofessional RN-LPN education. In 1981, practical nurse leaders enlisted the support of the Ontario Hospital Association, the Ontario Nursing Homes Association, and the Ontario Association of Registered Nursing Assistants to lobby the province of Ontario for an expanded role in health care (RPNAO, n.d.). The province’s practical nurse leaders also called for an immediate review of practical nursing curriculum, arguing that practical nurses were poorly utilized and no effort was being made to develop their potential. This provided an opportunity for LPN leaders, the government, and the CNO, which regulates both RNs and LPNs in Ontario, to explore the possibilities of intraprofessional education.

In July 1981, the CNO removed medication administration from the practical nursing curriculum and added instruction in aseptic technique (RPNAO, n.d.). Practical nurses had not made any tangible progress in their goal of expanding their scope of practice. RN leaders and associations were not identified among those who supported the efforts of practical nurses to increase their scope of practice (RPNAO). In 1993, medication administration was reintroduced to the practical nursing curriculum in Ontario, and the program was lengthened to one and one half years (RPNAO). During that same year, legislative amendments gave practical nurses in the province the right to use the title “nurse” and their official title was changed from Registered Nursing Assistant to Registered Practical Nurse (Government of Ontario, 2005).

Who benefits by removing skills from practical nurses’ scope of practice and then reintroducing the same skills within a twelve year span? Who benefits when RNs and LPNs are seen as requiring separate regulatory and political organizations as opposed to being made members of one profession? What has been the legacy for nursing in
teaching RNs and LPNs separately curriculum that both must learn? These questions are worth exploring, as they provide a richer understanding of how nursing education has evolved in Canada, and some of the factors that have constrained envisioning the possibilities that undergraduate intraprofessional RN-LPN education could offer nurses and the clients we care for.

1990’s: Health Care Restructuring Affects Nursing Education

The 1990’s witnessed significant changes in Canada’s health care system. A global economic recession in the 1980’s resulted in reduced federal-provincial transfer payments at a time when exponential growth in health care technology added to the economic cost of health care. Economic discourses led provincial governments to implement a series of sweeping changes in an attempt to control growing budget deficits. Changes included hospital mergers and closures, and the introduction of regional health planning (Storch & Meilicke, 1999). Nurses, the largest health care provider group, were targeted as a means of controlling costs. Many senior nursing positions were eliminated. Significant numbers of front line nurses lost their jobs or were reduced to part time work, forcing them to find work outside of Canada or in other fields (Canadian Nursing Advisory Committee, CNAC, 2002). My own lived experience of receiving three pink slips and trying to find and keep steady nursing work in the 1990’s leads me to expect that most nurses’ and nurse leaders’ preoccupation with concern about the loss of nursing jobs during this stressful decade precluded all consideration of intraprofessional nursing education.

During the 1990’s, funding for RN education seats was decreased by 26% as part of governments’ cost saving measures (CNAC, 2002). A national average of 8,500 RNs graduated each year from 1990-1994 (Ryten, 2002). Beginning in 1995, there was a
sharp decline in the number of graduates, with 1995 witnessing the lowest number of RN graduates, at 7,203, since 1964. In 1964, 7,261 RNs graduated, a time during which Canada had a young demographic and a population of 19.5 million. The number of graduate RNs dropped to its lowest in 2000, at 4,599. By 2001 Canada’s population had reached 31 million and was aging; 5,449 RNs graduated that year. Only 79% of Canadian RNs who graduated between 1990 and 2000 were registered in Canada in 2001 (Ryten). These statistics attest in part to the reduction in nursing education seats in Canada during the 1990’s-early 2000’s. They also speak to the political and economic discourses of provincial governments and health care organizations during that time.

The paucity of research on LPNs does not provide specific information on LPN education or numbers of graduates, but data informs us the number of LPNs in Canada decreased noticeably, from 83,539 in 1983, to 66,100 in 1999 (Ryten, 2002).

Nurses spend considerable time performing emotional and relational work and information exchange work (e.g. relaying information to, from and between clients, physicians, families, managers, other health care providers, and one another). This complex work cannot be operationalized as a commodity, that is, it cannot be bought and sold in today’s product driven corporate healthcare world. Healthcare database collection systems do not capture the intangible yet essential work nurses perform, rendering it invisible (Liaschenko, 2002; Rodney & Varcoe, 2001). What is captured is an excess number of nurses for the amount of physical work performed. What happens when much of the work that nurses perform is invisible to the public, nursing employers, and government? How can nurses make this essential work visible?
It is paradoxical that RN education in Canada was transformed during the tumultuous period health care witnessed in the last decade of the 20th century. The economic recession of the 1980’s encouraged community colleges, hospital based schools of nursing, and universities to discuss how they might collaborate to deliver baccalaureate education, which had been endorsed by all provincial nursing associations. This was important because university schools of nursing had limited physical, financial and faculty resources to absorb increased numbers of nursing students if community colleges stopped offering nursing education programs. As well, the additional economic costs associated with leaving home to attend university could deter students from choosing to study nursing. In 1989, the Vancouver General Hospital School of Nursing and the University of British Columbia pioneered a collaborative partnership, with the hospital offering the four year baccalaureate nursing education program at its site (Ross-Kerr & MacPhail, 1996). Collaborative partnerships soon formed across Canada, but not all provinces embraced the approach. A discussion of New Brunswick, Ontario, and British Columbia capture those province’s experiences.

New Brunswick Forgoes University-College RN School Collaboration

New Brunswick’s provincial nursing association initially lobbied its provincial government to keep the baccalaureate program solely in universities and agreed to collaboration only after college faculty and nursing unions lobbied hard to keep nursing education in the colleges (Pringle et al., 2004). However, economic discourses led the Government of New Brunswick to close community college based nursing programs. The government determined it would save money by giving the province’s two universities control over RN education. In 1991, New Brunswick’s five college RN programs were
closed, 100 nursing school seats were cut, and the ratio of RNs to LPNs was reduced in 
the province as a further cost saving measure (Pringle et al). What has a reduction in the 
number of sites offering RN education meant for nursing in New Brunswick? What is 
the impact on rural communities when nursing education is only offered in larger centres? 

**Ontario Mandates Collaborative University-College RN School Partnerships**

Universities and colleges in Ontario seemed inclined against implementing 
collaborative university-college partnerships for baccalaureate nursing education 
(Pringle et al., 2004). A few university-college partnerships were created in the 1990’s, 
but the majority of the province’s deans and directors of university and college schools of 
nursing found the challenges of collaboration overwhelming (Pringle et al.).

In December 1998, the CNO, Ontario’s regulatory nursing body, finally supported 
a baccalaureate nursing degree as the minimum entry for RN practice, and it 
recommended that universities and colleges achieve this through collaboration (Pringle et 
al., 2004). A nursing task force study commissioned by the province to explore the 
factors contributing to Ontario’s nursing shortage and examine the current state of nurses’ 
working conditions, endorsed the CNO’s recommendations in its January 1999 report. 
That same year, the Ontario government passed legislation requiring a baccalaureate 
degree as entry to RN practice effective January 1, 2005 (Pringle et al). When it became 
clear that Ontario’s universities and colleges were not going to willingly collaborate, the 
provincial government mandated them to do so (Pringle et al.).

Relationships have not always been amicable between Ontario’s colleges and 
universities, given their “gunshot” weddings. Some university-college partnerships have 
“divorced”. Since universities confer the nursing degree, affected colleges have had to 
find another university partner, or close their nursing programs. To date, this latter
scenario has not occurred. In most consortiums, colleges provide the first two years of RN education, following which students transfer to the partner university for their last two years of study. Geographic distance sometimes plays a role in determining the form of a collaborative partnership. For example, the geographic distances between isolated communities in my part of rural northeastern Ontario led to the creation of a collaboration that enables both university and college members to offer the full four years at each of their sites. What does it mean for students to be able to receive part or all of their nursing education close to home? How do university-college power imbalances affect faculty autonomy in developing nursing curricula?

British Columbia’s Collaborative Experience and Applied RN Degrees

In their early initiatives, collaborative partners in British Columbia worked with their provincial government to create a grass-root, power-with approach. The University of Victoria for example, used egalitarian discourses to develop an empowerment model of collaborative partnership with colleges, enabling some colleges to offer the full four year baccalaureate program on site, while others offered the first two years of the program before their nursing students moved to the university for the final two years of study (Pringle et al., 2004).

The balance of power shifted in 2003, when the Government of British Columbia passed legislation that allowed some colleges to become university colleges, which are given the power to award applied nursing degrees. At the same time, the government reduced nursing education funding to colleges that did not have the authority to grant degrees (Pringle et al., 2004). This is surprising, given the current shortage of nurses and Canada’s aging nursing population. Why is the Government of British Columbia taking this course of action? What are the implications for nursing education in the province?
We have seen how hard RN leaders have fought, over decades, to bring RN education into universities. Why have some nurse leaders supported moving nursing education out of universities? Why is nursing education moving out of universities in British Columbia at a time when other health sciences programs in Canada are seeking to make a university degree their minimum entry to practice? Are nurses turning away from the ideology of professionalization? Is it coincidental that applied nursing degree programs are being introduced in community colleges on the heels of the closure of community based diploma RN programs in most provinces in Canada? It is too early to know what the significance of applied nursing degrees will be for nursing as a discipline and as a profession. Does the applied degree nurse represent a new nursing category in Canada? If new ways of educating undergraduate RNs can be created, what are the possibilities for envisioning undergraduate intraprofessional RN-LPN education? Critically reflecting upon these questions is unlikely to provide simple answers. Nevertheless the questions are important for all nurses to explore and debate.

LPNs Have Not Yet Gained Control over Their Education

The paucity of published literature on LPNs in Canada provides limited insight into the efforts this nursing category has taken to gain control over its education and retain a foothold in the healthcare system. The available literature informs us that LPN leaders’ hard work to ensure practical nursing’s survival and recognition as a legitimate nursing category resulted in some positive outcomes. In 1977, for example, New Brunswick became the first province to grant self-governing legislation to its provincial licensed practical nursing association. This was followed in 1980 by Prince Edward Island and Manitoba (Pringle et al., 2004).
Some practical nursing programs were moved to high schools and hospitals as early as 1957 (RPNAO, n.d.). During the 1970’s and 80’s provincial governments, with the exception of Quebec, transferred the majority of the programs to community colleges (Pringle et al., 2004). The transfers helped alleviate, but did not eliminate, RN control over LPN enrollment and curriculum. RNs were still hired to teach LPN programs (Pringle et al.).

Today, most schools of practical nursing require that faculty have at least an undergraduate RN degree to teach practical nursing (Pringle et al., 2004). I currently teach nursing in both the baccalaureate and practical nursing programs. All of the full time practical nurse educators I know are RNs, as are all nurse educators who teach theory. A few, like me, are former practical nurses. I know of a few clinical teachers who are currently practical nurses. Although regulatory LPN bodies set general curriculum requirements, faculty has a direct hand in developing curriculum. Thus, it is reasonable to expect that RNs continue to significantly influence LPN students’ knowledge development. There is no apparent research on the level of educational preparation LPN teachers should have (Pringle et al.). LPNs have been a part of Canada’s health care system for 70 years. Why has research on LPNs in general been neglected? What are the implications for practical nurses when their educators are primarily RNs? What would it mean for LPNS to have LPN educators? RNs have been the primary educators of LPN students, and these teachers must have commented on the similarities in RN and LPN education. What discourses, ideologies, and other factors have constrained their consideration of undergraduate intraprofessional RN-LPN education?
LPN heads of professional and regulatory LPN bodies from all provinces and territories actively participated in and endorsed the recommendations of the National Nursing Competencies Project (1995-1997) (Pringle et al., 2004). As with RNs, the project determined the entry level competencies LPNs required. New sets of skills were identified that had formerly been the domain of the RN scope of practice. To accommodate the new skill sets, curriculum needed to be developed and educational programs needed to be expanded (Pringle et al.). Again, given the turbulent times nurses experienced during the 1990’s, it is reasonable to expect there was unlikely any consideration of undergraduate intraprofessional RN-LPN education.

The New Millennium and Interprofessional Education

By 1999, federal and provincial Deputy Ministers of Health realized low nursing numbers were having a significant impact on the health of Canadians. They responded by creating the Advisory Committee on Health Human Resources (ACHHR). Its goal was to “achieve and maintain an adequate supply of nursing personnel who are appropriately educated, distributed and deployed to meet the health needs of Canadian residents” (ACHHR, 2000, p.2). In 2000, the ACHHR released *The National Nursing Strategy for Canada*, our country’s first nation wide nursing strategy. The strategies outlined concerning education focused on determining the kind of nursing resources required, increasing the number of nursing seats, and marketing nursing education to potential students. By 2003, the results of these political discourses and actions saw an increase in RN education seats of 42% and an increase in LPN education seats of 45% (Advisory Committee on Health Delivery and Human Resources 2003). In 2004, 7,983 RNs graduated in Canada, a 65% increase in the number of graduates since 1999 (CNA, 2006).
In 2001, the Government of Canada responded to social discourses that expressed concern about the sustainability of Canada’s publicly funded health care system. Roy Romanow, a lawyer and former premier of Saskatchewan was commissioned to complete a comprehensive report on the future of health care in our country (Romanow, 2002). Members of the commission traveled across Canada to hear opinions about health care’s past, present and future from a cross section of Canadian public and health professionals. Known as the Romanow Report and released in November 2002, the report noted the existing shortages of health professionals, most notably nurses, a rising demand for chronic disease management as increasing numbers of Canadians age, and the corresponding need for a shift from primary care to primary health care to meet the evolving health needs of Canadians (Romanow). One recommendation outlined in the Romanow Report was specific to health profession education. It advised reviewing and revising existing health care education and training programs, and developing interprofessional education programs. The rationale was that interprofessional education would produce health professionals who were better able to work collaboratively within the multidisciplinary teams required for effective delivery of primary health care (Romanow).

In 2003, based on the recommendations of a number of commissions on health care reform, including the Romanow Report, the Prime Minister, provincial premiers and territorial leaders formulated the First Ministers’ Accord on Health Care Renewal (Health Canada, 2005). Central to this latest set of Canadian health care reforms are interprofessional education and primary health care (Health Canada, n.d.; Oandasan & Reeves, 2005).
It is interesting that while the CNA has released a position paper in support of interprofessional collaboration (CNA, 2005), it has not done the same for interprofessional education. Dutcher et al. (2005) report a current paucity of evidence that IPE improves collaborate practice among health professionals. Oandasan et al. (2004) found evidence that collaborative initiatives were beneficial among graduate students; however they note a current lack of empirical evidence that IPE will improve client care outcomes. It is interesting that in an era where evidence based practice is the preferred means of guiding healthcare decisions, a general lack of evidence for the benefits of IPE has not affected how it is being embraced. The federal government of Canada has dedicated $90 million over five years for IPE initiatives (Department of Finance, Canada, 2003). Universities and colleges across the country are developing interprofessional courses, some of which are at the undergraduate level (Canadian Interprofessional Health Collaborative, n.d.). Why has IPE been so quickly and widely embraced by educational institutions across Canada? What methods of evaluation are being used to determine the effectiveness of IPE?

Reservations about Undergraduate Interprofessional Education

Undergraduate education introduces students to the philosophy of their discipline. A discipline’s philosophy provides the framework for exploring ontological and epistemological questions about phenomenon that are central to the discipline (Meleis, 1997). It identifies the focus and goal of practice, provides the values and beliefs that guide members in research, theory development and practice, and forms a perspective from which members view the world (Meleis, 1997; Salsberry, 1994).

Undergraduate nursing education marks the beginning of the journey toward shaping students’ nursing identity. The differences between nursing as a discipline and a
profession are made clear. The unique contributions that the ontological and epistemological views of biomedical and humanistic perspectives have provided nursing knowledge and practice are explained. Students begin to learn how, as Chan (2002) describes, “live between the biomedical and the human science approaches” (p.744). In my view, this is essential to ethical nursing practice. Undergraduate education is a crucial time in nurses’ education because the ontological and epistemological claims that are taught, and the value assigned to them, will have a significant impact on students’ construction of self as nurse and how nursing is understood.

Nurse leaders have made significant strides in gaining control over nursing education, but there are contradictions in how we define nursing as a discipline. Northrup et al. (2004) define nursing as a scholarly academic discipline and a practice profession, but note other nurses have defined it as a professional discipline or an applied discipline. They critiqued these contradictions and raised them for questioning. The discipline of nursing is also often confused with the profession of nursing, inviting an understanding that nursing is an occupation or vocation (Donaldson and Crowley, 1978; Northrup et al.). The lack of a common understanding within nursing of how we define our discipline restricts our ability to articulate to others, including nursing students, who we are, what makes us distinct, and why we require a particular level of educational preparation. This has particular significance for undergraduate nursing students in an IPE class setting. If nurse educators are unable to make clear what the discipline of nursing consists of, how can we expect nursing students to be able to understand the distinctions between nursing and other health care disciplines? Nursing students who do not have a firm reference point from which to compare and contrast the differences and similarities between nursing and other disciplines are more likely to be influenced by the perspectives
of other health care disciplines. Nursing students’ lack of a clear understanding of their discipline will prevent them from articulating nursing’s uniqueness, and this is unlikely to promote IPE classmates’ respect for nurses or their knowledge.

The biomedical perspective continues to dominate health care, and nursing history has shown that nurses’ voices are often silenced or diminished when educational decisions are made. Nursing theory and research are relatively young enterprises, and nursing knowledge is devalued because it is poorly understood. While I wholeheartedly support interprofessional education for nurses at the graduate level, my reservations cause me to be guarded about endorsing undergraduate IPE initiatives without careful consideration of the consequences for nursing education and client care. I find I have many questions. What are the discourses driving IPE and whose best interests are being served? Where is the evidence that this is a client centered approach? How are nurse educators involved in securing an active nursing voice among IPE stakeholders? What steps are being taken to ensure that IPE teaches all involved students to value equally the humanistic paradigm and ensure it is thoroughly incorporated into course content? What measures will be implemented to ensure that undergraduate nurses are adequately supported and taught how to navigate the space in-between the humanistic and biomedical perspectives?

Undergraduate Intraprofessional RN-LPN Education

Rationale

There has been a consistent link between undergraduate RN and LPN educational programs since the birth of the LPN, with LPN education significantly influenced by changes in RN education. Of all health care providers, RNs and LPNs most often work together, yet they are not well informed about one another’s education, roles, or scope of
practice (Besner et al., 2005; Pringle et al., 2004). Both nursing categories study from the same body of nursing knowledge and share a common philosophy of nursing, yet they are separated by RN and LPN program silos. Nursing faculty seldom share teaching responsibilities for both nursing categories, and there are no structured classroom or clinical opportunities for RN and LPN students to learn about one another. Clinical placement agencies may limit nurses’ scope of practice to suit organizational needs, further restricting nursing students from learning about the full scope of practice each is educated and authorized to perform.

It is taken for granted that nurses collaborate with one another on a daily basis. The terms collaboration and teamwork are often used interchangeably; however, collaboration is not synonymous with teamwork. Teams are mutually dependent and may or may not share knowledge or decision making. Team members generally work together to provide different aspects of a client’s care needs (Oandasan et al., 2006). Collaboration enhances teamwork but does not require individuals to physically come together to share work (although this may occur).

Collaboration can range from independent parallel practice with autonomous practitioners working side by side, to interdependent co-provision of care (Oandasan et al., 2006). Collaboration requires willing participation in a joint venture, effective communication, and shared decision making and planning in a non-hierarchal relationship based on knowledge and expertise, not roles and titles (Henneman, Lee, & Cohen, 1998). Decisions must be jointly owned by all health care providers and responsibility for the outcomes of those decisions must be jointly shared.

Mutual trust and respect for the work and perspectives each nursing category brings to the collaborative relationship is crucial. Trust implies our firm belief in the
reliability, veracity, honesty and justice of another (Sykes, 1976). Respect is a means of demonstrating to another that he or she matters just as much as you (Milton, 2005). How can RN and LPN students learn to respect and trust one another when they are isolated from one another? In the absence of mutual trust and respect, how can we expect effective collaboration to occur, and what is the significance of this for client care? What would it mean for nursing if nursing students were provided with structured educational opportunities to learn about one another?

It is surprising how little evidence there is that undergraduate intraprofessional RN-LPN education has been considered during health care reform in Canada. RN and LPN students currently study and practice in parallel but separate worlds, yet they both must learn how to navigate the “in-betweens” of the biomedical and human science perspectives. They perform the relational and cognitive work that has been so difficult for nurses to articulate and make visible. The result is that like society, RN and LPN students are unaware of the breadth and depth of nursing knowledge and cognitive skills each utilizes in the course of their work. The invisibility of this essential nurses’ work causes nursing students to define scope of practice in terms of the physical tasks that are performed (Besner et al., 2005; Oelke et al., 2008). The realization that there is considerable overlap in physical work among RNs and LPNs, results in role confusion and a devaluation of the professional self (Besner et al.). A perceived need to protect “turf” also arises, and results in poor professional relationships, initially in school, and later in the workplace.

Nurses’ moral self identities form as we negotiate with self and others, within the context of relational moments that occur within the social organizations we are part of (Doane, 2002). Nursing education provides the first formal opportunity for students to
begin defining and understanding self as nurse. I believe nursing education has a moral
responsibility to help RN and LPN students develop an ethically informed path of
understanding that acknowledges and respects one another’s knowledge, roles and scope
of practice. This can foster an egalitarian relationship that is empowering and
emancipatory for nurses, and promotes safe, competent and ethical care. I also believe
improved knowledge about one another helps us articulate who we are and thus raises
visibility of the relational, emotional, and cognitive work we perform.

Undergraduate Intraprofessional Nursing Curricula

New nursing students bring societal discourses of what nursing is, who nurses are,
and what nurses do, to their first year of studies. Intraprofessional core curriculum
courses would provide the framework and structure for RN and LPN students to engage
in interactive learning experiences. Intraprofessional course curricula should incorporate
ethical principles that demonstrate respect and equal valuation all participants. Students
would be invited to share their initial and evolving understandings of nursing in a safe,
nonjudgmental environment that welcomes, acknowledges, and respects diverse points of
view. Dialogue must be actively encouraged and students must be guided in learning
how to critically reflect on the learning taking place. Ethical client care, client safety,
nursing competence, the importance of ethical consideration and respect for one another,
and the significance of all of these to collaborative, client centered practice should be
stressed throughout all intraprofessional course work.

An intraprofessional nursing practice class in the first year of studies would
enable RN and LPN students to realize early on that they perform virtually the same
physical work. In subsequent years, intraprofessional nursing practice classes would
reinforce respect for one another’s clinical abilities. Shared RN-LPN clinical placements
would provide students the opportunity to practice developing collaborative practice skills, and witness and share ways of learning how to work in-between the differing values of the biomedical and humanistic paradigms. A study conducted by Varcoe et al. (2004) found that nurses identified their actions as ethical (or not) in relation to the actions of others present and involved in an experience. Shared clinical practice experiences would nurture RN and LPN students’ evolving moral identities and foster trust and respect for one another’s nursing knowledge and capabilities.

An intraprofessional course in the first year of studies could also introduce RN and LPN students to common subject matter. Nursing philosophy, nursing as a discipline, nursing as a profession, the biomedical and humanistic paradigms, the history and evolution of nursing, nursing regulation, and roles and scope of practice are some examples of course material common to both nursing categories. In subsequent years, as students’ nursing identity evolved, intraprofessional classes could be developed to build on initial learning. For example, topics such as ethical and legal issues in nursing, regulatory body practice guidelines, and empowering and disempowering practices in healthcare could be introduced.

Intraprofessional classes must provide a forum for nursing students to engage in dialogue about their clinical work. This would help them understand that the physical tasks nurses perform are not unique to nursing, as is evident in the client care provided by other regulated health care providers, unregulated workers, family members and friends. Cognitive skills such as the depth and breadth of critical thinking, decision making, and professional judgment distinguish nursing care from the care provided by others (CNO, 2006). Each nursing category would be required to have a clear understanding of the competencies that guide their practice. Competencies consist of the specific knowledge,
skills, judgment and personal attributes that enable a nurse to practice safely and ethically (CNA, 2003). RN and LPN students would come to understand that scope of practice is based on principles that guide decision making, and they would learn how to recognize, appreciate, and respect one another’s unique contribution to health care.

Ontario as an Example

It would not take a great deal of effort to implement undergraduate intraprofessional RN-LPN education, and I offer my home province of Ontario as an example to prove this point. RNs and LPNs in Ontario share the same regulatory body, the CNO, which ensures nurses comply with the province’s Nursing Act and Regulated Health Professions Act (RHPA) (CNO, 2005a). RNs and LPNs have the same legislated scope of practice statement, which does not give nurses exclusive rights to perform the activities it outlines. Rather, it acknowledges there is some overlap with the scope of practice of other health professions (CNO, 2005b). The CNO developed one set of practice standards and guidelines that both nursing categories share, and has separate entry to practice competencies for each nursing category, reflective of their different foundational knowledge bases.

In Ontario, undergraduate RN education is a four year baccalaureate university degree. RNs study at a deeper and broader level, for two years longer than LPNs. LPNs complete a two year community college diploma program. LPNs in Ontario have the foundational knowledge to provide autonomous care for clients with less complex care needs, predictable responses and outcomes, and who are at lower risk for negative outcomes (CNO, 2005c). As the client’s care needs become more complex, less predictable, and at higher risk for negative outcomes, the LPN must increasingly consult and collaborate with the RN, whose foundational knowledge prepares him or her to meet
more complex overall care needs. The RN and LPN may determine that the LPN is able to meet some of the more increasingly complex client’s care needs provided they consult and collaborate closely. This acknowledges that with continued experience, LPNs, like RNs, can become experts in an area of practice within their own category. This does not necessarily mean that LPNs can gain foundational knowledge equivalent to the RN through experience. That depth and breadth of knowledge can only be obtained through formal RN education (CNO). Clients whose care needs are highly complex, unpredictable, and at high risk for negative outcomes require a competent RN to provide nursing care (refer to Appendix A).

Ontario’s RHPA outlines controlled acts that can be harmful if performed by an unqualified person (CNO, 2005b). RNs and LPNs are authorized to perform the same three out of thirteen controlled acts. Additionally, Ontario’s Nursing Act contains regulations that allow RNs and LPNs to initiate specified procedures outlined in the three controlled acts. Initiation means that the RN or LPN may decide that a specific procedure is required and carry it out independent of a physician’s or nurse practitioner’s order (CNO, 2006). Legislation allows RNs to initiate a greater number of procedures (refer to Appendix B).

Both nursing categories are autonomous practitioners, meaning they are independently able to carry out the responsibilities of their nursing category without close supervision (CNO, 2005c). The CNO does not maintain skills lists for RNs and LPNs because they have the same authority in legislation to perform controlled acts. However, having the authority and technical expertise to perform a procedure does not mean a nurse is competent to perform the procedure (CNO, 2005d). Cognitive ability in combination with an assessment of client status, environmental supports (e.g. polices,
procedures, equipment) and human resources supports (e.g. number and type of providers, and level of expertise) are essential to safe, ethical, and competent client care (CNO, 2005d). All nurses are expected to have sufficient education, knowledge, skill, and judgment to safely carry out the competencies identified by the CNO and recognize when their limitations preclude them from working to their full legislated scope of practice. Every nurse is accountable for his or her own actions and responsible for determining and acquiring the educational upgrading needed to maintain safe and competent practice (CNO, 2005c).

LPNs in Ontario attend the same community colleges that have partnered with universities to offer baccalaureate RN programs. LPN and RN programs are often located in the same building and utilize the same classrooms and clinical laboratory spaces. Undergraduate intraprofessional RN-LPN courses would require few if any capital expenditures in most cases. There would be costs associated with continuing education for nurse educators, a probable need to hire additional nurse educators to meet the needs of larger class sizes, and possibly additional support staff.

What Will Make it Happen

Action is needed at multiple levels and across different nursing and government sectors if undergraduate intraprofessional nursing education is to be given serious attention. Pringle et al. (2004) note the need for greater communication among nurse leaders from different nursing programs and recommend establishing a nursing council comprised of the different nursing categories. The linkages and foundational relationships created through such a council could serve as a useful starting point for national discussions about undergraduate intraprofessional nursing education. RN and
LPN nurse leaders need to be encouraged to envision the possibilities that undergraduate intraprofessional RN-LPN education can provide nursing.

Federal/provincial funding will be required to pay for nurse educator professional development concerning the regulatory colleges, pieces of legislation, roles and responsibilities, and professional associations of both nursing categories. Funding will also be required for undergraduate intraprofessional nursing education curriculum development, and additional human resources (nurse educators and support staff) to adequately meet the needs of intraprofessional nursing students.

A national standard for undergraduate intraprofessional RN-LPN education is needed. Canadian nurses must have confidence that their education is recognized and respected, and can be utilized wherever they work in our country. This is particularly important in the current era of significant nursing shortages. A national education standard for LPNs and RNs is a prerequisite to this. A two year diploma program should be the basic entry to practice level for Canadian LPNs. The baccalaureate as entry to practice should be a requirement for RNs across Canada.

RN and LPN program silos must be dismantled. Ways of achieving this include having nursing faculty become familiar with the educational requirements and scope of practice of both nursing categories, requiring nursing faculty to teach in both programs, and holding regular meetings that address concerns in both programs. Nurse educators need to determine how intraprofessional RN-LPN education can best be integrated into current curricula. Given the current attention to IPE, this should not be a difficult exercise.

We need to reach a common understanding about the discipline and profession of nursing that embraces and honours all nursing categories. Are we a scholarly academic
discipline and a practice profession, an applied discipline or a professional discipline? What is the significance for nursing in each of these understandings? Does nursing comprise separate disciplinary and professional categories or is it inclusive of all nurses, regardless of level of education and scope of practice? It is imperative that we reach a consensus on these matters. We cannot hope to articulate nursing’s distinct uniqueness to others until we are able to articulate it to ourselves with confidence.

Nurse leaders, educators, managers, and front line nursing staff must act as role models who “walk the talk” on a daily basis. Ideally, living good collaborative practice extends to everyone involved in helping clients meet their health needs. A positive, supportive culture in both the clinical and classroom setting is crucial. Students must be able to see nurses and others demonstrate all that collaborative practice entails, including ethical treatment, and equal valuation, mutual respect, and trust for one another.

Nurse educators must help students interpret and understand the context of the working relationships they witness and are part of, in both the classroom and the clinical setting. Nurse educators must also support and nurture nursing students’ evolving identity of self as nurse and guide them as they learn how to work the in-between space of the humanistic and biomedical perspectives. IPE curriculum must employ humanistic approaches that embody ethical practices including encouraging active student participation, nurturing participatory decision making, and emphasizing process oriented learning. Nursing students also need to understand the strengths and limitations of biomedical understandings in order to effectively work in the in-between spaces of the humanistic and biomedical perspectives.

In their research study on decision making by RNs and LPNs Boblin et al. (2006) found that both nursing categories reported utilizing assessment and problem
identification frequently. Less frequently reported were decision making components. Boblin et al. recommend making the decision making process more explicit for students. RN and LPN students need a safe, nonjudgmental environment in which to explore their similarities and differences, discover how their histories are intertwined, voice their misunderstandings about one another’s roles and responsibilities, and imagine the possibilities effective collaborative practice can provide them and their clients.

Finally, once established, research will need to be conducted on a broad range of areas specific to undergraduate intraprofessional RN-LPN education. At the same time, continued research on RN education is needed. Research on LPN education is urgently required.

Concluding Thoughts

Undergraduate RN and LPN education in Canada has been shaped by political, economic, and social discourses that have flowed from our paternalistic society’s notions about women’s place, work, and knowledge. Nurses have always risen to the challenges this has presented by seeking opportunities to advance nursing education in a manner that promotes the best interests of our clients, allows us to remain true to our codes of ethics, and nurtures our growth as a discipline.

Nurse leaders have shown vision, perseverance, vigilance, and resiliency in moving nursing education forward. Never have these attributes been more essential than they are today. Despite a paucity of research to prove its effectiveness, IPE is currently the centerpiece of health human resources education reform in Canada. We cannot predict what impact IPE will have on the disciplinary knowledge of undergraduate participants. However, nursing history informs us that nurses’ voices are not well heard when decisions about nursing education are made. The virtual absence of LPN voices at
IPE decision tables (Pringle, 2005) indicates that nurses’ voices continue to be fragmented. The lack of clear endorsement by the CAN for IPE is, in my view, an indication that nurses’ voices continue to be diminished and silenced.

Nursing education must continue as it always has, to respond to evolving societal notions about nurses and the work we perform. What do nurses envision for the future of nursing, and how will nursing education help us realize our goals? How will we respond to the evolving demands of the healthcare system in a manner that enables us to continue to expand our unique disciplinary knowledge? What possibilities for nursing would arise if we defined nursing as one inclusive discipline, and one inclusive profession with different levels of practice? What impact would this have on nursing’s public image, the visibility of our relational and ethical practice, and nurses and others’ understanding of nursing’s unique contribution to health care? I believe that undergraduate intraprofessional RN-LPN education offers us new possibilities for thinking, being, and doing in nursing, and I invite readers to envision the possibilities.
References


College of Nurses of Ontario (2005c). *Utilization of RNs and RPNs*. Toronto ON: Author.


Appendix A
RN and LPN Autonomy and Consultation/Collaboration
Influencing Factors

<table>
<thead>
<tr>
<th>LPNs and RNs can independently care for clients defined as low risk with little or no consultation.</th>
<th>LPNs and RN collaborate at varying degrees in the care of clients in the medium-risk category.</th>
<th>RNs care independently and LPNs may be involved in limited aspects of care provided to clients in the high-risk category.</th>
</tr>
</thead>
</table>

**Client Factors**

<table>
<thead>
<tr>
<th>Predictable</th>
<th>Moderately predictable</th>
<th>Unpredictable</th>
</tr>
</thead>
</table>
| • Outcomes and changes | • Health conditions may not be controlled or managed  
• A number of identifiable changes could occur  
• Timing may not be predictable | • Outcomes and changes |

<table>
<thead>
<tr>
<th>Less complex</th>
<th>Moderately complex</th>
<th>More Complex</th>
</tr>
</thead>
</table>
| • Care needs well defined  
• Coping mechanisms and support systems in place  
• Health condition well controlled  
• Little fluctuation over time  
• Individual, family or group | • Readily identifiable or established care needs which may/may not be related  
• Full range of coping mechanisms may/may not be in place | • Care needs not well defined/established or changing  
• Coping mechanisms and supports unknown, not functioning or not in place  
• Health condition not well controlled or managed  
• Requires close, frequent monitoring and reassessment  
• Fluctuating condition  
• Communities and populations |
<table>
<thead>
<tr>
<th>LPNs and RNs can independently care for clients defined as low risk with little or no consultation.</th>
<th>LPNs and RN collaborate at varying degrees in the care of clients in the medium-risk category.</th>
<th>RNs care independently and LPNs may be involved in limited aspects of care provided to clients in the high-risk category.</th>
</tr>
</thead>
</table>

**Client Factors**

<table>
<thead>
<tr>
<th>Low risk of negative outcome in response to care</th>
<th>Moderate risk of negative outcomes</th>
<th>High risk of negative outcome in response to care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Localized and manageable responses&lt;br&gt;• Obvious signs and symptoms</td>
<td>• A number of identifiable negative outcomes are possible&lt;br&gt;• Outcomes have a systemic effect creating an urgent or emergent situation</td>
<td>• Unpredictable, systemic or wide-ranging responses&lt;br&gt;• Signs and symptoms subtle and difficult to detect&lt;br&gt;• Effect may be immediate, systemic and/or create an urgent or emergent situation</td>
</tr>
</tbody>
</table>

**Environment**

<table>
<thead>
<tr>
<th>Many practice supports</th>
<th>Some practice supports</th>
<th>Few practice supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clear and identified supports (e.g., policies, plans of care assessment tools)&lt;br&gt;• High proportion of expert nurses&lt;br&gt;• High proportion of nurses familiar with environment</td>
<td>• Have policies, parameters, plans of care that may be individualized to meet client care needs&lt;br&gt;• Some independent decision making required</td>
<td>• Unclear or no policies, plans of care, or assessment tools&lt;br&gt;• Low proportion of expert nurses or high proportion of novices&lt;br&gt;• Low proportion of nurses familiar with the environment</td>
</tr>
<tr>
<td><strong>LPNs and RNs can independently care for clients defined as low risk with little or no consultation.</strong></td>
<td><strong>LPNs and RN collaborate at varying degrees in the care of clients in the medium-risk category.</strong></td>
<td><strong>RNs care independently and LPNs may be involved in limited aspects of care provided to clients in the high-risk category.</strong></td>
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</tbody>
</table>

## Environment

<table>
<thead>
<tr>
<th>Many consultative resources</th>
<th>Some consultative resources</th>
<th>Few consultative resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stable and predictable environment</strong></td>
<td><strong>Moderately stable and predictable environment</strong></td>
<td><strong>Unstable and unpredictable environment</strong></td>
</tr>
</tbody>
</table>
| - Low rate of client turnover | - Turnover of clients  
- Considerable variation of overall client care needs | - The number and types of clients requiring urgent care are not consistently predictable  
- It is difficult to identify an overall consistent level of client care requirements  
- Wide variety of care needs within a group  
- High rate of client turnover  
- Many unpredictable events |
| - Few unpredictable events |

Available from [http://www.cno.org/prac/work_together.htm](http://www.cno.org/prac/work_together.htm)
Appendix B

Procedures That May be Initiated by Nurses According to the Nursing Act

<table>
<thead>
<tr>
<th>An LPN may initiate, but cannot order another nurse to perform</th>
<th>An RN may initiate and/or provide an order for an RN or LPN to perform</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care of a wound below the dermis or below a mucous membrane:</td>
<td>Care of a wound below the dermis or below a mucous membrane:</td>
</tr>
<tr>
<td>■ cleansing</td>
<td>■ cleansing</td>
</tr>
<tr>
<td>■ soaking</td>
<td>■ soaking</td>
</tr>
<tr>
<td>■ dressing</td>
<td>■ irrigating</td>
</tr>
<tr>
<td></td>
<td>■ probing</td>
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<tr>
<td></td>
<td>■ debriding</td>
</tr>
<tr>
<td></td>
<td>■ packing</td>
</tr>
<tr>
<td></td>
<td>■ dressing</td>
</tr>
</tbody>
</table>

Venipuncture to:
- establish peripheral venous access and maintain patency when client requires medical attention and delaying venipuncture is likely to be harmful
- 0.9% NaCl only

For the purpose of assisting client with health management activities that require putting an instrument beyond the:
- point in the nasal passages where they normally narrow
- larynx
- opening of the urethra

For the purpose of assisting client with health management activities that involve putting an instrument beyond the:
- point in the nasal passages where they normally narrow
- larynx
- opening of the urethra

For the purpose of:
- assisting client with health management activities

For the purpose of:
- assessing client
- assisting client with health management activities
<table>
<thead>
<tr>
<th>Procedure that requires putting a hand or finger beyond the:</th>
<th>Procedure that requires putting an instrument, hand or finger beyond the:</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ labia majora</td>
<td>■ labia majora</td>
</tr>
</tbody>
</table>

For the purpose of:

■ assessing client
■ assisting client with health management activities

Procedure that requires putting an instrument or finger beyond:

■ the anal verge

For the purpose of:

■ assessing client
■ assisting client with health management activities

Procedure that requires putting an instrument or finger beyond:

■ the anal verge
■ an artificial opening into client’s body

Procedures that involve putting an instrument or finger into one of the body openings or into an artificial opening of the body for the purpose of treating a health problem cannot be initiated by a General Class RN or LPN. Authorized procedures are also limited to those procedures that do not require the use of a prescribed drug, as nurses in the General Class are not authorized to prescribe drugs.

Toronto ON: Author.