It's All a Matter of Degree: An Analysis of the BN:2000 Policy

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It's All a Matter of Degree: An Analysis of the BN:2000 Policy

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ABSTRACT

The Registered Nurses' Association of B.C. published its position statement in June of 1982 regarding future entry to practice requirements. Beginning in the year 2000 nurses entering the practice of nursing must have a baccalaureate degree in nursing. Those already working as nurses will be "grandfathered" in that they will not be required to upgrade their education to the baccalaureate level. However, they will experience impacts in the employment field due to increased job competition. Because this policy represents a dramatic and powerful change in the education of nurses, and eventually in the whole of health care in this province, the policy must be clearly and closely examined.

This study undertook an analysis of this policy. As a conceptual framework for the formulation and adoption five phases were identified. The second phase, which involves "rationales", provided the focus of the study. Andrew Dolan, of the University of Washington, discusses a similar policy formalized by the New York State Nurses' Association. He contends that the authors of such a policy must accept the onus of demonstrating that this kind of change will be an improvement and that it will be cost effective. Thus, a justification for a major

policy change such as the BN:2000 policy must be valid. Acceptable arguments are essential to the process. Therefore, the rationales for a specific policy must be measured and judged adequate according to set criteria. This is the topic of the third and fourth chapter of the study. The analysis of the document exposes an entirely unsubstantiated rationale.

The study first examines the history of nursing. One key theme emerging from this highlights the notion that different educations are related to different roles in the work place. Florence Nightingale, over one hundred years ago, was of the opinion that there should be two portals of entry to practice nursing. The one would be a broader and more complex education for the "lady" nurses, ie., teachers and administrators. The other type of education would be suitable for the general duty nurses; those who are the primary care-givers.

Other results of the study note an implicit overarching assumption in the BN:2000 that there is a deficit in the present education programs in nursing. Professional status appears to be an unstated value and the route to attaining that standing is the requisite of university preparation. The publication does not address the reality that public service is accountable to the community. The upshot of the study is alternatives to the baccalaureate position such as increased opportunity

for specialization or mandated education. Finally, the conclusion of the study is that, rather than providing acceptable arguments favouring the adoption and implementation of BN:2000, the position statement is an assertion only.

ACKNOWLEDGEMENTS

**This effort is dedicated to
my two treasures, Heather and Julia.
Each time I consider their lovely little faces
lost in sleep,
I find the determination to continue.**

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Chapter One
Introduction

Etzioni, in his book on the semi-professions, claims that nurses are placed on a continuum between semi-profession and profession and that it may be evolving along that continuum to the final status of full-fledged profession.[1] Given that all professions serve, nursing, as a semi-profession, provides public service to the community. As such, it carries responsibility for accountability to the public it serves. Appropriate education, licensure to practice, and cost-effectiveness provide the elements of that accountability. During the last decade the proposal for what constitutes an appropriate education for nurses has taken a new and radically different course. Each of the provinces' professional nursing associations has adopted policies requiring a baccalaureate education in nursing for entry to practice by the turn of the century. Previously, graduates from two year diploma programs sat the same registration examinations as the university graduates and thus qualified for employment as a nurse.

But continuing dialogue still ensues around what exactly constitutes an appropriate education for student nurses.

BN:2000 Policy Statement

In 1982 the Canadian Nurses' Association approved as policy the statement that "by the year 2000 the minimal

education requirement for entry into the practice of nursing should be the successful completion of a baccalaureate degree in nursing"[2]

The Registered Nurses' Association of British Columbia (RNABC) then published a similar position statement in June of that year. They expanded it with this:

> This position is a plan for the future. RNABC will continue to recognize the knowledge, skills, and experience of diploma nurses who are registered before 2000 and who meet the current practice standards. Registered nurses who have gained the experience and maintained the skills necessary to provide safe, competent nursing care will continue to be valued members of the profession.
>
> The Association recognizes that this major change can be achieved only with the cooperation of all those who will be affected and is committed to working towards the goal in collaboration with others.[3] (Hereafter I will refer to this policy as "BN:2000".)

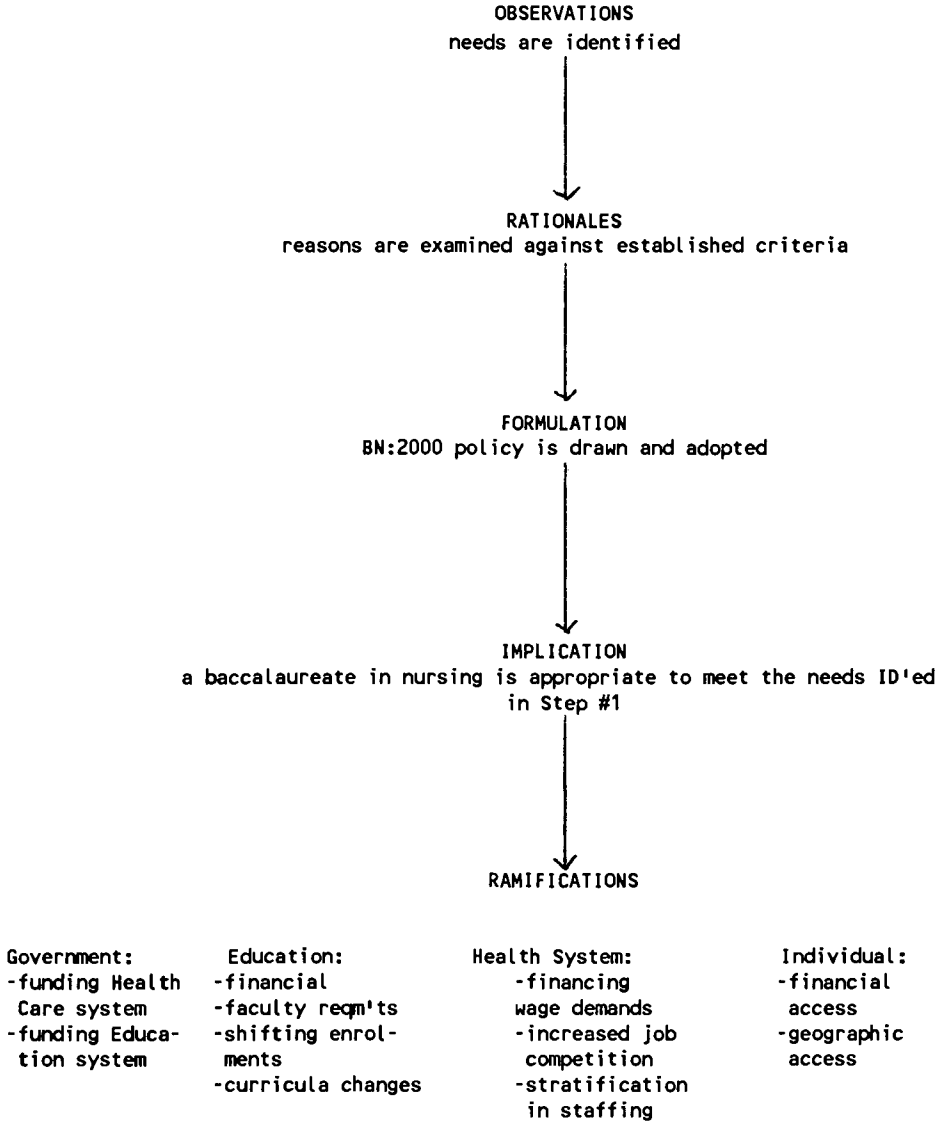
A fundamental concern that does not seem to have been addressed is, "Will this BN:2000 policy benefit our community? If so, how will it? And, finally, <u>is</u> it a necessary or even desirable goal?"

The implementation of the policy raises various issues worth consideration. Figure I is a flow chart of the five phases involved in policy development and adoption. Chapter 3 outlines the five steps identified in policy formation which have been developed by the author. All five phases are considered briefly, although the focus of this study is <u>only</u> the second stage, Rationales. The five phases are:

1)Observations: needs are identified,
2)Rationales: justification of the observations is

established in accordance with set criteria for acceptability,
3) Formulation: the policy is drafted and adopted,
4) Implications: the implementation of the policy will appropriately answer to the needs identified in step #1,
5) Ramifications: the various results of putting the policy into effect are realized . Figure I highlights the ramifications of BN:2000.

Figure I: The five steps of policy formation, adoption and implementation with reference to BN:2000.



The most obvious concern at the onset is financial: the government funding must shift from colleges to universities, and the Ministry of Health will eventually be faced with demands for enhanced budgets to meet greater wage demands as recognition of the degree status of registered nurses. Educational institutes will have to allocate more money to wages as the Faculty of Nursing grows in size to accommodate larger enrolment, while also meeting the expenses of enlarging graduate and doctoral programs in nursing in order to address the need for upgrading the education of faculty to university standards.

Secondarily, within the health delivery system, there will be the demands for better wages perceived to be commensurate with baccalaureate education, job competition will be exacerbated due to shifting balance in the educational preparation of the work force in nursing, and there will eventually be a social stratification in the nurse-patient relationship.

Finally, for the potential student the impact of the policy means possible difficulties with both financial and geographical accessibility to the program. Whereas an applicant may be able to afford the expenses of a two year college program, four years of university education may be out of the question. Relocating to a major urban locale might be unacceptable for any number of reasons. Probable

reduction in applications to schools of nursing will serve to augment the shortage of nurses that has dogged the workforce in B.C. for the past five years. Given the import of these ramifications, we must be certain that the policy rests on solid ground. These ramifications are considered further in Chapter 5.

Objective of the Study

My thesis analyzes this dramatic change in education requisite. Since, as Mann phrased it, "Policy is decision-making etched in stone"[4] and no analysis has yet been published, this topic is worthy of thoughtful consideration.

I have identified five phases implicit in the formulation of the BN:2000. These are: 1) Observations, 2) Rationales, 3) Formulation, 4)Implications and 5) Ramifications. When Mann writes of the nature of policy decision in education, he describes it as public, consequential, complex, uncertain, and dominated by competing legitimate interests.[5] Because of the character of policy making and the fact that the rationales should be thoroughly considered and weighed, an examination of the arguments for the BN:2000 is the thrust of my paper. I outline the published rationales for the policy. Subsequently, I describe the criteria for evaluating these rationales. "Any particular set of facts will be

consistent with a variety of theories and hypotheses" explains Majone.[6] "Since the official methodology provides no objective criterion for choosing under these circumstances, analysts cannot be blamed for selecting the explanation that fits their opinions or expectations. The fault lies in leaving those criteria unexamined."[7] Therefore, a clear and thoughtful consideration of the facts and criteria for accepting those facts offered in support of BN:2000 is mandated. I hold these arguments for the BN:2000 policy against the yardstick of the specific standards and, finally, offer a summary judgement of the rationales.

Outline of the Paper

Chapter two provides the context for the problem by outlining, briefly, the history of education in nursing. In a very general sense, there must have been care-givers, or nurses, originating at the very inception of humankind if only to guarantee survival of the species. Nursing evolved through various functions, status, and philosophies and the education in the discipline necessarily mirrored the nature of the times and cultures. Understandings of illness, the sciences, and women's place in society affected the organization and content of nursing education. Starting with a brief discussion of nursing in the ancient cultures, my brief progresses through changes in Europe,

then Canada. Finally, I delineate nursing education in British Columbia from the first school, established in 1899 to the present. There is a limited outline of nursing education currently available in B.C. Refer to Table II for a summary of the names of institutes having schools of nursing, their locations, and the type of program available at each school.

Criteria for rationales provides the topic for chapter three. The assumptions accepted in choice of rationales must be warranted and valid. Data must be correctly identified, selected, interpreted, and adequate. Also mandatory is the use of justified data appropriately as evidence for the argument. And, finally any evaluation would be remiss without clear headed examination of values implicitly and explicitly enmeshed in the rationales.

Subsequent to these explanations, Chapter four is an examination of the BN:2000 policies rationales against the established criteria for justification.

Chapter five considers the policy as a whole, and the possible alternatives to the solution of the problem identified. The terminal chapter is a conclusion regarding the validity of the rationales for the BN:2000 and suggestions regarding it.

Limitations of the study are due to the author's two fundamental understandings. My premise is that the vast majority of working nurses in this province belong to the

"semi-profession" category and as such must have a supra-ordinate value and goal of quality service. Additionally, education must be not only be sufficient but also appropriate for eventual employment roles.

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Chapter Two

A History of Education in Nursing

To set the discussion of the BN:2000 policy statement in its present context, the discussion turns to the evolution in nursing and education in nursing through history.

Nurses have existed and functioned in various capacities since the dawn of humankind. Innis suggests that "In a sense nursing is one of the oldest and fundamental of social activities".[1] The evolution of nurses' status in society, their practices, and their theories is inextricably intertwined with that of cultures, the place of women in those various cultures, and the gradual acquisition of scientific knowledge. It is impossible to discuss the progress of education in nursing without mentioning historical events, social change, and the advancement of medicine. Table II outlines various eras in history and concurrent development in nursing.

Table I: Highlights in the History of Nursing

Era	Development
Primitive Society	-ability to communicate and desire to thrive supported teaching and learning supportive habits and behaviours in some fundamental form
Babylonian	-marketplace consultations -therapeutic use of charms -use of vegetable and mineral mixtures -concern with appropriate hygienic and nutritional practices -bandaging wounds -massage therapy
Greek	-hospital-spas -home nursing of family members by women
Egypt	-established a school of midwifery -care of family in private homes by women -probably built the first hospitals
China	-nursing care done in private homes by women for family
Rome	-built hospitals throughout the empire, including Europe -sick and wounded soldiers were billeted in private homes
Early Christians	-only widows or virgins were permitted to work as nurses outside the home -Empress Helena built a hospital in Jerusalem -hospitals became institutions of care for travellers, beggars, and homeless

	-other citizens were nursed by married women in their own homes
700-900 A.D. Moslems	-built hospitals throughout the Empire
1100s Knights of St. John	-functioned as warrior-nurses with the military attitude of unquestioning obedience to rank and authority
Middle Ages in Europe	-three kinds of physicians: a)physicians, b)barber-surgeons, and c)surgeons -secular nurses began to assume more of the work of nursing but still under the aegis of churches -more options for women's employment outside the home
Reformation	-end of male nurses, essentially -the only "career" options for women aside from marriage was as a domestic or a nurse
1600s Canada	-three Augustinian nuns arrived from France to work as nurses -Jeanne Mance built the first hospital, Hotel Dieu, in Montreal (1644)
1700s	-first textbook for nursing was published in Vienna -a maternity hospital was built in England for education of both doctors and nurse-mid-wives (1739)
1859	-Florence Nightingale established the first school of nursing, not sponsored by a church, at St. Thomas's in London
1874	-the first school of nursing, in Canada, The Mack Training School, was organized in St.Catharine's, Ontario

1899	-the first school of nursing in B.C. founded at Vancouver General Hospital, Vancouver
1916	-the Graduate Nurses' Association of B.C. (later the RNABC) formed a Training School Committee to monitor and approve schools of nursing
1919	-the first baccalaureate program in the Commonwealth was initiated at UBC
1921	-student nurses sat the first standardized registration examinations
1950	-the beginning of the move away from the dominant "apprenticeship" model -schools began to reserve instructional "blocks", although the content was not yet co-related to the clinical practice
1967	-B.C. Institute of Technology offered the first college diploma program in nursing
1990	-there are ten colleges, throughout the province offering diploma programs -two universities offer articulation baccalaureates -one university offers a generic four year degree program -that same university offers a Masters degree in nursing

Greeks, Romans and Other Countrymen

Because primitive societies had the ability to communicate, think and remember, and the desire to survive and propagate, some individuals must have existed who cared for others physical well-being and taught, at least by

example.[2] Although no specific evidence of nursing is available, per se, between 5000 B.C. and A.D. 476, we can assume, from artifacts, that concern also existed regarding scientific medicine (despite a belief in the supernatural), education, and sanitation.[3]

According to Herodotus, a Greek historian, the ill in Babylon travelled to the marketplace in order to take up a position and receive solicitous advice from knowledgeable and interested passersby. Remnants of charms and various compounds of vegetable and mineral matter argue that physicians did function in this early society. Treatments also included sound nutrition, proper hygiene, rest, bandaging, and massage. Centuries later, the Greeks themselves constructed spa-like hospitals, which operated under the control of religious priests. Women held little esteem, consequently their nursing practices were confined to the home, they had no access to education, and were not allowed involvement in the community affairs. It was unusual for a woman to be a doctor or a midwife.[4]

"Nurses" were mentioned in both the Old Testament and the Talmud: their labours were confined to home visits to the ill. In Egypt, however, evidence suggests at least one school of midwifery, and papyruses of tetanus patients being fed by a nurse survive to modern day.[5] As in Greece, the nursing practices of women remained sequestered in the home. However, male nurses likely occupied the first

hospitals built. A medical manuscript, the "Charhaka Samhita", delineated characteristics of worthy nurses:

> There should be secured a body of attendants of good behaviour, distinguished for purity or cleanliness of habits, attached to the person for whose services they are engaged, possessed of cleverness and skill, endowed with kindness, skilled in every kind of service that a patient may require...clever in bathing or washing a patient...well skilled in making or cleaning beds... and skilful in waiting upon one that is ailing and never unwilling to do any act that they be commanded to do.[6]

Concurrently in Asia, the family unit was the fundamental structure in ancient China's culture, so nursing was presumably practised within the home.

With Rome's expansionist attitude and consequent wars, soldiers were generally billeted in private homes. Consequently, families were in competition with each other to assure better care. Hospitals with a capacity of about two hundred patients were evidently built along the Danube and the Rhine.[7]

During the early Christian era, women's duties were mainly confined to home. Therefore, only widows or virgins who had dedicated themselves to this Christian act of charity were acceptable for nursing anyone outside a private home. Several particular women are noted in history for their contribution to the work of nursing: Constantine's mother, the Empress Helena, travelled to Jerusalem after her conversion to Christianity and built a hospital in reparation for her son's sins. In A.D. 390

Fabiola, a Roman aristocrat, constructed a hospital for beggars. After the spas of the Roman society were closed more hospitals were built, but these were not patronized by any citizens of means: only travellers, the destitute, or the homeless came to the hospitals while the general populace were cared for in their own homes.[8] This practice continued past the advent of Florence Nightingale's dramatic innovations in nursing practice and education and the birth of more knowledgeable and scientific medical technologies.

Throughout the Moslem empire, hospitals were built between the 8th and 10th centuries.[9]

Two centuries later, the Knights of St. John functioned as warrior-nurses during the crusades. They either rode out a-soldiering or returned to hospitals to nurse the afflicted as need required. It's interesting to note that Christian duty called on these monks, most of whom came from well-to-do European families, to both kill and care. At any rate, the military attitude of obedience, rank, and subjection to authority influenced nursing philosophy for centuries.

Throughout the Middle Ages religious nurses provided care. As humankind progressed into the Renaissance, global affluence increased discovery and learning. Between A.D. 1450 and 1550, three types of physicians were delineated: the physician, the barber-surgeons, and the surgeons. And

secular nurses began to wrest the control of patient care from the religious orders. The primary concerns were hygiene and general care for indigents. The Reformation, during the 16th century, profoundly shifted politics and cultural activities away from established church control. It saw the end of male nurses and altered the social status of women. Until this event, under the influence of Catholicism, there were more opportunities and options open to women. The choice of nursing as a career was acceptable for females of ability. But, Protestantism again relegated women's position to the home. If a woman required an income, domestic employment was her only option, and nursing was considered to fall into this category, but was less attractive than even servant status.[10]

During the 1600s three Augustinian nuns immigrated to Canada and under the aegis of the Duchess of d'Aiguillon, worked as nurses in the Jesuit's Hotel Dieu, built in Quebec City in 1639. Later, in 1644 Jeanne Mance, enticed three Sisters of Charity to relocate from France, and built the Hotel Dieu in Montreal.[11]

While continental Europe remained concerned with the integrity of nursing, generally only women of very dubious character, motivation, and behaviour chose nursing as an opportunity for employment in Britain. However, the 18th century <u>did</u> see the publication, in Vienna,[12] of the first text having nursing as its topic, <u>and</u> a maternity hospital

became established in England with the mandate of educating both physicians and nurse-mid-wives (in 1739).[13]

This historical review emphasizes the notion that nursing (and education in the discipline) has been, and still is, heavily influenced by scientific knowledge, social structure, and the place of women in social organization. We see that in earlier times, while women primarily are valued only as wives, nursing care was provided for family members only in their own homes. In the middle ages, nursing still functioned under the auspices of Church, but was increasingly done by seculars. Women could avail themselves of increasing employment options. But during the Reformation, men left nursing to women, and the increasing control of the Church resulted in two choices for unmarried women: nursing or housekeeping.

Onward and Upward?

Florence Nightingale must be credited with being the mother of a formalized education in nursing, separate from the control of any religious affiliations. She seems to be one of the first to realize that nurses are not "born". Rather than concurring with the popular notion that every woman was inherently a good nurse, Nightingale wrote, "It has been said and written scores of times, that every woman makes a good nurse. I believe, on the contrary, that the very elements of nursing are all but unknown".[14] And she

demanded to know: "The everyday management of a large ward..., the knowing what are the laws of life and death for men, and the laws of health for wards...are these not matters of sufficient importance and difficulty to require learning by experience and careful inquiry, just as much as any other art?"[15] As a consequence of her labours in the Crimea and the subsequent adulation in the press, Ms. Nightingale became the recipient of thousand of pounds in donations. Because she was reluctant to assume control of these monies, Nightingale directed that a special fund be established and that the donations be used only for the education of nurses. Even a century ago, she was adamant that the students be autonomous, having no servile functions in the hospitals. To this end, the Florence Nightingale Fund paid a hospital directly for accepting students on an apprenticeship basis: but, they were not to "staff" the establishment. Unfortunately, alot of resistance to even the idea of recruiting students from the upper classes of society ensued, and the payments were routinely diverted to the general budget. Eventually, the students did, indeed, service the wards. Academics were pretty much an incidental.

Although Nightingale appreciated that good nursing practitioners were products of carefully considered academic knowledge as well as clinical experience, she did, erroneously in the minds of many modern nurses, firmly

condone the belief that the nurse must always be subservient to the physician. This attitude may have survived from the military-mindedness of the Knights of St. John in 12th century Europe. The servant/master relationship transpired despite the condition set by the Fund that the students must be subject to only the Matron's administration.

Nightingale's first school of nursing was initiated, in 1859, at St. Thomas's Hospital in London. According to her standards of "lady-like" attributes to be found in women of a higher class while still having the physical durability of the servant class, she selected entrants who would then emulate Nightingale's philosophy that nursing was an acceptable occupation for women to pursue. Previously, as mentioned earlier, only women of doubtful repute and usually slovenly and selfish habits were engaged in "nursing" in hospitals. There were allegations aplenty of drunkenness and theft. It had been estimated to be the "lowest of the low" options available to unmarried women.

But with the inception of schools of nursing, the quest for professionalism began. Baley comments in her history of nursing that "...It was always intended from the first and since to establish a profession, and to give incentive to those in it to rise by grades, grades only to be obtained by certified experience and character, to be rewarded by hospital rank and the pay of private service."[16]

It's apparent that, right from the very inception of schools of nursing, "professionalism" was a concern: there remains a pre-occupation with this concept unto this day.

Another dilemma inherited from this juncture in nursing education history is that Nightingale believed that there should be two levels of education for nurses: the first, basic scheme appropriate for the less intelligent but capable ward nurses, and the second specific for the nurse administrators of the wards (these most probably recruited from the upper strata of society).
This single route to practice stayed unchanged for seventy years.[17] Today, we see this opinion revisited in the continuing debate regarding diploma and baccalaureate preparation for nurses.

The popularity of Nightingale's nurses was immediate, in both the sphere of hospital organization and to the young women students, but initially very few of the graduated ladies remained in the hospital: they chose, instead, to nurse in the private homes of the more financially well-off. Bonham Carter, Nightingale's cousin and administrator of the Fund received her note stating, "My view you know is that the ultimate destination of all nursing is the nursing of the sick in their own homes... I look to the abolition of all hospitals and workhouse infirmaries. But it is no use to talk about the year 2000".[18] Alas, here we are broaching that exact time, and

the rationales for baccalaureate entry to practice include comments based on increasing prevalence of community health nursing. And, quite obviously hospitals have not been and will never be abolished. Ostensibly, increasing knowledge of Bacteriology (a discipline Nightingale resisted, incidentally) greatly influence the environment of hospitals. The ill became more amenable to hospitalization when the prevailing belief of hospitals being houses of death changed to that of homes of cure.

The suffragette movement and its interest in nursing (because it was considered "women's work") and the rapidly increasing number of schools of nursing, realized a need for regulation and standardization. Up to this point, the schools were unorganized and unevaluated. Therefore, in 1889 the British Nurses' Association stated that all schools must require: 1) first, a three year training period, followed by 2) registration exams, and then 3) a registration fee for entry to practice as an R.N. However, the Association had no substantial authority and power, so these recommendations were not legally adopted until about thirty years later. And, during this interim nursing became once more relegated to disfavour. The larger number of employment options available to women and the feminist dislike of a labour of women, yet dominated by men (the physicians)caused this disfavour. But, without a doubt Florence Nightingale and her Fund established the

discipline of nursing as necessary, valid, respectable, and worthy of thoughtful consideration to some degree.

Meanwhile in North America, most schools of nursing followed the Nightingale model. They were physically and functionally attached to a hospital and, despite Nightingale's adamant wishes that student nurses should be totally free of housekeeping duties, they did assuredly service the establishment. The first school of nursing in the United States was formed in 1839 in Philidelphia.[19] Later, in 1874, in St. Catharine's, Ontario, Miss Money and two nurses from Guy's Hospital in London, England, founded the first Canadian school of nursing, "The Mack Training School".[20] The next three and a half decades saw a proliferation of schools to the total of about seventy throughout Canada, and all of these were established on the Nightingale model.

Until Florence Nightingale began recruiting "ladies" as nurses, public facilities were homes of death. However, with the advent of "modern" nursing we observe that hospitals did not make nurses. Rather, nurses made hospitals. While medical knowledge in the nineteenth century slowly evolved, nurses' attention to the patients' environment succeeded where medicine had not. Good hygiene, sound nutrition and basic physical care combined to make people well. Eventually, as the face of hospitals changed increasing numbers were amenable to leaving private

nursing in the home and submitting themselves to treatment in public facilities.

Concurrent with the explosion of industry, technology and scientific knowledge, women's opportunities for education and employment have grown through the last century. Both World Wars appear to have been watersheds in the development of nursing generally as being socially required, valued and acceptable. The tasks of the nurse still include basic care of the patient's environment, but have expanded with the enormous advances in medical knowledge. The nurse has taken a place in the complex, multi-disciplinary team that now cares for the patient.

On the Home Front

In British Columbia, Vancouver General Hospital established the first school of nursing in 1899. It was called the "Vancouver City Training School for Nurses" and had a program lasting three years, although two women graduated after only two years because they had previous experience. An example of the physicians' domination of the nursing field is that the doctors controlled the meeting when it was decided that there would be a school established: the nursing staff had no influence in this decision. Florence Nightingale believed that the nursing department's organization should be autonomous, but that nurses should be "servants" and physicians the "masters".

Tradition seemed to evolve to where the nurse was "mother" and the physician was "father" who made all the decisions in the "family". Nurses are yet struggling against the impinging medical model in nursing.[21] The BN:2000 policy statement speaks of the necessity of student nurses acquiring "a strong nursing perspective" while working as a member of a multi-discipline team.

Between 1906 and 1914 V.G.H. tripled in bed capacity with a concomitant increase in the number of nursing students. Additional schools became located in Port Simpson, Bella Bella, Chemainus, and Kelowna, but because these had insufficient diversity to provide comprehensive learning, they associated themselves with the school at V.G.H. Students availed themselves of learning opportunities by attending lectures from doctors and ward "rounds", reading available texts, and interaction with senior nurses on the wards. There was no curriculum. St. Paul's hospital also had a school of nursing operating in much the same manner.

A critical time in the education of nurses in B.C. came about in 1916 when the Graduate Nurses' Association of B.C. convened the "Training School Committee". It had the responsibilities of: 1) outlining a course of study for student nurses which gradually evolved with more variety in subject matter and depth of instruction. This "reflected both medical advances and the wider recognition of nurses'

capabilities"[22] and 2) scholarships for students of enhanced ability.

In the entire Commonwealth, the first university-based school of nursing was established at the original site of U.B.C., physically juxtapositioned to V.G.H. and affiliated with it, in 1919. There were, at this time, five Canadian universities offering certificate programs, and by 1963 sixteen baccalaureate programs in nursing were offered across the country.[23] After studying Arts for two years, the students joined the non-degree student nurses in their third year. Later, the university students did an additional year studying Public Health Nursing specifically. This association remained until the late 1950s. More than sixty years ago, the rationale for this innovative curriculum was that "...the duties have extended to the field of scientific and preventative medicine, thus requiring a broader education and the assuming of much greater responsibilities than heretofore. Large areas have opened up in Public Health...and today many are doing work that was formerly done by medical men".[24] It also noted the need for teacher preparation, and courses in administration. Eventually, in the 1970s these particular courses were deleted from the course of studies because it was felt that they were better addressed in a graduate school, the first of which was located at the University of Western Ontario in 1959.[25] These arguments are still used by

the present proponents of the "Bachelor of Nursing: 2000" policy.

The first exams for provincial registration took place in 1921. Both the diploma and university graduates sat the same exam.

By about the second decade of the twentieth century the apprenticeship model for instructing student nurses was being investigated and some judged it inappropriate. The distraction of the second world war no doubt kept this concern in abeyance until the 1950s. Then many decided that the schools should be located within the public post-secondary education system.

As far back as the 1930s students were cautioned to "never forget that the patient was a person and a member of a family."[26] The instructors emphasized "intelligent inquiry versus mindless automaton-procedure following".[27] Factor number six of the BN:2000 policy statement echoes this emphasis.

In the 1950s, finally, the students had time reserved specifically for class time. They spent half the day at class and half the day providing patient care, in "blocks", but it took about ten years for the theory content to be co-ordinated with practicum. Toward the end of this decade, the students acquired experience at the Venereal Disease Control Clinic, G.F. Strong Rehabilitation Hospital, Imperial Oil, and took courses in Sociology and disaster

nursing. Eventually, the first year curriculum included an English Literature course, not unlike ones offered at the university level.

The British Columbia Institute of Technology (in Burnaby) developed the first two year diploma program within the post-secondary school system in 1967. It was, and still is, associated with hospitals to the extent that B.C.I.T. students received clinical experience in them, but the faculty on the wards was always from the technical school versus the hospital. However, there continued to be hospital-based diploma programs into the nineteen-eighties. St. Paul's Hospital School of Nursing closed its doors in 1974, but V.G.H. did not discontinue its program until 1988. At this time, rather than phase out the school altogether, the school again affiliated with U.B.C. and the students are enroled in a four year baccalaureate program.

The Current State of Affairs

Now ten colleges in British Columbia offer diploma programs in nursing. Only one university offers the "generic" four year baccalaureate (UBC), but two offer articulated degree programs (UBC and University of Victoria). These latter programs are two years in length, and are specially designed to articulate with graduation from a diploma program. Table I provides a list of

schools of nursing in B.C., their locations, and type of program offered. Ten College offer diploma programs, one university offers a generic degree, two universities offer articulated programs, and there is one master's degree available.

Table II: Schools of Nursing in the Province of British Columbia, Program Type, and Location of Campus.

Name of Institute and type of Program	Location
B.C. Institute of Technology diploma	Burnaby
Camosun College diploma	Victoria
Cariboo College diploma	Kamloops
College of New Caledonia diploma	Prince George
Douglas College diploma	New Westminster
Kwantlen College diploma	Surrey
Malaspina College diploma	Nanaimo
Okanagan College diploma	Kelowna
Selkirk College diploma	Castlegar
University of B.C. baccalaureate, generic & articulated masters	Vancouver
University of Victoria baccalaureate, articulated	Victoria
Vancouver Community College diploma	Vancouver

Table III provides a summary of the educational preparation of nurses already practising in B.C. Fully 85% of B.C.'s nurses graduated with diplomas, while the remaining 15% hold degrees in nursing. The data does not

indicate how many of these nurses completed articulated programs. These latter practitioners would have initially gained entry to practice with a diploma in nursing, then upgraded to a baccalaureate.

Table III: Educational Preparation of Registered Nurses in B.C. (1989).

Education	Number of Graduates	
Diploma	23,968	84.8%
Baccalaureate	4,019	14.2
Master's/Higher	345	1.2

Each institute establishes its own prerequisites for admission to the faculty, and designs its own curriculum. All graduates from any of the programs must pass a standardized examination for registration with the professional association and for employment within the province of B.C.

Summary

This historical review provides several notions germane to a discussion of the R.N.A.B.C.'s BN:2000 policy rationale. It mentions the progression in medicine, and hence nursing care, through belief in the supernatural, use of charms, and compounds of vegetative and mineral matters, and education in hygiene and nutrition. As scientific knowledge became broader and deeper, health care mirrored that. The RNABC's position paper regarding the

baccalaureate prerequisite to entry to practice nursing, outlines twelve "factors" as rationales for the stand. Some of these discussions are echoes of concerns in nursing. Factors #3, 1, 2, 4, and 11 raise concerns about the evolving complexity of health care. The first and last discuss the need for nurses to be "research-literate". Number one refers to the "cure" versus the "care" models of nursing and mentions the shift in pathology etiology that has occurred over the decades, as do factors four and two. Factor ten addresses the concern for the ethical dilemmas that have arisen subsequent to the development of scientific knowledge through the ages.

Whether nursing was carried out in the home or in public hospital often depended on the socio-economic status of the patient. The wealthy stayed home and received better care from either family members or experienced women brought into the home while the poor very reluctantly went to hospitals that afforded little therapy. Ms. Nightingale sought to abolish hospitals entirely. The subject of community-based health care is discussed in factors five and twelve.

Finally, the BN:2000 policy seems to promote a single educational preparation for all nurses. Florence Nightingale studied this more than a hundred years ago. She opted for two portals of entry to practice, preceded by education having different content and experience.

These two programs prepared the students either for general duty nursing functions or for administrative or education job descriptions.

Many of the concerns facing nursing in B.C. presently have roots in history.

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Chapter Three
The Criteria for Rationales in Policy Formation

One of the purposes of this paper is to develop criteria for acceptance of the rationales which lead logically to accepting a specific policy. This is the focus of Chapter Three. Chapter Four subsequently discusses the published rationales of the BN:2000 policy, holds them against the criteria, and finally suggests whether or not the basis for BN:2000 is valid.

Phases of Policy Formation

The five phases of policy formulation and implementation that I have developed through a literature review are: 1) Observation, 2) Rationales, 3)Formulation., 4) Implementation and 5) Ramifications. Each flows into the next, and, logically, each forms the basis for the subsequent phases. It becomes a delicate puzzle, teasing out the separate threads of only one issue. The feature of complexity, as Majone[1] describes education policy, is one of the most profound characteristics. However, the concern of this thesis is only one phase, that of phase two, Rationales.

Phase Two: Rationales

Rationales are noted as the second phase of policy formation. At this juncture, the arguments developed must

logically and justifiably couple the observations of the identified problem to the strategy leading to eradication of, or improvement in, the issue. Due to the consequentiality of decision making, the rationales must be clearly and conscientiously examined. Rogers calls it "a process of reasoned choice tied to a specific situation".[2] These reasons for the development and adoption of policy are the arguments for its very existence and thus must be able to withstand rigorous assessment against standards of acceptability. Majone writes: "Arguments are only more or less plausible, more or less convincing to a particular audience...There is nothing intrinsically reprehensible in selecting the particular combination of facts, values, and methods that seem to be most appropriate to convince a particular audience".[3] However, all those factors that are explicit and implicit in selected rationales must be justified in order that the policy may have integrity because, "Argument is the key process through which citizens and policy makers arrive at moral judgements and policy judgements".[4]

Likewise, standards for justification must be thoughtfully discerned. They must be necessary and sufficient to the argument. "Any particular set of facts will be consistent with a variety of theories and hypotheses. Since the official methodology provides no objective criterion for choosing under these circumstances,

analysts cannot be blamed for selecting the explanation that fits their opinions or expectations. The fault lies in leaving those criteria unexamined"[5], explains Majone.

Four specifics must be considered when testing rationale in relation to the established criteria. These are: 1) both implicit and explicit assumptions involved in the process, 2) accurate data, 3) appropriate use of data as evidence linking the data to the suitable option, and 4) illumination of implicit as well as explicit values inherent in the policy making process.

Assumption: The initial consideration taken into account is the effect of assumption in policy formation. We often hear the phrase, "It is safe to assume...". No doubt, in decision making, as in so many other daily functions, assumptions play an influential role. Given, though, policy's "public"[6] nature these assumptions require assiduous probing within a logical framework that is both clear and concise. "There must be integrity in the justifications advanced for the formation and acceptance of each assumption"[7], states Brobow. The actors in this process must do a self-audit for bias, prejudices, vested interests, and/or motivations predicated on irrelevant experiences or attitudes. Assumptions based on personal experiences, wishful thinking, or faith alone are not fully warranted. Those accepting the task of policy making accept the sine qua non of objectivity and lucid

accountability.

Data: The second element of justification for accepting the rationale is the adequacy of data collection. Most obviously, data included in the statement of rationales is required to be true fact and, secondly, clearly related to the argument. To guarantee the quality of data certain notions need consideration:

1) The problem must firstly be correctly identified and described. Otherwise, incorrect data will be gathered. A problem situation may be easily recognised, but when the incorrect causative agent is labelled, we can proceed to collect data logically related to the cause upon which we are focusing. Eventually, we may formulate reasons for coming to a correct conclusion (but the reasons may be unwarranted) or we might arrive at an erroneous decision using incorrect arguments. Any of the four phases of policy making can be fraught with pitfalls, but if we tumble into one of these yawning abysses relatively early in the process, it's logical that we're more inclined to stay off the correct track. And having arrived at the conclusion we may find that we've come to the perfect solution undermined by a dearth of integrity in the previous, basic stages. Or, we may have come to an entirely incorrect decision and not even know it.

2) It is imperative that data be collected from multiple sources. Methods for gathering it must vary, when

possible. Disallowing bias, a narrowed perspective, and/or incorrect data are the reasons for this requirement.

3) While interpreting the data collected, that is, placing it into context (thereby giving it meaning), those involved must exercise considerate discrimination in selection of data. They must be able to demonstrate clear relationships between the chosen data and the rationales, while factoring out anything unrelated or extraneous[8], writes Carley. The product of incorrect information can all too easily be an incorrect policy that will do little or nothing to effectively address the identified problem.

4) To be adequate, the data used for the delineation of argument needs to be reliable and, therefore, reproducible. Should the information be elicited only in isolation and only serendipitously, doubt must be cast on its validity.

Attention to these four imperatives in data collection, extraction, and transformation works to ensure development of justifiable argument for policy making.

Having guaranteed quality of information (through discrimination of relevant data), only that information germane to the proposition must be included. But, there is also the consideration that vital information is not lost through data reduction. Majone writes that there must be "goodness of fit".[9] The appropriateness of the information must be sufficient to warrant the logical

progression from the data to the formation of the rationales. Additionally, it should be "robust": it must exhibit the traits of vigorous strength in its form and construction so that it can successfully be critically and closely examined for its worthiness.[10] Information presentation and causal linkages must be explicit because "explanation provides the means to control events, as they tie particular actions that may, or may not, be taken to a set of expected impacts or consequences", states Rogers.[11]

"To the extent that knowledge is grounded in interests its pursuit is energized and motivated by them and at the same time knowledge is always limited by the same interests."[12] Knowledge is power and therefore can be politically manipulated to control that resource (knowledge), thus translating to distribution of political power. Since policy making is the stuff of politics, strict adherence to measuring information put forth in argument against criteria works to guarantee the integrity of the policy.

Evidence: "Evidence", the third matter included in logical policy formation, is comprised of selected information which is brought into the argument at particular junctures in order to persuade, as described by Majone[13]. It stands to reason that incorrectly positioning of information in the argument's structure, and/or indiscriminately chosen style of presentation for a

distinct audience will undermine the argument. This may result from obscuring the real issues, or by causing the audience to accept information as "facts" versus "evidence". That is, says Brobow, it may destroy the effect of information with "no regard to intrinsic cognitive content".[14]

Values Made Explicit: The final component in policy making that must be addressed is values. Argument bereft of value judgement is impossible[15] and to attempt to isolate them from our rational capabilities is "artificial"[16] at best and patently a "threat to all notion of public deliberation and defensible policy choices"[17], according to Majone.

Rogers states that values must be explicitly taken into account "primarily because it furthers deliberation and reasoned choice." He concludes that "Simple assumption based solely on faith will not do".[18] In fact, Carley claims that consideration of the values of the actors must be integral since "no analysis is understood until it's clear what, where and whose value judgements are part of the analysis".[19]

Conclusion

In summary then, for a policy decision to be accepted the arguments, or rationales, put forth must withstand assiduous comparison to certain criteria. Without these,

the policy is indefensible. These criteria function to guarantee that the assumptions, data, information and evidence, and finally the values involved in the decision making process is valid and germane to the specific policy's formulation and adoption. Without conscientious attention to the criteria for validating policy rationales we may too easily be left with a thing that is "full of sound and fury, signifying nothing".

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Chapter Four

A Rational Analysis of the BN:2000 Rationales

What, then, is the basis for the dramatic education policy adopted by the professional nurses's association of British Columbia? Are the data, assumptions, evidence, and values instrumental in the formulation and acceptance justified and appropriate?

The Rationales of BN:2000

The following is an excerpt from the "Entry to the Practice of Nursing in Year 2000" position statement published by the RNABC (November 1983).:

> Rationale
>
> Historically there have been constant adjustments to the nursing education system in order prepare graduates who can meet the health needs of Canadians, function competently within contemporary health care delivery systems, and respond to developments within the nursing discipline...
>
> Currently we face a critical decision point. The health status of Canadians has changed markedly over the past thirty years, and predictions can be made about the probable nature of health problems as we move into the twenty-first century. Changes in health care delivery, particularly those associated with the introduction of a national medical and hospital care system, the explosive growth in high technology treatment methods, and the development of primary care and community-based services, have affected the education and work of all health care professionals. In addition, rapid developments in the evolution of the nursing discipline have combined with these other elements to necessitate a review of the initial and ongoing educational needs of nurses.

These changes, and their impact on nursing practice, can be summarized as follows:

> -From approximately 1900 to the present, there has been a shift in cause of death from infectious diseases to chronic illnesses and accidents...In the case of chronic illness, a care rather than a cure model is required. Where curative remains important, highly sophisticated crisis management skills are required. ("Factor 1")
>
> -As a result of increased life expectancy most nurses will be caring for older citizens on a regular basis. The primary orientation to care for this population requires intervention by nurses skilled in meeting special needs caused by the aging process. With the increase in the older population (85+ years) population...the base of care will shift from the large acute care instructions to the long term care sectors...All nurses will require specialized knowledge and skills to meet the needs of older individuals and their families...in the home setting. ("Factor 2")
>
> -The patient hospitalized in an acute care facility currently experiences a higher degree of acuity and complexity of illness than was the case in the '50s and '60s. This trend can be expected to continue. Nursing practice in these settings is based on knowledge in the biological, social and medical sciences and requires nursing competencies appropriate to managing patients in biological crisis. There are social and psychological factors associated with acceptance and adaptation to hospitalization and the treatment regime. In order to provide quality around-the-clock care, nurses need the ability to understand, interpret and translate research data from the basic and applied sciences into effective care measures. ("Factor 3")
>
> -In 1981 the leading causes of death

in B.C. were: 1)heart disease 2)cancer 3)accidents and adverse effects 4)cerebrovascular disease 5)respiratory disease...

These statistics reveal an increase in diseases which have been linked to lifestyle factors and stress. If nursing is to make its contribution in effectively changing this morbidity/mortality pattern, helping people to understand this relationship and assisting them to alter lifestyle patterns is one component of nursing practice which will need continued and increased emphasis. The staff nurse in the hospital or community setting has the greatest contact time with patients and is available during times the patient reveals a readiness to learn. to accomplish this goal, nurses will need to refine their knowledge in health education and counselling strategies at the basic educational level. ("Factor 4")

-The major portion of B.C. health care dollars is allocated to hospital/medical care. Challenges have been made to the appropriateness of continuing to centralize health care in expensive, high technology hospitals.

Many innovative programs have been developed and/or proposed to lessen the need for costly hospitalization...In many instances nurses have led in developing alternative modes of care...pioneering innovations in existing care systems...and expanding their role which have maintained cost effectiveness...

Nurses have been essential to the success of these innovations, but present educational programs, except those offered in universities, do little to prepare nurses for non hospital-based services. Assuring that nurses have the requisite knowledge and performance abilities to continue making these kinds of contributions is a sound investment for those concerned with balancing quality care and cost-effectiveness. ("Factor 5")

-In order to provide care which meets current standards today's hospitals employ large numbers of health professionals and health technologists. Appropriately, nursing coordinates the multiple activities of these various groups for the benefit of the patient. The nursing profession's long established insistence on considering the person as a whole being who also lives within a family/community/ society diminishes the fragmentation of care inherent in the complex hospital system. ("Factor 6")

-Literally thousands of general duty nurses assume "charge" positions on one or more nursing units during evening and night shift and in the absence of the head nurse. Often their preparation for the administrative component of the "charge" position is gained solely through experience. Large numbers of nursing auxiliary staff introduced after World War II are evident today and may continue to be present in some form in the future as the health car industry strives to identify manpower requirements. Basic academic preparation in management is needed by the nurse so that she may "administer" effectively.
("Factor 7")

-A trend towards a multidisciplinary team approach to health care has seen increasing numbers of nurses participating on teams with other health care professionals rather than practising solely with other nurses. To assure that the nursing needs of patients are consistently addressed, staff-level nurses, in addition to those in more senior positions, must have adequate opportunity to develop a strong nursing perspective as well as an understanding of the roles of other team members. Because basic orientation to practice is established in the initial educational experience, it is essential that opportunity to develop

a multidisciplinary perspective be assured in preparatory nursing programs. This is most effectively accomplished in settings where other health disciplines are educated. ("Factor 8")

-Within health care agencies, concern with enhancing organizational efficiency and effectiveness has been evident and, as the health care system responds to present and future economic realities, that trend can be predicted to continue. Decentralization, primary nursing assignments, and quality assurance programs are but a few examples. In each instance, the skill demands placed on the registered nurse have been directly affected. Problem-solving; decision making; accountability for actions to clients, managers, and health care team members; organizational know-how; and cost-effective planning in designing nursing strategies are now nursing competencies expected and needed by employers. ("Factor 9")

-Complex ethical dilemmas face all health care workers. Increasingly, nurses recognize their need to apply theories in ethics as they work with colleagues in other health disciplines. ("Factor 10")

-In the '70s, the trend toward research-based practice and research-based nursing education was in its early stages. Presently, nursing research has "taken hold" in university nursing faculties and, with an increase in university prepared practitioners, is beginning to penetrate the service delivery system. Patients are the beneficiaries. An RNABC affiliated research interest group promotes these developments. The use of valid research findings in practice and the generation of relevant research questions requires that "front-line" nurses have research literacy. The development of such attitudes and skills occurs successfully with university, a milieu which has research as one of its mandates. ("Factor 11")

> -Proposals for future health care delivery patterns emphasize expansion of the present focus on illness/medical care, with a curative orientation, to one which includes a focus on health promotion, disease/accident prevention, rehabilitative and supportive care.
>
> The RNABC believes that primary care, that is, "essential health services which can reasonably be made available to individuals and families through centres in their own neighbourhoods and communities" must be the first health service available to the consumer...Nurses who have the requisite preparation to deliver primary care services are critical to the success of community based care. Presently, the community health nurse plays a valuable and necessary role in community health services. A marked expansion of this role is needed to provide a more cost-effective, feasible means of ensuring quality care for people in this province in the future. ("Factor 12")

The above factors provide a valid basis for changing in the minimal requirement for entry into the practice of nursing by the year 2000 to a baccalaureate degree in nursing.

For reasons of pragmatism and lucidity, the rationale will therefore be categorized and discussed under three headings: these are 1) Social Considerations, 2) Employment Arguments, and 3) Economic Factors. Each paragraph in the excerpt devoted to one particular concern will be referenced as "factors". See Table IV for a list of the factors and the key points of each.

N.B. "Factors" designation is the author's.

Table IV: The Catagories of BN:2000 "Factors" and Their Key Points

Category	Key Points
Social Considerations	
Factors # 1	-changing patterns in illness
2	-increasing proportion of population over 65 years
4	-higher lifestyle-related illness
10	-dilemmas in ethics
Employment Arguments	
6	-nurse as co-ordinator of multidisciplinary health team
8	-need for strong nursing perspective
3	-quality 24 hour nursing care
11	-use of research by "frontline nurses"
7	-general duty nurse as administrator
Economic Factors	
5&12	-nurse in community health programs
9	-organizational efficiency and problem-solving

Social Considerations

Contained within the first grouping, Social, are the first (changing patterns in illness), the second (increasing proportion of the population over the age of sixty-five years), the fourth (higher incidence of illness due to lifestyle), and the tenth (complex dilemmas in ethics).

At the onset the most obvious comment regarding all four statements in this category is that none of them mention the word "baccalaureate" or "degree". They are totally lacking in any explicit or implicit causal link between any of the proffered data and the argument for the BN:2000 policy. The authors have neglected to use any factual evidence to support any form of argument.

With specific attention to factor number one: It is

true that mortality rates having the etiology of infective organisms have lessened (notwithstanding the devastation of the AIDS epidemic, estimated by the World Health Organization to claim six million lives, globally, by the end of this century). And, over time, there has been an increase in death due to chronic illness and accidents. But the argument only very sketchily suggests the appropriateness of a "cure" versus a "care" model.

Luckman and Sorensen explain that

> ...Nursing is associated with, not defined by, medicine and surgery. Medicine and surgery have to do with the diagnosis and treatment of disease or pathologic conditions in human beings. Nursing, on the other hand, has primarily to do with the <u>care</u> (author's emphasis), comfort, and support of people whose patterns of daily life are in some way threatened. A disease process that requires medical or surgical therapeutic intervention is <u>one</u> of the stresses that can interfere with normal human function. This means that people experiencing disease and medical-surgical therapeutic regimes often require nursing care...Medical-surgical practices often (although not always) occur side by side and in an inter-related fashion.[1]

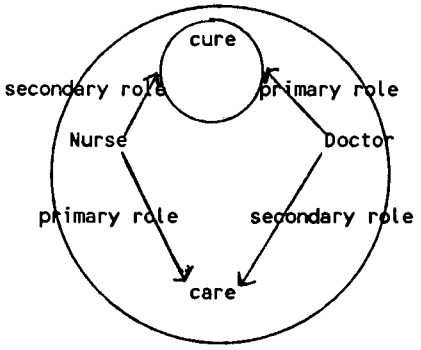

Figure II: The "care" versus "cure" model. (taken from Bower-Ferres, "Loeb Center and its Philosophy of Nursing", American J. of Nursing 75:810, May, 1975.)

Factor #1 indicates that "care" is indicated in chronic illnesses (ostensibly, "chronic" rules out "cure"). However, "Where curative care remains impossible, highly sophisticated crisis management skills are required". Presumably, "accidents" is an example of the need for curative care. Taking Luckman and Sorensen's explanation into account, medical-surgical nursing calls on curative skills.

The data implicit in this argument is valid, but how that is used as evidence for the BN:2000 policy is not at all clear. To employ this data justifiably, the authors must demonstrate that baccalaureate graduates show superior curative and caring skills in the appropriate scenarios since data is used properly as evidence in linking the facts to the chosen option or strategy. Where is the causal link, data-to-statement?

Presently, college diploma programs all include courses and clinical experience in "caring" nursing

procedures. This is concentrated in the initial courses and clinical experience which routinely is located in long term care facilities during which students learn basic nursing functions.

All the college programs include medical-surgical experience providing opportunity the learner to encounter and master fundamental "curative" care. If "crisis" is defined as "as unstable or crucial time or state of affairs whose outcome will make a decisive difference for better or worse"[2], patients requiring "highly sophisticated crisis management skills" are located in Critical Care areas of any hospital. These departments include Emergency, Intensive Care Unit, Post-Anesthetic Recovery, Operating Room and others. According to "The Nurse Manpower Study", Vol. III, only 5% of the hospital's patients, but 50% of the nursing staff are situated in Critical Care areas.[3] For each particular category unique nursing skills and knowledge comprise the content of specialized post-diploma courses available, none of which are addressed in the baccalaureate program.

In more general terms, studies have indicated that baccalaureate graduates are less adept in "hands on" skills than diploma graduates.[4] This may be, in part, resultant from less clinical experience in the university degree programs.

Factor #2 (paragraph two of the BN:2000 rationales)

correctly asserts that percentage population over age 65 years is growing. However, the writers assume that there will be more "community programs, extended and intermediate care facilities" provided to accommodate the aged needs. This presupposes that the province's Health Ministry will allot larger funds specifically for the building, maintenance and staffing of these.

Finally the paragraph ends, "All nurses will require specialized knowledge and skills to meet the needs of older individuals and their families...". Of the 20,930 registered nurses employed in nursing during 1985 in B.C., 1,166 of these (5.5%) staffed extended care hospitals. In this subgroup, 6% had baccalaureate degrees: this equates to 0.32% of the total nurse work force. Community programs function under the aegis of Public Health agencies and Home Care, employing 1,807 registered nurses (8.63% of the work force) during that same year. In this group, 698 workers had B.N.s, which equals 38.62% of the community health nurses, but only 3.30% of the total employed nurses.[5]

By 1989, the proportion of R.N.s working in Long Term Care (LTC) had dropped from the previously noted 5.57% to 5.30% (a decrease of about 4%), which is virtually stable. The data provided for the years 1984 to 1989 points to the fact that there is no trend toward increased R.N. employment in LTC/Nursing Homes.[6]

According to the RNABC records, 2,129 R.N.s were staff

in Community Health and Home Care and the percentage of the total of registered nurses had not varied over the seven years previous to 1989 (hovering at about 6%). Again, this population is stable, rather than increasing in proportion of the total work force. Refer to Table V for a summary of the numbers of nurses currently employed in B.C. in Extended Care facilities, Community Health and Home Care programs.

Table V: Registered Nurses in B.C. employed in Extended Care Hospitals, Long Term Care, Community Health and Home Care.[7]

	Total	Extended Care	LTC	Community/Home
RNs 1985	20,930	1,153	1,166	1,1807
%/total		5.4	5.6	8.6
BNs 1985	2,798		77	698
%/total			0.4	3.3
%/subgroup			6.0	38.6
RNs 1989	24,805	1,254	1,565	2,129
%/total		5.3	6.6	9.0

While it is clear from demographics that our province's population will continue to enlarge the fraction of "seniors" and that these people will require health care either as "well-elders" or patients, it is <u>not</u> clear whether the institutionalized will be located in LTC or in acute care hospitals. If the former becomes the case, a smaller number of R.N.s will be the care-givers (although, the majority of R.N.s on staff will be administrative personnel, and presently only 11% of these have university degree preparation and none have a master's degree[8]) than

if the patients are admitted to acute care facilities, simply by function of numbers. Since a much greater proportion of R.N.s work in the latter description (75% of the work force[9]), the second scenario would result in more nurses caring for seniors. The numbers do not indicate that the concern with special baccalaureate preparation is practical. In either case, there is no demonstration that a university degree better prepares a nurse to care for people in their later years. Is it necessary?

As it stands, colleges have already integrated gerontology courses into their programs.[10] "The Nurse Manpower Study" recommends, in part, that education "policy...address...definition of future system supports to provide a critical mass of academically prepared nurses for all fields of endeavour...".[11] This consideration specifies that enough workers should be appropriately prepared to function in each and all of the various job descriptions in nursing, ("critical mass"), ie., options should be available in education. But it does <u>not</u> suggest that <u>all</u> graduates should be equally and adequately prepared to work in <u>all</u> distinct employment milieux.

Factor #4 (paragraph four) makes the point that while we used to die of germs, we now die of bad habits. This statement suggests that because nurses in both community health and hospitals are most probably present with patients during those "teachable moments", future nurses

"will need to refine their knowledge in health education and counselling strategies at the basic educational levels". Whether this "basic" education is a university or college program is not indicated and is, therefore, open to speculation.

Firstly, there is the question of whether patients often experiencing significant physical and psychological trauma in hospital (where 75% of R.N.s earn a living) are indeed likely to exhibit any moments during which they are open to learning. Stress is generally considered detrimental to absorbing information and/or altering ingrained behaviours.

Secondly, the statement entirely ignores the fact that there are experts in life-style counselling ready, available, experienced and effective. These are nutritionists, kinesiologists, physiotherapists, occupational therapists, and psychologists. Perhaps, what is needed at the very start of this BN:2000 policy discussion is a definition of what a nurse <u>is</u>. Nurses are not any of the aforementioned. "For the health care system to function, hospitals must function. And for hospitals to function, nurses must nurse. They must care, monitor, nurture, succour, aid, comfort, medicate, interact, and advocate."[12]

Lastly, college programs include the "lifestyle" consideration. BCIT's calendar lists a Basic Health Science

course entitled "Personal Fitness Management" and the description reads that it is a "...course designed to emphasize the relationship of physical fitness to life style patterns".[13] GNNU 100 Nursing I accentuates "the stressors associated with life style patterns and assisting the individual by supporting appropriate responses . The common response of general adaptation syndrome is introduced...The student is further introduced to the basic concepts of...interactive skills and the helping relationship...".[14] Later in GNNU 200 Nursing II, "The student will use selected interactive skills to initiate, maintain, and terminate a helping relationship with patients... Community visits will be integrated throughout the course".[15] Interactive skills are further refined in GNNU 300 Nursing III.

Throughout the program at BCIT, there are four fundamental components that are consistently and routinely included in each and every course and clinical experience: 1)"Nursing Core", 2)"Nursing Skills", 3)"Professional Development", and 4)"Clinical". Teaching and learning fall under the second component, Nursing Skills. More of how these components are applied follows. Suffice to say that the nurse as a teacher and the patient as a learner is conscientiously taken into account in this program. One of the nine "Terminal Objectives" in the BCIT curriculum states: "...the graduate of the BCIT General Nursing

Program teaches individual and involved family members to develop and/or maintain appropriate responses to attain or maintain optimal health".[16] And this program is typical of our provinces diploma programs.

Since nurses encounter "complex ethical dilemmas", factor #10 declares, they realize "their need to apply theories in ethics", being members of the health care team. In the brevity of this statement there is a dearth of substantive reasoning. It is an assertion only; not an argument.

Abortion is as old as humankind, as is euthanasia and treatment of those mentally and physically disadvantaged. Society and the health care system continue to grapple with these contentious issues. In the broader picture, the health system functions under the aegis of the legal system which, in turn, is structured, directed, and monitored by elected representatives of the society for whose benefit the systems proceed. For example: it is <u>not</u> the health system, let alone individuals within it, that determines whether abortion will/will not be accessible. Rather, it is the federal government determining legislation. Society sets the norms and values and while health care personnel make efforts toward public education, the system always serves society.

A narrower concern is the nursing component within the system. Nurses surely function integrally in many

diverse situations wherein ethics are a consideration. However, the nurse, as an employee, is an agent of the institution and thus follows policies established by the administration.

Previously mentioned were the four fundamental components woven into each course. Ethics are studied under the heading of "Professional Development". As these components are incorporated in an integrated manner, it's possible that the matters are more immediately relevant. At the start, ethics are studied in a theoretical context: Are there such things as ethics? What are they? What are the basis for them? Subsequently, as the students progress through diversified kinds of nursing, moral concerns particular to the specialty become topical. An instance is: during Gerontology students consider the debate of prolonging physical life through artificial means.

Again, as with the educational role of the nurse, the strategy for addressing the nurse as a moral agent in the program at BCIT is representative of most college programs in B.C.

In conclusion, the foregoing discussion of the four "social" factors of the BN:2000 policy statement shows that they do not serve as arguments for the position taken by the province's professional nurses association. The criteria for acceptable argument are 1)objectivity and accountability in drawing assumptions, 2)reliable, related,

and sufficient data clearly showing causal linkage to the position taken by the policy makers, 3)data used in an appropriate and timely style as evidence supportive of the policy and 4)values explicitly stated and ownership of them declared.

A combination of the four factors essentially states that, over time, certain patterns have arisen. A larger segment of our society are seniors, dysfunction is more frequently now a result of chronic illness, accidents, and/or behaviours, and every member of the health team encounters contentious ethical predicaments. The main assumption identifiable is that the trends specified will continue: immunization programs will be maintained and new infectious diseases will elicit efforts toward innoculating agents (see the quest for the AIDS vaccine). Having substantially conquered death by microorganisms, mortality etiology will continue to shift to accidents and chronic disorders, but with attention to sound nutrition, housing, and preventative strategies, more people will live longer. It's quite evident that new technologies will give rise to morals debates which we do not imagine at present.

But, while the assumptions seem reasonable none of those factors mention "baccalaureate" or "university". Even <u>if</u> we accept the <u>implication</u> that the factors mandate a degree in nursing, there is yet no causal linkage expressed and thus the relatedness of the scant data (which

is true) is not apparent. This translates, eventually, to the realization that there is no evidence that the factors support or warrant the BN:2000 policy, since evidence is data inserted into the argument in a persuasive manner.

Employment Factors

Factor #6 deals with the nurse as a member of a multidisciplined team who serves to "co-ordinate...for the benefit of the patient", while #8 speaks of the need for development of "a multidisciplinary perspective" with "a strong nursing perspective".

Numbers 3 and 11 concern the identified needs for all nurses to be research literate. The former factor states this is required in order that nurses will afford "quality around-the-clock care", while the latter states the notion of "frontline nurses" using research through "development of such attitudes and skills" necessary "within university, a milieu which has research as one of its mandates". Finally factor #7 says that "basic academic preparation in management is needed by the nurse so that she may "administer" effectively". The general duty nurse is in charge on shift, weekends, and holidays while the head nurse is not present.

For the second time the only statement that uses a specific term regarding the degree-earning process is number eleven which intimates that nursing students will cultivate a research interest on a university campus. Thus,

again, the tie between the assertion and the decision is amorphous at best, and therefore unacceptable.

There is no data of any description to support any of the five statements. Consequently, there exists no evidence.

Because nurses co-ordinate the activities of the various disciplines caring for the patient, factor six reads, "the nursing profession's...insistence on considering the person as a whole being who also lives within a family/community/society diminishes the fragmentation of care..."

An excerpt from BCIT's General Nursing program curriculum guide, under the heading of "Beliefs About the Individual, Health, and Nursing", declares "each individual is a unique human being with biological, psychological and social dimensions and functions as an integrated whole...People are social beings and live within the context of family and community...

Nursing is one of the professions that assist people to achieve optimal health. Nursing's unique function is to care for people who require assistance to satisfy their needs...Nurses also assume responsibility for the delegation and supervision of nursing tasks performed by health care workers..."[17]

Of the 15,791 R.N.s employed in hospitals in 1985 in B.C., only 1,598 (10%) of that contingent had

baccalaureates. 1,099 degree graduates worked as general duty R.N.s, the remainder being administrative or educational personnel. Therefore, there is a further reduction of degree graduates actually working as bedside co-ordinators to only 7%. If 93% of these frontline "care organizers" are diploma graduates and their college programs address the notion of the individual human as a singular entity within complex social systems, where is the degree prerequisite argument? There is no data, evidence, and/or explicit value serving as a cornerstone for this factor.

Alluding once more to the multi-faceted care, factor #8 states that student nurses are more likely to gain the "multidisciplinary perspective...in settings where other health disciplines are educated". The affirmation does not state exactly which disciplines, nor which educational institutes, are being considered. Many health technologists linked directly to patient care are products of college programs. Respiratory therapists are intrinsically involved at the bedside. Prosthetics and orthotic technicians complete diploma programs. Biomedical engineering, medical electrophysiology, environmental health, health information systems, occupational health and safety, diagnostic sonography, medical radiography, nuclear medicine, cytogenetics, and medical laboratory technology programs are all established outside the university system. If the

policy writers choose to ignore these dozen dimension of care, and confine themselves to only align the disciplines of medicine and physiotherapy, they still do not illuminate the causal link. If the multidisciplinary perspective is attributed to shared classes, then the students must have common course content. Standardized knowledge suggests a direct contradiction to the diverse orientations which is mentioned in factor number eight.

The dynamic interaction and interrelationships of the various team members are evidenced in the treatment process, ie., in the hospital milieu. It is here that discussion, explanation, exchange, planning, and evaluation transpire. Given that, baccalaureate students are at a disadvantage since they are apportioned less clinical time than are their diploma counterparts.[18]

Statement #7 speaks to the need for "charge" nurses having "basic academic preparation in management". It is the nature of the "in-charge" position that a more clinically experienced nurse is assigned the responsibility of organizing the unit and staff for the patients' benefit for a short period of time, ie., an eight or twelve hour shift. Therefore, as appreciation of the bedside work is vital. Perhaps this can best, and only, be acquired through actually delivering care. It is not within the mandate to set policy or procedure, hire staff, or evaluate any of these.

GNNU 450: Nursing 5 at BCIT focuses on "organization and leadership skills and the responsibilities of the graduate nurse... Students are expected to...assume responsibility for care given to patients by a nursing team".[19] Another terminal objective at BCIT is that the graduated nurse "demonstrates leadership in selected groups and/or with individuals".[20] The RNABC's policy statement asserts that "basic" education is required in adminstration skills. While it is apparent that colleges have included that in the programs, it is not apparent how a baccalaureate preparation is more advantageous.

"...nurses need the ability to understand, interpret and translate research data from the basic and applied sciences into effective care measures" so that continual quality nursing care be provided, states factor number three, while number eleven indicates that correct attitudes towards and acquisition of skills for research literacy "occurs successfully within university".

There is no data arguing that research abilities are learned better "within the university", nor that these cannot be included in a diploma program. And, the causal linkage between the evidence and the concluding statement is not explained.

Exemplifying that research literacy can be acquired during a college program is BCIT's "CTCR 105: Human Development". The text, Human Development by Papalia and

Olds (McGraw-Hill, 1989), includes an entire chapter on research methodology. The course manual has in it sections entitled "Methods for Studying People", "Collecting and Interpreting Information", "Observer Effects", "How Researchers Use Statistics" and more.[21] An overview of research terminology precedes the first assignment in which each student selects three research articles for evaluation. What limitations are there in the specific study, and what use can be made of the study in the clinical scene? are the questions that must be answered by the student. As well as the text, there is a module incorporating an article extracted from the Journal of Nursing Administration entitled "Reading a Research Article", a section of terminology, and several other article of research in nursing.

Therefore, for factors 3 and 11 to be judged acceptable as arguments for the BN:2000 policy, the authors are required to prove that a) research literacy is advantageous in delivering quality care, and b) the aptitude is acquired more efficiently or more effectively on a university campus.

Economic Factors

These include factors numbered 5, 9, and 12.

Statements five and twelve seem essentially the same, addressing the idea of community health functions. They are

categorized under this last heading because the document advances the notion that more community health services will translate to savings in health dollars. While the latter describes "primary nursing" as services accessible in "neighbourhoods and communities" (in hospitals the same term designates an assignment wherein only one nurse provides all of the nursing functions for her patients), and indicates that there is a need for enhanced accessibility to this resource, the former specifies some of those programs (home care, patient-teaching,etc.) and asserts that "present education programs, except those offered in university, do little to prepare nurses for non hospital-based services".

There is, again, a dearth of data and hence no evidence. The third paragraph indicates that there is a deficiency in the college curriculum with respect to "non-hospital services". In 1989 708 nurses were employed in home care, 1,421 in community health, 206 in business/industry, and 534 in physicians' offices.[22] This equates to 3%, 6%, 0.9% and 2.2% of the total work force respectively. Therefore, these comments are relevant to about 12% of R.N.s employed in B.C. What the BN:2000 is saying, then, is that 100% of student nurses should study content related to issues that impacts on only 12% in practice. In a cost/benefit analysis this seems insupportable.

There is the implicit assumption that increased proportion of nurses will be functioning in "community" (and that they will need degree preparation). This ignores the reality that such alternative resources are established and made available at governments whim. There does not seem to be convincing proof that the ministry in B.C. is committed to sustained increased funding for any innovations in health care.

The BCIT calender specifies that in GNNU 200 Nursing 2 and GNNU 300 Nursing 3, "Community visits are integrated throughout the course". "A community visit related to substance abuse is included" in GNNU 400 Nursing 4.[23]

Additionally, there are programs offered in Environmental Health and Occupational Health and Safety Nursing at BCIT. These are surely "community" services.

The error of not showing direct evidence that a baccalaureate is necessary to answer this reported need is once more apparent.

Factor #9 speaks of the "concern with...organizational efficiency and effectiveness" and expected competencies in "problem-solving, decision-making, accountability for actions...", though there is no argument advanced for the BN policy. If the writers wished to proffer that degree graduates demonstrated superior skills at problem-solving, decision-making and other personal, attitudinal elements, they would also be required to prove that these qualities

are a result of the degree-earning process versus facets already part of the students' personality upon entry to the program. Frederickson and Mayer state: "We found no significant difference in the process of problem solving between baccalaureate degrees and the associate degree students".[24]

"The substance of the majority of work that nurses do is labour intensive and technical", states The Nurse Manpower Study, Volume III.[25] The reality of the job does not appear congruent with the philosophy of university education, if "education" is "acquisition of knowledge in depth and breadth in a morally justifiable manner".[26]

An economic factor not taken into account that may offset supposed efficiency in the work place is the cost of educating all student nurses at a baccalaureate level.

Most obvious are expenses to the individual pupil: tuition, living costs, relocation expenses, and lost income. The B.C. Nurses' Union calculates that a two year diploma costs about $4,197.00 for the program and between $16,000.00 and $19,000.00 living expenses. This contrasts with an outlay of approximately $10,613.00 for tuition fees for the baccalaureate degree and: $34,700.00 and $39,900.00 for living expenses. Lost revenue has not been incorporated into the estimates, but it is plain that this factor would be twice the amount for a four year degree as it would be for the two year diploma. Further, the

computations indicate that it "would take a minimum of 76 years of the current qualification differential of $70.00/month to recoup the costs of a two year absence" (from the work force in order to complete a baccalaureate).[27]

Other expenditures not so easily realized are those to society in terms of tax dollars. When we consider university versus college funding, ministry costs will multiply. Presently approximately one hundred students complete the BN program at UBC while graduation from the twelve college programs is many times that. Moving these several hundred college students to a university campus translates into enhanced costs. Data regarding attrition rates in the different programs and success rates at registration examinations is not forthcoming from the RNABC. Although Dolan claims that there is no co-relation between pass rate and quality of care[28], should there be a significant difference in these expense components, they would have to be factored into any equation in a cost-benefit analysis.

Moreover, as Dolan itemizes costs, he includes the number of years of service that the different program graduates contribute to the health system. That is: is there an appreciable variance in length of employment between the degree and diploma graduates? He indicates that there is. He cites a study conducted by Altman that

"indicates that the percentage of baccalaureate licence holders who leave the labour force is greater than that for other programs".[29] The researcher's explanation for this finding is that "labour force participation rate has more to do with personal characteristics and the role of women in society than the characteristics of the job".[30] And that marital status is the controlling factor in the relationship. "Dropout rates are positively co-related with social status of the spouse, and we can safely assume that baccalaureate graduates marry further up the social ladder"[31] than graduates from other programs.

Danton calculates an additional 3200 teachers will be required for the implementation of the policy in Canada.[32] Costs must include post-graduate preparation for faculty (currently only about thirty percent of the teaching staff at BCIT have Masters level preparation) and for the subsequent demands for enhanced salaries commensurate with the academic preparation.

A second order impact is the inestimable costs to society which we are compelled to acknowledge since this is a public policy. The cost is that of possible social stratification in the nurse-patient relationship. If, as Dolan opines, the policy is discriminatory against lower income (hence some racial groups)[33] it is reasonable to envision a situation where in the work force evolves to exclusively upper-middle class nurses while the patient

contingent continues to represent every socio-economic subgroup (possibly disproportionately lower income sets). Will this exclusivity be reflected in the perception of and attitude of patients toward nurses and visa versa? This is a risk that has not been assessed in the three factors dealing with financial reasons pro BN:2000.

These final three factors again are not justifiable rationales for the BN:2000 policy since they meet none of the prescribed criteria. Assumptions are not clearly and objectively defined. There is no data whatsoever, and therefore the causal linkage generally illuminated through evidence is non-existent. In the content, the writers have failed to explicate values.

Summary

Although the Canadian Nurses Association wrote:

> Convincing arguments must be made that upgrading nursing education in accord with year 2000 goals is not only rational...but also cost effective... Strong arguments must therefore be made that increasing expenditures for nursing education will be more than compensated by savings in health care expenditures. Such arguments may have to be made in the absence of good data on education costs,[34]

the RNABC has not made any arguments regarding the cost/benefits of the BN:2000 policy. The rationality of the goals has not been displayed in any way. In all, the twelve factors put forth by the RNABC, when analyzed in a lucid and systematic manner, are shown to be assertions only, not arguments.

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Chapter Five
Conclusion and Discussion

Aside from examining the rationales of the BN:2000 policy, this paper proposes to discuss several very general concerns of the policy and to offer other options. These are overarching assumptions, compared to those detailed in the previous chapter which related specifically to the Rationales of the policy. Values will also be discussed in a broader consideration. Further, the paper proposes to suggest viable alternatives to BN:2000.

General Consideration of the BN:2000 Policy

Assumptions

Assumptions precede often implicitly, but properly explicitly, any decision-making process. This policy has two over-arching suppositions. They are these: there is something wrong with the practice of nursing in B.C. and changes in education is the answer to the deficiency.

However, the B.C. Nurses' Union states that:

> Generally, there has been little change in content or operation of jobs which did not ask for a degree previously but now do.
>
> The majority of incumbents currently working in the generic band of function do not possess a BSN and have satisfactorily carried out the job for some time. The skills and knowledges needed to carry out the job as documented in the job description do not show a specific link to skill and knowledge taught in the degree program.[1]

Additionally, the government of Ontario takes this position:

> There is no evidence to suggest diploma nurses are not effectively meeting the patient care needs of the Ontario public. Nevertheless, it is clear that the health care system can benefit when registered nurses employed in some areas and levels of practice have the broad educational base provided by BSN programs. These areas and levels of practice have yet to be clearly defined.
>
> Employment statistics suggest that baccalaureate educated nurses are not by and large assuming roles and responsibilities which are distinct from diploma prepared nurses...
>
> The nursing profession and employers of nursing need to define on a continuing basis roles, tasks and skills required for the various levels and types of nursing practice. Out of this definition, appropriate educational prerequisites corresponding to levels of practice should emerge. However, on the basis of present knowledge and identified trends, a nursing degree requirement for all registered nurses is not supportable...[2]

The Alberta government publicly stated that it does not support the BN policy in that province[3] and in our province the Ministry of Advanced Education writes that the matter is still under consideration, but that no conclusions have yet been reached.[4]

The Manitoba Organization of Nurses' Association "found that not all nursing jobs require a baccalaureate degree"[5] The Nurse Manpower Study says that the second in importance of specific workplace factors in employee retention is appropriate match between job description and the individual's educational preparation.[6]

In New Brunswick, the nurses' union "does not support the view that for nursing practice a baccalaureate is

necessary, nor necessary by the year 2001".[7]

Dolan claims that the onus of proving change will result in improvement in the present state of affairs in on those who promote that change.[8] The RNABC has not proven that a BN is a necessary preparation for the neophyte.

If we did accept the assumption that there is a deficit in the nursing care in B.C., the next assumption is that education is the answer to that problem. Our choices may well be delineated by our perception. Dolan posits that because nursing leaders are also very frequently educators, they "tend to be obsessed with educational remedies" and that "academicians have long been accused of a tendency toward building bigger and bigger programs designed to produce more likenesses of themselves rather than what the market wants".[9]

Finally, as one physician writes:

> Some years ago the decision was made that nursing had to be an "academic" profession and all nurses had to be university graduates, with at least a bachelor's degree and preferably more. There is nothing wrong with this, but the pursuit of academic degrees does not produce better nurses. Degrees may mean they can perform the non-nursing aspects are not what drew them into the profession. And they will not keep them in it.[10]

The author continues his explanation that nursing's bureaucrats rise in the hierarchy...and "as they rise they create ridiculous and unworkable policies that those with fewer academic qualifications must follow".[11]

Refer to Figure III for a summary of the other

possible sources causing a deficiency in the quality of nursing care in B.C. The educational solution appears to ignore other possibilities. If, indeed, there is a problem with the delivery of care to the citizens of B.C., it is possible that the source is in the delivery system itself: staffing has been in a crisis in this province for over four years. Recently, it was established that there are over six hundred job vacancies in the province.[12]

Perhaps nursing staff is preoccupied with non-nursing functions and therefore not able to function effectively at the bedside.

Possibly the support systems for nursing are not sufficient or necessary equipment is not available.

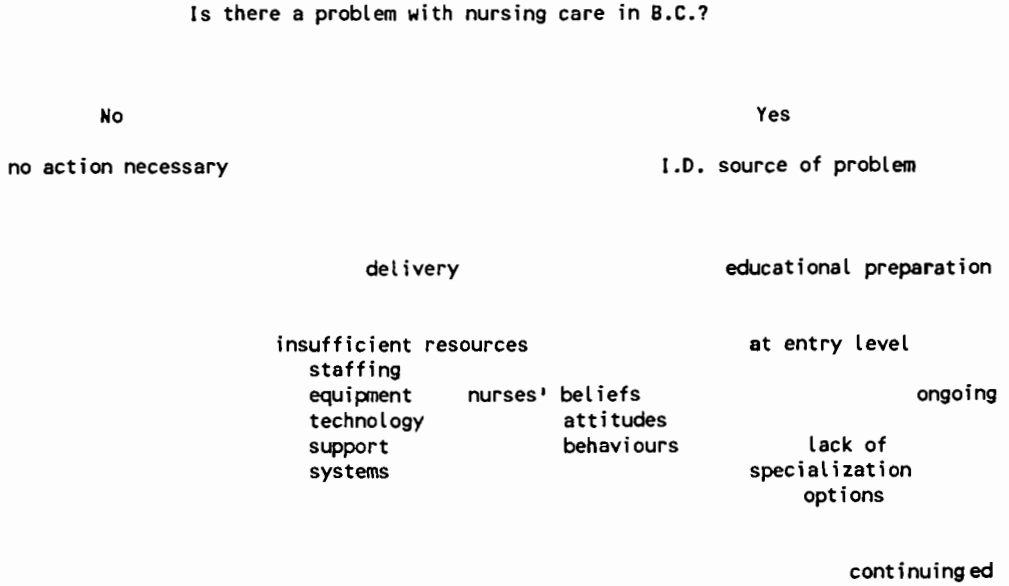
If the problem <u>is</u> in the education of nurses, attention to input rather than output variables may be more appropriate. Rather than legislating that all entrants to practice have a higher education, ie. a baccalaureate, more rigid screening of applicants to the schools of nursing or of the programs themselves might be the answer. These solutions may work better to guarantee a more superior practitioner. Once the nurse has entered the workforce, requirements for continuing education could ensure life-long learning and some positive stimulation in care giving.

Whichever option is chosen, there must be a responsible evaluation once the changes are in effect.

Rationality, according to Carley, in decision theory

is "to select a course of action from a group of possible courses of action, which has a given set of predicted consequences in terms of some welfare function...Also called "planning" it is that activity that concerns itself with proposals for the future with the evaluation of alternative proposals and with the methods by which those proposals may be achieved".[13] Thus, the RNABC is required to work through the five stages of: 1) problem identification, 2) generating all important strategies for problem, 3) listing all important results predictable for each option and probability of each result, 4) comparing consequence to the goal of the problem solution, and 5) determining which result of the various strategies best matches the stated goal.[14]

Figure III: A Proposed Critical Path for a Rational Analysis of the BN:2000 question. Various strategies for each of the identified problems would require assessment.



There are two additional deliberations. The first is that, as Majone puts it, "It is possible for actors to make elaborate, detailed statements of their plans. However, the error comes if we assume that the plans then control their behaviour. If we watch closely it will become clear that the behaviour is under the control of more determinants than just the vocally stated plan".[15] A baccalaureate does not assure better patient care, if that is the problem identified. The other confounding factors can be found in the health care delivery system or in the workforce's attitudes or beliefs. Possible problems can be located in either basic or continuing education. One writer states that most working nurses are more concerned with maintaining their previously acquired skills and knowledge than advancing them.[16] In this instance it seems that a legislation for approved continuing education of for re-registration annually might be an appropriate strategy for dealing with the problem (as is done in California).

The BN:2000 factors describe a concern for the evolving complexity in health care. Specialization options, either during basic education, or post-graduation, may be a solution here.

The Importance of Values in Policy Making and Analysis

A previous statement suggested that the professional association's motivation in seeking to alter educational requirements is concern over excellence of patient care. This highlights the role of values in policy making and analysis. The policy making activity is suffused with values and rational analysis achieves relevancy only when values have been explicitly identified.[17,18] In fact, both Mann[19] and Bobrow[20] make it clear that one hallmark of policy making is the presence of conflicting or competing interests and Brobow[21] further states that the values must be studied in three dimensions:

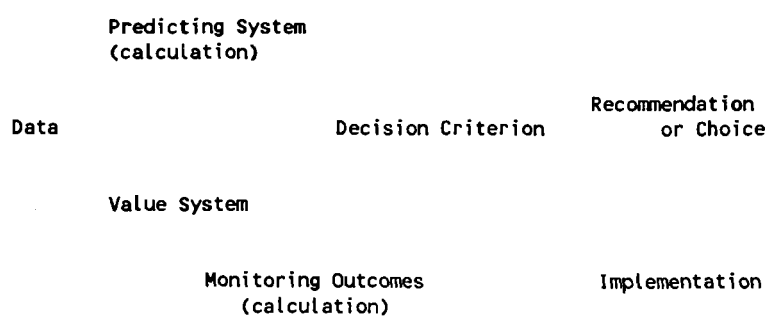
1) the timing of allowing the value the effect the process and for how long,

2) what amount of the value is sufficient, and

3) deciding the priority of each value in relation to each other.

Mann illuminates the importance of a value system into context when he places it after data collection, but prior to measuring options against decision criteria. See Figure II for a schematic of Mann's[22] decision making model.

Figure IV: A Schematic of Mann's Decision Making Model



The schematic indicates that collected data is filtered through a value system before it can be measured against set standards for decision making. Therefore, values logically affect the recommendation or choice in its turn. Implementing the decision impacts on the environment, thus necessitating effect-monitoring with feedback into ongoing decision making.

We might presume that the problem that the RNABC identified is a lack of quality in nursing care in B.C., and that it has chosen higher education as the answer to the problem. If, however, the Association valued a more pragmatic approach to the dilemma, then timing of the BN:2000 might be questionable. In the United States more women are applying to schools of medicine than nursing. There, in the past five years vacancies in nursing have tripled and is estimated to be 120,000. The nursing programs in the States showed a 26% drop in enrolment

between 1976 and 1987. Twenty percent of nurses surveyed indicated that they would be leaving nursing within the next three years.[23] When it is documented that over six hundred job vacancies in the province remain unfilled for several years, perhaps a more practical approach may be to recruit more nurses,or augment support components so that the present workforce is freed up to do only nursing functions, making the delivery more efficient. If the value is university education, is it necessary for all entrants to have a degree? As documented previously many organizations including nursing associations and unions, and government ministries think not. Required education must be co-related to job description, therefore a broader-based education may be appropriate for nursing administration, research, and education, but not for general-duty functions. Is the degree education valued at a higher priority than efficient and effective patient care? If, as the Ontario government as stated, the community is receiving quality care, how does the RNABC argue the numerous and considerable costs of the BN:2000?

"A value set provides a basis for orientation in and interpretation of a complex world and for formulation of appropriate responses to that world."[24] Given that nursing is a public service, it seems logical that quality patient care should of greatest concern.

If the unstated value in the BN:2000 policy is

professionalism and higher education is seen as a route to it, that should be explicitly stated. The next step would be to rationally determine whether nursing is a profession, a semi-profession, or neither. Like our policy analysis, criteria must be chosen to establish professionalism and nursing must be measured against standards to ascertain if the claim of fully-fledged professional status is true. If it was found not to be a profession, the RNABC would have to generate any plausible strategies (possibly including university education) that would function to confirm nursing as a profession.

Morality of the BN:2000 Policy

Tong posits that morality depends on the reasons for doing versus the consequences of the action and that rationality is the basis for morality. "Reason, and reason alone, transcends the contingencies of space and time".[25]

The BN:2000 policy statement demonstrates no acceptable rationales.

Is it morally defensible? The same author enumerates five components that determine whether a risk is acceptable:

1) probability that harm will result and then,
2) the seriousness of that harm,
3) probability that the goal arguing for acceptance of the risk will in fact result from the chosen course of action, then
4) the value of achieving that goal (which Tong notes is very, very subjective), and finally

5) the necessity of the risk to the goal.[26]

If we accept, as does the Alberta Ministry of Health, that the citizens of our province receive quality care from predominantly diploma-graduated nurses, some of the economic risks of the BN:2000 cannot be warranted. The economics encompass the budgets of both the Advanced Education and Health Ministries, all hospitals and health care agencies employing nurses, the finances of all colleges and universities offering programs in nursing and the individuals student's costs. All of these eventually perk down to tax dollars garnered from the province's constituents. Should B.C.'s people be expected to pay for BN:2000 when its advantage is in question?

Additionally, there is the real risk that BN:2000 implementation will directly and quickly lead to both a drop in applications to programs in nursing and an increase in attrition from nursing (due to increased job competition between degree and non-degree graduates). This will work only to exacerbate the nursing crisis documented for the past six years in B.C.[27]

Finally, social stratification between care givers and patients may be a considerable risk. Will a workforce comprised primarily of upper middle class, those who can afford four years of university education costs, afford the same interpersonal dynamics in patient care as does one of socio-economic diversity?

Subsequently, these must be assessed for their value. How heavily do they weigh? If the negative results transpire, how damaging will they be? The B.C. Nurses' Union calculates that financial costs to the student for a four year baccalaureate degree varies from between $45,313 to $50,513 while a diploma program costs from $20,852 to $32,772.[28] The savings of the diploma program is obvious. These figures cannot include the costs of relocating to one of two major urban areas containing a university. An applicant to a diploma program, on the other hand has a choice of ten colleges scattered throughout the province and therefore may incur a smaller debt-load.

Costs of transferring the present programs from college to universities must be accounted plus the expense of augmenting the faculties of nursing, ie., increasing the number of doctorates, in order to compare favourably with any other faculty. Costs of fewer application to the schools and increased attrition from the workforce must be addressed.

Qualitative studies regarding the nurse-patient relationship and nurse attributes are required before the cost of a uniformly prepared nurse can be realized in socio-economic terms.

The value of the risk, ie., the seriousness of the harmful effects, can be tabulated numerically when we consider the economics of implementation. They are

noteworthy and necessitate thoughtful judgement. Given that nursing is a public service effecting all socio-economic groups in our community, the effect of stratification in the health care milieux is serious, indeed.

Tong's third risk component is the probability that the goal of the policy actually becoming realized. There seems little doubt that BN:2000 implementation will take place. Some colleges are presently negotiating to establish a relationship with one of the universities whereby the students will be graduates of a baccalaureate program. However, if the implicit goal of the policy is better quality care or professionalism, there is reasonable doubt. In the former case, studies have not demonstrated a significant advantage in care done by degree versus non-degree grads.[29] In the latter case, there are many criteria for professionalism and nursing would have to successfully meet all of them before it could be accepted as a profession.

Possibly, the most subjective estimate is the value of achieving the goal of BN:2000. If that achievement is exceptionally important, considerable risks can be condoned. The cost is worth the benefit. Ostensibly, the RNABC has determined that this is the case. However, given that it is a public policy and the province's citizens will shoulder the expenses perhaps the <u>public</u> should have opportunity to evaluate and reject or accept the policy.

Finally, we consider whether the identified risks truly mandated in order to achieve the goal of the policy. It's impossible to imagine implementing BN:2000 without appreciable economic and social outlay.

Refer to Figure V for a possible "risk equation" for BN:2000.

Figure V: An Equation for Estimating the Morality of a Policy.

(P harm X value of harm) + (P realizing goal X Value of goal realization) + risk necessity to goal =
moral acceptability

This paper identifies several possibly serious, harmful effects of BN:2000, therefore the first components of the equation equal "ten" each, if we use a scale of zero to ten. The probability of the goal (all new entrants will have BNs) is high since the educational institutes are complying with RNABC's legislative fiat.

The risk necessity appears mandatory to achievement of the goal, therefore it is assigned a "10". We derive a total of "210" when we use the RNABC's high value for the goal (set at "10").

If, for reasons of economy or lack of substantive proof of BN superiority, the value of the goal is assigned a zero, the total drops to "110".

Tong's five considerations for morality in policy making provide a framework for lucidly deciding whether a specific policy is morally acceptable. BN:2000 should be put to such scrutiny prior to acceptance.

Integrity of the BN:2000 Policy

There are two points to seriously take into account that may work to undermine the integrity of BN:2000. Dolan in his paper dealing with the New York state nurses' baccalaureate policy brings to light the first. He states that the grandfathering clause threatens policy's wholesomeness.[30] If the proponents believe that baccalaureate education is so vital in nursing, how can they on the other hand accept that nurses employed, but having an inferior preparation, are yet acceptable? They are willing to promote the policy despite tremendous costs, while still giving the nod to "second rate" practitioners. If the policy is so important, can the policy makers and supporters have it both ways?

The second consideration is that the RNABC has no policy regarding immigrant nurses.[31] Presently, one in ten nurses in the U.S. is from overseas[32], Ontario recently recruited from Great Britain, and St. Paul's Hospital in Vancouver contracted to employ Californian nurses privately just this past summer. Seemingly most of these practitioners would already be employed and therefore be

included in the grandfathering clause. But, if any were newly graduated, should they be required to be baccalaureate holders as are newly graduated British Columbian nurses?

General Comments

It is apparent from a broader discussion of BN:2000 that at best it is poorly conceived and badly timed. The structure and organization of the policy statement outlining the factors forming the foundation of the policy are vague, repetitive, circuitous, and unfounded. The publication offers no arguments for the policy.

The assumptions that nursing care in B.C. is lacking and that educational upgrading is the appropriate remedy are not identified nor validated . If it was a fact that there is a problem with nursing care many possible sources for the dysfunction must be investigated. These could include a problem in care delivery due to lack of resources, outdated technologies, insufficient support systems, and unsuitable job descriptions.

If the deficiency was identified in education of nurses other options should be clearly and judiciously examined, such as more stringent qualifications for students and schools alike. Registration exams could be higher calibre. These strategies may work to provide better qualified entrants to practice. Specialization options in

both the basic and post diploma programs could provide the knowledge and skills necessary for neophytes to enter practice in a discipline such as Critical Care or Paediatrics. At the same time, the post diploma programs coupled with mandated continuing education would support ongoing learning and upgrading.

The onus is on the professional association to demonstrate that it has assessed care delivery in a lucid manner and has subsequently considered all possible explanations for observations and all likely remedies. Only then can the RNABC claim that it has formulated a responsive, responsible and reasonable policy.

Conclusion

This paper traced the evolution in nursing and nursing education through history to present day British Columbia. It can be said that the work and status of nursing has been, and still is, a reflection of scientific knowledge and women's position in society. Thus we have arrived at a point where the complex cure model has been added to the traditional care model of nursing. It is not sufficient any longer that nursing procedures encompass only supportive health regimes focusing on the patient's environment. Technological advances translate into therapies unheard of only two decades ago. The question is: "In order to serve the public as effectively and efficiently as possible, what

is an appropriate education for entry to practice nursing?"

The RNABC decided that a baccalaureate is the prerequisite and has published a position paper outlining twelve "factors" arguing for the BN:2000 policy.

In the five-phase sequence of policy formation and adoption "Rationales" comes second, following discriminating observation of the problem set, and before formulation of the policy statement. Only after clear observation and identification of the dilemma can valid arguments for a particular course of action be advanced. The validity of the arguments is established when judged against established criteria.

These criteria for judgement are:

1) Explicit identification of assumptions operating in the policy making process. It must be shown that the assumptions are truly warranted.

2) There is a requirement that data be collected in a discriminating manner and that it be reproducible.

3)Evidence, the judicious use of data, must clearly illuminate the causal link between supportive data and the option chosen when the specific policy statement is formed.

4) Finally, the value system at work must be examined. When at least some aspects of policy are not quantifiable Mood explains, "Analysis rests at least in part on debatable value judgements".[1] Tong writes that "The policy world is populated neither by pure facts nor by pure

values, but by value laden facts...".[2] To qualify as a rationale the values inherent in the policy must be expressly considered.

At the onset of reading the "Entry to Practice of Nursing in Year 2000" position statement from the RNABC, it is notable that the document is repetitive, vague and circuitous. On closer examination, there is a profound lack of data. Therefore, there is no supportive evidence for the position. Neither assumptions nor values are identified.

Consequently, what has been published is an ipse dixit. It is not an acceptable argument for BN:2000: it is an assertion only.

Because nursing has been, and is, an echo of women's social status, the policy makers would do well to realize what nursing is in <u>fact</u> rather than what they seem to wish it to be, a profession.

Notwithstanding the ongoing staffing crisis in B.C., there are considerable reasons to re-think BN:2000. Beside the problem of retention[3], <u>attracting</u> people to schools of nursing is a predicament. A four year baccalaureate in nursing will meet stiff opposition when other baccalaureates (such as Education) offer eventual employment at higher salaries and more amenable life styles for the same investment. There are many more options for women that were not available a short time ago. Increasing numbers of women are choosing fields that were previously

male-dominated, such as Engineering. If fewer and fewer people select nursing as a career will the people of B.C. be <u>better</u> served with the implementation of the BN:2000 policy? And, can the value of professionalism supersede that of quality in public service?

Tong writes that "an action is rational to the extent that it contributes to the mega-activity that Aristotle terms "eudaemonia"".[4] When we consider that "eudaemonia" indicates "happiness" or "flourishing", it is difficult to concede that BN:2000 is rational. Rather, the policy is ill-conceived, poorly argued, badly timed and expensive. Given that nursing is a public service, BN:2000 is a public policy. Many declare that the citizens have been, and still are, receiving adequately good care from graduates of the present education system. Therefore, the RNABC is required to argue convincingly that its proposed change in the status quo is necessary <u>and</u> advantageous. It has failed to do so with its policy position statement. "In sum, the rational person is that person who not only knows, but is also willing to do, that which is good for one and all...".[5]

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