The RN-RPN Schism: A Reflection on Ethical Leadership

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Nursing leaders have spent decades creating a schism between registered nurses (RN) and registered practical nurses (RPN). This schism has largely preserved the previous models of care while compromising our code of ethics as expressed by the Canadian Nursing Association (2017). Partitioning nursing based on access to the university system has resulted in suffering and harm for RPNs.

Baccalaureate Entry to Practice

Arguments in favour of the RN-RPN split revolve around the idea of *baccalaureate entry to practice*. Nursing leaders believe that only a four-year university education is sufficient to train nurses for practice in our complex, modern healthcare environment, and BScN-trained nurses facilitate better patient outcomes (Dyck et al., 2021).

However, in Ontario's many compressed time frame (CTF) BScN programs, a student attends nursing school for five semesters, the same length as a typical RPN diploma. The professors in my RPN program hold advanced nursing degrees and teach in both the RPN and BScN programs. Our books are written for BScN RNs, as evidenced by their lack of representation of RPNs. Furthermore, clinical immersion is a novel pedagogical strategy for CTF (Kaddoura et al., 2012) used in the RPN curriculum. No research exists comparing these similar courses of study, so it remains unclear how they would produce different results.

The second claim is that patients have better outcomes when their nurses have BScN credentials (Dyck et al., 2021). Though evidence supports this, the effect size varies, with several studies showing no improvement in mortality outcomes (Audet et al., 2018). Estabrooks et al. (2005), the only Canadian study, sent a survey to all registered nurses in Alberta. Due in part to the lack of response, more than half of Alberta hospitals were excluded from the analysis. Their research shows that a subset of patients treated experienced reduced all-cause mortality during one year when a higher percentage of nurses reported having BScN credentials. This is an interesting result, but Estabrooks et al. (2005) warns that longitudinal data is lacking, and we must "exercise caution in interpreting and generalizing" (p. 82) the findings. A later systematic review agrees that longitudinal studies are required "to determine if levels of RN education are causally related to mortality" (Audet et al., 2018, p. 143). The Canadian Nursing Association (2017) calls on Nurses to use "evidence-based decision making" (p. 16). Nursing leaders should reflect on the quality of the evidence used to support the baccalaureate entry to practice, given the absence of evidence for superior CTF BScN preparation and limited evidence for improved patient outcomes in Canada.

Nurses are called to address systemic issues affecting patient health outcomes (Canadian Nursing Association, 2017, p. 11). Assuming that BScN nurses produce significantly better patient outcomes, meeting this standard would have required nursing leaders to phase out diploma nurses (RPNs) or limit their role in acute care. Nursing leaders (a) created the RPN designation, perpetually enshrining college-prepared nurses in Ontario healthcare and (b) grandfathered in diploma RNs . Since the College of Nurses of Ontario (CNO, 2024) does not track the educational level of registrants, it is unclear how the nursing educational mix has evolved. Though data is lacking, post-schism

healthcare delivery broadly replicates the old system: a combination of diploma and degree nurses care for clients. RPNs are supposed to care for lower acuity patients (CNO, 2014), but more RPNs work in acute care (Registered Practical Nurses Association of Ontario [WeRPN], 2024) than any other setting, and up to 75% report caring for medically complex patients (WeRPN, 2024).

Discriminatory Institutions

Though many RPNs and BScNs share the same professors, textbooks, and study duration, academic nursing leaders do not value practical nursing education. This is most clearly seen when examining the available bridging options for RPNs wishing to pursue a BScN. An RPN with 70+ credits of nursing education and 2 years of full-time, bedside experience as a licensed nurse must study, at minimum, for 22 months to receive a BScN (Western University, 2024a). A student with no nursing background and ten university credits in any discipline may earn the same BScN in 19 months (Western University, 2024b). For the contemporary nursing leaders who operate these programs, the knowledge, skill, and judgment of an experienced nurse are of negligible value toward a degree.

Canadian universities have excluded undesirable populations since their formation, and this exclusiveness remains in the form of "overwhelming patterns of racism and Whiteness" (Cranston & Bennett, 2024, p. 126). By shackling their perceptions of valuable nursing education to discriminatory institutions, nursing leaders have failed to honour our ethic of non-discrimination (Canadian Nursing Association, 2017, p. 15) and their obligation to recognize "that vulnerable groups in society are systemically disadvantaged […] and take action to overcome barriers" (Canadian Nursing Association, 2017, p. 19).

Failure of Distributive Justice

Many academic papers promote diversity, equity, and inclusion initiatives to recruit diverse students to university. Nursing leaders should look outside the academy toward untapped reservoirs of diverse talent, such as Ontario's colleges. If BScN training leads to better outcomes, nursing leaders should advocate replacing the RPN curriculum with the CTF curriculum at colleges. Enabling colleges to grant BScNs on accelerated timescales could further their goal of increasing nurse education while maintaining the economic and structural incentives that drive college attendance. By hoarding the most valuable education inside universities, nursing leaders fail to uphold our ethic of distributive justice (Canadian Nursing Association, 2017, p. 15).

Harm to RPNs

For nearly two hundred years, trained nurses were considered broadly equal; "a nurse is a nurse is a nurse". The schism has separated RPNs from our diploma RN forebearers, leading to role conflict (Nowrouzi-Kia et al., 2022) and lack of fair compensation (WeRPN, 2024, p. 8). While the evidence of the benefits of the schism is lacking, it is clear that RPNs are suffering: 81% do not feel supported in the workplace, 83% believe they are unfairly compensated, and 48% plan to leave the profession (WeRPN, 2024). In conclusion, "Nurses are accountable for their actions" (Canadian Nursing Association, 2017, p. 16). It is time for nursing leaders to study the consequences of the RN-RPN schism in Ontario and reflect on the ethical compromises and the material harm they have caused our profession.

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