A STUDY OF THE PROFESSIONALIZATION AND PROFESSIONALISM OF NURSING: 1960 - 1980

by

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Chapter 1

INTRODUCTION

One of the most powerful and important ideas in the belief system of nursing is the idea of attaining professional status (ANA, 1979; Brown, 1948; Etzioni, 1969; Gamer, 1979; Merton, 1957). The disposition of nursing's professional quest, however, is hotly debated by those within the nursing community, as well as among scholars outside of nursing (Etzioni, 1969; Gamer, 1979; Stuart, 1981). Some view nursing as a semi-profession, a sub-profession, or as a marginal profession (Etzioni, 1969); others use the title of professional because of courtesy and tradition; and still others report claims of its attainment as an accomplished fact (Stuart, 1981). Hence, although there is substantial agreement that nursing is seeking professional status, significant disagreement exists as to where nursing is in relation to its achievement.

"Professions occupy an important position in American society. The performance of necessary services . . . and the well-being of society are greatly dependent on the activities of professional groups" (Stuart, 1981, p. 18). The attainment of professional status involves more than the mere identification of it as an objective, for it is society that grants the prestige and the effective monopoly status associated with recognized professions. In order to gain this recognition, groups must engage in activities designed to bring them prestige,

status, and respectability. It is a tedious process, usually requiring group commitment, an environment conducive to its development, and the passage of time.

Professional recognition is granted to few in our society and sought by many (Stuart, 1981). As such, it involves struggles on two levels--intergroup and intragroup (Gamer, 1979; Stuart, 1981). First, the manner or content of the groups belief system or its commitment to a professional ideology is not always fully embraced by various interest groups within the occupational sect. This situation exists in nursing. Some nurses see themselves as providing a highly skilled technical service as physicians's assistants (Gamer, 1979), while others believe that nursing is an essential and distinct element in the provision of health care. This ideal holds that nurses are equal to and independent of physicians in health care delivery systems (Stuart, 1981).

On another level, struggle can ensue between distinct occupational groups who are competing in the same environment for society's approval. If nursing attains professional status it will have to do so primarily at the expense of physicians who control access to health care services. This struggle exists in today's health care system, and primarily involves a debate over who will independently deliver health care services designed to keep clients well--nurses or physicians. Thus, given both internal division and external competition, nursing's drive to attain professional status is meeting with significant resistance.

Nursing's concern with professional status is not a new issue, quite the contrary. Concern regarding this matter has been expressed

in the literature over the years (ANA, 1979). It is, however, an issue of renewed interest. Today's health care system offers an opportunity for nurses to gain in status by meeting the changing expectations of society. These expectations involve changing the health care system from one primarily designed to care for people once they become ill, to one designed to keep people well. Nurses have formally declared an interest in providing society's health promotion needs as independent primary care providers. Such an opportunity holds promise for the achievement of professional status (Roberts, 1979). Thus, with this renewed opportunity, it is important to ask questions about nursing's struggle to achieve professional status.

Historically, the word "profession" has been applied to the "learned professions" of law, medicine, and theology. Cogan (1953) notes that there have been numerous attempts to define "profession." There are "dictionary and legal definitions, arbitrary and applied definitions, definitions expressed in terms of power and prestige, and definitions in terms of internal regulation" (Cogan, 1953, pp. 24-36).

Recently, however, scholars have attempted to refine general and somewhat abstract definitional approaches by restructuring the conceptualization of professions and professionals, and by identifying specific characteristics or attributes associated with them. The purpose of this activity is to refine the subjective nature of decisions regarding occupational groups vis-a-vis their professional status, thereby promoting a more objective orientation in such exercises. Such attempts are worthy of review.

Vollmer and Mills (1966) argue that general abstract approaches can be substantially altered and the conceptualization of professions vastly improved if we avoid the use of the term "profession" in any other context except that of an abstract model of occupational organization. Such an approach provides "the form of occupational organization that would result if any group became a profession" (Vollmer & Mills, 1966, p. vii).

For these scholars, the conceptualization of a profession as an abstract form, non-existent in reality, avoids the forced choice judgment of whether a group is or is not a profession. It offers the opportunity of conceptualizing the development of an occupational group towards professional status as a dynamic process "whereby many occupations can be observed to change" (Vollmer & Mills, 1966, p. vii) with respect to certain characteristics in the direction of the abstract ideal type. These scholars label this evolutionary activity as the process of professionalization. Therefore, they do not ask if a group is or is not a profession but, rather, ask questions about how professionalized it is by identifying and measuring, over time, characteristics commonly associated with professions.

This approach views this process on the basis of a continuum or scale along which an occupation moves as it struggles to achieve professional status (Goode, 1957; Greenwood, 1957; Moore, 1970; Vollmer & Mills, 1966). Thus, in a hypothetical sense all occupations can be placed at some point on the continuum. Finally, Vollmer and Mills

(1966) suggest that the term "profession" be reserved for groups of colleagues that have achieved a relatively high degree of professionalization. In other words, there is theoretically at least, some point or threshold on the continuum, beyond which the designation "profession" is possible. Opinions can vary markedly as to where that threshold is located, and what groups lie beyond it, but as a minimal criterion there seems substantial agreement that the baccalaureate degree is requisite for professional status designation (Greenwood, 1957; Moore, 1970; Reiss, 1955; Vollmer and Mills, 1966). Moreover, Greenwood (1957) points out, that as the occupational group develops and specialization emerges the rise of graduate professional education beyond the baccalaureate level will become mandatory.

This minimal threshold requirement encompasses highly professionalized groups as well as those of lesser status such as educators, social workers, and nurses. This designation may, however, serve to shed some light on why opinions regarding these marginal professions generate such controversy when forced choice (profession--non-profession) judgments are argued. Thus, while the problem of clearcut professional designation remains, the complexity of the issue is somewhat resolved. Suffice it to say that there is a threshold, and that some groups which lie beyond this point are in the shadows. Studies which seek to reduce the ambiguity of this area, therefore, take on added significance.

The efforts of Vollmer and Mills (1966) are further refined when scholarly works regarding professional characteristics or

attributes are incorporated. Greenwood's (1957) professional criteria are typical of this approach. While they are not exhaustive, they do provide a more definitive frame of reference. His professional characteristics/attributes are: (1) general systematic knowledge; (2) authority over clients; (3) community rather than self-interest; (4) self-control or autonomy; (5) recognition by the community; and (6) a distinctive culture. Each of these elements will be briefly explored to promote a more explicit understanding of their meaning.

1. General Systematic Knowledge. As previously indicated the term "learned" has traditionally been applied to professional groups. The period of education is long and intensive, and characterized by the acquisition of skills which flow from and are supported by a fund of knowledge. The site and character of this educational preparation has changed over time from that of apprentice learning to the training school, finally establishing professional education in the college/university setting.

2. Authority Over Clients. In a professional client relationship, the professional establishes what is appropriate for the client, and the client is expected to accept, indeed accede, to the judgment. This type of relationship is one reflection of the approval which characterizes the delegation of responsibility accorded professionals by society.

3. Community Rather Than Self-interest. A distinctive characteristic of a profession is its orientation to public service. The professional group first serves the needs of the client, and places these needs ahead of their own personal gain or commercial profit.

4. Self-control, Autonomy. This element or attribute of a profession involves an assessment of how work activities are controlled. The idea that professionals engage in unilateral decision making informs this characteristic. It reflects the delegation of responsibility, to the group, by society to judge and sanction the practice of individual members or aspiring members of the professional group. Basically, it represents a barrier against lay interference in the work activities of the group.

5. Recognition by the Community. This attribute involves recognition by society of the need and value of the service provided by the group. The community accepts the power of the profession in relation to the service. A formal reflection of this acceptance by society is the license granted by the state to engage in the service.

6. A Distinctive Culture. The professional culture develops around formal and informal groups and includes distinctive values, norms, symbols, and rituals. Ethical codes, emblems, insignias, and uniform are considered reflections of the group's distinctive culture. Culture can also be defined as a shared system of beliefs and a more general way of examining this distinctive culture is by making inquiries about the ideological orientations of the occupational group. Ideology

refers to "a fairly coherent set of ideas" (Silva & Slaughter, 1980, p. 814), which serves to clarify and promote resolution of timely issues. Thus, the ideology of an occupational group can either impel or limit changes in society.

Greenwood's attributes in concert with the Vollmer and Mills' concept of professionalization as a process enriches and refines our understanding of the evolution of occupational groups in our society. Problems, however, still remain, and thought provoking questions can be posed. With regard to attributes, for instance, to what extent do groups have to reflect these characteristics and what form do they have to take before the designation "profession" is appropriate? Are some of the characteristics of greater importance or value than others? In other words, what qualitative and quantitative combinations could be equated with professional status? The answers to these and other questions regarding professions lie in the future and are beyond the scope of this study. An awareness of such substantive issues, however, does seem mandatory when dealing in the area of professionalization.

This brief explanation of Greenwood's professional characteristics and the Vollmer and Mills' concept of the process of professionalization has been undertaken in order to provide a basis for examining nursing's current struggle for professional status. Specific circumstances and events which surround nursing's quest for professional status in today's society will be reviewed in order to clarify specifics with regard to this particular group.

In 1965, the American Nurses Association (ANA) issued a position paper which called for the clarification, elevation and standardization

of the nursing education system. Specifically, the paper stated that: (1) the education of all individuals licensed to practice nursing should take place in institutions of higher education, and (2) the minimum preparation for entry level professional nursing practice should be a baccalaureate degree in nursing.

The changes advocated by this position paper are significant with respect to the emerging nature of the American health care system and the development of nursing as a profession. By doing this the ANA leadership expressed a desire to gain both occupational and social prestige, status, and respectability. Through the successful inclusion of nursing education in the ranks of higher education, nursing would move closer to acceptance as a profession, achieving the desired status and control of entry into practice.

In order to provide a basis for understanding the development of this statement, a brief examination of the forces-social, political and economic--which shape nursing and the health care system is undertaken. This task is based on the belief that in order to understand the present, the past must be examined. In addition, since changes occur as separate events related to specific groups or selected services, we tend to view and react to these changes as isolated phenomena without developing a fundamental understanding of relationships among events or trends inherent in them (Palmiere, 1974).

Physicians have, through the centuries, succeeded in developing, utilizing, and controlling the skills and knowledge necessary to safeguard man's health status. In meeting the health care needs of

society physicians are recognized as a highly professionalized group. Recently, however, developments in the health care system have combined to create conditions which threaten the traditional leadership role of the physician in the system, and create "professionalizing" opportunities for nurses and nursing in that system.

In a scant seventy years, the health care delivery system of the solo medical practitioner has given way to that of the medical-industrial complex (Ehrenreich, 1970). The post World War II period saw a steep decline in the pre-war solo medical practitioner, and a concomitant rise in the influence of medical institutions--hospitals and medical schools. This change was not unlike that which occurred shortly after the turn of the century when the small factory gave way to the large corporation. "The shift of the center of medical gravity is the result of three complimentary forces: changes in technology, changes in financing, and changes in the prestige structure of the medical profession" (Ehrenreich, 1970, p. 31).

Knowledge, including that which is technical and theoretical, now doubles every two years (Mauksch, 1974). This situation was greatly accelerated in the postwar period through the expansion of federal expenditures for biomedical research. It went from $50 million to about $1,200 million on an annual basis, with approximately $350 million of the total directed at medical schools. The by-product of this investment has been a revolution in new knowledge and techniques directed at the control of disease (Carnegie, 1970).

Not only did the government play a key role in financing the expansion of the knowledge frontier, but also the expansion of those

institutions through which the knowledge and technology would be made available to the public. The Hill-Burton legislation provided large sums of money for the expansion and modernization of acute care facilities. The American Medical Association was a primary supporter of this legislation. Medical care became a national priority, and the problem of public policy was how to get more of it (Roberts, 1979).

The primary, indeed the sole, provider of this expanded and improved care was the physician. They paid a price, however, in promoting the development of hospitals, and that price was independence. Physicians are fast becoming institutionalized practitioners. They can no longer practice in isolation. They rely on those in their own field to help identify and incorporate in their practice new techniques and advances. They rely on other specialists outside their field for patient referrals. They rely on the medical center and community hospital for access to the technology of modern medicine. No physician can hope to acquire the equipment necessary nor employ the technicians required to operate the tools of the trade. They rely on the organization of group practice. In short, the old general practitioner who could treat the cough, deliver the baby, and take out brother's appendix has vanished.

Thus, the basic formula was established. The postwar philosophy of social egalitarianism promoted health care as a right, rather than a privilege. Primary health care providers supported the enlargement of the access system, and the federal government poured billions into expanding the system to meet the created need. Needless to say, there were few objections. Opportunities abounded; new technology brought

with it employment opportunities, as businesses such as insurance companies, pharmaceutical houses, and hospital supply and equipment companies expanded to meet the needs created by the system. Health care, Ehrenreich (1970) asserts became an efficient and effective money making system. Within this newly developed system, the cost of health care began to rise relentlessly. With the rise in costs came a rise in insurance premiums. The result was that the poor and elderly who needed health care most were least able to pay. The hospitals, of course, could not be expected to continue offering services to non-paying clients; and so, in 1965, these factors and the egalitarian social reorganization movement combined, and the federal government became a source of funding for medical care when Medicare and Medicaid were enacted into law (Ehrenreich, 1970). The door was opened to the disenfranchised.

> The empires, the medical-industrial complex, and the money which spawned them, are still big. But the "Health New Deal"--the mid sixties' gesture toward a more rational and egalitarian health system--lies in wreckage across the land. Medicare is a disappointment; Medicaid is a scandal. Regional Medical Programs and Comprehensive Health Planning are two new overlays of irrationality on top of the system they were meant to restructure. (Ehrenreich, 1970, p. 232)

Thus, the American health care system entered a state of crisis (Carnegie, 1970). With the costs of therapeutic measures continuing to rise, emphasis turned toward preventing the need for hospitalization. In addition, the growth of specialty medical practice created a vacuum in the provision of basic health services.

Nursing has the opportunity to fill the vacuum left by the growth of specialty medical practice and society's assertion that

health should be maintained, instead of allowing people to become ill. (Ehrenreich, 1970; Murphy, 1977; O'Koreon, 1978). The practitioners associated with the actualization of this opportunity would be knowledgeable, skilled, scientifically based primary health care providers whose basic goal is to keep people well. Such a practice could be free of direct physician supervision. Further, the role has a health care system "gatekeeper" potential. In other words, nurses would be in a position to exercise considerable control over physician referrals, when their clients became ill. Finally, it seems clear that this type of practice is oriented towards client needs, rather than needs created by maintenance of an illness oriented system. In short, nurses have a "professionalizing" opportunity.

The process of professionalization is not a phenomena that can be directly observed or tested in an experimental setting. Movement of an occupational area toward professionalization is an uneven process, and may affect various nursing types in various ways. For example, nurse-midwives have succeeded in establishing a practice that reflects many of the attributes commonly associated with the professions. In some jurisdictions, these individuals have been granted privileges to admit their clients to acute care facilities for delivery, and have been able to secure direct reimbursement for their services from insurance companies. They are able to meet the needs of the vast majority of clients who have uncomplicated pregnancies, thereby potentially limiting the practice of obstetricians.

The professionalization of an occupational group is subject to the attainment of attributes or characteristics associated with professional status. Research designed to examine the progression of groups towards professionalization requires a welding of beliefs about professions, theory concerning characteristics of professions, and the grounding of observable traits taken from this theory in the world of practice. Data sources must include aspects or components of occupational group development that are more fully realized, as well as those representative of the group's overall status. Judgments regarding professional development requires a melting state research process (Glaser and Strauss, 1967).

Nursing educators in baccalaureate and higher degree programs represent an aspect or component of professional evolution. These individuals play vital roles in establishing practitioner certification standards, the dissemination and knowledge production functions, and in the process of socializing practitioners to nursing's values, attitudes, and beliefs. They represent the standard in nursing education, as well as the cutting edge. Considering the importance of the professional school in the evolution of occupational groups towards professional status, studies which focus on nursing's professionalization and professionalism should emphasize the faculty who prepare practitioners. They play a pivotal role in the socialization of the entire nursing group (Astin, 1977). The ability of nursing to capitalize on the "professionalizing" opportunity may be primarily dependent on nursing education faculty in these settings.

The purpose of this study is to describe and document how nursing is changing and if it is changing in keeping with the process of professionalization. The purpose will be addressed through a grounded field methodology which will: (1) operationally define attributes commonly associated with professions into measurable constructs; (2) triangulate various sources of evidence for these professional characteristics in the field; and (3) develop hypotheses concerning the movement of nursing towards professionalization.

Chapter 2

REVIEW OF THE LITERATURE

In order to provide an appropriate theoretical framework for this study of professionalization and professionalism, this chapter will be devoted to the achievement of two objectives. First, contributions to the literature on professionalization and professionalism will be reviewed with special reference to nursing. The purpose of this activity will be to place nursing within the professional context. Specific attention will be focused on academic nursing and on the manifestations of this groups' professional characteristics in the mid-1960s. This period is especially important since it marks the time when the American Nurses' Association took a position on baccalaureate education as the entry level credential for professional practitioners.

Secondly, the ideological orientation of an occupational group can either promote or limit changes in society. In order to better understand this phenomenon, a research study which examines the development of professional ideology will be reviewed.

I. Professionalization and Professionalism

These two bodies of sociological literature fall, quite naturally, into two categories. The first category of inquiry involves efforts on the part of scholars to distinguish professions from other occupations. This task has, for the most part, been reduced to identifying

a set of attributes which serve to describe and/or delineate differences between these two groups. This analytical methodology is generally referred to as "the factorial approach" (Turner & Hodge, 1970; Vollmer and Mills, 1966). The second category of inquiry involves an attempt by theorists to identify a professional developmental sequence. This analytical framework is termed "the process approach" (Vollmer & Mills, 1966, p. 27).

When attributes or factors are used in the analysis of professions, studies are usually undertaken at a specific point in time. The process approach, on the other hand, has a longitudinal focus. Both of these viewpoints can be concerned with the individual or group as units of analysis. In other words, an occupational group or an individual member of a group can be analyzed for professional growth on the basis of characteristics or developmental sequence. When the perspective is a group the term "professionalization" is appropriate. When the individual is the analytical unit the term "professionalism" is used (Vollmer & Mills, 1966).

These combinations--"factors" from the group and individual points of view, and "process" from a group and individual point of view--provide a logical approach for a literature review. This structure is based on the fact that the factors or attributes remain the same; it is only the analytical unit-group or individual-that varies. The factorial analysis of professionalization and professionalism will be reviewed under the same topical area. The process, or longitudinal approach, to professionalization and professionalism will be reviewed under

separate topical areas since the criteria used in developmental analysis varies with the unit being assessed.

The Factorial Approach to Professionalization and Professionalism

The analytical framework for professionalization is the collective, with the evaluation being done at a specific point in time. Barber (1967), Goode (1957), Greenwood (1957), Moore (1970), Parsons (1939, 1968) are those most commonly associated with this functional orientation. Though there are divergent opinions among the group as to the number and priority of the factors, a degree of consensus is evident.

Ritzer (1972) utilized the works of these authors to develop characteristics or attributes which discriminate between professions and occupations. It should be understood that these characteristics are seen by Ritzer on a continuum, rather than in a forced choice framework of either being in evidence or not being in evidence. The variables he identifies are presented as continuous in nature, and he implies that there are basic qualitative differences between the professions, semi-professions, and non-professions when these factors are considered.

The factorial approach to professionalism utilizes the individual as the analytical unit. The objective of this method is to identify characteristics in the individual that are associated with professions, thereby informing decisions regarding professional status. The factorial approach to professionalization, on the other hand, focuses on the group

as the analytical unit. In this area, the objective is to inform similar decisions about groups.

Ritzer (1972) proposes six criteria that should furnish a basis for the analysis of professions and professionals. The following is a brief review of these six characteristics.

(1) Systematic Knowledge Base. The first attribute involves a systematic knowledge base into which the professional is initiated through an extensive training period. The acquisition of this knowledge takes place in higher education institutions, and is accompanied by some form of certification. In addition, the knowledge base becomes the sole possession of the school situated in the college or university. Although training can be undertaken in different institutional settings, the professional schools are the sole avenue that can lead to certification. This structure binds the dispensation of knowledge to the acquisition of the professional license.

Historically, nursing's knowledge base has not been the sole possession of programs situated in the academy. In 1965, there were a total of 1,182 schools engaged in the production of basic students prepared to take the licensure exam. Of this total, 813 were hospital-based diploma granting programs; 172 were associate degree programs primarily housed in community colleges; 197 baccalaureate degree granting programs and 56 master's programs (NLN Data Book, 1981).

When the individual is considered with regard to the systematic knowledge base two points of view emerge. First, the assignment of this professional characteristic is dependent on acquiring basic pre-

paration and certification in the higher education setting. Secondly, Ritzer (1972) argues that individuals who have acquired greater amounts of the knowledge base, within their field of endeavor, are assigned a higher level of professional status. Academic credentials are one means of making judgments regarding how much of a knowledge base an individual commands. In other words, as individual members of occupational groups earn advanced degrees, the more professional the individual and, hence, the group becomes according to sociological theorists in this area (Greenwood, 1957; Moore, 1970; Ritzer, 1972). Nursing educators provide an interesting example with respect to this characteristic.

In 1964, the National League began to report biennial statistics on nursing educators and nursing education. At this point in time, there were 12,563 nurse faculty employed on a full-time basis in diploma, associate degree, and baccalaureate and higher degree programs. Of this number, 1.3% held an earned doctorate, 37.9% a master's degree, 41.7% a baccalaureate degree, 1.1% an associate degree, and 18% a nursing diploma. In 1964, there were 3,128 faculty employed in baccalaureate and higher degree programs. This group's educational preparation was distributed as follows: 4.6% (145) held an earned doctorate, 80% (2,502) a master's degree, 15.2% (475) a baccalaureate degree, 0% an associate degree, and 0.2% (6) a nursing diploma (NLN Data Book, 1981). Greenwood (1957) and Hughes (1971) contend that there are other aspects of systematic knowledge base which serve to define the advancement of an occupational group.

Greenwood (1957) argues that a wholly theoretical orientation is insufficient. He asserts that the critical discriminant between

professions and non-professions is that "the skills that characterize a profession flow from and are supported by a fund of knowledge that has been organized into an internally consistent system, called a "body of theory" (Greenwood, 1957, p. 46). His contribution further defines the concept by clarifying what may be potential confusion between professional knowledge and superior skills. For example, some occupations such as cabinet making, tool-and-die work, diamond cutting and monument engraving require the mastery of high level skills. Although these skills may require lengthy institutional training, they do not flow from nor are they supported by an organized body of theory. "To focus on the element of skill per se in describing the professions is to miss the kernel of their uniqueness" (Greenwood, 1957, p. 46).

Hughes (1971) proposes that the crucial aspect of professional knowledge lies in its esoteric nature, esoteric in the sense that the client is in no position to judge the quality of the service provided, nor the validity of the behavioral norms that inform that service. Thus, professional knowledge is both systematic and esoteric.

Freidson (1970) states that nursing education has historically been lower level medical education. This viewpoint is based on the assumption that the bulk of what nurses acquire in the way of knowledge and skills are borrowed from medicine's body of theory. He states that "to escape subordination to medical authority, it must find some area of work over which it can claim and maintain a monopoly . . ." (p. 56). The need for nursing to develop its own body of theory has been acknowledged in the nursing literature since the 1950's (Stuart, 1981).

(2) Authority over Clients. This attribute refers to the structure of the professional/client relationship. For the professional, "The life crisis of others are their routine . . . heart surgery, defense in murder trials, burial ceremonies, and battle" (Hughes, 1958, pp. 54-55). In each of these situations the client hands his future over to the professional in exchange for their expertise and objective determination. The client is placed in the position of having to trust the professional. In turn, the professional is expected to utilize the wealth of their knowledge and exercise their personal judgment in the client's best interest.

The client is characterized by an inability to judge his needs, or the worthiness of the professional to meet those needs (Ritzer, 1972). This aspect of the relationship, however, does have its limitations, and generally they involve the scope of responsibility confirmed by the license. A sort of official backing is required to delve, for instance, into the personal affairs of others in defending a client in a murder trial. Beyond the limits of the license, the professional becomes a layman (Hughes, 1958).

In the academy, the professional/client relationship becomes the faculty/student relationship. The student is generally characterized as unable to judge his own needs; and they expect the educator to use their expertise to guide their progress.

Faculty authority over students is reflected in three distinct activities. First, faculty establish program admission requirements and they also determine graduation or certification requirements.

Third, educators also determine the shape and content of the curriculum. Activities such as establishing course requirements and evaluating student progress would also be examples of the faculty authority over students.

In 1965, the diploma school dominated the nursing education scene. The admission requirements of diploma programs featured criteria primarily associated with a trade school point of view. A high school diploma and a minimal age requirement were generally the only criteria candidates had to meet. The students' worth was established subsequent to formal admission during a probationary period which required more in the way of physical stamina than theoretical capability (Mazero, 1972). Graduation requirements involved little more than a "C" average and satisfactory clinical performance.

Admission requirements in the baccalaureate setting were more complex, and in some cases reflected the submission of the same information as that for other undergraduate applicants, but the standards that had to be met by the candidate were generally lower than other schools. Deloughery and Griffin (1977) report that graduation or certification requirements included satisfactory clinical performance and a minimal grade point average of 2.0. Requirements also typically included specific grades in nursing courses. Thus, while a student might get a "D" in nutrition, a "C" was the minimum accepted for "Maternal and Child Health Nursing."

The discretion exercised by faculty in determining the shape and content of the curriculum has historically been limited (Deloughery and Griffin, 1977). The emphasis was on practical experience rather

than classroom exposure to principles and concepts. Indeed, in many states, regulations specified the number of hours required in different curricular areas, as well as content to be included within that area. In short, the emphasis was on "doing", not why one was "doing". Large blocks of the curriculum were taught by physicians. They were felt to be just as capable, if not more capable, of teaching students to be nurses than nurse faculty. Nursing educators did not teach without third party influence who participated in determining what was best for the student.

The dominant curricular pattern in schools of nursing in the mid-1960's was that commonly referred to as the "medical model." This meant that the program was developed around five primary instructional areas--medicine, surgery, obstetrics, pediatrics, and psychiatric nursing. This curriculum model had its beginnings in medical schools, and was adopted as the appropriate framework in nursing programs (Mazero, 1972).

In summary, the discretion exercised by nursing faculty in shaping nursing curriculum and course content in 1965 was directly influenced by individuals outside the nursing educator group. One author (Henry, 1981) suggests that baccalaureate and higher degree education retained the authority model established in the hospital bureaucracy. No scientific evidence is given to support this assertion.

(3) Community Rather Than Self-interest. This is one of the less concrete professional attributes, but perhaps the key one if we consider that it is one of the more consistent features in professional

ideologies. "Professionals ideally emphasize helping others, while non-professionals are interested in helping themselves" (Ritzer, 1972, p. 58). Parsons (1939) identifies this professional characteristic as a basic human motivation--altruism. A stock broker, for instance, is thought of as pursuing his own self-interest, while the lawyer serves the interest of others.

Ritzer (1972) disagrees with Parsons (1939) stating that community interest should not be seen as altruistic motivation but rather as a difference in action. "Professionals are more likely to act with the community in mind and non-professionals are likely to act in a self-interested manner." This view, however, leaves the problem of attributing basic motives unresolved.

The community characteristic is perhaps best dealt with by McIver (1922). He asserts that the crucial element in a profession is a blend, not of form, but of spirit. This spiritual aspect is personified in the ethical code it creates. Therefore, the critical distinction between the professions and occupations lies in the assertion that something more than common work and techniques are needed for a code of ethics to result. He illustrates his position by asserting that most activities in the business would reflect an orientation of "each in pursuit of his own success" (MacIver, 1922, p. 52). The general will of the community is accomplished only when the service ideal controls the profit ideal. This latter distinction highlights the professions which recognize and proclaim for themselves the ideal of community service and unity.

The recognition of this specific difference between professions and non-professions is exemplified in ethical codes, such as that of the American Nurse's Association. This code serves as a guideline for practice and conduct. It establishes expections for service, respect for the patient, maintenance of individual competence, and high quality nursing care. It also expresses expections regarding the loyalty or service exemplified by nursing's commitment to the dignity of the patient as an individual, and activities undertaken on behalf of this goal. This attribute has been a predominant nursing characteristic and is strong in both service personnel and nursing educators (Stuart, 1981).

The community orientation of an occupational group is also evident in the educational programs it develops to meet the needs of society. Programs in colleges of education, for example, designed to prepare community college administrators as opposed to specialists in adult education are examples of a groups efforts to meet community needs. A parallel example in nursing education would involve the development of educational programs to prepare specialists who can meet the emerging health care requirements of society (Brubacher & Rudy, 1976).

In 1965, there were 56 master's programs in nursing, with an enrollment of 3,123 full and part-time students. At the same point in time, there were 4 doctoral programs and 211 students enrolled on a full and part-time basis (NLN Data Book, 1981). These programs were generally limited to the preparation of nursing educators. Graduate

programs designed to educate clinical practitioners were virtually non-existent, as were those for administrators and researchers in service and education (Mazero, 1972).

Continuing education or professional development activities are indicators of an individual's (groups) commitment to the community (Ritzer, 1972). In the mid-1960's, basic nursing education was viewed as preparation for a lifetime. Continuing education in nursing designed to update knowledge and skills was not only lacking, but generally felt to be unnecessary (Stuart, 1981).

(4) Professional Autonomy. This attribute is closely related to the esoteric nature of professional knowledge, professional authority over clients, and the community orientation of the profession. Freidson (1970) proposes that it is the key characteristic of the professions, the most vital difference with the rest of the occupations. Professional autonomy refers to the monopoly that society grants to the professional group to recruit, initiate, and certify practitioners. It also covers the authority to judge and sanction the practice of the individual professional.

This characteristic has the solo practitioner as its basic model in the literature, but Hughes (1958) states that this factor can also be applied to professionals irrespective of the setting in which they practice. The most common example of this situation is the modern bureaucracy. For Hughes, a professional working in a bureaucracy or in association with other professionals has the potential of developing an authority relationship with a client. Physicians, for example, who are

employed by health maintenance organizations have relationships with their clients similar to that of the self-employed physician. The bureaucratic-professional conflict openly expressed in the literature arises over who is the client--the employing organization or the individuals provided with the service. Professional codes of ethics are quite clear on this point. The professional's responsibility is to the individual client, rather than to the employing organization (Greenwood, in Vollmer & Mills, 1966, p. 12).

The critical aspect of this professional attribute, is the professional organization of this autonomy. Freidson (1970) argues:

> . . . the most strategic distinction lies in legitimate, organized autonomy--that a profession is distinct from other occupations in that it has been given the right to control its own work. Some occupations like circus jugglers or magicians possess a de facto autonomy by the esoteric or isolated character of their work, but their autonomy is more accidental than not. . . (p. 72)

When couched in these terms, this professional characteristic presents two important facets. On the one hand, individual professionals are self-controlled through a lengthy socialization process designed to build up technical competence and a firm commitment to the values and norms of the professional group and culture of the profession.

Secondly, professional autonomy represents a barrier for the group against lay interference, and even that which might be realized from agencies of society such as government and the occupants of its offices. Thus, it would seem that professional autonomy may be nothing more or less than a different twist on authority over clients.

In authority over clients, the actual or potential recipient of the service is kept from making judgments of professional competence. In a different, but related sense, the professional autonomy characteristic focuses on the license of a profession, its ability to maneuver, to pursue thoughts and to teach or learn how to do their labor well. It also incorporates the ability to tell others what is important in their professional practice. The criteria developed by faculty for decisions regarding the appointment, promotion and tenure of individuals in the academic community are representative of how professionals exercise their autonomy. These procedures represent the academicians right to recruit, initiate, and certify its practitioners.

Henry (1981) argues that nursing faculty have not been required to meet the same expectations in these three areas as their colleagues in other disciplines. She states that tenure, promotion and appointment standards will be advanced as faculty become more professional.

The mid-1960's were dominated by hospital schools nursing where tenure was not an option. Appointment was controlled by administration and all faculty were referred to as instructors, obviating the need for formal promotion procedures (Barrett, 1978). Henry (1981) states that "in reviewing the nursing literature, no mention is made of tenure . . . until 1978" (p. 240). Considering nursing educators employed in the 197 baccalaureate programs in 1965, it seems logical to conclude that appointment, promotion and tenure criteria were not a major consideration in their work environment.

Another aspect of autonomy involves honor societies and the selection of its members. This activity reflects group judgment regard-

ing an individual's worth. Sigma Theta Tau, nursing's national honor society, organized its first chapter in 1922. In 1965, there were only 31 chapters established in the 197 baccalaureate and higher degree programs.

On an individual basis, professional autonomy allows judgments regarding practitioners in terms of the manner in which they vary their experience with autonomy. In other words, an assessment is made as to how the work activities are controlled. Thus, scholars using this point of reference try to determine whether the practitioner is a member of professional organizations, the activity level that the membership generates, the length of training, and whether a mentor relationship is evident (Hall, 1969). The number of unilateral decisions and the commitment of the practitioner to the idea that professionals should make their own decisions without client interference dominates (Hall, 1969).

(5) Recognition by the Community. Ritzer's (1972) formulation of this characteristic recognizes the formal license granted by the state, but goes beyond it, in that it involves an evaluation of the profession in its different characteristics, an evaluation which must be viewed independent of the political power enjoyed by the professional group in question. Ritzer (1972) proposes that it is highly questionable that an occupation could wage a successful political campaign for society's recognition if it did not possess some of the core characteristics discussed here to a significant degree. Thus, the failure of some occupations, such as education, social work, and nursing to obtain uniform recognition of their professional status is not a failure

because of a lack of political power. The failure is one of lacking, and rather dramatically so, some of the dimensions of professionalization.

This issue is perhaps best reduced to one of persuasion. The community at large, or at least the controlling elites, would have to be persuaded by the occupational group of the need and value of the profession. The community has to accept the power of the profession (Ritzer, 1972).

Professions are occupations which have been able to "sacralize" (make sacred) a professional niche (Jackson, 1970, p. 5). This means that the profession's tools and tasks belong in the realm of the sacred, one apart from the secular, everyday life, and reinforced by control grounded in formal training.

An illustration of the sacred tools and the tasks can be drawn from the medical profession. Prescribing drugs is an example of a physician task that has been made sacred. No other member of any occupational group is authorized by society to prescribe medications for human beings. Another example of a sacred task is that of diagnosis and treatment. Osteopaths and chiropractors are the only other health related occupational groups to whom society has granted the right to diagnose and treat human illness, but in each of these cases the authorization to prescribe drugs has been denied.

The scope and responsibilities of practice in the provision of health care is set forth in the statutes governing practice in the various states. In other words, practice acts generally describe what

a practitioner may do and what they may not do, once the license to practice has been granted. Thus, they reflect the contract between the occupational group and society. In 1965, the majority of state nurse practice acts required that nursing practice be under the direction and supervision of physicians (Kelly, 1972).

(6) A Distinctive Culture. The professional culture develops around formal and informal groups and includes distinctive values, norms, symbols, and rituals (Greenwood, 1957).

Among the values are expressions of the first five professional characteristics mentioned, in addition to some unique to the individual group. Some of these values are incorporated into norms that take their form in ethical codes and other laws internal to the profession. Symbols might include an ensemble of emblems, insignias, dresses, and instruments; ritualized behaviors, a host of discourses, gestures, and rituals of circumstance. Veblen (1953) proposes that these rituals and symbols, especially those associated with academic rites, such as cap, gown and hood, are meaningful examples.

The crucial aspect of this attribute, however, seems to be in the professional mentality or ideology. Thus, the factors which are used to characterize the professional occupations can successfully be regarded as characteristic of the ideology of all the professions (Hagan, 1976). Stuart (1981) argues that nursing has historically had two conflicting ideological orientations. The first of these is termed the "diploma" orientation. This ideology views nursing as sub-

ordinate to medicine. The second ideology is termed the "professional" orientation. It features an independent autonomous practitioner, prepared for practice in an institution of higher education. This conflict is best described by the disagreement which occurred in 1965 following the submission of the entry into practice position paper by the ANA (Stuart, 1981).

The Process Approach to Professionalization

This method of analysis is focused on the professional group and the objective is to analyze its developmental sequence. Ritzer (1972) has reviewed the works of the primary contributors in this area --Wilensky (1964) and Caplow in Vollmer and Mills (1966) -- and combined their steps into the following series of stages:

1. Full-time occupation
2. Name change
3. National association
4. Training school
5. Code of ethics
6. Political agitation to secure legal and popular support

The majority of scholars who have utilized this approach focus their efforts on an analysis of the last two centuries in which the new professions have arisen (Carr-Saunders, 1928). The nineteenth and twentieth centuries have received particular attention since "it was not until the nineteenth century was some way advanced that new professions began to achieve recognition in rapid succession" (Carr-Saunders, 1928, p. 2).

The process whereby an occupation acquires the status of a profession is the phenomenon under study. This method, then, starts with a factorial characterization of selected occupations as professions. Wilensky (1964), for example, distinguishes the following occupations depending on how far they have traveled down the professionalizing road.

1. The recognized professions who have traveled the entire road: law, the clergy, and university teaching, "established solidly since the late middle ages; military officers, who between the sixteenth and nineteenth centuries" developed a professionalism based on a sense of brotherhood in a self-regulating group dedicated to codes of honor and service; and dentistry and engineering professionalized in the early 1900's.

2. Those in the process of professionalization: social work, veterinary medicine, civil servants such as city planners, foundation executives, and administrators of social agencies and hospitals.

3. Borderline professionalization: primary and secondary school teachers, pharmacists and librarians.

4. Occupations which refer to themselves as professional, but are not so identified by others as such: public relations, advertising executives, morticians.

The analysis of tracing professionalization as a process implies a dynamic perspective of a historical and social nature. The aspiring profession strives to meet the demands of society thereby gaining political power to promote their societal valuation. In this manner,

the profession engages the social, economic, and political forces operating in the environment. Nursing can be seen from this perspective.

In 1966, the first year that the National League for Nursing reported part-time data, a total of 2,177 faculty were employed on a part-time basis in all types of nursing schools (N = 1,206). At this same point in time, there were 13,476 full-time educators in all registered nursing programs. With specific reference to baccalaureate and higher degree programs, 459 faculty in 208 programs were working part-time, while 4,073 were employed full-time (NLN Data Book, 1981).

With regard to Ritzer's name change criteria, the term "registered nurse" applied to graduates of the three types of educational programs in 1965. The position paper issued by the ANA, however, proposed a change in this area by indicating that the designation "registered nurse" should be reserved for the baccalaureate graduate. Various names, such as "technical nurse" or "nurse associate" have been posed as an appropriate title for those graduates of diploma and associate degree programs.

Ritzer's third process criteria refers to the development of a professional association. From another point of view, however, the mere creation of the organization seems an insufficient point of view. Of equal importance is the support the association receives from the membership. ANA membership, when one considers its percentage of the total number of nurses, has generally been poor. While figures reflecting the participation of nursing educators in the association are not available, this group has traditionally been identified as leaders in the activities of the professional association (Barrett, 1978).

The training school was firmly established by 1965, but the attention of the occupational group's leadership had turned to the elevation of educational standards. The hospital based training program dominated with 813 schools. The total number of programs across all categories was 1,182.

Ritzer's fifth criterion, a code of ethics, had been promulgated by the ANA prior to 1965, but in the practice world it was the ethical judgments of physicians that dominated. In other words, the ethical judgment of physicians took precedence over those of nursing. In fact, it was not uncommon for physicians to use their influence when the performance of nurses was questioned (Smith and Davis, 1980).

Finally, political agitation to secure legal and popular support had succeeded in establishing a licensure system by examination for nurses. The state document which accompanied licensure, commonly referred to as the nurse practice act, described the scope of nursing practice. These acts have necessarily had an impact on the educational programs and the activities of nursing educators. In 1965, nurse practice acts, as drafted, placed a significant amount of nursing practice under the supervision of physicians (Kelly, 1972).

The Process Approach to Professionalism

The process approach to professionalism is concerned with identifying a series of steps or stages, through which the individual practitioner passes in becoming a professional. In addition, it is concerned with identifying stages within a professional career. Thus,

this aspect is concerned with the individual's socialization into the profession and with the professional career (Ritzer, 1972).

Socialization and career should not be seen as two distinct stages but rather intertwined aspects of the same process. Socialization refers to the personal, cultural, and ideological augmentation of the individual. The life of a professional is an ongoing process of socialization, both before and after the achievement of certification. The career aspect can and should also be viewed as an ongoing process. Therefore, rather than seeing socialization as a process wherein professionals embrace or assimilate professional values and norms, the concept should be directed at a learning process and to one of initiation into the professional culture or role (Oleson & Wittaker in Jackson, 1970, p. 192).

In the academy, one of the primary means by which this process can be identified is through the appointment, promotion, and tenure processes. Faculty appointment involves colleague judgments regarding the worthiness of an individual to serve, and promotion, the achievement of performance standards which have been established and reviewed by a group of peers. A tenure recommendation by one's peers marks successful completion of this rite of passage--full incorporation in the occupational group. Failure to attain appointment, promotion, or tenure can signal failure in being fully accepted by one's professional peers.

The study of professional socialization has been primarily directed at the formal stage of training in the professional career.

Professional socialization, however, does not begin nor end with this experience. Professional socialization begins early in life and continues throughout the span of the career.

For Merton et al. (1957) socialization is a learning process, while Hughes (1958) conceives it as a process of acculturation, where "the period of initiation into the role (of the physician) appears to be one where the two cultures, lay and professional, interact within the individual" (p. 180). Regardless, however, of the nature of the change, change in the individual does occur and socialization is seen as being the basis for this alteration.

Autonomy, a pivotal notion in professionalization (Freidson, 1970) has its counterpart in professionalism. Commitment is recognized as an essential feature of professionalism. Indeed, the very origin of the word professional is one who "professes," or one who affirms his adherence to certain ideals at the same time he lays claim to them (Ritzer, 1972).

The meaning of professional runs through the varying characterizations of professions and professionals. It is reflected in the extent to which the individual's resolution and claim to ideals, in addition to the incorporation of the individual in the community, constitutes the essence of the professional model. This is true of the factorial and process approaches to professionalism and professionalization. In other words, placement on the continuum of professionalism is largely dependent on the autonomy and commitment evidenced in the individual.

From the perspective of professionalism, the act of becoming committed is the act of becoming mobilized (Hughes, 1958). It can also be said that the individual devotes his/her energies to specific collective actions, the pursuit of ideals, specific tasks, or projects. When this engagement or allocation of energies takes place, it can be judged that commitment has occurred. In summary, commitment is the process whereby the individual becomes a resource in group or individual projects.

The idea of commitment (allocation of energy) allows one to speak of this rather vague and abstract concept in terms of tasks or activities, commitment to ideas and ideals, to career, to organization, to occupation, and life style. For example, one of the manifestations of an individual's commitment to the occupational group is the amount of energy they allocate on behalf of the professional association. Membership would be a basic reflection of the mobilization of energies, with a higher degree of professional orientation seen in such activities as committee participation and elected or appointed office, at the local, state, and/or national level.

Looking at nursing within this context, activity in the professional association has been poor. In 1960, the ANA reported a membership of 170,911. This number represents only 33.9 percent of those employed in the practice of nursing. In 1966, the percentage of members to employed nurses had fallen to 26.3 percent (ANA, 1981). In a more specialized sense academic nurses may, in addition, elect to allocate energies on behalf of the educator group in faculty service and/or service in the larger community. An example of activities in

this latter category might be service on the board of a hospital or fund raising for the American Cancer Society.

From another perspective, judgments regarding commitment can entail the career orientation of the individual. For example, the professionalism of an academic nurse whose work history is continuous, rather than episodic, could be considered to have exhibited a higher degree of professional commitment than one that does not.

Epstein (1970) argues that the work and personal lives of women cannot be looked at meaningfully without examining the cultural themes and value systems of American society. "It is no surprise to any observer of American life that the image of the perfect woman . . . and the participation of women in the professions are contradictory, ambiguous, and sources of personal strain." (Epstein, 1970, p. 19). Even outside the recognized professions, society has defined the role of the woman as that of wife and mother, and commitment to the ideal has been significant. In 1965, the ideals of women did not generally incorporate the idea of career. Nursing is not an exception to this premise.

Throughout this section sociological scholars on the process approach to professionalism have referred to the socialization of the individual to the values, ideas and images of professional life. This emphasis is consistent with the identification by other theorists of a distinctive professional culture. Section 6, page 32, should be reviewed for details regarding this relationship.

Summary. This section has been concerned with examining the sociological contribution of scholars in the study of professions. By discriminating between analytical and temporal units, three areas of inquiry were established and explored. These perspectives identified professional attributes or characteristics that can be identified, observed, and measured. As such it provides a means by which judgments can be made regarding the movement of a group, and its individual members, towards professionalization and professionalism.

II. Ideology as Related to Professionalization and Professionalism

Webster (1976) defines ideology as "the body of ideas characteristic of a particular individual, group, or culture: the assertions, theories, and aims that constitute a political, social and economic program" (p. 349). In other words, the ideology of an individual or group of individuals refers to a characteristic intellectual pattern of thinking or perspective.

Silva and Slaughter (1980) enlarge and expand the definition of ideology by referring to it as:

> a fairly coherent set of ideas explaining the problematic issues of the day and offering solutions to them. As such, ideologies help organize their adherent's beliefs and hopes about their world's present and future . . . [it] offers a framework for interpreting issues and conflicts encountered in everyday life . . . . Finally, these elements combine to supply an imperative for collective action . . . . Ideologies thus either inhibit or inspire social movements (p. 814)

The desire of an individual or group to attain professional status would be such a social movement. Hence, it becomes vital to

investigate the manner or content of thinking about professionalism and professionalization held by nursing, and nursing educators specifically.

In order to develop a more comprehensive understanding of this concept and methods by which it can be investigated, a study which examined professional ideology will be reviewed. The study which produced the book, Boys in White, was designed to investigate the ideology of medical students. Becker (1961) argued that

> it seemed reasonable to assume that students left medical school with a set of ideas about medicine and medical practice that differed from the ideas they entered with, ideas they could not have had in advance of the concrete foretaste of practice (p. 17).

This study of ideological development in medical school was conducted at the University of Kansas. Participant observation, the inclusion of the researcher in the daily experiences of the students, was the major research method employed. Semi-structured interviews, with a random sample of students were also utilized. The study did not follow one group of students through medical school, but, rather, sampled extensively from those in their first, third and fourth year of study.

The study focused on one aspect of the medical school experience. It specifically looked at the way students collectively formulated and acted on their developing perspectives about medical school. The term "perspective" was used "to refer to a coordinated set of ideas and actions a person uses in dealing with some problematic situations. . ."

Ordinarily, such general notions are called values, attitudes, orientations, motives, or other terms (Becker et al., 1961, p. 34).

Becker (1961) found that a rapid and profound change occurred among freshmen students, with respect to their ideas and activities about their academic work. This change occurred between the time they entered school and mid-October of their freshmen year. Upon entering school, the long-range perspective of these students was idealistic in content. They defined medicine as "the best profession" and their goal was to become the ideal physician. This idea was behaviorally translated, in the academic setting, as requiring a high level of student effort "directed at learning everything." (p. 93). The alteration of this initial ideal during the first few weeks of school is situational and immediate. The students effort to "learn it all" met with frustration and failure.

Through interviews and participant observation Becker and his associates found that the initial student idealism gave way to a provisional one in which some degree of group consensus emerged. The students agreed that they could not learn all the material presented by their faculty, and that the situation called for decisions regarding what material they would study.

The criterion utilized in identifying the material was, however, different. One group selected material on the criterion - "important for future medical practice" (p. 138), and another group on the criterion - "what faculty want them to know" (p. 135). This ideological split within the group was resolved by mid-October of the freshmen

year in favor of the "what faculty want them to know." This perspective remained throughout their student career. Thus, in span of a few weeks the ideals of the class regarding their academic work changed from that of long hours of intensive study designed to "learn it all", to long hours designed to learn what faculty want them to know.

The third and fourth years of medical school entail an environment quite different from that experienced by the students during their freshmen and sophomore years. The first two years are predominantly theoretical in their orientation, the third and fourth years are dominated by patient care experience. Becker et al (1961) found that when students enter the clinical years they have two primary goals: (1) to complete their training, and (2) to learn what is required to successfully practice medicine.

> Working in the medical center, they become involved in medical culture and might be expected to begin to internalize it; but we shall show that while medical culture influences student culture, and indeed furnishes much of the material from which it is constructed, it operates only within the limits permitted by the students' immediate situations (p. 191).

In this new clinical setting the students are exposed to two ideals strongly emphasized in medical culture and by practicing physicians. These ideals are medical responsibility and clinical experience. In the clinical setting Becker identifies that when students are faced with the problem of where to place their effort, they utilize these two ideals and formulate from them, two perspectives which dominate student culture.

> Medical responsibility is responsibility for the patients well being, and the exercise of medical responsibility is seen as the basic and key actions of the practicing physician. The physician is most a physician when he exercises this responsibility (p. 224).

The medical student is exposed to this view in a variety of circumstances, and incorporates the responsibility ideal in their school work. Becker (1961) summarizes the ideology that develops in the following statements:

> (1) It is important for a doctor to have had the opportunity to exercise medical responsibility.
>
> (2) School activities are good and worth devoting one's effort to insofar as they provide opportunities to perform procedures and engage in activities which constitute an exercise of medical responsibility.
>
> (3) One must make a determined effort to get as many chances to exercise responsibility as possible.
>
> (4) Being allowed to exercise responsibility, and handing ones opportunities to do so skillfully and well, are important signs of one's personal work and hence have symbolic value beyond the actual experience involved. (pp. 254-255).

The researchers generated these ideological propositions from their interviews and participant observation data. Becker (1961) states that the students hold these perspectives and organize their situational behavior around them.

The second idea which dominates the clinical years is that of clinical experience. The student ideology that developed around this perspective is summarized below:

> (1) It is important for a doctor to have clinical experience.
>
> (2) School activities are good insofar as they give students the opportunity to acquire clinical experience or give them access to the clinical experience of their teachers.
>
> (3) A student is making real progress toward his goal of preparing for practice when he can demonstrate to himself and others that he has observed some lessons from clinical experience (pp. 257-258).

The adoption of these two perspectives gives the student a professional way of viewing events and personal experiences. Becker asserts that failure to develop in this manner creates the potential of looking at patients with the layman's eye. The physician develops a somewhat impersonal way of dealing with situations which the layman may describe as upsetting or traumatic. Incorporation of the responsibility and experience ideals alters the lay view and sets the stage for development of the practicing physician ideology. During the medical school years, students transform their naive idealism into a specific set of student perspectives. "To these perspectives, we give the name student culture" (Becker, et al. 1961, p. 435).

Professionals also develop a distinctive culture as the occupational group moves along the professionalization continuum. The professional ideology of nurses is a central concern of this study. The study by Becker et al. includes two techniques that seem particularity relevant to this inquiry.

Becker (1961) identified medical student ideology by collecting data on how they viewed problematic situations. The first of these problems had to do with what theoretical material they would learn. This investigation is concerned with the development of nursing's ideology as an aspect of the professionalization process. The issues or problems which confront nursing today are, therefore, one means of exploring the development of nursing's values, attitudes, and ideals.

The conflict regarding entry into practice that developed in the nursing community after the 1965 ANA statement on baccalaureate

education is one example of how an issue can provide information regarding ideological orientation. Other issues in nursing such as physician/nurse relationships and nurse/client relationships provide a framework within which this important area of professional evolution can be examined.

Secondly, the Becker study also utilized semi-structured interviews as a means of collecting data. This technique seems particularly well suited to identifying the ideological development of an individual. A number of individual interviews could be undertaken to support inferences about the larger group. Nursing educators have played and continue to play a major leadership role in the nursing community. The ideological orientation of this group of nurses is of primary importance in examining nursing's professionalization and professionalism.

The combination of these two techniques in exploring the development of professional ideology is promising. Within an issue or problem oriented framework, interviews could be structured to identify the individual's belief system, and by inference, that of the larger group. In this respect, the methodology of Boys in White serves to inform the design of this study.

Summary. The purpose of this chapter was twofold. First, a literature review on professionalization and professionalism was undertaken in order to identify the attributes commonly associated with professionals and place nursing within that context. A study which examined the development of professional ideology in medical students, Boys in White, was reviewed since a major portion of

this study is directed at gathering information regarding nursing's ideology.

This material, plus that in the previous chapter, provides the appropriate foundation to operationally define the attributes commonly associated with professions into measurable constructs and design a research method to triangulate evidence of these characteristics in the field. The following chapter is devoted to reviewing how these goals will be achieved.

Chapter 3

METHODOLOGY

Introduction

This chapter deals with the research questions, general design of the study, the instrumentation, data collection, and data analysis to be used in this investigation of professionalization and professionalism.

To guide the study research questions based on characteristics commonly associated with professions and professionals were developed. In order to promote clarification, theoretical references to these characteristics, previously reviewed in depth in Chapter 2, are provided in conjunction with the questions.

As formulated, the questions reflect change over time. This temporal orientation is directly related to the assertion by Vollmer and Mills (1966) that occupations change, relative to certain characteristics, during the process of professional evolution. Furthermore, this line of inquiry is consistent with the Vollmer and Mills' premise that we do not ask if a group is or is not a profession but, rather, we ask questions about how professionalized it is by identifying and gathering data, over time, about characteristics commonly associated with professions. Thus, this study does not seek to answer whether nursing is or is not a profession, but rather how it has changed and if it is changing in relation to the characteristics associated with professional status.

The questions also indicate how the attributes commonly associated with professional evolution are used in this study. For example, society delegates to professional groups, such as academicians, the right to recruit, initiate, and certify members of their group. In higher education this responsibility is reflected in the appointment, promotion and tenure criteria established by faculty. The process aspect of professionalization and professionalism involves change in such a characteristic. The change can reasonably be expected to manifest itself in such criteria if nursing is becoming more professionalized. For instance, data could be expected to show that an earned doctorate is a minimum requirement for promotion to an associate professor, whereas a master's degree previously met requirements. Thus, in order to generate hypotheses regarding nursing's professionalization, this evolutionary aspect received major consideration.

Grounded field theory is utilized as the research methodology for this study. This avenue is employed due to the method's inductive process. A primary intent of this ressearch is to identify properties or aspects of this professionalization process for further study, in order to develop a deeper understanding of nursing's evolution as an occupational group. Thus, the device of general field theory is utilized to see if given point "A", change can be identified at point "B" (Glaser and Strauss, 1967).

It should be noted, however, that the study varies in one respect from the basic grounded field theory methodology. The literature is used to identify characteristics or attributes commonly

associated with professionals, in order to develop measurable constructs. The utilization of field theory generally calls for literature utilization following the data gathering exercise. In this particular situation it was necessary to consult the literature on professionalism and professionalization in order to gather data in meaningful and appropriate areas. Further, a well developed literature on nursing's professionalization was not available. Thus the theory generating properties of grounded field theory are not realized in this study.

The study spans a period of twenty years. Where appropriate, data was collected in five year increments beginning with 1960 and ending with 1980. Although 1965 was previously estalbished as a benchmark year, 1960 data is also gathered in order to provide information regarding professionalism and professionalization prior to the ANA statement on basic educational preparation at the baccalaureate level. With these considerations in mind the following six research questions were developed.

1. Have the number and type of the academic credentials earned by faculty changed over time?

Theoretical Base. One of the primary characteristics of a profession involves a systematic knowledge base into which the professional is initiated through an extensive educational process. The acquisition of this knowledge takes place in higher education institutions and is accompanied by some form of certification. When the individual is considered with regard to the systematic knowledge base

two points are pertinent. First, the assignment of this professional characteristic is dependent upon acquiring basic preparation and certification in the higher education setting. Secondly, Ritzer (1972) argues that individuals who have acquired greater amounts of the knowledge base within the field of endeavor are assigned a higher level of professional status. Academic credentials are one means of making judgments regarding how much of a knowledge base an individual commands. In other words, as individual members of an occupational group earn advanced degrees, the more professional the individual and, hence, the group becomes (Greenwood, 1957; Moore, 1970; Ritzer, 1972).

2. Are the entry and certification requirements established by faculty for students in the baccalaureate and higher degree setting changing?

Theoretical Base. The professional is able to establish stringent requirements for what the aspiring practitioner, or student, must know, and the student is expected to accept, indeed accede, to the judgment. In the development of the legal and medical professions, aspiring practitioners had to accept the discipline of the professional school as a requirement for inclusion in the occupational group. The Flexner Report, issued in 1910, was instrumental in promoting change in the educational preparation of physicians.

The development of the profession's systematic knowledge base and the resulting trend toward specialization are reflected in the criteria by which these aspiring professionals' are judged. As Greenwood (1957) argues, a wholly theoretical orientation is not

sufficient, for the critical discriminate between professions and non-professions is that "the skills that characterize a profession flow from and are supported by a fund of knowledge . . ." (Greenwood, 1957, p. 46).

Faculty are called upon to establish both entrance and certification/graduation requirements. Thus, a rise in qualifications for admission and credentials would be an indicator of increased professionalization.

3. Are educational programs designed to prepare nurse specialists being developed in baccalaureate and higher degree schools?

Theoretical Base. A distinctive characteristic of a profession is its orientation to public service. The group first serves the needs of the client, and places these needs ahead of their own. The community orientation of an occupational group is also evident in the educational programs it develops to meet the needs of society. (Ritzer, 1972).

Since World War II, society has experienced a phenomenal increase in the knowledge base and in technological capability. The health care industry has been dramatically affected by this change as evidenced by the development of intensive care units, open-heart surgery and kidney dialysis, to mention a few. These changes in knowledge and technology, and the needs of society must be recognized by occupational groups who provide services. Nursing is one of those occupational groups.

The change in knowledge, both theoretical and technological, accelerates the development of speciality practice (Reiss, 1955). Thus, there is a great diversity in the tasks performed by members of the professional group. In the medical profession, for example, one can specialize in pathology, radiology, anesthesiology, and hemotology, among others.

One of the primary justifications for this study is the opportunity nurses currently have in the health care system to meet the health promotion needs of patients, rather than solely concentrating on the resolution of illness. This is one example of how a profession can develop specialty practices to meet the needs of society. Generally, however, as the knowledge base expands and the complexity of patient care increases, educational programs designed to prepare practitioners for specialized services should emerge as one reflection of increased professionalization.

4. Have the criteria by which decisions are made regarding the competence of faculty changed? More specifically, do the appointment, promotion and tenure criteria developed by faculty for peer review reflect the evolution of higher performance standards?

Theoretical Base. Society grants the professional group the authority to judge and sanction the practice of the individual professional. (Greenwood, 1957). This right can be seen at many levels in professional groups, but one of the classic manifestations is in higher education. Here, it is the faculty who set the criteria by

which judgments regarding their own competency are made through appointment, promotion and tenure. Thus, these criteria can reflect, the evolution of higher performance standards in the professionalization process.

The change in appointment, promotion and tenure criteria is closely related, also, to the development of the knowledge base. As the professionalization process develops and the preparation of practitioners moves into higher education there is a long and intensive period of study required for incorporation into the occupational group. This is reflected in the requirements set for those individuals engaged in preparation and renewal of the individual practitioner.

5. Has society changed its view regarding the role of nursing in providing health care service?

Theoretical Base. Society must recognize the need and value of the service provided by the group if the group is to advance (Greenwood, 1957). As society alters its views regarding an occupational group, the role that group plays in public service should change so as to reflect increasing responsibility and trust between the parties. The process involved in the alteration of the contract between the occupational group and society is a political process. Society determines its needs and occupational groups vie to meet those needs. It is society that ultimately determines who is granted professional privilege.

"Every profession strives to persuade the community to sanction its authority within certain spheres . . ." (Greenwood, 1957, p. 48). Those spheres of authority most earnestly sought are

control over the educational function, through an accreditation process; control over admission to the profession through licensure; and standards of professional performance regulated solely by the professional group. Changes in these areas are indicative of an alteration in the relationship between nursing and society (Reiss, 1955).

6. Does nursing demonstrate a shared and consistent system of beliefs?

Theoretical Base. Professional groups develop a distinct professional culture (Greenwood, 1957). Culture is defined as a shared and consistent system of beliefs.

This attribute is related to those previously identified. For example, the belief system of nursing should reveal a commitment to the idea that long and intensive educational preparation is necessary for professional practice. Significant variation among nurses with regard to this idea and other attributes associated with professionals would be evidence of substantially incomplete professional evolution.

Design of the Study

This research study utilizes a qualitative research methodology to examine the research questions discussed above. Denzin (1978) states that in qualitative research a combination of approaches in the study of the same social phenomena is essential; this principle is referred to as triangulation.

> Triangulation is a plan of action that will raise sociologists above the personalistic biases that stem from single methodologies. By combining methods in the same study, observers can partially overcome the deficiencies that flow from . . . one method. (Denzin, 1978, p. 294).

Researchers can triangulate by methodology and also by data source.

> Data sources, are to be distinguised from methods of generating data. The latter term refers to research methods per se, and not to sources of data as such. By triangulating data sources, analysts can efficiently employ the same methods to maximum theoretical advantage (Denzin, 1978, p. 295).

Table 1 reflects the triangulation of data sources employed in generating data for this study. In the extreme left column data sources are identified and across the top of the matrix the areas of content. The content areas were formulated to generate data about conceptions or perceptions of what it means to be qualified to practice nursing. The first content area column (see Table 1) addresses the meaning of qualification, or what beliefs, values and attitudes are expressed about qualifications for practice. The second content area addresses requirements for qualification, and the third column legal and institutional qualification requirements. In order to simplify further reference, these areas will be referred to as belief, attributes, and control content areas respectively.

Three data sources are identified in the matrix. The first data source is public literature. These documents are: "distinguished by the fact that they are prepared for . . . examination by some set of others." (Denzin, 1978, p. 218). Historical texts and legal couments are examples of such public literature. The second

TABLE 1

DATA MATRIX

Stipulated Qualifications

		Content Areas	
Source	Meaning of Qualification	Requirements for Qualification	Legal and Institutional Control on Qualification
Public Literature	#1 A) ANA convention addresses by the President B) Dictionary definition of "nurse" and "nursing"	#2 Evaluation of new educational programs, innovations in three nursing history texts	#3 Changes in the Nurse Practice Act in the State of institutional site
Credential Archives	#4 Classified Ads for nurses 1) specialty area 2) degree requirements 3) required experience in Nursing Outlook, Washington Post	#5 Academic Credentials Earned by Faculty A) NLN Data B) Site Data	#6 Appointment, Promotion and Tenure Criteria
Institutional Site	#7 Semi-structured Interviews	#8 Entry and graduation requirements	#9 Changes in program/ curriculum offerings

data source are archival records. These documents typically reach a limited audience. Autobiographies are an exception to this general statement (Denzin, 1978). School catalogs, specialty journals, and faculty handbooks are examples of these documents.

The third source of data is an educational organization which offers baccalaureate and higher degrees in nursing. The selection of an institutional site for this study allowed the investigator to make an intensive investigation of a social unit. Further, it promoted the assimilation of "data about the present status, past experiences, and environmental forces that contribute to the . . . behavior of the unit" (Van Dalen, 1973, p. 207). An institutional focus is well suited to situations characterized by a lack of understanding and information regarding a social phenomena (Craig and Metze, 1979). Such an in depth level of understanding is essential for the development of hypotheses for further testing with respect to professionalization and professionalism.

The study site is a school established in 1889 as a hospital based diploma school of nursing. This program remained dominant until 1952 when an autonomous four year program leading to a bachelor's degree was established. In 1954, the school developed a graduate nursing program to award the Master of Science degree with a major in nursing. Thus, the study site is representative of

the baccalaureate and higher degree programs. It was considered particularly important that the study site reflect the evolutionary process of nursing education from a diploma based beginning to the baccalaureate and higher degree programs. In this setting, the values, attitudes and beliefs of both eras are likely to be represented. Such a blend is more desirable than an educational institution initially developed as a baccalaureate institution.

Concentration on nursing's past and present, when considering an institutional study site, is inadequate, for it should also represent nursing's future. In 1979, the school established a doctoral program designed to meet requirements for a Ph.D. in nursing. The NLN reported only twenty-two such programs in 1980 (NLN Data Book, 1981). The institution represents nursing's past, present, and future. If there is evidence of change, with respect to professionalization, this environment should yield that evidence.

Data Collection

Data collection will be reviewed with reference to each of the cells in the matrix depicted in Table I. Further, it should be noted that the development of the data matrix was guided by the research questions.

1. Beliefs - Literature. a) The inaugural addresses of American Nurses' Association presidents from 1960 to 1980 were re-

viewed for expressions regarding their beliefs, attitudes, and values. Such data identifies the ideological orientation of those elected to the top leadership position of the professional association (Emmest and Brooks, 1970). Inaugural addresses of ANA presidents were found in One Strong Voice, and in ANA convention publications.

These data also serve to reinforce the identification of issues in nursing related to its professional development. For example, the historical "handmaiden" role of the nurse, with respect to the physician, could certainly be expected to be in conflict with the professional characteristic of authority over client and, thus, a part of the professionalization process. The exploration of such an issue during interviews will shed light on the ideological orientation of nursing educators (see Beliefs-Site section of data collection - cell #7).

b) Dictionary definitions of "nurse" and "nursing" over the twenty year span, 1960-1980, were collected. These definitions were reviewed in order to report findings regarding their functional and educational orientations. The dictionaries utilized were:

(a) Webster's Third New International Dictionary Unabridged. Springfield, Massachusetts.

(b) Thomas, C. L., ed. Taber's Cyclopedic Medical Dictionary, Philadelphia: F. A. Davis.

(c) Duncan, H. A. Duncan's Dictionary for Nurses. New York: Springer Publishing.

Definitions in each edition of the dictionaries during the study's time span were gathered. These data sources provide information on nursing's belief system and the belief system of society about nursing.

2. Attributes - Literature. Three historical nursing texts were reviewed for the purpose of identifying reports of new educational programs and innovations in academic nursing. This data source should fill any gaps in curriculum development that might be present at the institutional site. Such a review further serves to substantiate findings at the institutional site. The texts were selected from the historical section of "Reference Sources for Nursing" published in the May, 1978 edition of Nursing Outlook. Of the citations listed, the following three texts best represented the study's time span and topic under examination. The texts selected were:

(a) Deloughery, G. L. and Griffin, G. J. History and Trends of Professional Nursing, St. Louis, Mosby, 1977.

(b) Dolan, J. Nursing in Society: A Historical Prospective, W. B. Saunders, 1973.

(c) Stewart, I. M., and Austin, A. L. eds. History of Nursing, 5th ed. New York: G. P. Putnam's Sons, 1962.

3. Control - Literature. Nurse practice acts are state statutes which describe the regulation and scope of nursing practice

allowed within that jurisdiction. These acts represent the practice contract between nursing and society (Stuart, 1981). Further, they generally outline the understanding between society and the occupational group regarding control over the educational function, licensure regulations and regulation of performance standards. Thus, they are a tangible manifestations of nursing's professionalization process. All nurse practice acts legislated in the state of the institutional site (1960-1980) were reviewed. Analytical emphasis was placed on how the acts differed over the twenty year span of the study.

4. Beliefs - Archives. Classified advertisements found in Nursing Outlook, and The Washington Post were reviewed. One issue of each of these publications was obtained on a quarterly basis in 1960, 1965, 1970, 1975 and 1980. All the classified ads for nursing positions in each of these publications were reviewed. Specific analytical interest was directed at whether education, experience and specialization were mentioned in the ads.

5. Attributes - Archives. National League for Nursing (NLN) data regarding the number and type of academic credentials held by faculty in baccalaureate and higher degree programs for the twenty-year period was gathered. This data was found in the NLN Nursing Data Book (1981). Similar data were gathered for faculty employed at the institutional site, in five year increments, beginning with 1960.

6. Control - Archives. The appointment, promotion and tenure criteria at the institutional site were reviewed and analyzed for performance requirements. Faculty handbooks, memoranda and archival records were used to collect this data.

7. Beliefs - Site. "By and large, interviewing serves best to get at information, impressions and feelings that can be verbally reported" (Doby, 1967, p. 279). Doby (1967) and Borg (1963) state that the open-ended interview offers the researcher an opportunity to obtain indepth information since the ability to further explain and clarify communication is present. The interview "permits gathering valuable data that could not be successfully obtained by any other approach" (Borg, 1963, p. 223). An open-ended interview method was employed in this study.

This technique requires the researcher to establish a positive rapport during the interview in order to promote an environment to enhance communication. Doby (1967) indicates that such an environment can be established by avoiding behaviors which might be perceived as leading or coercive. In addition, the interviewer should demonstrate acceptance of the respondent and the respondents remarks. The skill of the interviewer is paramount. This researcher has practiced nursing in a variety of capacities for twenty years. Such a practice involves the development and utilization of psycho-social skills. Further, a nurse researcher will facilitate communication and acceptance on the interviewees part.

A random proportional stratified sampling technique with replacement was utilized to select interviewees. Potential respondents were defined as registered nurses who hold faculty rank at the research site. The group was stratified according to the ranks of instructor, assistant professor, associate professor and professor. The study site had 150 faculty who met these requirements. Twenty-five interviews had to be conducted in order to gain an understanding of the groups belief system (Krejcie and Morgan, 1970), with 10% confidence and 15% precision levels.

$$S = X^2 NP(1-P \div d^2 (N-1) + X^2 P (1-P)$$

S = required sample size

X^2 = the table value of chi-square for 1 degree of freedom at the desired confidence level.

N = the population size

P = the population proportion

d = the degree of accuracy expressed as a proportion

$$S = \frac{(2.71)\ (150)\ (\frac{1}{4})}{(.15)^2\ (149) + 2.71\ (\frac{1}{4})} = 25$$

The following material outlines how the proportional random sample was computed.

	Faculty by Strata	%	Sample by Strata
Instructor	42	.28	7
Assistant Professor	76	.50	12
Associate Professor	22	.15	4
Professor	10	.07	2
Total	150	100%	25

If a randomly selected subject declined or was unable to participate in the study another selection was randomly made from the appropriate strata.

A series of questions geared to guide the interview were developed and seven major issue areas in nursing identified for exploration (See Appendix A). If the issue areas were not covered as a natural or unsolicited part of the interview the interviewer prompted their exploration. The issue areas are felt to be particularly sensitive to information regarding ideological orientation, and were developed primarily from the inaugural addresses of ANA presidents.

Each interviewee was asked to provide the investigator with a copy of her curriculum vitae for demographic data. The respondents agreement and subsequent participation in the study was held in confidence. Following random selection potential interviewees were contacted by personal letter to request their participation. A form was included for the faculty member to record their decision about participation. All interviews were tape recorded. (See Appendix A).

8. Attributes - Site. The study site (school of nursing) catalog was reviewed every five years (1960-1980) to gather data regarding admission and graduation requirements for each program area.

9. Control - Site. The school's catalog was also utilized to identify program changes. The data gathering method was the same here as that in cell number eight.

Data Analysis

Qualitative content analysis of the data is the primary technique employed in reporting the findings of this study. Descriptive statistics such as frequency distributions, percentages, measures of central tendency and graphic representations of data

Of primary consideration in qualitative data analysis is the identification of threads or themes. For example, in reviewing interview data attention is focused on identifying consistent or repetitive comments and views from one subject to another. Specific attention is directed at identifying consistent and inconsistent orientations.

Data are first reported by matrix cell within content area. For example, data from matrix cells one, four and seven, which represent findings in the beliefs content area, are reported and reviewed in order to identify major findings. A similar process is followed for the control and attributes content areas.

Following the completion of the within content area report and review findings are analyzed across data source. Thus, matrix cells one, two and three, which report findings in public literature, are analyzed for internal consistency. The same process is applied to archival and institutional site data.

The goal of the fourth chapter is to report and analyze data by a row and column approach. The fifth and concluding chapter presents a condensed list of findings, answers the research questions, identifies conclusions and makes recommendations.

Chapter 4

RESULTS OF THE STUDY

Introduction

This study of professionalism and professionalization in nursing is designed to describe and document nursing's occupational development from 1960-1980. The achievement of this objective is addressed through a grounded field theory methodology. In Chapter 3, characteristics commonly associated with professions and professionals were operationally defined as measurable constructs through the development of six research questions. The triangulation of data sources was achieved through the use of public literature, credential archives, and an educational institution.

Following this development, a matrix was formulated (See Table 1) that identified information sources utilized in generating data and areas of content. The research questions served to guide the study and the matrix as the structural component for data collection. This chapter is devoted to reporting the results of the study. The data matrix is utilized as a framework in achieving this objective. Emphasis is directed at sifting through the data in order to identify changes over time which reflect nursing's professionalization process.

This phenomena, change, is a key element, for as Vollmer and Mills (1966) assert, a profession should be conceptualized as

an abstract form, non-existent in reality. This perspective avoids the forced choice judgment of whether a group is or is not a profession, and offers the opportunity of conceptualizing the development of a group towards professional status as a dynamic process "whereby occupations can be observed to change" (Vollmer and Mills, 1966, p. vii) with respect to certain characteristics.

A structured approach is utilized to organize the data report. First, findings within content areas - beliefs, attributes, control - reported by matrix cell. For example, data from matrix cells number one, four and seven constitute findings for the content area reflecting beliefs. A similar mechanism is utilized for the attributes and control content areas. The objective of this exercise is to report content area findings. The report and analysis by content area is concluded by developing a data profile for findings within the area of beliefs, attitudes and control.

An analysis for internal consistency, designed to examine the quality of the data across sources, will follow the content area data report and analysis. This analysis results in a findings profile across data sources. For example, data matrix cells number one, two and three will be analyzed for internal consistency. The comparison across sources and within content areas supports the development of a condensed list of findings in the final chapter.

Data Report - Beliefs

Data Matrix Cell-One A: Beliefs/Literature

During the national conventions of the American Nurses' Association (ANA), individuals who have served as the organization's president during the two years between conventions, review association activities, identify problems confronting nursing, and propose future directions for the association and the occupational group. "As witnesses to nursing history, the presidents of the American Nurses' Association address the pressing issues facing the profession during their terms in office" (One Strong Voice, 1976, p. 292).

These addresses serve as a data source for the sixth research question which seeks to establish whether nursing has a shared and consistent system of beliefs. They also provide a means of identifying activities which reflect behavioral characteristics associated with professional groups. Thus, this data source is reviewed as one means of determining whether a shared and consistent system of beliefs can be identified in the nursing community.

During the twenty year span of this study, eight individuals served as president of ANA. Table 2 identifies those who served, and their term(s) of office. At each convention, the president delivers an address. The text of these speeches was obtained from One Strong Voice (1976) and from publications by ANA summarizing convention activities. The addresses were reviewed for belief

Table 2

American Nurses' Association
Presidents and Terms of Office: 1960-1980*

1.	Mathilda Scheuer	1958 - 1960
		1960 - 1962
2.	Margaret Dolan	1962 - 1964
3.	Jo Eleanor Elliott	1964 - 1966
		1966 - 1968
4.	Dorothy A. Cornelius	1968 - 1970
5.	Hildegard E. Peplau	1970 - 1972
6.	Rosamond C. Gabrielson	1972 - 1974
		1974 - 1976
7.	Ann Zimmerman	1976 - 1978
8.	Barbara Nichols	1978 - 1980

*Officers are elected for two year terms.

statements, and a summary of each address within this analytical framework follows. The addresses were also reviewed by a graduate student in nursing. The purpose of this procedure was to control for investigator bias in the identification of belief statements.

"The Far-Reaching Plans"
Mathilda Scheuer
May, 1960

In the Scheuer address strong emphasis is placed on a research goal for nursing. This movement is seen as a means by which to stimulate nurses "to identify and enlarge the scientific principles on which nursing rests, and to encourage them in the affirmation of these principles through nursing practice" (One Strong Voice, 1976, p. 543). The methodology by which this goal will be realized is not identified, however, the development of the American Nurses' Foundation, an organization dedicated to the support of nursing research, was initially funded by the ANA in 1955.

The president expressed strong support for a national health insurance program providing for recognition of nursing service and patient care improvement. Direct reimbursement for nursing services is implied. Three other themes emerge in this address. First, a resolution is set forth which calls for collective bargaining as a means of solving employer/employee problems. Secondly, reference is made to the first joint ANA and AMA (American Medical Association) committee formed to identify

areas of agreement and disagreement. The purpose of this committee is identified as building "a bridge of common belief" (One Strong Voice, 1976, p. 544). Finally, the need to protect the public from unqualified practitioners is addressed, and state organizations are charged to examine and institute mechanisms to protect the public.

"The Largest Professional Organization of Nurses"
Mathilda Scheuer
May, 1962

The primary theme of this address is directed at identifying how ANA meets the needs of its members and the service needs of the public. Standard setting, preparation of policy statements, resolutions, and guidance by the association are identified as methods by which this goal is met. Elevation of nursing education standards is also mentioned in conjunction with the need to emphasize the improvement of clinical practice.

Continued strong support for health insurance for the elderly is evident. A closer liaison with the student nurse organization, and a chronic lack of funds for the professional association's programs receive attention.

"The Accelerated Decade - 1954-1964"
Margaret B. Dolan
June, 1964

The backdrop for this address is the knowledge explosion and technological change realized in the preceding decade. The implication of these changes are seen as dictating that nursing practice must change to meet the new demands, and nursing education must

change in order to prepare practitioners for the altered practice environment. Major emphasis is placed on the necessity to do research, and on the need to support the position that the primary role of the professional nurse is that of clinical practitioner. Education is not seen as standing alone, but tied to economic return, and economic standing is identified as a measure of professional standing. Collective bargaining is pinpointed as a technique which can be used in facilitating this change process.

Finally, the need for a strong viable professional organization is highlighted, and a theme prevails that if the ANA fails to represent nurses they may have to surrender that right to others. A changing environment characterizes the focus of this presidential address.

"The Challenge of Today: Directions for Tomorrow"
Jo Eleanor Elliott
June, 1966

The primary topic highlighting this speech is the interrelationship between nursing education and nursing practice. This convention is the first following the association's 1965 entry into practice position paper, which called for the baccalaureate degree as the minimum credential for professional practice. Education is seen as the means by which clinical practice can be enhanced to meet the publics' health care needs. Clinical sessions are now a primary feature of convention activities, and economic and general welfare concerns are tied to an emphasis on a higher level clinical

practice, in order for society to support an increase in economic reward.

A strong research focus continues. Elliott refers to the fact that during the past biennium the first two research conferences were sponsored by ANA. These events are referred to as milestones. Finally, the movement to establish strong collaborative relationships with other organizations is highlighted. Those receiving primary emphasis are the AMA, NLN and the National Student Nurses' Association (NSNA). Joint statements on working relationships, and planning for nursing education are mentioned as by-products of this endeavor. Elliott makes the point that nursing does not exist in isolation, and that "we cannot accomplish all we want to accomplish along . . ." (One Strong Voice, 1965, p. 569).

"Positive Action for Meeting Health Needs"
Jo Eleanor Elliott
May, 1968

Elliott's remarks state that the association has identified four action priorities - nursing practice, education, nursing services and economic and general welfare. She asserts that "actions in these areas have reflected both the forces in society with which we need to be involved, and the needs of members to fulfill more effectively our reason for being: that people need nursing care" (One Strong Voice, 1976, p. 572).

Clinical practice concerns are reflected by the fact that divisions on practice have become the primary basis for organization-

al membership. These divisions are reported to be in the process of developing practice standards and moving towards the formulation of boards for certification of clinical competency in specialized areas.

The Commission on Nursing Education is pictured as active in assisting the association to improve the quality and quantity of nursing education. Particular emphasis in the area of nursing services is placed on ANA's association with other organizations concerned with the delivery of organized nursing services. The AHA and AMA are paramount here, with the continued activity of the AHA-ANA Liaison Committee and the ANA-AMA National Conference for Professional Nurses and Physicians. Economic and General Welfare programs are presented by Elliott as a vital part of the association's efforts on the behalf of nurses and better care for all Americans.

The final section of Elliott's speech is entitled "The Obligation to Society." She states that nursing must focus on the needs of society and the ways in which nursing's needs interface with major social problems.

"Is ANA Relevant in the Seventies?"
Dorothy A. Cornelius
May, 1970

The text of this address is dominated by recounting cutbacks in staff and programming which occurred during the preceding biennium. These cutbacks were necessary due to a severe financial crisis. This address concentrates on two factors. First, the president

reports that discussions between ANA and organizations such as AMA, AHA, NLN and NSNA continue to develop. She asserts that the nature of the discussions between these organizations have taken on a more substantive tone, in that issues and concerns are debated and discussed, whereas previous meetings were generally devoted to reports of organizational activities.

Secondly, she questions the relevancy and role of the professional association in the coming decade. This questioning seems related to the financial setback. This section concludes with a call for free and open discussion designed to create a cohesive, united, and involved organization.

"A Time to Stand Up and Be Counted"
Hildegard E. Peplau
May, 1972

The basic thrust of Peplau's remarks are oriented towards conflict resolution. She clearly indicates that this is a time of turmoil in the nursing group - one featuring opportunities for an expanded practice role as well as one of countervailing forces (One Strong Voice, 1976).

> Or, to put the matter another way, the power of the forward thrust of the profession, and the counterpulls upon it at this time, seem roughly equal. And this is the test: Whether or not the will and the energy of nurses can be mobilized sufficiently to meet the new challenges now on the horizon . . . (One Strong Voice, 1976, pp. 585-586).

The president speaks to the need for nursing to focus on the health care needs of society as a means of advancing the group and making a positive contribution. She expresses fundamental concern

at the lack of awareness among the occupational group as to why researchers must have full support.

Finally, for the first time, the need for political activity by nurses and nursing is mentioned.

> Silence gives consent, it is said. This the time for nurses to stand up and be counted as men and women who intend to continue the advancement of . . . nursing in the public interest. (One Strong Voice, 1976, pp. 589-590).

"Toward a New Reformation"
Rosamond C. Gabrielson
June, 1974

Rosamond Gabrielson served two terms as the President of the American Nurses' Association. Her first address is characterized by an appeal for unity among nursing's special interest groups, and strong support for the association to turn its attention towards meeting the needs of staff nurses. An active participation in decision making activities by the rank and file is urged as is the need for the association to conduct a vigorous economic and general welfare program. "We must make human and financial resources of the association available to enhance the power of the staff nurse" (One Strong Voice, 1965, p. 596).

"Tomorrow's Challenge"
Rosamond C. Gabrielson
June, 1976

This address was delivered shortly before our nations bicentennial celebration, and the eightieth anniversary of the ANA. These events are drawn as a demarcation point, and the speech reviews

past accomplishments of the association and calls for a new beginning-a futuristically oriented profession.

The president asserts that she believes the future will be dominated by a society that supports the revamping of a health care system designed to keep the consumer well. She believes that nursing recognizes and supports this change in emphasis, but she urges that to recognize a need does not necessarily yield the initiative for such change.

The change Gabrielson refers to is that of nurses as primary care providers. She urges nursing to engage in activities designed to convince the public, government, and other health care disciplines that nurses can discharge such responsibilities. She identifies fee-for-service as the formal recognition required to establish a primary care provider role.

Finally, Gabrielson argues that the foremost priority must be the advancement of nursing. She reminds the members in her concluding remarks that this may mean sacrificing individual interests for greater group benefits, as well as sacrificing nursing's interests for the public welfare.

"Tomorrows Health/Todays Challenge"
Anne Zimmerman
June, 1978

Three topics dominate Zimmerman's remarks: 1) organization of the association; 2) entry into practice; and 3) professional evolution.

The president's remarks regarding the organizational structure of the association point to other problems. The primary thrust is directed at how the association can continue to directly participate in collective bargaining activities when the membership is so heavily composed of those in management and educational positions. Zimmerman argues that the association is called upon to provide local constituency legal and financial support without adequate resources.

At the core of these concerns is the entry into practice issue. The disagreement within the occupational group with regard to this stand continues to have an effect on membership. Zimmerman argues:

> Our major concern should be to continually sharpen our focus on the future . . . sacrifice will be necessary to better the world of nursing for those who come after us. The opposition to progress being expressed now will continue unless we evidence our intent . . . . (ANA, 1979, p. 22).

Finally, Zimmerman, turns her attention to the transfer of functions from one profession to another. She seems to be addressing a "what is nursing" concern when she directly quotes from the words of sociologist Robert Merton:

> The essential point is that the redefinition and transference of professional functions is a never ending process. Each profession must work to identify the functions it can discharge best. Occasionally, it will find collaboration from other professions, but, since this is not always so, it must be prepared for conflict. This is a troublesome part of professional life . . . . If this unceasing process of transfers of functions in the zone of ambiquity is to benefit society, there must be enduring liaisons between adjacent professions . . . . These liaisons will not settle all issues in dispute, but it will minimize them. (ANA, 1979, p. 22).

Zimmerman closes by arguing that when an occupational group shifts from subordinate, order taking behaviors, resistance will be the natural order of things, and the need for resolve and knowledge will heighten.

"Let There Be Light"
Barbara Nichols
June, 1980

The subjects addressed by President Nichols reflect familiar themes. The future of nursing education; the utilization and direct involvement of the association in collective bargaining; and the chronic problem of the organizations failure to recruit and retain large numbers of nurses, dominate the speech.

The thoughts expressed regarding these issues are essentially unchanged. Collective bargaining is viewed as a legitimate and fundamental activity of the association, yet, Nichols cautions that other trade unions have made progress in organizing nurses. Support for the baccalaureate degree as a basic professional credential is voiced. Further, the president ties education to knowledge and knowledge to compensation. The chronic problem of member recruitment and retention is reviewed, and a call for unity and cohesiveness is issued. The need for unity is the theme which dominates her remarks.

Analysis

The beliefs expressed in the speeches of ANA presidents are, for the most part, fairly consistent in their orientation. The emphasis placed on different areas fluctuates, with environmental conditions, but a basic formula can be seen.

First, it seems clear that one major emphasis is directed at the need to elevate educational standards for nursing practice. This consideration is consistently tied to the need for nursing to respond to the technological and knowledge changes which have occurred in society. Thus, credence is given to the need for higher educational standards due to a changing environment. The rationale for this movement is based on a commitment to meet the needs of society.

The relationship between education and a higher level practice is extended in that this combination is tied to economic reward. Further, financial reward is not infrequently tied to professional standing. Thus, a basic theme emerges - a high level practice designed to meet the needs of society can only be realized through elevated educational standards. When nursing moves to meet these needs, economic reward and professional standing will follow.

The focus on meeting the needs of society is strong. The orientation takes different forms, but remains throughout the different addresses. In the early 1960's, strong support is voiced for health insurance for the poor and elderly. This is altered in the 1970's to one emphasizing the need for reconstruction of the health care system to meet wellness - oriented goals and objectives. A major role is seen for nursing in such a system via direct fee-for-service.

Collective bargaining, as a method to be utilized in realizing economic rewards, receives increasing emphasis and credence. It is seen as a means of forcing economic rewards for the nursing major-

ity that is institutionally bound, and as the means by which nurses can gain a strong voice in the decision-making processes which shape the practice environment.

There is, however, one major theme in the belief statements of these individuals that limits action based on the beliefs. The need for unity of purpose among those in the nursing community receives major attention. It seems evident that there is considerable disagreement among nurses as to whether an independent, autonomous practice, based on higher educational standards is desirable, or whether a subordinate technically based, assistant to physicians practice orientation should dominate. This split is evidenced by a marked drop in ANA membership following the 1965 position statement on entry into practice, and continual concern regarding the financial viability of the professional association. Collective bargaining is also seen as a means by which membership can be increased, thereby resolving problems associated with finance and program development.

A belief in the need for research to expand nursing's knowledge base receives attention, but the belief is also voiced by one ANA president that this need is not shared or supported by the nursing community. This viewpoint seems to be at least partially based on the lack of financial support given to the American Nurses' Foundation.

The fact that nursing's role in society will be shaped not only by its own actions, but those of others is discussed. In order to address the natural intergroup struggle for the prestige, status,

and respectability accorded professional groups, ANA presidents consistently express the belief that contact and dialogue with the AMA, AHA, NLN, and National Student Nurses Association is mandatory. Further, the need to negotiate substantive issues is expressed. In sum, a strong belief for political activity on every level is voiced.

Finally, the future of the association, as well as the primary role of the nurse as a clinical practitioner, is addressed on a fairly consistent basis. The remarks seemingly reflect a need to identify and establish the role of the association. Practice standards, policy development, position statements and leadership are voiced as appropriate activities but support for these does not seem to develop and intragroup disarray dominates.

Data Matrix Cell - One B: Beliefs/Literature

Three dictionaries were selected from the May, 1978 publication of "Reference Sources for Nursing" in Nursing Outlook. Definitions of "nurse" and "nursing" were reviewed in every edition of each of the dictionaries during the twenty year span of the study (1960-1980). Analytical emphasis was placed on definitional change and on the functional and educational orientations of the definitions over time. This data reflects beliefs within the health care community. It also promotes resolution of the research question which asks if society has changed its view regarding nursing's role.

a. Duncan's Dictionary for Nurses. This work was written by a nurse author in 1971. Only one edition of the dictionary was

published during the study's time span. The full text of Duncan's definitions of "nurse" and "nursing" can be found in Appendix B.

No specific educational requirements or expectations are stated in the definition. Graduate and registered nurses are referred to as those who have graduated from a school of nursing, but no mention is made of where that school is housed.

The functional focus of the material is meaningful. It seems heavily skewed to an illness orientation - "one who cares for sick, wounded, or helpless" - "her function is to give immediate and expert care to the injuries received by employees . . . to follow up on sick and injured employees" (Duncan, 1971, p. 243). Health maintenance and prevention of illness roles are identified in the public health nurse, school nurse, and occupational nurse sub-definitions. In the brief definition of "nursing", health maintenance is identified as a functional interest.

Although health maintenance and prevention are identified as nursing activities, they appear to be viewed as activities external to the acute care setting. Further, they are included under the broad definition of nursing, whereas the strict definition points towards illness oriented client care. It should also be noted that Duncan defines the practice of nursing as occurring under the direction of a physician.

b. Webster's Third New International Dictionary. Four editions of this dictionary were published during the study's time

span - 1961, 1966, 1971, 1976. These publication dates are fairly consistent with those time periods receiving major emphasis in this study. The 1961, 1966, 1971 and 1976 definitions of "nurse" and "nursing" are exactly the same. The 1976 definitions can be found in Appendix B.

"Nursing" is defined in all four editions as a occupational group composed of varied activities. The variety or nature of the activities is not addressed. The definitions of "nurse" are, for the most part, slanted towards human activities associated with suckling, nourishing, cultivation, fostering and cherishing.

When referring to the occupational aspect of nursing, Webster defines the nurse as one especially trained to care for the sick, injured and infirmed, under the direction and supervision of the physician. In this respect Webster and Duncan are consistent in their views. A specialized orientation is lacking in Webster, and the only mention of education is that of "special training."

c. Taber's Cyclopedic Medical Dictionary. The Taber's definition of "nurse" over six editions (1961, 1963, 1968, 1970, 1973, 1977) give evidence of a changing orientation. (See Appendix B) In 1961, Taber's describes a "nurse" as "one who cares for the sick or wounded, esp. a registered nurse" (1961, p. N-34). Change is first noted in the 1973 edition - "One who cares for the sick, wounded, or feeble, esp. one who makes a profession of it after successfully completing a prescribed course in a school of nursing." (1973, p. N-43)

This definition seems to be fairly consistent with those of Webster and Duncan, but the 1977 definition of "nurse" in Taber's is markedly different from any previously published.

> nurse (L. *nutrix*, nurse). 1. An individual who is professionally trained to be a member of the health care team. The extent of participation varies from simple patient-care tasks to the most expert professional techniques necessary in acute life threatening situations. The ability of a nurse to function in making self-directed judgments and to act independently will depend on his or her professional background, motivation, and opportunity for professional development. The health care team includes the technical nurse who is technique-oriented and deals with the commonly recurring nursing problems and knows standardized procedures and medically delegated techniques. Also included in the team is the professional nurse who is prepared to assume responsibility for the care of individuals and groups through a colleague relationship with a physician. The roles of nurses constantly change in response to the growth of biomedical knowledge, changes in patterns of demand for health services, and the evolution of professional relationships among nurses, physicians, and other health professionals. 2. To feed an infant at the breast. 3. To perform the duties of caring for an invalid. 4. To care for a young child. (pp. N-42, N-44).

This definition recognizes two levels of nursing practice, technical and professional. Further, it identifies a colleagial lationship between the professional nurse and the physician, with the opportunity for self-directed judgments and independent acts by the nurse.

Educational requirements are not explicitly addressed, but professional practice is identified as dependent on "a professional background, motivation and opportunities for professional development." (Taber's, 1977, p. N-42) The 1977 definition also recognizes that the role of the nurse is constantly being altered due to changes in the knowledge base, patterns of care demanded by society, and the evolution of professional relationships. These elements are directly

related to the process of professionalization. One other major change is worthy of note. In the 1973 Taber's, the term "clinician" appears, indicating that a general knowledge base is possessed by nurse clinicians, in addition to an area of specialized practice.

The definition of "nursing" does not substantially change over the twenty year period. It does state that nursing is scientifically based. It also includes references to breast feeding and lactation.

Analysis

Both Webster and Duncan emphasize that nursing is primarily related to activities associated with the care of the sick, as opposed to a wellness orientation. Further, nourishing activities such as suckling, cultivating, fostering and cherishing dominate. An analytical, scientifically based practice is absent in these definitions. These two sources are also in agreement that nursing practice occurs under physician direction and supervision. This assertion is not qualified or circumscribed in any way, and as such does not reflect the professional attributes of group practice autonomy or authority over client. A changing orientation is not evident in these two data sources.

On the other hand, in Taber's the inclusion of the clinician category and the alteration in the 1977 definition of nurse reflect substantial change. Further, it indicates that nursing practice is based on a general body of theory, (See Appendix B) and that the clinician "nurse-type" has developed specialized clinical expertise.

The nurse is identified as being able to work independently and teach other members of the health care team. The inclusion of this category, and its identified characteristics is a marked departure from the more traditional and fundamental categories of nursing practice listed in prior editions i.e. private duty, scrub, community, school nurse. Change in the generic nurse definition and the inclusion of a clinician category are seen as the primary changes evidenced in Taber's. The substance of these two changes seem meaningful as they recognize a theoretical base for practice, independent decision-making and a colleagial nursing-physician relationship, rather than the superior-subordinate cited in the other data sources.

Conclusions based on this dictionary material are speculative at best. One conclusion seems warranted. If we accept Webster's material as indicative of society's belief system about nursing, the acceptance of nursing as a developing professional group is lacking. Not only have the definitions of "nurse" and "nursing" not changed in twenty years, but these definitions refer to subordinate and passive roles and are void of any recognition of practice complexity or theoretical orientation. If we accept the changing orientation found in Taber's, characteristics commonly associated with professional status are evident. A lack of agreement was found between these three sources. In summary, a changing role for nursing is recognized in 1977 by health care community literature for a similar view appears virtually unknown in a dictionary intended for general use, and in one published by a registered nurse.

Data Matrix Cell - Four: Beliefs/Archives

The data collected for this matrix cell reports findings regarding specific characteristics in the classified ads of Nursing Outlook and The Washington Post. One edition of each of these publications was selected on a quarterly basis. The classified ads in the January, April, July and October issues of Nursing Outlook, from 1960-1980 were reviewed. Each ad was analyzed for position, academic credentials required or preferred, if any, and experience required or preferred, if any. Classified ads reflect values, attitudes, and beliefs within the occupational group towards educational preparation, experience and specialization. Further, they shed light on the acceptance by society of a changing role orientation. Thus, this data are directly related to the fifth and sixth research questions.

One Sunday edition of The Washington Post was reviewed with like characteristics being examined. The Post editions were randomly selected on the basis of four Sunday editions per month (five where appropriate). All the classified ads for nursing positions in each of these publications were reviewed.

Table 3 summarizes findings in Nursing Outlook. A total of 1,861 classified ads were reviewed during the twenty year period. A larger number of ads were found in the issues reviewed in 1965 and 1970. It should be noted that during this period (1965-1970), 70 baccalaureate programs (197 to 267), and 265 associate degree programs (1972 to 437) were opened, thus, creating an increased demand for faculty. In the same period 177 diploma schools ceased operation

Table 3

Summary of Classified Ads by Academic Credentials and Experience in Nursing Outlook: 1960-1980

	Number	Academic Credentials Required or Preferred	Experience Required or Preferred	Education and Experience Specified
1960	341	216 (63.3%)	168 (49.3%)	160 (46.9%)
1965	454	284 (62.5)	182 (40.1)	176 (38.7)
1970	454	334 (74)	178 (39.2)	185 (40.7)
1975	300	276 (92)	153 (51)	154 (51.3)
1980	312	282 (90.4)	179 (57.4)	180 (57.6)
Total	1861	1392 (74.8%)	860 (46.2%)	855 (45.9%)

(NLN Data Book, 1981). Nursing Outlook is a respected journal in the nursing education community. The increase in the number of ads appears to reflect need and circulation patterns.

With regard to academic credentials and experience data two patterns appear to emerge. First, an increasing emphasis is placed on the requirement or preference for academic credentials. Not only does the percentage of ads requiring or indicating employer desire for certain credentials steadily increase, but a strong preference seems indicated for academic preparation, as opposed to experience. Ads requiring or preferring both credentials and experience show a steady but relatively small percentage increase over the twenty year period.

The nature of the positions advertised in Nursing Outlook changes rather substantially in terms of specialization. Appendix C lists ad position titles for the twenty year period. Educational positions, as well as service positions, become clinically specific, and faculty is recruited for their clinical area of expertise, rather than as instructional generalists. Oncology, pediatric nurse practitioner, primary care, rehabilitation and geriatrics faculty, are some of the specialties which emerge. In addition, delineation is seen between graduate, undergraduate, associate degree and diploma faculty, and some of the position titles (Assistant Professor, Associate Professor, Dean) more commonly found in higher education emerge, as opposed to the more traditional "nursing instructor" title.

Standards regarding academic preparation, required or preferred, become more stringent. In the early years, the ads indicate that a BSN is required, MSN preferred for faculty appointment. By 1970 preference for doctoral preparation begins to develop, the master's degree being required. By 1975, very few education ads mention the baccalaureate as the basic requirement, having given way to "master's required" and doctorate preferred. During 1975, 19 to 26 percent of the ads requiring or preferring credentials indicate a desire for an earned doctorate. In 1980, the percentage ranges from 37 to 67 percent of those ads specifying this educational criteria.

The ads in Nursing Outlook directly related to service demonstrate a similar pattern. Advertisements for general duty of staff nurses begin to be unit or clinically specific. In other words, nurses are sought for public health, pediatrics, obstetrics, and intensive care, rather than just registered staff nurses. In 1970, recruitment of clinical specialists is initiated and in 1975 nurse practitioner recruitment emerges. The specificity of the clinical orientation becomes more refined as the years progress - family planning nurse specialist, oncology nurse specialist, critical care clinical specialist and family nurse clinician. Educational requirements generally become more stringent for service positions, but at a slower change rate when compared with education.

The advertisements in The Washington Post are more representative of positions sought for nursing service. In this sector, the value placed on experience seems to bear more weight than that in

education. A total of 393 ads were reviewed (See Table 4). During the twenty year period only 21 percent (83) of the advertisements specified academic credentials, while 37 percent required or preferred an experienced respondent. When both the education and experience variables were evaluated, 66 or 16.8 percent of the ads requested this combination.

With respect to indications of specialization (Appendix C) the Post ads began to indicate change in 1975 with the emergence of requests for the services of "nurse clinicians." The change is more dramatic in 1980, when the services of clinical specialists, intensive care nurses, hemodialysis specialists, triage nurses, and occupational health nurses, among others, are sought. The diversification in titles is quite striking.

Analysis

To the extent that classified advertisements reflect the acceptance of role variation by society and the standards of occupational groups, there does appear to be an increasing demand for higher level academic preparation in nursing education and service. This phenomena seems to have progressed more in education than in service; however, the change process appears to have been initiated earlier in education than service.

The educational community ads indicate a strong preference for academic preparation rather than experience, in a forced choice

Table 4

Summary of Classified Ads by Academic Credentials and Experience in The Washington Post: 1960-1980

	Number	Academic Credentials Required or Preferred	Experience Required or Preferred	Education and Experience Specified
1960	16	1 (6.25%)	0 (0%)	0 (0%)
1965	21	2 (9.5)	4 (19.0)	2 (9.5)
1970	56	8 (14.3)	10 (17.9)	4 (7.1)
1975	88	29 (33)	40 (45.5)	20 (22.7)
1980	212	43 (20.3)	92 (43.4)	40 (18.9)
Total	393	83 (21.1%)	146 (37.2%)	66 (16.8%)

analytical framework, while the service related ads indicate an opposite orientation. A larger data base from the service world would provide a more substantial comparison on which to propose differing value structures in these two sectors. Other social, economic, and political variables, such as the job market, do mediate occupational group development, and these constraints should be kept in mind. Irrespective of these intervening variables, a trend toward higher standards and specialization does seem evident in service. It is particularly evident in nursing education.

Data Matrix Cell - Seven: Beliefs/Site

Data in this matrix cell reports findings based on twenty-five interviews with faculty at the institutional site. One of the six characteristics commonly associated with the process of professionalization is the evolution of a distinctive group culture. Culture can be defined as a shared system of values, attitudes and beliefs. A more general way of examining a group's cultural status is by making inquiries about its ideological orientations. Ideology refers to "a fairly coherent set of ideas" (Silva and Slaughter, 1980, p. 4) which serve to clarify and promote the resolution of timely issues.

A series of six questions were developed to guide the interviews. Six issue areas, felt to be particularly sensitive to information regarding ideological orientation were identified (See Appendix A). If, during the course of the interview, information regarding these areas was not elicited spontaneously, responses

were directly prompted. The identified issues were primarily developed from the addresses of former ANA presidents. This data is related to answering the sixth research question which asks if nursing has a shared and consistent system of beliefs.

A random proportional stratified sampling technique with replacement was used to select subjects. The group was stratified according to faculty rank. Two professors, four associate professors, twelve assistant professors, and seven instructors were interviewed. All interviews were tape recorded. Each subject was asked to provide the investigator with a copy of their curriculum vitae. A brief review of these documents was undertaken in order to provide some demographic data on the subjects.

Fifty-six percent (14) of the subjects received their basic educational preparation in a hospital school of nursing, 40 percent (10) in the baccalaureate setting, and one subject was basically prepared in an associate degree program. Sections of their vitae describing work experience revealed career periods from four to forty-two years, with a mean of 13 years in nursing.

The highest earned academic credential of nineteen interviewees (76%) was the master's degree, six (24%) had earned doctoral degrees. This distribution is fairly consistent with the academic preparation of the institutional site faculty as a whole which was found to be 74 percent (master's) and 26 percent (doctorate). Five subjects also reported active doctoral study.

When considering both faculty rank and educational preparation, the respondents holding the rank of professor had earned doctorates. Associate professor educational attainment was split, one had a master's degree and three had doctorates. Two of the twelve assistant professors had earned doctorates. The remainder of the assistant professor group and the entire instructor group (7) were prepared at the master's level.

Ten of the twenty-five interviewees earned their master's degrees at the institutional site, and one earned her doctoral degree in another school of the parent institution. Four members of the sample obtained their baccalaureate degrees at the institutional site, and two reported preparation as nurse practitioners. The sample was entirely female. From those resumes (17) that listed birth date, the respondents ages ranged from 30 to 52 years.

The interviews were primarily conducted during the summer of 1981, when classes were not in session. The investigator felt that this timing was advantageous in that the respondents were less pressured than during the academic year, more inclined to relax and devote a longer period of time to responses. In the vast majority of cases, interviews took place at the institutional site.

In preparing interview data for review, the following process was utilized. In the responses to each question all individual ideas expressed were identified. The investigator then reduced the data to unique statements by entering them on the vertical axis of a matrix. On the horizontal axis of the matrix there was a column for each

interview. If, in subsequent interviews a previously identified thought was verbalized, it was so noted. Thus, utilizing this method, each unique expression was identified and the frequency across interviews with which is was expressed.

For example, in interview twenty-one the subject stated that "nursing education and nursing service are not united." This same idea was verbalized in three other interviews. While the words used to articulate this thought in the four interviews understandably varied, the belief was constant. When the nature of the belief statement changed, a separate analytical item was developed. Thus, when subject number eighteen stated that "nursing service and nursing education need to work more closely together", a separate item was listed. Although these two statements are obviously closely related, in a categorical sense, the interpretation of the statements can vary considerably. One states a belief, the other acknowledges a condition and further expresses the need for change.

The interview data is reported by question and response category. Specific reference is made to the different ideas communicated by the subjects and the frequency with which they expressed similar ideological orientations. A final section will report information on the degree to which the sensitive areas required prompting in order to obtain feedback.

Question 1 - How do you believe nursing has changed over the past twenty years, 1960-1980?

Of the six questions included in the interview schedule, this one generated the highest response rate. That is to say, that in terms of interview time, the largest amount was devoted to dealing with this question, and the greatest number of response items were identified from this question.

Forty-one individual or unique response items were identified from interview data for this question. These expressions seemed to fall, quite naturely, into five response categories: education, research, economic and general welfare, collective bargaining and role. A sixth category, other, was also included for those ideological expressions which did not seem to fit the categorization. The data report is structured around these categories.

Education

Twelve individual or unique ideas were expressed by respondents within this category. They are reported by rank order. By far, the most frequently identified change, during the period 1960-1980, is the escalation or advancement of requirements in the education of nurses. Twenty-two subjects or 88% of the interviewees expressed this belief in responding to this specific question. The manner in which they articulated their thoughts provides a clearer perspective of how they defined advanced educational requirements.

> I think the most significant change is that nursing has moved into institutions of higher education and out of hospitals.

> I can only talk from my own experience which was originally diploma school and now working in a school that is a four year program. The main change I think is going from the diploma

> to the B.S. and putting more emphasis on a broader background of science, not focusing so much on nursing concept courses, that kind of thing and focusing more on science and principles.
>
> I think one of the biggest changes we have seen in nursing has to do with nursing education. In the 1960's we were saying that 80 percent of our nurses were coming from diploma programs, and I recently read something that said 30 percent are from diploma programs, so I see that as one of the biggest changes in nursing, nursing education.
>
> The single greatest change is the emphasis placed on moving nursing programs into academic institutions.
>
> I think just in general the educational preparation. I believe the pressures from ANA in terms of criteria for minimal level of acceptance being at the baccalaureate level. I think more and more nurses feel the pressure to go back to school.
>
> Changes educationally from being predominantly a diploma to a baccalaureate being minimum and on to higher degrees being essential.

These statements are fairly typical of those responses in this area. Two themes seem to dominate in understanding what is meant by the escalation of educational requirements. First, it seems clear that these respondents recognize the shift of nursing programs into academic institutions as a major change. It is interesting to note that of the twenty-five subjects only four mentioned the development of the community college nursing program in a change context. The focus was predominantly on the development of the baccalaureate program and the decline of hospital based education. This emphasis seems understandable when considering the educational affiliation of the interviewees and the entry into practice issue.

A second theme in terms of educational advancement appears related to a belief that the quality of the nursing education experience has changed and improved.

> The emphasis has turned from knowing how to knowing why, as well as how. We've learned that its vital for nursing to know why something is indicated in the case of a client, not just how to do it when ordered by the physician.
>
> Our curriculum development is centered on providing the student with a broad conceptual and scientific base. The emphasis is on theoretical development of the student, not primarily on their technical development as it was in yesterdays diploma school.

In summary, two changes related to professionalization were identified. First, nursing education has associated itself with higher education, as opposed to it previous association with the service institution. Secondly, the education of nurses is now theoretically based rather than technically based, emphasizing the acquisition of concepts and principles on which to predicate nursing practice.

The second most frequently (9 or 36 percent) mentioned educational change expressed reflected recognition of pressure for their own advanced academic preparation. The following comment is typical of those who identified this change.

> If we want more responsibility, autonomy, and professional status you have to live up to the commitments that everybody else has to live up to, and that is to be educated. We have to have doctorates now to keep our positions. Not everybody is pleased about the prospect of going back to school, but we have to make choices. It was bound to happen. The handwriting has been on the wall for some time.

This expression seems directly related to a change in tenure criteria adopted by the university, however when addressing their changing institutional orientations the respondents did not seem to feel that this change was unique to their discipline. On the contrary, the escalation of faculty educational requirements seemed

accepted as a natural event by this group in the process of nursing's assimilation in the community of scholars. The effect of this change on the nursing school was profound. Previously, (See Appointment, Promotion and Tenure Data - Cell Six) tenure application did not require an earned doctorate. This was altered at the institutional site early in 1981. Thus, non-tenured faculty who had not earned a doctorate were faced with the prospect of losing their positions at the university upon completion of their seventh year of employment. Viewpoints seemed to indicate that while the requirement was not overwhelmingly endorsed, it was certainly not unexpected either.

The third educationally oriented idea expressed concerned change in the relationship between nursing service and nursing education. It was identified by eight of the respondents. The two quotes which follow are typical of the responses.

> In terms of the separation of those who prepare nurses and those who give nursing care the result has been negative, it is clear that we had to gain control over the educational function, but the price we paid was a large one. Service nurses and faculty have two different perspectives, and they don't communicate very well. They need to be closer and share common goals and objectives. A second negative consequence of that split has been that the research that nurses have done has tended to focus on educational research on nurses rather than on clinical nursing problems.

> As an instructor I was not always the expert and there was no problem working with service people and having them assist in teaching and we would assist in care. It was a very cooperative kind of thing. I took some time off to raise my family, and when I returned to teaching it had swung the whole opposite. Nursing educators were there and they were the main and only ones that would do the education. It was discouraged to call upon service people to assist unless you, the instructor, were

> there doing a supervising kind of thing. I think as educators began to change the curriculum and move away from the medical model many of the service people still functioned that way and had difficulty switching their frame of reference to an integrated, holistic point of view.

The fourth most commonly identified educational change was similar to the third. In this case however, respondents quite simply stated that a separation of education and service had occurred during the 1960-1980 period. No value judgment was expressed, however, as to its worthiness. In the responses there seemed a straight forward acceptance of an altered relationship.

Thus, seventy-two percent (18) of the interviewees identified an altered relationship between service and education as a major change in nursing, and eight expressed belif that the separation was unfortunate. In general, the respondents who expressed a value orientation, with regard to the service/education split, felt that it yielded negative as well as positive results. A desire to retain the advances realized by the separation and rectify its resultant deficiencies was evident. Two respondents recognized that unification models were currently being proposed, and in some cases implemented, but the nature of these efforts were not described in any detail.

The entry into practice issue and the conflict generated by this movement was specifically identified by 5 respondents as a change. It was, however, implicitly referred to within other aspects of interviewees comment, (i.e. educational change and ANA pressure), but these references were factual in nature as opposed to conflict

oriented. The following quotes are representative of those identifying the conflict.

> One of the things that is essential that we have to do is come to an agreement to decide, and then assist with the change and then more on depending upon where you are on the basic entry into practice. We haven't come to any consensus, which to me, is devastating because it just keeps us from moving forward. We have to get to the baccalaureate level to be the minimum entry.

> These diploma people just won't recognize or don't want to recognize that nursing needs to align itself with the other disciplines in higher education. We've been arguing about this issue for almost twenty years. Diploma education was appropriate for nurses years ago, but our leaders had the foresight to recognize the changing needs of the health care system. I sometimes think that we will have to wait until they die off to get going.

Whether the entry issue was mentioned in response to this question or others, one factor stood out. The interviewees supported the baccalaureate degree as basic to professional nursing. A significant degree of frustration was expressed with regard to a perceived resistance among others to support the ANA's position.

Four interviewees referred to an expanded/increased nursing knowledge base and technical expansion when identifying changes, and further proposed that this expansion has created difficulty for the nursing community.

> I think the knowledge base has changed radically. Also, the technical base is increased tremendously and these kind of go hand and hand. From the standpoint that you can teach them a technical skill and it can be a fairly complex skill, you can take somebody and teach them the knowledge base of that technical skill and they may have the knowledge but not be quite as apt or adept at using the technical skill. Its caused problems in nursing and its caused problems in nursing education - because it still seems to me that the world out there values the technical ability, rather than the intellectual. I don't think we are making much progress getting the public to buy that we need thinkers.

> One of the major changes has been the change in the knowledge base. There is so much to know if you are going to meet the needs of the patients - and you no sooner learn it than a change occurs. If the knowledge remains stable the technology is altered - so there is always something happening. I just wish the service people understood that you can't get it all into four years. Twenty years ago you went from student to practitioner and hardly notice the change. Now the change is so dramatic we find that some simply cannot make the adjustment.

The emotional tone connected with these comments was profound. The investigator was left with the view that educators feel that they value knowledge and service values technical achievement. Thus, not only did the subjects identify two changes, but a conflict in value orientation which developed as a result.

The interviewees (4) also identified that the medical model had been abandoned in structuring nursing curriculum in favor of an integrated approach. This alteration reflected special meaning for the faculty in that the change seemingly represented headway in achieving independence from physician domination. The medical model (medicine, surgery, pediatrics, obstetrics, psychiatry) is the traditional means used for structuring medical school curriculum. It was adopted by nursing schools during their development. These subjects identified discontinuance of the medical model as a change. The view of this situation seems best expressed in the following comment:

> Nursing has gone through many changes. When I was in school, graduating in 1961, we were being taught the medical model. Now we are moving into an integrated curriculum. Some of the schools develop their own philosophy, sort of using different pieces of systems theory, stress theory, and nursing process. Others have tried to formulate curriculum around a specific nursing theorist. Research can then be directed at theory

> development and that is really what we need to do. We don't want to make the same mistake as the docs - nurses need to care for the whole person not just the illness. These changes in approach will help us do that.

Two faculty identified the decline of the diploma school as a distinct change in nursing's educational environment, without tying this change to educational development in other sectors.

> The major change that has occurred is that the diploma school is dead. Those of us who have been around long enough really have the hindsight to appreciate the profound nature of change that has taken place. We still have a few diploma schools left, and there is always talk about the good ole days coming back, but we all know they're dead, and there is no reason to believe they will be back.

Of the twelve unique changes identified by the faculty, the remaining five were verbalized by only one respondent each. The first of these involved the identification of conflict between educated and non-educated nurses.

> We are seeing more educated and better qualified people occupy nursing's leadership positions. I think some people, those that haven't earned the credentials are threatened by those who have the preparation. It is kind of like if you have your diploma in nursing, you have chosen not to go back to school, you are, for the most part, partly safe in that particular institution. If you leave that institution, I think the feeling is that you won't get a similar position. When you see graduates come in with the BSN, MSN, doctorates, it becomes more threatening and because of that people won't support the advancement of nursing - not because it's bad for nursing but because it's bad for them.

Specific reference was made by one subject that the push for credentials is being felt in service, and by another that promotion is now based on factors other than length of service.

> We are seeing nurses with higher levels of preparation, particularly in nursing service. People don't get positions just because they happen to go to a diploma school and happen to be around the hospital for ten years.

> We are seeing more educated and qualified people in leadership positions, particularly in nursing administration. That is where the educational preparation has been lacking in the past.

The final statement under the educational change category expressed an opinion that nursing education makes it difficult for those diploma nurses prepared years ago to more forward.

> We can no longer afford to ignore that people learn by means other than a formal classroom. It's demoralizing for a nurse with ten, fifteen or even just five years of experience to be placed in a senior med-surg course with totally inexperienced students. Some schools actually treat returning R.N.'s like that. It's bad enough that we make them repeat content area they obviously know, but at least they have a group to share their feelings with. It's so important that we move forward but we don't seem to be doing much to promote advancement in the majority group, and as long as that's the case their resistance will be a problem.

In summary, twelve alterations in nursing's educational environment were identified in response to the investigators first question. The movement of nursing education into higher education, and the decline of the service based diploma program proved to be the most frequently identified topical area. Pressure for faculty to earn doctoral degrees and increased emphasis on credentials in the service setting was also identified. The value placed on experience in service as the basis for promotion was seen as declining. The relationship between service and education was highlighted as one area of change and a belief expressed that their current state of separation is undesirable.

The adoption of an integrated curriculum model in place of the traditional medical model was viewed as a change and one means

of establishing nursing's identify. Curriculum was also indirectly highlighted when the knowledge and technological expansion experienced by the health care system was identified. Faculty expressed concern with the amount of material they feel students need to be well prepared practitioners and the amount they can adequately transmit during a four year period.

Conflict between groups of nurses identified as the educated and non-educated was expressed, as was disagreement among nurses over the entry into practice issue. The movement of nursing towards defining "nurse" as requiring a baccalaureate degree received attention, as well as the belief that requirements for non-degree nurses to earn their degrees are too rigid.

In this category conflict seems to be a dominant feature. The one change area which received strong consistent support was the alignment of nursing with higher education and the need to establish the baccalaureate degree as a basic credential for professional practice. Pressure,conflict and divergent viewpoints seem to predominate elsewhere.

Research

The second change category developed for reporting purposes was research. Five related, yet distinct change thoughts were recognized by those interviewed. The most frequently mentioned change was quite simply - "We are doing research." Without exception, it was seen as a positive factor, though some frustration was ex-

pressed as to how faculty can find time to engage in research. The following quote best reflects the breadth of responses.

> Then nursing research, I think, is another area that has really changed a lot in terms of becoming much more prevalent, much more respected, more acceptable, and there is more of it than there was several years ago.

Six subjects identified research as a change, while expressing the feeling that not enough research is being done. One member of the group stated that faculty at the institutional site were conducting studies in local agencies. This was seen as positive activity, one that serves to mend the relationship between health care providers and educators.

One subject expressed strong support for research, but recognized a need to emphasize clinical research rather than research in nursing education. This fifth viewpoint seemed closely related to another identifying the need to build a scientific base for practice through research.

> We need to operate in every respect with the client as the center. But that is not always what you find being practiced. The purpose of research is to develop a knowledge base, a science of nursing, and if you don't develop your research activity in the client's direction then you're not functioning in a nursing framework.

This expression reflected the majority of the feelings identified. The respondent identified more research as a change and placed high value on the scientific process. She pointed out, however, the need to continue research activity, but in a direction that would benefit clinical practice.

Of the fourteen subjects who identified research as a change and expressed attitudes about it, a positive value orientation dominated. The need to conduct clinical research received major emphasis by one subject.

Economic and General Welfare

Respondents also identified four changes which seemed to fall under the category economic and general welfare. One subject stated that the financial situation of nurses had improved during the 1960-1980 period. She recognized a general unrest regarding economic reward, but suggested that we not ignore past progress.

Seven other subjects bemoaned the economic reward system for nurses in both service and education. The following best summarizes the expressed viewpoints.

> Practicing nurses earn less than checkers in the grocery store. When you think of the study required, the responsibility accepted, its a disgrace. We are rooted historically in a religious context and it seems as if the poverty vows dominate. It's well established that female faculty are not as well compensated as their male counterparts. There's been change, but not nearly enough.

Three subjects tied the lack of economic reward to nursing's lack of power in the health care system.

> Look at the docs. They got money and the power followed thereafter. That's probably an oversimplication of the process, but when it takes every penny to keep your head above water, there isn't much left over for developing the kind of power base we need.

Finally, the fourth unique thought expressed within the category of economic and general welfare identified a need for con-

tinuing change in how nurses are compensated. Five subjects specifically mentioned direct third party payer reimbursement for practicing nurses.

> The midwives achieved a major victory when direct third party payment was legislated for them in this state. As long as we continue to work for others and not for ourselves we will never move ahead. Nurses have to provide quality care to clients, and get paid directly for it. That will be tough to do.

In summary, economic and general welfare items were identified in articulating change in nursing. In the main, the changes to date were not seen as adequate or just. Direct third party payer reimbursement was expressed by faculty as a means of achieving appropriate recognition, and implicitly seemed identified as a means of building a sound economic base.

Collective Bargaining

A related category, collective bargaining, was mentioned in response to the first question by twelve of the subjects. It was prompted in the remaining thirteen interviews because it had previously been identified as one of the more sensitive areas for gathering data regarding ideological orientation.

Data in this area were deeply split. Some respondents saw advances through collective bargaining (CB), but labelled it as "advances through negative means." Others saw collective bargaining as a tool that could be selectively applied to improve employment conditions. A third orientation embraced the full incorporation of collective bargaining in nursing's value system. Other faculty saw

collective bargaining as totally unacceptable. Thus, responses were distributed along a continuum from totally unacceptable to fully acceptable, with more moderate views in between. Quotes are provided to reflect the variety of viewpoints expressed.

> When I was working in the early 60's there was a lot of talk about professionalism. I have seen nurses in smaller areas beginning to make advances. Some has come about to me negatively through unionization and striking, but others have come through a lot of hard work by a lot of caring people.

> There is no doubt that collective bargaining is seen more today than it was twenty years ago. It's not for me, but sometimes it seems as if it's the only way to get ahead.

> Collective bargaining is not a blue collar activity as it was in the 20's and 30's, but a legitimate means by which we can advance our profession and provide circumstances by which we can gain control of our practice. We not only owe it to ourselves but, more importantly to our patients. One of these days we have to recognize that those in authority will not willingly step aside and let nurses advance at their expense. The formation of unions is a necessary means of getting what's long overdue.

> Collective bargaining is not the way to go. There's no doubt that there's more of it today than ever before but if we want to gain society's respect, that's not the way to go about it. I just cringe when I see television reports of nurses walking the picket line. Collective action is what we need - a solid front not picket lines and strikes.

Some fifty percent of the interviewees had to be prompted for collective bargaining information. Their level of awareness is understandably less than what might be expected of those working in the service setting. With this condition in mind, their beliefs in this area reflect substantial variance in viewpoint. This finding was not entirely unexpected, given the controversial views expressed by nurses regarding ANA's position on collective bargaining.

Role

Although the most consistent change statements by the faculty involved alterations in the educational area, the highest number of unique expressions centered around role modifications. A number of faculty responses referred to emerging specialty practice, while others seem to identify change within an independence/dependence framework and the nature of nursing's relationship with other health care providers, most notably the physician. Ten individual attitudes or beliefs were communicated by subjects in this category.

> I see change mostly along the lines of independence versus dependence. Nursing process was not identified earlier. As a diploma graduate I did what I was supposed to do. I didn't know why, and I'm not real sure I knew what I was doing. Now nurses are more outspoken about questioning what they are doing and why they are doing it. Now in many cases we know better, and that gives one a broader base on which to act.

This response by one subject adequately summarizes an idea expressed by almost half of the faculty interviewed. The essence of the belief stated that nurses are no longer engaged in task completion, but engaged in making clinical judgments which require high levels of cognitive function. Two other subjects stated this same belief somewhat differently.

> The diploma nurse acted intuitively, the baccalaureate nurse acts on a knowledge base. The mere fact that this has occurred represents a marked change.

Nine members of the sample group identified an expansion in nursing's role as health care providers.

> I think the practice of nursing has taken on a much more active role in the community and in all different types of settings - community clinics, health departments.

> Twenty years ago who heard of nurse practitioners or clinical specialists. We have members of our psychiatric faculty in private practice doing group therapy. These kinds of things were unheard of twenty years ago.

Six interviewees mentioned that nursing was involved in developing a role in preventive care.

> Nursing's focus is a holistic one. We are turning to meet the needs of clients, not so much to get them well when they are sick, although we do that, but to care for them in such a way that we prevent illness. I think society wants a health care system that tries to keep them from becoming ill, rather than one which awaits their illness. Nursing can, should, meet that need.

In summary, faculty reported a major change over the twenty year period in nursing's role. The hospital based task oriented diploma nurse has been re-shaped in the form of a highly specialized independent clinical decision maker. In another arena nursing's influence in the community sector has advanced and its interest in preventative care escalated. Although less frequently verbalized by the interviewees, some expressed doubts regarding the extent of the change.

> There are some pockets of autonomy, but I'd wager that if you could measure it we would find an awful lot of handmaidens out there. Autonomy isn't really reflected in who gets up to give the doctor a chair but in one's ability to make clinical judgments and act without checking with the doctor first. There's very little of that kind of practice going on in hospitals, and after all is said and done that's where most nurses are working.

Another member of the group indicated that some nurses in expanded roles are nothing more or less than junior doctors.

> Nurses are engaged in developing new roles, but some of them are nothing more or less than junior doctors. They have acquired some different skills and devote themselves to acting

> as an assistant to the physician. Nursing is different from medicine - we should care for the client, doctors cure the patient.

In summary, a number of ideas were expressed by faculty regarding an expanded role in nursing. There seems to be agreement that specialized roles have developed over the last twenty years, but far less agreement as to whether the practice of these expanded role nurses reflects increasing independence or simply the delegation of activities previously associated with medical practice. The following quotations are provided as a means of demonstrating the variance in this area of belief among respondents.

> Primary nursing care as far as I am concerned made a statement that nursing has a distinct and separate responsibility to patients. When responsibility is delegated on a continuing basis it promotes the development of an independent practice.

> I think nursing practice has revolved in the past twenty years from moving away from the handmaiden aspect of things to where a small branch of nursing wanted to get into more independent roles and began to formulate the nurse practitioner role.

> I can remember that far back and we never questioned anything. Physicians were never questioned - shoot, they were seen as infallable. We moved through a stage then where we were able to make higher level assessments, but we used terms like "seems" and "appears" to make them known. Now we say that the patient had a run of V-tach. That's diagnosis and we certainly weren't doing that twenty years ago. The ICU nurse probably has more independent decision-making in her practice than any other nurse - well maybe the community health nurse.

The thoughts of faculty with regard to role were generally related to aspects of specialization and independence. Other expressions in the role area were somewhat different.

> There has been a substantial change in our relationship with physicians. They are far less superior - subordinate in

> their orientation and much more collegial. I think it's particularly true with the younger physician. They ask your opinion and discuss their treatment plans, that's new.
>
> Physician-nurse relationships have gone from being subserviant and passive to being riddled with conflict. I think it's one of the major changes I've seen over the years. The whole orientation is different. When you are taught, for example, the importance of preoperative teaching and the surgeon says "no", the resulting difference of opinion does not make for an open and productive environment.

The area of nurse-physician relationships did not require prompting. Expressions regarding autonomy referred to the nurse-physician aspect. It was quite evident that such relationships were on the minds of those interviewed even though their viewpoints varied.

Two final ideas expressed by faculty in this category bear mentioning. Two members of the group mentioned their belief that there have been a movement in nursing back to the bedside and away from administrative functions. This was seen as positive, perhaps a bit overdue.

Finally, in the area of role one respondent spoke quite openly with respect to how nursing's role is viewed by society.

> Nursing is directing all of its energies towards a more professional practice. I'm not sure society really wants that. They certainly don't buy that we are thinkers - all you have to do is watch television and read the popular literature to arrive at that judgment. They still think of us as mopping fevered brows and carrying bed pans. I sometimes wonder what it will take for them to find out that in hospitals at least nurses are just about the only system around to protect the patient from potential disaster.

This report of expressions in the role category concludes responses to the first question. These were, however, six ex-

pressions of change/belief which did not seem related to the established categories. The data for question one will conclude with a report of that information.

Six of the twenty-five interviewees remarked that nursing's involvement in political activity has emerged over the past twenty years. The formation and support by ANA of a political action arm, N-CAP was highlighted as one tangible aspect of this changing orientation. Subjects saw activity increasing at the local and state levels through nursing's involvement in local HSA (Health Systems Agency) boards, as well as activity related to alterations in nurse practice acts. In general, an increased awareness of the political process in shaping the health care system was evidenced.

A second ideal expressed was not oriented toward change but toward need. Involvement in professional association activities was identified as a needed area for change.

> We are the largest group of providers in the health care system and have the least influence, and the principal reason for that is that we do not present a unified front. Membership in ANA is at an all time low. Nobody really seems to care whether we contribute to the formation of health care policy or not.

This lack of unity was also expressed by another subject in a different manner. She indicated that students seem more individually oriented than group oriented.

> The "me" generation seems to dominate these days. They dislike group work and demonstrate a lack of trust in their fellow-students. Our future advancement will require a group commitment. I'm not sure it will be there in time.

Two interviewees noted that the passage of twenty years has brought more men into nursing's ranks. This change was seen as positive in order to alter the dominant femaleness of nursing which was seen as undesirable.

Finally, concern was expressed about two nursing educator traits. First, faculty were seen by one respondent as not being, for the most part, clinically competent. Secondly, one expressed the thought that nursing education and educators were isolated in the academic community.

> It's simply not sufficient to talk nursing and not be able to practice it. A very large component of our practice is tied to technology, and when the so-called experts are not able to adequately manage in the real world creditability suffers. Faculty have to be able to practice nursing as well as preach it.

> We talk to students a lot about collaborative practice and the interdisciplinary approach. Problem is that we talk those things, but don't do them. Most of us don't actively practice nursing and there are few to none who practice collaboratively with another nurse or a physician. None of the other disciplines to my knowledge take courses for credit in the nursing school and we don't share our expertise within the university. We have a fine program in administration, but I often ask myself why we don't offer that graduate program in conjunction with the business school. We are more isolated than we ought to be, and there is a lot to be gained by stepping outside our immediate environment.

These remarks conclude the data report for the first interview question. The second question asked subjects to identify how the changes they identified in nursing were reflected in their school. The data report on interviews continues by reporting responses in this area.

Question 2 - To what extent does your nursing school reflect these changes?

In general, the answers to this question centered on the school's curriculum. Respondents stated that the faculty exercise primary control over the curriculum and that it is shaped in accordance with faculty viewpoints.

Interviewees felt strongly that the programs offered at the school of nursing reflected the changes in nursing. The baccalaureate degree and the R.N. program were seen as a major reflection of the school's commitment to advancing nursing as a profession. Several members of the group expressed a belief that the quality of the student was evidence of the changes.

The graduate programs received particular attention in the subjects responses. Specific aspects were singled out by some respondents, but in general the evolution of the graduate program at the master's level, and the development of a doctoral program received primary attention.

The faculty identified the development of the primary care program at the master's level as reflecting change in nursing, and as a reflection of the school's desire to meet the health care needs of society. The gerontology track and the preparation of the clinical specialist were highlighted in the responses. The following excerpts are representative of faculty views.

> Well, I think the fact that there is such a big primary care department is definitely a reflection of the change in

> emphasis on the capabilities of the nurse, that she is actually able to function in a role previously attributed to the physician.
>
> Our clinical specialist role in the graduate program I think is another reflection of how we try to carry out that change here. In terms of research, where there are research courses both the graduate and the undergraduate level are, I think, evident of how that is carried out here, and also the research that is going on here at the moment. I think the doctoral program is going to increasingly stimulate research.
>
> I believe the move to an integrated curriculum relfects our commitment to a holistic approach. I am very pleased with the product of our undergraduate program. I feel very safe having a graduate of this program care for me or a member of my family. I guess there can be no higher recommendation than that.
>
> The very existence of the generic baccalaureate program and the R.N. program is a public statement of our feelings on the entry into practice issue . . . . When you look at what's happened to the master's program over the years it's hard to believe. The emphasis on preparation for specialty practice is a direct reflection of the changes which have taken place. Even the development of the public policy track makes a statement of our belief that nursing has something special to contribute.

Another area of emphasis in responding to this question centered on behaviors the school attempts to instill in its graduates. Patterns of critical thinking and analytical skill development received major attention in this response theme. The emphasis on knowing why, not just how, was seen as an essential aspect of the curriculum. Research courses in the undergraduate program, as well as the graduate programs, were also felt to represent changing value systems in nursing. Several faculty also stated that by providing students with experiences in agencies other than the acute care setting, the school professed its belief that nursing care did not begin and end in the hospital setting.

Faculty activities were also identified as a reflection of changes in nursing. The involvement of faculty in professional organizations such as the ANA are NLN were highlighted. The increasing emphasis on faculty credentials at the school was identified as a reflection of change, as well the growing commitment of the school and faculty to move the nursing discipline into the mainstream of higher education.

The emphasis placed on faculty research and community service was reported by the interviewees, and evoked a fair amount of feeling by some respondents.

> The pressure is on to do research, particularly clinical research, and I think that's good. Heavens knows we need to build a knowledge base that is unique to nursing. I just don't know when I'm going to get it done, and I don't feel that I have the skills to do the kind of research that's required.

> Well they are very committed to research here as you probably know. Administration sees research and community service as the two top missions with teaching being third in line if you will. The undergraduate faculty at this present time does not have the amount of time that we would like to have to do it because we are carrying such a heavy teaching load. So what you might be doing is frequently on your own time and it is way beyond the 60 or 70 hours that you give this place. So that is a bind, but the commitment is here and the school is working towards freeing up faculty for decreasing teaching and changing our curriculum so some can do it. More of us probably do community service because it falls in line with our clinical agencies many times.

> The pressure is really on to get the doctorate and that makes sense when you think about increasing our productivity in terms of research. So the pressures are just tremendous in terms of I think a lot of people are saying - yes - we need Ph.D. people teaching clinical and getting up at 5:00 a.m. Because I really feel that a master's prepared person can do that. I do not feel that people who are at the Ph.D. level should be teaching clinical . . . . I think those

people are the ones that need to be the researchers and need to be working on those kinds of things.

In summary, this group identified three categories that reflected the changes in nursing at the school. First, the curriculum development was seen as a direct reflection of the school's commitment to nursing's development. Specialty programs at the master's level, development of the doctoral program, and the baccalaureate, both generic and R.N., were consistently identified as reflections of change.

The attempt to instill thought patterns of a critical nature in students was felt to be a major focus throughout the curriculum. Innovations, assertiveness, questioning type behaviors were highlighted in this response.

Finally, the respondents saw the faculty acting as role models of change. Community involvement, organizational activities, and continuance of their formal education beyond the master's level were emphasized as representing the faculty's commitment to a changing environment. The need for faculty involvement in research was verbalized, as was a value for knowledge production as a means of moving nursing forward, but a fair amount of concern was expressed as to how faculty will meet the requirement to conduct research.

Question 3 - How do you believe nursing education has changed in this twenty year span?

Responses to this question were markedly limited due to the educationally oriented responses to the first question. Respondents

did report, within the context of this question, change oriented comments others included in dealing with the initial question.

The decrease in diploma schools of nursing and the association of nursing with higher education was once again reported. The emphasis placed on the theoretical preparation of students, concepts, principles, and research courses in nursing curriculum was stressed, sometimes repetitively. Some interviewees expressed change in curricular focus by identifying the decrease in psycho-motor skill development and increase in psycho-social content for patient care.

The introduction of research courses at the baccalaureate level, and the development of the doctoral program, with its heavy emphasis on research, were again identified. Further, the need for clinical research was expressed by six faculty within this context.

Four unique ideas regarding change in nursing education were found in responses to this question that were not verbalized earlier. First, four faculty specifically addressed the development of the associate degree nursing programs as a major change in nursing. They did not see its development as a positive event. The following quote is typical of the attitude expressed.

> The AD programs were virtually unknown in 1960. You certainly can't say that today. I wish baccalaureate education could have grown in the same proportion. We've got too many technically prepared nurses, and not enough professionals.

The inclusion of leadership skills in the baccalaureate curriculum was seen by one member of the group as a change. One subject saw this as necessary inorder to provide the product of

baccalaureate education with skill development to enhance leadership potential.

The third unique idea identified centered on changes in students, specifically student rights. One interviewee proposed that twenty years ago students accepted the educational institution as a given. Today, she said, students participate in faculty evaluation, curriculum review, and determination of course requirements. In addition, it's not uncommon for faculty to get sued for one thing or another.

Finally, two subjects felt that a teaching technology had developed between 1960-1980 in the form of audio-visual aids. One subject said:

> We are blessed with an A-V lab that really makes the change rather obvious. It makes a major contribution in moving students along. I remember what it was like to teach without it and I think its better this way.

In summary, many of the ideas communicated in responding to the first question were included when subjects considered their responses to this question. Four changes, not previously verbalized, dealt with the development of AD programs, the inclusion of leadership skills in the baccalaureate curriculum, the evolution of students rights and the growth and utilization of A-V technology.

Question 4 - How will nursing change in the next ten years?

The group seemed somewhat perplexed by this query, and in initial responses spoke to the difficulty of "crystal ball" type

exercises. One subject felt that little change could be accomplished by nursing in ten years, proposing twenty-five as a better frame of reference. Once past their initial reluctance to predict, the answers to this question seemingly extended those previously elicited.

Fourteen subjects expressed the belief that the emphasis on health oriented, preventive care will increase, and that the current educational emphasis will promote nursing's ability to meet health maintenance needs.

On the other hand, two interviewees expressed concern regarding nursing's ability to move towards a primary care posture due to an anticipated "physician glut."

> There's been enough around for everybody, and the docs really weren't interested in maintaining health. Now it appears that they are in the process of over-producing themselves. They'll move to meet whatever needs are there, and they have the power to push us out.

Concern with the economy seemed to stimulate a number of responses. Two subjects saw an increase in home health care programs as a means of keeping costs down. They felt that this would be good for the health care industry, since nursing seeks a strong role in the community health.

Another subject had support from two other interviewees when she expressed the belief that the economy may dictate the hiring of lower level personnel to provide patient care, rather than the higher payed registered nurse. On the other hand, one faculty member felt that the economy would bring unemployed nurses back into practice,

thereby easing the shortage, while still another predicted a continuing shortage and higher salaries. This latter viewpoint was supported by a belief that women would be increasingly attracted to the more prestigious higher paying occupations as one means of coping with hard times. There were only three comments regarding salaries and the future. All three expressed the belief that increased economic reward is a necessity if a competent supply of professionals is maintained.

Irrespective of the economy and how it might influence the supply of nurses, there was general agreement that the practice environment would continue its complex and comprehensive development. There was a strong feeling that technological sophistication in health care would continue to increase, markedly affecting the nature of nursing practice.

Due to the alterations in the environment, a change in the nature of nursing practice was seen by several faculty. Three believed that we will see, over the next ten years, increasing specialization as evidenced by more nurse practitioners, nurse-midwives and independent community based nurses. Four members of the group tied this development to the third-party reimbursement issue. The following quote is representative:

> The struggle over direct reimbursement for nurses is bound to continue. There's going to be a bitter struggle, and I'm not sure how its going to come out. I know one thing through - its tough to remain salaried when you feel as capable of providing quality care as those raking it in. Because of nursing's holistic orientation a nurse practitioner in collaborative practice can make a difference in the size of a physician's

practice. The primary problem is she doesn't get a fair share of what she brings in.

On the educational side of things seven subjects expressed the belief that the need for credentials in academic nurses will continue to increase. This view was also applied by some to nurses in the service setting. Pressure to conduct research, particularly clinical research was seen as increasing. One of respondents summarized the group's feeling when she said, "Publish or perish will find its way into schools of nursing."

Four faculty predicted that nursing service and nursing education would move to close the gap created over the past years. Their beliefs seemed to stem from collaborative models currently in place, particularly those in large academic health centers. Two respondents specifically referred to work by their institution to establish ties within the community hospital sector.

Although not specifically tied to a closer working relationship between education and service, six sample members believed that faculty will be more directly involved in patient care in the coming years. There was an emotional quality to this subject matter that made the belief take on significant importance to those verbalizing their feelings.

> We've been admonished because we sit in the ivory tower and have little or no idea how to apply the knowledge we have acquired. I feel that if we are unable to utilize our theoretical expertise in the practice world we lose in serving as a role model for our students and in governing and maintaining the respect of our peers in practice. I don't expect practitioners to be master teachers, but I've accepted that they have the right to expect us to be better than average providers.

The "crystal ball" did yield beliefs that there will be two levels of educational preparation - AD and BSN. The continuing decline of diploma program was not predicted, it was accepted. It should be noted that one respondent predicted continued pressure from other groups, notably physicians, to keep the educational level of nurses down in order to pay them less and justify a subordinate position in the health care system.

On a parallel course, faculty expressed belief that two levels of nursing practice will emerge over the next decade. One respondent labelled the levels as the multi-purpose nurse and the specialized nurse. The continued assumption of responsibilities, previously associated with physicians, was seen as one aspect of practice evolution, as was continued emphasis on psycho-social client need and nursing care oriented towards responses to illness, not merely the illness itself.

A number of the remarks by faculty dealt with their feelings regarding the independence/dependence issue. In the main, their beliefs were directed at more cooperative and collaborative relationships between nursing and other health care providers in the future. Physicians were specifically identified in several interviews.

Interviewees saw more independence and autonomy for nurses and nursing in the future, and more productive relationships with physicians. One respondent tied her feelings about physician-nurse relationships and autonomy to nurses moving away from hospital based practices.

> The traditional hospital triad - administration, medical staff and nursing does not readily facilitate advancement. Administration is as much concerned with control as the physicians are. If professional nursing is to advance an environment outside the traditional setting is the place to do it.

The remaining comments predicting beliefs about the future spoke to advancement in shaping the health care system. Two respondents indicated a belief that nursing would play a larger role in institutional policy-making decisions. Another interviewee saw nursing involvement in ethical decisions.

Five respondents collectively identified nurse involvement on commissions, boards of directors, public bodies and as elected public servants. A total of nine saw political activity as a major thrust in the coming decade, and one subject proposed a higher level of participation in professional association activities by the rank and file.

With regard to collective bargaining only one member of the sample mentioned future oriented beliefs regarding this area. She indicated that this activity would be more responsible in the future, less concerned with self and more concerned with issues directly related to patient care.

In summary, when asked to verbalize their feelings regarding nursing's future the sample group indicated changes in several areas. The advance in knowledge and technology was seen as continuing. The importance of credentials in service and education would increase. Expectations regarding research and publication would escalate in the academic setting.

The group saw advances in community activities by nurses, including boards of trustees, political bodies and policy development. Future professional practice was viewed as featuring autonomy and independence, although there was some feeling expressed that these environmental characteristics would be more easily attained by nurses practicing outside the hospital. Particular emphasis was placed on developing nursing practice that is directed at health maintenance rather than illness resolution.

Varying opinions were offered as to how economic factors would effect nurses and nursing. Some saw it as increasing salaries while other felt it would force institutions to decrease the number of registered nurses employed and increase ancillary workers.

Faculty involvement in providing direct client care, closer ties between service and education, two levels of nursing education and nursing practice were also perceived as a part of nursing's future. The comments were generally optimistic in nature, though some concern that a professional level would never be attained was expressed.

Question 5 - In what way will your school participate in these changes?

The primary means by which the interviewees saw their school participating in the identified changes was via the curriculum. The inclusion of physical diagnostic skills in the undergraduate program, emphasis on preventive care, interdisciplinary discussions of ethical

issues in the classroom, and the development of programs to meet the health care needs of society were highlighted in responses.

The continuing efforts of faculty to earn advanced academic credentials, particularly at the doctoral level, was seen as participating in the changes. Research conducted and supported by the school and its faculty, as well as faculty publications were also seen as representative of support.

Political activity by faculty at the local, state and national levels was viewed as vital in shaping a health care system responsive to nursing's needs. Direct patient care participation by faculty in community agencies and support for cooperative programs between education and service received emphasis. The school's commitment to continuing education and the resources allocated in that direction by the school was identified as one tangible means of supporting ongoing development of providers.

Interestingly enough, one subject expressed the belief that the major means by which the school supported the perceived changes had already been accomplished.

> For the most part, tomorrow's leaders in nursing have already graduated. We achieve our major effect through them. I look for return from today's student in the 90's and beyond.

Question 6 - What role do you believe the nursing education community plays in these changes?

For the most part, responses to this question were extremely limited because the group felt that the nature of nursing education's

participation would be similar to the school's involvement. Two additional changes were, however, verbalized.

The development of doctoral programs in other schools was viewed as desirable, but only if the faculty were qualified to undertake such an effort. Secondly, the growth of programs at the graduate level was seen as meeting the demand for specialty preparation in nursing practice. Programs in oncology and rehabilitative nursing were offered as examples of such programs.

Issue Oriented Areas

As previously indicated six issue oriented areas were identified from addresses by ANA presidents. These areas (See Appendix A) were felt to be particularly sensitive to information regarding ideological orientation. If, during the interview information regarding these areas was not spontaneously elicited, responses were directly prompted.

Almost fifty percent of the respondents failed to mention collective bargaining during the course of their interviews. This occurrence was reported as a part of documenting responses to the first interview question, thus, it is not included in this section. Almost without exception responses had to be prompted regarding the predominant female composition of nursing, and its effect on occupational development. Of the twenty-five interviewees only three subjects mentioned the sexual composition of nursing as a problem; a fourth subject mentioned the increase of males in nursing as a positive factor.

When prompted, this question brought quick and decisive responses. Respondents agreed that due to nursing's female composition it had been slow to develop as an occupational group. The passive, subservient role of women in society was highlighted in responses, as was the failure of women as a group to work together for the common good. The women's movement was felt to be a positive environmental force for nursing, and many expressed the belief that as the women's movement went so would nursing.

The majority of respondents expressed support for the inclusion of more men in nursing, but some felt that male nurses would end up in the leadership positions, and nursing would remain male dominated, only from within in addition to without.

Hope, in the form of future nurses was expressed, for the faculty felt that they attempted to socialize their students, or rather resocialize their students to a more independent, self-assured viewpoint. There was general agreement that the role of women in our society was undergoing change, but that the kind of change required was many years in the future.

The failure of nursing educators to mention sexual stereotype as a problem in nursing's professional evolution is interesting, and many reasons for it could be advanced. On subject concluded:

> Now why do you suppose I didn't mention that before . . . well, probably because things really haven't changed much in this society for women. And, gee, you just don't notice the male/female thing much when you work in a female dominated setting.

Two subjects were asked to specifically address physician/ nurse relationships. Both responded that they felt the "handmaiden thing" was definately less in degree. The issue areas of education, nurse/client relationships, and service to society did not require probing.

Six interviewees were directly asked how the clinical setting in which nursing is practice had changed. Two subjects reported that they really didn't feel it had changed much at all, with acute care hospital employment dominating the practice setting. The remaining subjects identified nurses in independent practice, an increase in community health nursing, and collaborative physician/nurse practices as varient.

Data Profile - Beliefs

The content area of beliefs is addressed in matrix cells one, four and seven. Cell one includes addresses by ANA presidents and dictionary definitions. The fourth cell reports data from classified ads which examine position, educational credentials required or preferred, if any, and experience required or preferred, if any. Cell seven addresses the twenty-five interviews conducted at the institutional site. This profile emphasizes the identification of themes/changes in this content area.

There is a strong recognition and belief expressed among faculty and ANA presidents regarding the movement of nursing into higher education institutions. Although expressed in varying ways the message is clear. The presidents of the ANA and interviewed

faculty wholeheartedly support the housing of nursing programs in higher education. Major emphasis is placed on the baccalaureate program, as opposed to the associate degree in identifying this educational change. The baccalaureate degree as an entry level credential is accepted without question in both of these sources.

The academic preparation of faculty also received attention within all three cells. Faculty reported increasing pressure to earn doctoral degrees, and the need to continue advancement. Data from the classified ads and from presidential addresses supported continued advancement in the faculty ranks.

Aspects of the relationship between nursing education and nursing service was seen in all three cells. The conflict between these two was reported in the addresses, was reflected in the differing requirements for practice in the ads, and reported by faculty in their interviews.

American Nurses' Association presidents articulated support for research in nursing, particularly clinical research. A belief in research also seems evident in the classified ads, through the increasing emphasis placed on doctoral preparation. This value is also verbalized by faculty, though frustration is expressed as to how they can accomplish research along with other responsibilities.

All three cells support the notion that nursing's knowledge base is expanding. The escalation of academic credentials in both service and education; the expressed beliefs of nursing's leadership; the change in Taber's 1977 definition; and the views of faculty

all speak to this area. The need to emphasize analytical skills, principles and concepts are reflections of this orientation.

Faculty and ANA leaders are also in agreement when the matter of nursing's compensation is addressed. Not only do both agree that money is generally inadequate, but that a direct fee-for-service is appropriate for professional level practice. The ads are mute on this point. ANA presidents support collective bargaining as a means of advancing renumeration; faculty do not support this viewpoint.

The largest source of information regarding faculty beliefs about nursing had to do with the role of nurses in the health care system. When considered as a whole, there seems little consensus within the group of subjects as to where nursing is and what it is about. On one point there seems to be general agreement. The role of nursing has changed in the last twenty years, but consensus as to the nature of the role change is clouded.

Some feel that intuitive, task oriented nursing practice has been replaced by a practice which features independent judgments requiring high levels of cognitive function. Others express the view that there is little, if any, independent decision-making activity by nurses. Judgments are being made by nurses regarding the patient's status, but unilateral intervention they propose is severely curtailed except in highly specialized situations.

This viewpoint is fairly consistent with Taber's, that some nursing practice is routine and deals with commonly recurring pro-

blems, and another level of practice deals with highly variable acute situations requiring independent self-directed judgments. Some argued that the self-directed independent group, are not nurses, but "junior doctors." Others indicate that those nurses engaged in doing "things" and not knowing why, are not nurses. The question becomes what and who is a nurse?

The ANA presidents seem to support the notion that the intuitive task oriented individual is not a nurse, or at least does not represent their belief system. Suffice it to say that there is substantial variation as to belief as to what is nursing. This variation in viewpoint was not a problem twenty years ago, thus it seems apparent that considerable role conflict and ambiguity exists today in the nursing community.

Finally, in reporting beliefs, this section would not be complete without mentioning the emergence of a political awareness in nursing. This orientation was reported by faculty as a change and supported by the remarks of ANA presidents. These reports recognize that the acquisition of professional status involves competition and struggle for society's recognition. A developing awareness of this process seems evident, but shared as a belief by few of the many.

Data Report - Attributes

Data Matrix Cell - Two: Attributes/Literature

Data in this matrix cell reports findings in three historical nursing texts. These publications were reviewed in order to identify

reports of new educational programs and innovations in academic nursing. This data should fill any gaps in curriculum development at the institutional site, and serve to substantiate site findings as well. The texts selected for review from the historical section of "Reference Sources for Nursing" in the May, 1978 edition of Nursing Outlook best represented the study's time span and topic under examination. The findings will be reported in the order of their publication. The data collected in this cell is related to the third research question which seeks information regarding the development of specialty education. It also addresses the evolution of nursing's professional culture reflected in the sixth research question.

A History of Nursing by Stewart and Austin was published by G. P. Putnam's Sons in 1962. Three sections within this text yield data regarding nursing and nursing education. They are entitled: "Aspects of Modern Nursing To Be Specially Noted" (p. 154); "More Recent Studies and Trends" (p. 224); and "Some Evidences of Nursing Progress" (p.483).

The authors note early in the text that attention must be given to the stages of nursing's development as "an independently organized vocation or profession . . . with its own functions . . . and its established place in the economic, social and educational structure . . . ." (p.154). They urge the clarification of expanded roles in order that those responsible for the development of educational programs, the preparation of nurses, and the delivery of service, can prepare to meet coming requirements.

The report of a study regarding nurses is highlighted. The Brown Report, Nursing for the Future, published in 1948, under the auspices of the Russell Sage Foundation, focused on developing ideas and trends. The report visualized the development of two nursing groups, professional and practical, with the practical group working under the direction of the professional group. Dr. Brown's study further proposed that the role and preparation of the professional group should be substantially upgraded. The preparation of the professional nurse was envisioned as occurring at the baccalaureate level.

Stewart and Austin (1962) report cooperation between representatives of the community college system and nursing educators to design and develop a combined academic and technical curriculum to qualify graduates for the licensure exam. The authors indicate that these junior/community college programs are no longer considered experimental but are expanding in substantial numbers. The authors sum up their appraisal of nursing education's future in the following quotation.

> The professional development of nursing implies . . . higher standards of education . . . . The education of nurses, professional and non-professional, basic and advanced, now receives much more careful and extended study. Schools of nursing are recognized more and more as educational institutions and nursing education as a branch of professional work that is included in the programs of higher educational institutions." (p. 483).

The second text reviewed, Dolan's Nursing in Society: A Historical Perspective, (1973), also reports the Brown study. Dolan however, gives stronger emphasis to a study reported in 1970, "An

Abstract for Action." The research which initiated this study came out of work conducted by the Surgeon General's Consultant Group on Nursing in 1963. Their report entitled "Toward Quality in Nursing" recommended a national investigation of nursing education. Funds donated by the American Nurses' Foundation, and the Avalon and Kellogg Foundations supported the research reported in "An Abstract for Action." The commission which conducted the study consisted of twelve members, three of whom were nurses, and it was chaired by Allen Wallis, President, University of Rochester.

The study substantiated the findings and recommendations of previous works by Goldmark (1923) and Brown (1948). "It was reported that the decisions of Dr. Brown and this Commission were remarkably similar." (Dolan, 1973, p. 318). The 1965 ANA Position Paper was mentioned in the commission's report as not being well received by many nurses and even more physicians and hospital administrators. This reaction was ascribed to the position paper's lack of appreciation for the contributions made by the hospital schools of nursing.

Finally, Dolan reports that the American Nurses' Association issued a statement in 1969 regarding graduate nursing education. The statement asserted that the purpose of graduate study should be the preparation of clinicians able to improve patient care through the advancement and application of nursing science.

Deloughery and Griffin in their work entitled, History and Trends of Professional Nursing, (1977) also chronicle the findings of the Goldmark study (1923), the Brown study and the commission's, "An

Abstract for Action." Their report and comments regarding these events are similar to Dolan's in their content. In addition to documenting these studies, they make six points about nursing education that merit review.

First, they identify the community college and their associate degree programs in nursing as one of the most dynamic forces in higher education. They term the growth of these nursing programs a "fantastic proliferation" (p. 154). The second educational innovation highlighted involves the establishment of continuing education programs by private and public institutions as a means of assuring continued competence in practice.

The emergence of educational programs to prepare nurse practitioners at the University of Colorado in 1965 is reported. Deloughery and Griffin state that "the development of these practitioners roles has resulted in more nursingparticipation in a wider variety of kinds as well as quality of health care, national health policy formulation, and enjoyment of newly founded colleague relationships" (p. 173). In addition to the development of nurse practitioner programs, these authors point to the increasing number of nurses with earned doctorates. They suggest, however, that the growth of doctoral programs in nursing schools should proceed slowly, and that nursing should draw from other disciplines so that those earning doctoral degrees can be socialized to a more independent autonomous orientation.

The fifth point made by these authors indicates that traditional nursing education patterns are being challenged. They identify that there is increasing emphasis on career mobility, the ladder concept, or the open curriculum. (It should be noted that Dolan identified the open curriculum concept in her text, but the reference is transitory). Deloughery and Griffin emphasize and expand on this issue. All of these terms refer to a concept which emphasizes articulation between educational programs. In such a system the individual's movement from practical nursing programs through graduate programs is markedly enchanced. They term the open curriculum as ". . . one of the most discussed issues in nursing at the present time" (p. 170).

Finally, the authors propose that nursing faculty have not been fully acculturated to the academic community. They see nursing as traditionally task oriented rather than theory oriented. The pressure to publish and conduct research is seen as having an impact on the development of academic nursing. "These expectations serve as a stimulus in moving toward true professionalization and making the profession in fact an academic endeavor" (p. 171).

Analysis

The Brown (1948) study and "An Abstract for Action" (1970) recommend the development of two levels of nursing practice - technical and professional. They further suggest that the education of nurses should be housed in higher education institutions. Thus, these studies support the ANA's 1965 Position Paper prior to its development and subsequent to its publication.

The rise of the associate degree programs in nursing, primarily housed in junior and community colleges is reported as a major change, as is the development of programs to prepare nurse practitioners. Further, the need for clinicians with graduate degrees, who can develop and advance the application of nursing science is reported.

Continuing education programs designed to assure continued practitioner growth and development emerges in the 70's, as does the concept of an articulated education system - practical nursing preparation through graduate school experience. The identification of doctoral program growth in nursing and the incomplete acculturation of nursing faculty in the academic community is reported.

Data Matrix Cell - Five: Attributes/Archives

The data collected for this matrix cell reports the number and type of academic credentials earned by faculty in baccalaureate and higher degree programs. Information was collected at the institutional site, and from the national perspective, as reported by the NLN. Data collection by the NLN regarding faculty academic preparation was not initiated until 1964, thus, 1960 national data are not included. Table 5 reflects a compilation of both national and institutional data from 1965-1980. Table 6 reports academic preparation of faculty at the institutional study site from 1960-1980, by highest earned credentials. Data reported within this matrix cell is directly related to this study's first research question which asks whether the number and type of academic credentials earned by faculty have changed over time.

Table 5
Comparison of Full and Part-time Faculty, By Highest Earned Credential, Nationally and at the Institutional Site: 1965-1980

Year	Total Faculty Reported		Highest Earned Credential							
			Doctorate		Masters		Baccalaureate		Other	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1965-66										
National	4,532	100	294	.065	3,545	.782	675	.149	18	.004
Institutional	67	100	6	.089	60	.895	1	.015	-	-
1970-71										
National	5,564	100	327	.059	4,304	.774	889	.160	44	.008
Institutional	131	100	7	.053	122	.931	2	.015	-	-
1975-76										
National	10,328	100	908	.088	7,835	.759	1,532	.148	53	.005
Institutional	202	100	27	.134	170	.842	5	.025	-	-
1980-81										
National	11,639	100	1,374	.118	9,352	.803	903	.078	10	.001
Institutional	150	100	39	.260	111	.740	-	-	-	-

Sources:

NLN Nursing Data Book 1980, Statistical Information Nursing Education and Newly Licensed Nurses. National League for Nursing, New York, 1981, pp. 94, 102.

Institutional Site Catalogs; Faculty Listings

Although the percentage of faculty prepared at the master's level increased nationally by only two percent (.782 to .803) in fifteen years (1965-1980), the number of faculty prepared at master's level rose from 3,545 to 9,352. A similar pattern emerges when doctoral preparation is examined. The overall percentage of doctoral degrees increased from approximately 7 to 12 percent, while the number of faculty holding the doctoral degree increased from 294 to 1,374.

It should be noted that these alterations in educational preparation occurred during a concomitant period of expansion in baccalaureate and higher degree nursing education. During the fifteen year span, 1965-1980, the number of baccalaureate programs in nursing increased from 197 to 363. Master's and doctoral programs increased from 53 to 127, and 4 to 22 respectively (NLN Data Book, 1981). Further, total faculty employed increased from 4,532 to 11,639. Thus, it appears that academic preparation was not sacrificed in the face of growth. During this same expansion period, the employment of faculty with baccalaureate preparation declined by approximately 7 percent.

Change is more pronounced at the institutional site. (See Table 6). While the net increase in faculty size from 1965 to 1980 was 83, the percentage of those holding doctoral degrees increased from 9 percent in 1965 to 26 percent in 1980. This is a 17 percent increase realized during a 44.7 percent net increase in faculty size. It should also be noted that although there was

only a net increase of 19 faculty members between 1970 and 1980, there was a 20 percent increase in faculty prepared at the doctoral level. This change would appear, at least in part, related to the development and initiation of a doctoral program. Administrative long range planning for such a program would have necessarily included the active recruitment and development of doctorally prepared faculty. The formulation of specialized master's programs might also have contributed to this movement. The decrease in the number of faculty at the institutional site (202 to 150) between 1975 and 1980 was primarily due to the closure of two satellite contract campuses.

Direct comparisons between national and institutional data should be approached cautiously, for like academic entities are not being compared. Nursing schools which offer graduate degrees are reported in the same data base as educational institutions solely dedicated to the basic degree. Data from the institutional site would be more meaningful if comparisons within its own sector could be made.

With these comparative limitations in mind, doctoral statistics do not seem to indicate a major change, when comparing national and institutional data, until 1975 when there is almost a 5 percent difference in this area. Institutional data regarding master's preparation is substantially different from that reported nationally in that it is consistently ahead of the national scene, declining only in the face of a concomitant increase in doctorally

Table 6
Full and Part-time Nurse Faculty, By Highest Earned Credential
At the Institutional Site: 1960-1980

Academic Year	Total Faculty Reported		Highest Earned Credential							
			Doctorate		Masters		Baccalaureate		Other	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1960-61	32	100	3	.094	24	.750	5	.156	-	-
1965-66	67	100	6	.089	60	.895	1	.015	-	-
1970-71	131	100	7	.053	122	.931	2	.015	-	-
1975-76	202	100	27	.134	170	.842	5	.025	-	-
1980-81	150	100	39	.260	111	.740	0	-	-	-

Source:

Institutional Site Catalogs; Faculty Listing

prepared faculty at the school. Organizational development appears to be one factor underlying this deviance.

Summary

When both the national and institutional figures are examined it seems apparent that the academic credentials of faculty in baccalaureate and higher degree settings have changed both in number and type since 1960. Comparisons between national and institutional data are ill-advised,however, since like entities are not being compared. In both sectors, faculty academic preparation was not sacrificed in the face of growth.

The change is more evident at the institutional site than nationally. Doctoral preparation increased by 17 percent in twenty years even in the face of faculty growth. On the national scene, master's preparation was maintained during a marked educational expansion, while in fifteen years a 5 percent increase in doctoral preparation was seen under the same circumstances. Change is evident in the number and type of academic degrees, but more pronounced at the institutional site. This is not totally unexpected in an institution which reflects nursing's past, present and future. The change is recent, but it is there. As such, this data represents a shift towards a more extensive training period for academic nurses, and the acquisition of greater amounts of the knowledge base. Academic credentials are one means of judging how much of the knowledge base an individual or occupational group commands. As they increase

the more professionalized the individual and, hence, the group becomes (Greenwood, 1957; Moore, 1980; Ritzer, 1972).

Data Matrix Cell - Eight: Attributes/Site

The data collected for this matrix cell examines the entry and certification (graduation) requirements established at the institutional site, by program area, during the study's time span. The data is related to the research question (2) which asks whether certification and entry requirements for students are changing. The undergraduate curriculum features both a generic baccalaureate degree in nursing, and one for registered nurses prepared in associate degree and diploma educational settings. Graduate programs at the master's and doctoral levels are also offered. Findings and analysis will be reported by program area.

Generic Baccalaureate - Entrance Requirements:

Report

The generic baccalaureate entrance requirements are described somewhat differently due to a major change in curriculum structure at the institutional site in 1970. This change was due to the implementation of a lower-division, upper-division structure. Thus, students were not admitted to the school of nursing directly from high school, but generally speaking, after two academic years of pre-professional education. Table 8 compares the entrance requirements for generic students across the twenty year time span of the study, and Table 7 compares course requirements by semester hours. This display of data generates an interesting pattern.

Table 7

Comparison of Generic Baccalaureate Entrance
Requirements by Course and Semester Hours: 1960-1980

	1960	1965	1970	1975		1980
English (including speech)	14	11	11	3		3
Math	3	3	3			
P.E.	4	2	2	Social Sc. 12	Social Sc.	12
Psychology	3	3	3	Humanities 15	Humanities	15
Science & Theory of Health	0	2	0	Electives 6-10	Electives	6
History-Gov't	9	6	6			
Zoology-Anatomy & Physiology	12	12	12	6-8		8
Physics	0	4	0			
Microbiology	4	4	4	3-4		4
Growth & Dev.	0	3	0			
Chemistry	10	12	8	6-8		8
Fine Arts-Philosophy	0	3	3			
Sociology	3	3	3			
Elective	0	0	3			
Nutrition	3	3	3	3		3
Nursing	6	5	0			
Total	71	76	61	59		59

Source:
Institutional Site School Catalogs

Table 8
Comparison of Generic Baccalaureate Entrance Requirements at the Institutional Site: 1960-1980

Program	1960	1965	1970	1975	1980
GENERIC BACCALAUREATE PROGRAM - ENTRANCE REQUIREMENTS	1. Graduation from accredited secondary school. 2. Recommendation of school principal. 3. Desirable distribution of high school credits. a) english-4 credits b) math - (1) algebra-1 credit (required) (2) geometry-1 credit (desired) c) history and social studies, 1 credit required, 1 desired. d) foreign language-1 credit desired. e) biological, physical sciences-1 required in biology, chemistry and/or physics. 4. Fitness for nursing in health, personality and moral character.	Requirements remain the same with one exception. 1. Two math courses required rather than one required/one desired.	Upper division lower division framework established. Thus, students admitted to nursing program as college juniors. Entrance requirements now focus on freshman and sophomore course work. A college preparatory program in high school is suggested and emphasis is placed on need for course work in chemistry, biology and physics. 1. Outline of lower division requirements follows: Freshman Year 001 English Composition . . . . . 3 credits 001 Zoology-General Zoology . 4 credits 001 Chemistry-General Chemistry 4 credits 010 Math or 018 Introd. to Mathematics or Analysis .3 credits PHED-Physical Activities . . 1 credits Total 15 credits	1. Minimum of "C" in Anatomy and Physiology. 2. 59 semester hours of lower division credit required. 3. Requires that courses in chemistry, anatomy and physiology and microbiology must have been completed by the student prior to application. 4. Detailed lower division requirements follow: Preprofessional Course English Composition . . . . . .3 credits +Human Anatomy and Physiology (C or better grade) . . . . . .6-8 credits +Microbiology (C or better grade) . . . . . .3-4 credits +Chemistry (including some organic chemistry content). .6-8 credits *+Social Sciences . . . . . 12 credits **Humanities. 15 credits Nutrition (presently recommended;required for incoming juniors.	1. Lower division course requirements and the policies governing these courses follows: Professional upper division education in nursing requires a foundation of learning provided by required lower-division college courses. Prior to fall matriculation in the undergraduate program, all students must have completed the following lower division course requirements at an accredited college or university: English Composition . . . . . 3 credits Chemistry Including Lab (inorganic & organic content) . . 8 credits Human Anatomy & Physiology Including Lab ("C" or better grade) . . . . . 8 credits Microbiology Including Lab ("C" or better grade) . . . . . 4 credits *Social Sciences . . . . . 12 credits **Humanities. 15 credits Nutrition (sophomore level). . . . 3 credits Electives . . 6 Minimum of 59 credits

Source: Institutional Site School Catalogs

Table 8 (continued)

Program	1960	1965	1970	1975	1980
GENERIC BACCALAUREATE PROGRAM - ENTRANCE REQUIREMENTS			001 Sociology-Introd. to Sociology. 3 credits 001 Psychology-Introd. to Psychology . . . . . 3 credits 003 Chemistry-General Chemistry. 4 credits 007 Speech-Public Speaking . 2 credits Fine Arts or Philosophy . . . . . 3 credits PHED-Physical Activities. . . 1 credit Total 16 credits Sophomore Year 003 English-World Literature . . . 3 credits History . . . 3 credits 014 Zoology-Human Anatomy & Physiology . . . . . 4 credits 001 Microbiology-General Microbiology . . . . . 4 credits Total 14 credits 004 English-World Literature . . . 3 credits History . . . 3 credits 015 Zoology-Human Anatomy & Physiology . . . . . 4 credits 080 Nutrition-Nutrition for Health Services . . . . . 3 credits Elective . . . 3 credits Total 16 credits	fall, 1977, and thereafter) . . . . . 3 credits Electives6-10 credits Total 59-60 credits Social Sciences include sociology, psychology, political science, economics, geography, anthropology. Humanities include literature, history, philosophy, foreign languages, mathematics, fine arts. In addition, the School of Nursing has established the following policies: 1. Foreign Language-Humanities credit will be given for the first semester elementary course in a language (i.e. FREN 101, ITAL 101, etc.) only if additional credit is earned in that language. However, the first course can be used for elective credit even if no additional credit in that language is earned. 2. Fine Arts-Humanities credit will be given for one "studio" course in	*Must include at least one course in sociology and one course in psychology. **Must include courses selected from at least three disciplines within the humanities areas. Policies Governing Transfer of Lower Division Credits The following is a list of policies which govern the transfer of college credits to the School of Nursing: 1. Human anatomy and physiology, chemistry and microbiology must be courses taken by students who plan to or could use them as credits toward a major in these areas. In other words, they cannot be terminal courses for non-majors; i.e. students majoring in nursing, physical education, etc. 2. Required natural science courses (chemistry, microbiology and human anatomy and physiology) must include laboratory experience.

Table 8 (continued)

Program	1960	1965	1970	1975	1980
GENERIC BACCALAUREATE PROGRAM - ENTRANCE REQUIREMENTS			2. A 2.0 cumulative grade point average in lower division work required.	the fine arts (i.e. class in piano, painting, etc.) only if credit in the appropriate survey course is also earned (music literature, history or art, etc.). +Social, physical and natural science courses taken 10 years prior to student's admission date will not be accepted (effective 77/78). *Must include at least one course in sociology and one course in psychology. **Must include courses selected from at least three disciplines within the Humanities area.	3. Courses in religion will be accepted in transfer when they have been taught within a framework which oversteps specific sectarian concerns and/or dogma. Religion courses whose content is exclusively/primarily limited to sectarian dogma will not be accepted in transfer. 4. Basic nutrition must be a course with prerequisites of organic chemistry and anatomy. 5. Humanities credit will be given for one "studio" course in the fine arts; (i.e., class in piano and painting) only if credit in the appropriate survey course is also earned (music literature, history of art, etc.). 6. "D's" are not transferable for anatomy and physiology and microbiology from either in-state or out-of-state institutions. For other courses, D's are transferable from in-state public institutions only.

Table 8 (continued)

Program	1960	1965	1970	1975	1980
GENERIC BACCALAUREATE PROGRAM - ENTRANCE REQUIREMENTS					7. Courses taken on a Pass/Fail basis may be used for elective credits only. 8. Credits earned in courses titled Human Growth and Development are not applicable toward preprofessional course requirements. This content is taught within the School of Nursing (Junion year). 9. Remedial and/or repetitive courses are not applicable for credit. 10. Nursing courses are not transferable. 11. Foreign Language-Humanities credit will be given for the first semester elementary course in a language (i.e., FREN 101, ITAL 101) only if additional credit is earned in that language. However, the first course can be used for elective credit even if no additional credit in that language is earned. 12. Social, physical and natural science courses taken 10 or more years prior to a student's matriculation date will

Table 8 (continued)

Program	1960	1965	1970	1975	1980
GENERIC BACCALAUREATE PROGRAM - ENTRANCE REQUIREMENTS					not be accepted. 13. Only students with an overall grade point average of a 2.0 or better will be considered for admission to the School of Nursing. 14. Only 59 applicable credits are necessary for matriculation to the School of Nursing. A maximum of 60 credits will be applied toward the matriculation grade point average; additional credits earned by the student will be viewed by the Admissions Committee as credit for enrichment but will not be calculated in the Student's matriculation grade point average. 15. Whenever possible, credits recorded on an applicant's transcript will be used as the basis for calculating the matriculation grade point average rather then those grades resulting from courses listed on the "Courses in Progress" sheet, which is a form included in the official application.

Table 8 (continued)

Program	1960	1965	1970	1975	1980
GENERIC BACCALAUREATE PROGRAM - ENTRANCE REQUIREMENTS					2. Submission of Allied Health Professions Admission Test now required.

The total number of semester hours required in the generic program is reduced during the twenty year period, and a rather specific entrance requirements pattern emerges. The biological and natural sciences experience little change. Anatomy and Physiology remains a firm requirement, with Zoology being deleted in 1975. Microbiology and Nutrition are unchanged in their requirements, and although chemistry is reduced by 4 semester hours, course work remains in both inorganic and organic. Basic physics first appears in the 1965 curriculum plan and disappears thereafter.

Change in the area of the humanities, social sciences, and electives is noteworthy. Utilizing the definitions of the institutional site (See Table 7) a shift to the inclusion of more course work in the humanities, social sciences and electives is evident. Entrance requirements in the 1960, 1965, and 1970 feature six hours in the social sciences; 12 hours in the humanities and three hours of electives. By 1980, the requirements in the social sciences have doubled (12sh): three hours of humanities added, for a total of 15, and elective subjects increased to six.

With reference to the remainder of the entrance requirements, a course in growth and development appears in 1965 and disappears in 1970. The same pattern is found for a course entitled, "Science and Theory of Health." Nursing courses required in 1960 and 1965 are deleted with the implementation of the lower-division, upper-division framework. The most obvious course reduction (Table 7) over the years is found in English (including Speech) entrance

requirements. This is decreased from 14 to three semester hours over the twenty year period. The physical education requirement is deleted in 1975.

In addition to changes in course work required, the years reveal the development of some rather specific expectations with regard to the quality of the pre-professional experience (See Table 8). In 1970, a minimum 2.0 cumulative grade point average is required in lower-division work for upper-division consideration. In 1975, course work in human anatomy and physiology (A&P), chemistry and microbiology must be completed prior to application, so as to be part of the admission assessment process. In 1980, these courses must be those required of majors in the subject area, rather than terminal courses for non-majors. Further, by 1980, they must include a laboratory experience for credit. In 1980, a "C" or better in A&P and microbiology is required.

Established requisites in the humanities and social sciences are further circumscribed in 1975 by requiring one course in sociology and one in psychology. Courses meeting stipulations for the humanities have to represent at least three distinct disciplines. Unique features are also established for studio courses, foreign languages and the timeliness of lower-division course work.

In 1980, additional stipulations are developed with regard to the quality of the nutrition course, and constraints are placed on the nature of religion courses. Further restrictions are imposed on pass/fail course work, remedial or repetitive courses,

and calculation of the entering grade point average. Additionally in 1980, the Allied Health Professions Admission Test is required of all applicants for upper-division work (See Table 8, 1980 column).

Analysis

During the years 1960-1980 the entrance requirements for generic baccalaureate education at the institutional site are refined and upgraded. They indicate the development of more stringent criteria by which the student/client is judged.

The establishment of rather firm criteria with regard to acceptable competency and the quality of the course work are evident. The closure, for credit, of less demanding courses, such as those in the sciences without laboratories, is found. Further, the additional utilization of a standardized test in admission decision-making seems to reflect higher standards, or a need to be more definitive in entrance decisions. It could also be postulated that standards regarding the computation of an applicants grade point average indicate a highly competitive atmosphere.

A value for course work in the humanities and social sciences emerges over time, yielding broad-based preparation in the liberal arts at the pre-professional level. A compromise appears to have been struck between the need for courses in the sciences and those devoted to development of the individual. Finally, by switching to an upper-division admissions procedure more definitive information is available regarding the applicants potential through

prior academic performance. These changes reflect substantial alteration in admission standards during the study's time span.

Generic Baccalaureate - Graduation Requirements:

Report and Analysis

Graduation/certification requirements over the twenty year period are fairly consistent and reflect little substantial change. The major alterations which take place are in the area of grade requirements. In 1970, a minimum grade of "C" is established for nursing courses in order to receive credit. This is further refined in 1980 to require a "C" in both the formal or classroom aspect of nursing courses as well as the application of theory in the clinical setting (See Table 9).

Performance standards for graduation are tightened in 1980. While a cumulative GPA of 2.0 on a 4.0 scale is necessary for graduation, a further stipulation is added. A minimum of 2.0 GPA for each semester is now mandated, thus tightening performance standards.

Registered Nurse Baccalaureate - Entrance/Graduation Requirements:

Report and Analysis

The entrance requirements for prospective registered nurse baccalaureate students are the same as those of the generic program. The R.N. student is offered opportunities to challenge lower-division course requirements and junior year nursing courses for

Table 9
Comparison of Generic Baccalaureate Graduation Requirements
at the Institutional Site: 1960-1980

Program	1960	1965	1970	1975	1980
GENERIC BACCALAUREATE PROGRAM - GRADUATION REQUIREMENTS	1. One year or more of residential work-minimum 30 sh taken on site. 2. 132 sh of academic work, including 4 of physical education. 3. A 2.0 grade point average on a 4.0 scale.	1. Year of study in residence now specified as the last year of study. 2. 142 sh of academic credit including 3 of physical education now required. 3. GPA requirements the same.	1. GPA - Same 2. 121 required for graduation. 3. "C" or better required in nursing courses in order to receive credit. 4. Residency requirement unchanged.	1. GPA - Same 2. "C" in nursing courses 3. 122 sh of course work. 4. Faculty recommendation. 5. Residency requirement - Same.	1. Minimum 2.0 GPA each semester, and an overall 2.0 GPA at graduation. 2. 122 sh of course work. 3. "C" or better in both clinical and didactic portion of nursing courses. 4. Faculty recommendation.

Source: Institutional Site School Catalogs

advanced standing, in order to verify prior growth and development through professional and personal experience.

Upper-division graduation requirements in the R.N. program reflect those of the generic program. Some specific course work such as that devoted to public health or community nursing is evident. This course work is mandatory, as associate and diploma schools generally do not include public health in their curriculum.

In summary, the admission and graduation requirements for the registered nurse baccalaureate program reflect the same orientation and attributes as those of the generic program (See Tables 10 and 11).

Graduate Program - Entrance Requirements: Report and Analysis

Entrance requirements for graduate study at the master's level are upgraded between 1960 and 1980. Whereas "acceptable academic standing" in baccalaureate work is satisfactory for admission in 1960, 1965, and 1970, by 1975 a GPA of 3.0 is stated as the minimum requirement. Probationary status on admission is provided for those with a GPA of less than 3.0 (See Table 12). Submission of Graduate Record Examination (GRE) scores and Miller Analogues test scores are required for the first time in 1975, as is prior completion of a basic course in statistics. Of particular note is the statement that an upper-division major in nursing leading to a BSN is required for admission. This stipulation would seemingly preclude admission of those with baccalaureate degrees in other disciplines.

Table 10
Comparison of Registered Nurse Baccalaureate Entrance Requirements at the Institutional Site: 1960-1980

Program	1960	1965	1970	1975	1980
R.N. PROGRAM FOR BACCALAUREATE DEGREE - ENTRANCE REQUIREMENTS	1. Graduation from accredited hospital school of nursing. 2. Successfully passed the state board examinations.	Same as 1960. Associate degree registered nurses now mentioned as eligible candidates for admission.	1. Completion of lower division courses as required for generic students. 2. A 2.0 cumulative average.	Same	Same

Source: Institutional Site School Catalogs

Table 11
Comparison of Registered Nurse Baccalaureate Graduation Requirements at the Institutional Site: 1960-1980

Program	1960	1965	1970	1975	1980
R.N. PROGRAM FOR THE BACCALAUREATE DEGREE - GRADUATION REQUIREMENTS	1. 128 of course work - no GPA requirement. 2. 30 completed in residence.	Same - except 138 now required for graduation.	1. Completion of 65 sh of upper division work as follows: General Requirements-Upper Division Social Sciences-(Psychology, Sociology, Anthropology) . . . . . 9 credits Electives. . .12 credits Nursing Nursing 153-Public Health . . . . 2 credits Nursing 154-Principles of Management of Nursing Unit . . . . . 2 credits Nursing 155-Survey of Professional Nursing . . . . . 2 credits Nursing 156-Public Health Nursing . . . . . 5 credits Prev. Med. 158-Biostatistics . . 3 credits Nursing 159-Clinical Practicum. . . 2 credits Nursing 160-Comprehensive Nursing Care . . . . . 5 credits Nursing 199-Pro-Seminar . . . . . 2 credits Total 44 credits 2. A 2.0 cumulative GPA.	1. Completion of 120 of course work. 2. All other generic student requirements.	Same

Source: Institutional Site School Catalogs

Table 12
Comparison of Graduate Program Entrance
Requirements at the Institutional Site: 1960-1980

Program	1960	1965	1970	1975	1980
GRADUATE STUDY - ENTRANCE REQUIREMENTS	1. A registered nurse with a baccalaureate degree, "with recognized academic standing." 2. Clinical experience in the specific clinical area of program application.	1. Same as 1960. (College or university course in the physical, natural and behaviorial sciences are now indicated as required for program admission, specifics not given).	1. Graduation from a baccalaureate program with acceptable academic standing. 2. Evidence of personal and professional references and, if possible, an interview.	1. B.S.N. with upper division major from an accredited NLN* program. 2. Prior completion of a basic course in statistics. 3. Evidence of nursing licensure. 4. Submission of Graduate Record Examination Scores, Miller Analogues Test scores. 5. Undergraduate GPA of 3.0 on a 4.0 scale. (below 3.0 probationary status). 6. Personal and professional qualifications via references and personal interview. *National League for Nursing.	Unchanged except in areas noted: 1. Provisional acceptance for candidates with GPA between 2.75 and 3.0 2. Personal interview required for Primary Care program. 3. Clinical experience required for primary care, community health, maternal-child and psychiatric programs, and majors in education and administration. Doctoral Program 1. A masters in nursing from an accredited NLN program. 2. One graduate level course in research and inferential statistics. 3. A 3.0 GPA on all previous course work. (cumulative) 4. GRE and Miller Analogues scores. 5. Earned licensure. 6. Personal and professional recommendations 7. A personal interview.

Source: Institutional Site School Catalogs

Requirements are further circumscribed in 1980 with provisional acceptance limited to those with a baccalaureate GPA between 2.75 and 3.0. Personal interview requirements become more pronounced in both 1975 and 1980. Additionally, all the graduate majors require clinical experience for admission, except those in medical-surgical nursing, gerontological nursing, and nursing health policy.

In summary, admission requirements for graduate study at the institutional site become somewhat more stringent over time. The specific identification of GPA requirements, the exclusion of those prepared with baccalaureate majors in other disciplines, the utilization of objective test data, personal interview requirements, and clinical application of the knowledge base prior to advanced study are seen.

The design of the doctoral program curriculum which first appears in 1980 data, will be discussed elsewhere. Admission requirements for this program include a master's in nursing from an NLN accredited program; a graduate level course in research and inferential statistics; a cumulative GPA of 3.0; licensure; GRE and Miller Analogues scores; a personal interview, and personal and professional recommendations. No comparisons across time are possible since the doctoral program has not been previously offered.

Graduate Program - Graduation Requirements: Report and Analysis

Table 13 compares graduation requirements, 1960-1980, for all graduate programs at the institutional site. Comparisons are problematic given the degree of specialization that emerges.

Table 13
Comparison of Graduate Program Graduation Requirements at the Institutional Site: 1960-1980

Program	1960	1965	1970	1975	1980
GRADUATE STUDY - GRADUATION REQUIREMENTS	1. Two semesters in residence. 2. 3.0 GPA on a 4.0 scale. 3. Satisfactory completion of 30 semester hours of course work: a) 24 courses b) 6 thesis 4. a) 12 in major field-administration/education. b) 8 in minor field-clinical portion. c) 12 of courses at 200 level or above.	Major change seen in specific program requirements. General Requirements 1. 3.0 GPA on a 4.0 scale. 2. Two semesters in residency. 3. Thesis Program Requirements A. Nursing administration (1) 40 sh 34 course/6 thesis. (2) three semesters (3) 22 sh in major 12 in minor (4) 22 sh at 200 level or above. B. General Psychiatry (1) 36 sh, 30 course/6 thesis (2) 3 semesters (3) 8 sh in minor field (4) 20 sh at 200 level or above. C. Child Psychiatry 1. 53 sh of course work 2. 4 semesters D. Medicine-Surgery 1. 35, 29 course/6 thesis 2. 12 sh at 200 level or above 3. 12 sh in major/8 sh in minor	1. Three semesters or the equivalant in residence. 2. 3.0 GPA on a 4.0 scale. 3. Successful completion of a comprehensive exam. 4. Successful completion of a thesis or a non-thesis option.* 5. Semester hours of course credit by program area. *Non-thesis option-3-6 additional elective semester hours of credit and two scholarily papers.	1. Completion of a planned program of study within five years after admission. 2. 3.0 GPA on a 4.0 scale. 3. Grades of "C" not accepted for credit. 4. "B" on higher required in all nursing courses. 5. One year of full time study or its equivalent 6. Completion of a thesis or non-thesis option. (non-thesis - six additional elective credits and one scholarily seminar paper).	Master's Program: Same as 1975 Doctoral Program: 1. Completion of planed program within nine year period (five years between matriculation and admission to candidacy; four years following admission to candidacy.) 2. Admission to candidacy for the doctoral degree. 3. Cumulative GPA of 3.0. 4. Successful completion of preliminary, comprehensive, and final oral examinations. 5. Completion of a satisfactory dissertation. 6. Completion of two consecutive semesters of full time study.

Source: Institutional Site School Catalogs

Table 13 (continued)

Program	1960	1965	1970	1975	1980
GRADUATE STUDY - GRADUATION REQUIREMENTS		E. Maternal-Child 1. 35 sh 29 course/ 6 thesis 2. 12sh in major/8 sh in minor 3. 12 sh at 200 level or above F. Public Health 1. 39 sh 33 course/ 6 thesis 2. 3 semesters 3. 8 sh in minor 4. 20 sh at the 200 level or above.			

In 1960, graduation requirements for all programs are governed by the same criteria. Two residential semesters are required and a GPA of 3.0. Satisfactory completion of 30 semester hours, 24 in course work and 6 for a thesis are mandated. Twelve semester hours in the students major field and eight in the minor or clinical concentration are indicated. Twelve hours in courses are required at the 200 level or above.

Major change is evident in 1965, in that specialty areas of concentration have developed markedly different semester hour graduation requirements (See Table 13). This variation persists through the remainder of the study's time span. Across all of the major areas, a 3.0 GPA, two semesters in residence, and a thesis are required.

In 1970, the residency requirement is increased to three semesters. A GPA of 3.0 remains a constant, and the successful completion of a comprehensive exam is not required of all students. The mandatory thesis requirement has been dropped in favor of a thesis/non-thesis option (4-6 additional semester hours in electives and two scholarly papers).

Graduation standards for 1975 and 1980 are uniform across the programs. A grade of "C" in any course work is not accepted for credit, and a "B" is required in all nursing courses. A GPA of 3.0 is mandatory for successful program completion, as is one year of full time study. The thesis/non-thesis option remains, however, the non-thesis requirement has been set at six semester

hours in electives and one scholarly paper. A written comprehensive exam is required of all students.

Less variance is seen in the number of credits required for graduation by program area in 1980 with 41-45 credits required in all areas except Primary Care Nursing. In this specialty, credits are extended over four semesters, requiring 54 credit hours for completion.

Completion of doctoral program requires a cumulative GPA of 3.0, successful completion of preliminary, comprehensive and final oral examinations. A dissertation is mandatory, as is completion of two consecutive semesters of full time study. The entire program must be completed within nine calendar years, with admission to candidacy within five years. Comparisons over time are not possible due to the short period of the program's existence.

Analysis

The emergence of higher level standards for graduation/ certification over time is boarderline. A cumulative GPA of 3.0 for completion remains constant throughout the twenty year period. The overall length of the programs and prescribed courses of study, however, do appear to require longer and more intensive periods of study. In 1960, 30 semester hours of study is sufficient to satisfy requirements across programs, while 41-45 credits is the minimum necessary by 1980.

Although a thesis requirement dominates in 1960 and 1965, it gives way to an alternative method, the non-thesis option in 1970.

One can only speculate as to the rationale for this alteration. Socialization with respect to the scientific process, however, seems a higher level standard than that reflected in electives and a scholarly paper. More stringent grade standards do emerge in 1975 when "C" work in any subject area receives no credit. In 1975, students are required to obtain a minimum grade of "B" in all nursing courses. These alterations, however, do not appear to reflect substantial change.

Data Profile - Attributes

Matrix cells which address attributes data draw their findings from public literature, the institutional site and archival sources. Public literature is addressed through a review of historical nursing texts which reflect the study's time span and the topic under examination. Archival sources report academic credentials of nursing faculty at the institutional site and from the national perspective, and entry and graduation requirements across educational programs were reviewed at the institutional site. Analytical emphasis within content area is directed at identifying change oriented themes.

The historical texts identify that the nursing education community should be housed in higher education and that increasing emphasis should be directed toward nurses achieving higher level preparation. This orientation certainly seems supported by the academic credentials earned by faculty, and in the upgrading and refinement of certain admission and graduation criteria.

The initiation of nurse practitioner preparation reflects reports in texts of the desirability of nurse practitioner roles in the health care setting. Further, the value placed on the production of qualified and competent nurses appears in the texts, elevation of admission standards and development of faculty in the face of marked expansion.

Data Report - Control

Data Matrix Cell - Three: Control/Literature

Greenwood (1957) argues that occupational groups seek to persuade society to authorize its activities in certain areas. The areas most earnestly sought are control over the educational function, through an accreditation process; control over admission to the group through licensure; and standards of professional performance regulated by the occupational group. (Reiss, 1955). Change in these areas would be one means of assessing the process of professionalization.

Nurse practice acts are state statutes which describe the scope of nursing practice allowed within that jurisdiction, and generally incorporate statutes regulating the areas identified above. As such, they represent the practice contract between nursing and society. (Stuart, 1981). Thus, they are tangible manifestations of the professionalization process. In this study, nurse practice act data supports the development of propositions regarding the development of nursing's role in society. The fifth research question probes this area of professional evolution.

The nurse practice acts were obtained through the legislative library service. Five acts were passed by the legislature between 1960 and 1980. Review of these acts (1963, 1967, 1974, 1977, 1980) found that the content fell into eight major categories. With these categories in mind, review and analysis was undertaken in a retrospective manner, in that the sections of the most recent act were traced back through previous acts to discover origins and trace development. This technique readily facilitated the identification of change over time. The data is reported by categories or sections and begins with the oldest act, proceeding forward in time. A series of tables, developed on the basis of eight categories, traces their development through the twenty year period. They provide a complete report of the findings.

Section I - Purpose Statement and Title (Table 14). Once incorporated in the 1967 act, the purpose statement remains unchanged. The statement indicates that the act was developed to safeguard the life and health of citizens. It further provides that it is unlawful to represent oneself as a registered nurse unless duly licensed under the act's provisions.

The five acts legislated during the 1960-1980 period have three different titles. In 1963 the act is entitled "Registration of Nurses and Licensed Practical Nurses." In 1967, the title becomes "Nurse Licensing Act," and in 1974, "Nurse Practice Act" is utilized. The title remains unchanged after 1974.

Section II - Definitions (Table 15). A section on definitions is not included prior to the 1967 legislation. From this point on two definitions are included. "Board" is defined as the State Board of Examiners of Nurses, and a definition of professional nursing practice is included. It is the latter portion of this section that undergoes alteration over the years.

In 1967, professional nursing is defined as involving the care of the ill, injured, infirmed, and activities related to health maintenance and illness prevention. It is also stated that nursing care requires specialized skill and judgment based on the application of knowledge. The act states that the practice of nursing is dependent on the prescription of a licensed physician or dentist. The 1967 act precludes diagnostic acts or prescription of therapeutic or corrective measures by nurses. The 1974 act reflects substantial change in these and other areas.

Nursing practice is acknowledged to include independent functions which are performed autonomously or in collaboration with other health care providers. References to diagnosis and prescription are not explicitly addressed, but the legislation does speak (See 1974) to the identification of additional acts in nursing practice recognized jointly by the medical community and nursing.

Two additional changes are evident. The 1967 act speaks to the utilization of specialized knowledge, judgment, and skill, as well as the role of biological, physiological, behavioral and social sciences. These factors are identified as basic to the

Table 14
Comparison of the Purpose Statement and Titles
in the Nurse Practice Act: 1960-1980

Section	1963	1967	1974	1977	1980
1. PURPOSE STATEMENT AND TITLE	None Title: "Registration of Nurses and Licensed Practical Nurses"	"In order to safeguard life and health, no person shall practice or offer to practice professional nursing or practical nursing in the state unless licensed as hereinafter provided. It shall be unlawful for any person not licensed under the provisions of this subtitle to practice or offer to practice professional nursing or practical nursing or to use any sign, card or device to indicate that such person is a professional nurse, a registered nurse or a practical nurse. Title: "Nurse Licensing Act"	Same Title: Nurse Practice Act	Same Remains unchanged after incorporation in 1974 act.	Same

Table 15
Development of Definitions Incorporated in the Nurse Practice Act: 1960-1980

Section	1963	1967	1974	1977	1980
11. DEFINITIONS	A section on definitions is not included in this act.	"Board" means State Board of Examiners of Nurses. "Practice of Professional Nursing" means the performance for compensation of any acts in the observation, care and counsel of the ill, injured or infirmed, or in the maintenance of health on prevention of illness of others, or in the supervision and teaching of other personnel, or the administration of medications and treatments as prescribed by a licensed physician or dentist; requiring substantial specialized judgment and skill and based on knowledge and application of the principles of biological, physical and social science. The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures."	"Board" definition unchanged "The practice of registered nursing means the performance of acts requiring substantial specialized knowedge, judgment and skill based upon the principle of the biological physiological behavioral and sociological sciences in either: a) The assessment, problem identification, implementation, and evaluation of the health needs of individuals, families or communities for purposes of maintaining health, preventing illness and caring for the ill, injured or infirm. b) The performance of such additional acts requiring formal education and clinical experience or its equivalent and which are recognized jointly by the medical and nursing	"Board" definition unchanged Same "planning" added in section "a" just prior to implementation. "and health care action capabilities" inserted between, "needs" and "individuals" (section a) after "infirm" added "and providing rehabilitation". (section a) "b" unchanged	"Board" definition unchanged Same

Table 15 (continued)

Section	1963	1967	1974	1977	1980
II. DEFINITIONS			professions as proper to be performed by nurses licensed under this subtitle and which are authorized by the Board through its rules and regulations. c) The administration, supervision, delegation, and evaluation of nursing practice. d) The teaching of nursing. e) The practice of nursing includes both independent nursing functions and delegated medical functions, and may be performed autonomously or in collaboration with other health team members, or may be delegated by a registered nurse to other nursing personnel.	"c" unchanged "d" unchanged "e" deleted "or may be delegated by a registered nurse to other nursing personnel"	

utilization of assessment, problem identification, implementation and evaluation behaviors in client care needs. Secondly, in 1974 the terminology "registered nursing" replaces "professional nursing."

Change in the 1977 act is minimal, and seemingly directed at refining and clarifying the definition. Planning is identified as a necessary step in client care, and a nursing role in rehabilitative activities is included.

Section III - Filling Vacancies on State Board of Examiners of Nursing (Table 16). Over the years, the State Board of Examiners of Nurses, is altered in size, composition, and appointment requirements. During this study's entire time frame, the state's professional association is responsible for nominating prospective Board members. Final selection and appointment is made by the governor.

In 1963 the Board is composed of five registered nurses. This increases to six registered nurses by 1977. In 1974, two licensed practical nurses are added to represent this nursing group. Their number of representatives is increased to three in 1977. Throughout the acts, their selection and appointment procedure parallels that of the registered nurse.

Appointment requirements for registered nurse representatives become more complex and detailed as the years go by. The 1967 act calls for state residency, licensure and U.S. citizenship as membership requirements. Four of the five registered nurses must hold baccalaureate or higher degrees in nursing, with active practice

Table 16
Regulations Governing the Filling of Vacancies
on State Board of Examiners: 1960-1980

Section	1963	1967	1974	1977	1980
III. FILLING VACANCIES ON STATE BOARD OF EXAMINERS	Established board of 5 individuals, with at least five years of experience each. Members selected from nominations by the state professional association for term of 3 years or to fill unexpired term. Total of five members.	Same appointment process, however minimal appointment criteria are put forth to include: and state residency; citizenship, hold state licensure; 5 years experience in nursing administration or education with active practice in either for minimum of three years prior to appointment or reappointment. Four of the five members must hold a baccalaureate or higher degree in nursing or education for appointment	Board increased to 7 members, 5 of whom shall be registered nurses, other 2 LPN's. Three year terms for maximum 9 year period of service. Professional association ,submits nominus as previously described. With this act state LPN body submits similar list for their representatives appointment. Membership requirements unchanged for RN members, LPN members required to meet same criteria with regard to experience. Four members required to have advanced educational preparation.	Board increased to nine members-six RN's and 3 LPN's. Registered nurse appointments must now be made on the basis of specified categories. Three educational representatives, one each to represent baccalaureate, associate and LPN nursing education. Three representatives from service; one from administration and two from clinical practice. Nominations still submitted by professional association. Terms remain 3 years in length with a maximum service period of 9 years. Of the six RN representatives, all must have advanced educational preparation, except one clinician representative.	Same

in either education or administration prior to appointment. The minimum term of office remains at three years.

In 1977, appointments are required on the basis of specified categories. Three educational representatives are required, one each from the baccalaureate, associate and LPN nursing education programs. Three service connected appointments are identified, with one nursing service administrator and two clinical practice representatives. All registered nurse members of the Board are required to have master's preparation now, except the LPN educator, who is required to hold a baccalaureate degree. One of the two clinician representatives is not required to hold a degree.

Section IV - Powers and Duties - Advisory Committees; Compensation Expenses; Meetings; Officers; Quorum; Disposition of Funds; Examination of Applicants for Licensure; Records (of the Board of Nurse Examiners) (Table 17). The 1963 licensing act does not contain a section on by-laws to govern proceeding's of the Board. The nature of the proceedings is not addressed, except that the Board is delegated the responsibility for prosecuting violators of the act. Control over the nursing education function, as a responsibility of the Board, is not addressed until 1967. In this act, the Board is required to keep a current list of approved nursing programs and set program standards. It is additionally authorized to periodically survey nursing programs in the state on the basis of the standards developed and promulgated by the Board. Further, the Board is authorized, (initially in 1967) to adopt and revise

Table 17
Developmental Comparison of Legislation Regarding
Powers, Duties and Administrative Regulations Governing the State Board of
Nurse Examiners: 1960-1980

Section	1963	1967	1974	1977	1980
IV. POWERS AND DUTIES GENERALLY: ADVISORY COMMITTEES; COMPENSATION EXPENSES; MEETINGS; OFFICERS; QUORUM; DISPOSITION OF FUNDS; EXAMINATION OF APPLICANTS FOR LICENSURE; RECORDS. (OF THE BOARD OF NURSE EXAMINERS)	No specific subtitle outlining duties and responsibilities of the Board. One subtitle does appear to be the rudiment from which subsequent sections were developed. The members of the State Board of Examiners of Nurses shall annually in the month of May elect from their members a president and a secretary who shall be the treasurer. Three members of the Board shall constitute a quorum, and special meetings of the Board shall be called by the secretary upon written request of any two members. The Board of Examiners of Nurses is authorized to frame such bylaws as may be necessary to govern its proceedings. The secretary shall be required to keep a record of all meetings of the Board, including a register of the names of all nurses duly registered under this subtitle, which	(a) The board shall have the following powers and duties: (1) To adopt and, from time to time, revise such rules and regulations not inconsistent with the law, as may be necessary to enable it to carry into effect the provisions of this subtitle. (2) To prescribe standards for educational programs preparing persons for licensure under this subtitle. (3) To provide for surveys of such programs at such times as it may deem necessary. (4) To maintain a curren list of institutions whose programs meet the requirements of this subtitle and of the Board. (5) To examine, license, and renew the licenses of qualified applicants. (6) To conduct hearings upon charges calling for discipline of a licensee or denial, revocation or suspension of a license.	Same as 1967.	(a) The Board shall have the following powers and duties: (1) To adopt and revise standards of nursing practice performed by registered and licensed practical nurses. (2) To determine when the performance of additional acts, under emergency or other conditions requiring education and clinical experience as recognized by the medical and nursing professions, are proper to be performed by registered nurses or licensed practical nurses within whatever conditions are authorized by the Board. (3) To prescribe standards for educational programs preparing persons for licensure under this subtitle. (4) To provide for surveys of those programs at whatever times it considers necessary. (5) To maintain a current list of institutions whose programs meet the requirements of	Same with one additional subtitle. (18) To maintain up-to-date lists of all nurse midwives and certified nurse practitioners licensed by the State.

Table 17 (continued)

Section	1963	1967	1974	1977	1980
IV. POWERS AND DUTIES GENERALLY: ADVISORY COMMITTEES; COMPENSATION EXPENSES; MEETINGS; OFFICERS; QUORUM; DISPOSITION OF FUNDS; EXAMINATION OF APPLICANTS FOR LICENSURE: RECORDS. (OF THE BOARD OF NURSE EXAMINERS)	shall at all reasonable times be open to public scrutiny, and the Board shall cause the prosecution of all persons violating any of the provisions of this subtitle, and may incur necessary expenses on this behalf. The treasurer, before entering upon the discharge of the duties of treasurer shall give bond in the sum of two thousand dollars ($2,000.00) with a corporate surety, to be approved by the Board. The members of the Board shall receive ten dollars ($10.00) for each day actually engaged in this service, and all legitimate and necessary expenses. Said expenses and salaries shall be paid from fees received by the Board under the provisions of this subtitle, and no part of salaries or other expenses of the Board shall be paid out of the State treasury.	(7) To cause the prosecution of all persons violating this subtitle and to have power to incur necessary expenses therefor. (8) To keep records of all of its proceedings. (9) To make an annual report to the Governor and to the Secretary of Health and Mental Hygiene. (10) To appoint and employ such persons as may be necessary to carry on the work of the Board. (11) To define the duties of its employees. (12) To set the amounts of and classify from time to time registration fees and fees for renewal of licenses, which fees shall be reasonably related to the costs of administering this subtitle. (13) To limit by regulation the number of re-examinations which may be taken by an applicant after failure, except that applicants under Section 296(d) of this article shall have the privilege of at least one re-examination after the first failure.		this subtitle and of the Board. (6) To examine, license, and renew the licenses of qualified applicants. (7) To conduct hearings upon charges calling for discipline of a licensee or denial, revocation or suspension of a license. (8) To cause the prosecution of all persons violating this subtitle and to have power to incur necessary expenses relating to the prosecution. (9) To set the amounts of and classify from time to time registration fees and fees for renewal of licenses, which fees shall be set forth in the regulations which are reasonably related to the costs of administering this subtitle. (10) To limit by regulation the number of re-examinations which may be taken by an applicant after failure, except that applicants under section 296(d) of this article shall have the privilege of at least one reexamination after the first failure.	

Table 17 (continued)

Section	1963	1967	1974	1977	1980
IV. POWERS AND DUTIES GENERALLY: ADVISORY COMMITTEES; COMPENSATION EXPENSES; MEETINGS; OFFICERS; QUORUM; DISPOSITION OF FUNDS; EXAMINATION OF APPLICANTS FOR LICENSURE: RECORDS. (OF THE BOARD OF NURSE EXAMINERS)		(14) To promulgate rules authorizing practice of professional nursing or practical nursing, as the case may be, under such limitations and professional supervision as the Board may require, by otherwise qualified persons who are temporarily in this State or whose applications for licensure by examination are pending but who have not had an opportunity to take the examination or, if taken, before the results of the examination are known; provided that no such authority shall extend to any person who shall have theretofore failed the examination. (b) The Board shall meet annually in the month of May and shall elect from its members a president and a secretary who shall also be the treasurer. It shall hold such other meetings during the year as are deemed necessary to transact its business or as requested by the Secretary of Health and Mental Hygiene. A majority of the Board including one officer shall		(11) To promulgate rules authorizing practice of registered nursing or licensed practical nursing, as the case may be, under whatever limitations and professional supervision the Board requires, by otherwise qualified persons who are temporarily in this State or whose applications for licensure by examination are pending but who have not had an opportunity to take the examination, or, if taken, before the results of the examination are known. (12) To adopt and, from time to time, revise rules and regulations not inconsistent with the law, as are necessary to enable it to carry into effect the provisions of this subtitle. (13) To keep records of all its proceedings. (14) To make an annual report to the Governor and to the Secretary of Health and Mental Hygiene. (15) To appoint and employ persons necessary	

Table 17 (continued)

Section	1963	1967	1974	1977	1980
IV. POWERS AND DUTIES GENERALLY: ADVISORY COMMITTEES; COMPENSATION EXPENSES; MEETINGS; OFFICERS; QUORUM; DISPOSITION OF FUNDS; EXAMINATION OF APPLICANTS FOR LICENSURE: RECORDS. (OF THE BOARD OF NURSE EXAMINERS)		constitute a quorum at any meeting. The secretary-treasurer of the Board shall keep a record of all its meetings and a register of the names of all nurses licensed under this subtitle which shall be open to public inspection with adequate restrictions for its safekeeping. The treasurer, upon entering the duties as treasurer, shall be covered by a surety bond in accordance with the provisions of Sections 46 through 50 of Article 78A of the Annotated Code of and shall be responsible for collecting any funds of the members to the State for reimbursement. All moneys collected by the Board shall be deposited with the State Treasurer and credited by the State Comptroller to a special fund for payment of all authorized expenses of the Board as provided annually in the State Budget. At the close of the fiscal year the secretary-treasurer		to carry on the work of the Board. (16) To define the duties of its employees. (17) To require public and private employers of nurses (except private individuals) and employment agencies to report periodically as required the names and recordation numbers of all persons employed or placed by them for the practice of nursing. (b) The Board shall provide mechanisms for the ongoing evaluation of master planning in the areas of nursing practice, education and licensure to identify issues which may have an impact on standards of nursing practice in the State. The Board shall appoint or recognize specific task advisory committees to assist it in forecasting directions of nursing practice, evaluate the impact of identified issues on nursing practice, and provide recommendations when appropriate. Each advisory	

Table 17 (continued)

Section	1963	1967	1974	1977	1980
IV. POWERS AND DUTIES GENERALLY: ADVISORY COMMITTEES; COMPENSATION EXPENSES; MEETINGS; OFFICERS; QUORUM; DISPOSITION OF FUNDS; EXAMINATION OF APPLICANTS FOR LICENSURE: RECORDS. (OF THE BOARD OF NURSE EXAMINERS)		shall report on the financial status of the Board to the State Comptroller and to the Secretary of Health and Mental Hygiene at that time any surplus funds shall revert into the State treasury. (c) Each member of the Board shall receive twenty-five dollars per day for each day that the member is actually engaged in the business of the Board, and in addition shall be reimbursed for the reasonable expenses incurred in such business. (d) The Board shall meet at least once each year for the purpose of examining all applicants for licensure under the terms of this subtitle. Notice of such meeting shall be published in a newspaper of general circulation in the state and a nursing journal at least thirty days prior to the examination meeting.		committee shall consist of at least 3 members who have expertise in the specific problem or area of nursing practice, education or licensure requiring investigation. Members of advisory committees shall be reimbursed for their ordinary and necessary expenses incurred in the performance of their duties. (c) Each member of the Board shall receive $40 per day for each day that the member is actually engaged in the business of the Board, and in addition shall be reimbursed for expenses incurred in such business in accordance with the standard travel regulations. (d) The Board shall meet annually in May and shall elect from its members a president and a secretary who shall also be the treasurer. It shall hold other meetings during the year necessary to transact its business or as	

Table 17 (continued)

Section	1963	1967	1974	1977	1980
IV. POWERS AND DUTIES GENERALLY: ADVISORY COMMITTEES; COMPENSATION EXPENSES; MEETINGS; OFFICERS; QUORUM; DISPOSITION OF FUNDS; EXAMINATION OF APPLICANTS FOR LICENSURE: RECORDS. (OF THE BOARD OF NURSE EXAMINERS)				requested by the Secretary of Health and Mental Hygiene. Five members of the Board including one officer shall constitute a quorum at any meeting. The secretary-treasurer of the Board shall keep a record of all its meetings and a register of the names of all nurses licensed under this subtitle which shall be open to public inspection with adequate restrictions for its safekeeping. He shall give bond in the sum of $2,000 to the State and shall be responsible for collecting any funds of the Board, and shall also be responsible for certifying the expenses of the members to the State for reimbursement. All moneys collected by the Board shall be paid over to the State for reimbursement. All moneys collected by the Board shall be paid over to the State Treasurer, and shall become general funds of the State.	

Table 17 (continued)

Section	1963	1967	1974	1977	1980
IV. POWERS AND DUTIES GENERALLY: ADVISORY COMMITTEES; COMPENSATION EXPENSES; MEETINGS; OFFICERS; QUORUM; DISPOSITION OF FUNDS; EXAMINATION OF APPLICANTS FOR LICENSURE: RECORDS. (OF THE BOARD OF NURSE EXAMINERS)				These moneys shall be disbursed by the Comptroller only pursuant to an appropriation made in accordance with sections 32 and 52 of Article 3 of the Constitution or pursuant to the provisions of sections 1 through 15, inclusive, of Article 15A of the Code, title "Budget and Fiscal Planning," as amended from time to time. (e) The Board shall meet at least once each year for the purpose of examining all applicants for licensure under the terms of this subtitle. Notice of the meeting shall be published in a newspaper of general circulation in the State and a nursing journal at least 30 days prior to the examination meeting. (f) In matters concerning licensing or disciplining of individual nurses the quorum shall consist of no less than two licensed practical nurses in matters concerning a licensed practical nurse.	

Table 17 (continued)

Section	1963	1967	1974	1977	1980
IV. POWERS AND DUTIES GENERALLY: ADVISORY COMMITTEES; COMPENSATION EXPENSES; MEETINGS; OFFICERS; QUORUM; DISPOSITION OF FUNDS; EXAMINATION OF APPLICANTS FOR LICENSURE: RECORDS. (OF THE BOARD OF NURSE EXAMINERS)				(g)(1) All records of the Board pertaining to any licenses, former licenses or applicant for a license by name or identifying number or symbol shall be kept confidential except from members of the Board, its duly authorized employees, the individual involved and his expressly authorized agents, and shall be exampt from process and from the provisions of Article 76A, title, "Public Information," Section 1 through 5, of this Code except the following: (i) Records of successful completion of an examination; (ii) Records of licensure or renewal of a license; (iii) Records showing the fact that a particular individual is not licensed or was not licensed at a particular time; (iv) The record of proceedings under section 299 unless the final decision in the proceeding is unfavorable to the party complained against.	

Table 17 (continued)

Section	1963	1967	1974	1977	1980
IV. POWERS AND DUTIES GENERALLY: ADVISORY COMMITTEES; COMPENSATION EXPENSES; MEETINGS; OFFICERS; QUORUM; DISPOSITION OF FUNDS; EXAMINATION OF APPLICANTS FOR LICENSURE: RECORDS. (OF THE BOARD OF NURSE EXAMINERS)				However, the record shall be open for inspection and copying by the parties to the proceedings and their counsel and shall be transmitted to the reviewing court, if the review of the Board's decision is dully requested by law. (2) An individual, however, may in writing waive the protection of this subsection as to any designated record pertaining to him for any purpose specified by him.	

rules and regulations governing nursing practice. The term "standards" is not utilized until the 1977 legislation. At this time, the Board is authorized to adopt and revise practice performance standards, and to determine in corporation with its medical counterpart, when additional activities can appropriately be performed by registered nurses.

The remainder of the Board's legislated authority and obligations fall into two areas. First, procedural authority is delegated to the Board, for example, to hire staff to carry out the work of the Board, keep records of all proceedings, and make an annual report to the Governor. The primary focus of Board's function throughout the 1960-1980 time span rests in the control it exercises over performance standards and admission to the occupational group through licensure. Detail regarding authorization to practice increases through the period, by addressing matters such as the practice of applicants awaiting results of the licensure examination. The Board's basic responsibilities in the area of licensure remain constant.

The 1977 act does include one provision heretofore not mentioned. Sub-section IV, 17b requires the Board to appoint or recognize specific advisory committees to assist in forecasting the direction of nursing practice, evaluate the impact of identified issues on practice and provide recommendations when appropriate. The areas of potential inquiry are identified as nursing practice, education, and licensure.

In summary, although the procedural details regarding authority over licensure become more detailed, the function remains delegated to the Nursing Board by the State. The emergence of accreditation regulation over educational programs is established during this time frame, as is the power to set nursing practice standards. Increasing emphasis is placed on the academic credentials of Board members. The definition of practice scope and responsibilities increasingly emphasizes the cognitive domain, and establishes that some functions are independent of physician supervision. Further, decisions regarding expanded or specialized functions are established as a cooperative effort between physicians and nurses, rather than unilateral decision-making by physicians as called for in the 1967 legislation.

Section V - Licenses - Registered Nurses and Renewal (Table 18). This section of the law is divided into two content areas. The first deals with licensure renewal. The second set of statutes govern the primary licensure process in the state. The law, with respect to licensure renewal remains constant through the acts revisions in 1974, 1977, and 1980. The legislation enacted in 1963 and 1967 differs in language, but not in substance. In essence, this legislation call for licensure renewal every two years; mandates that those practicing with a lapsed license are in violation of the law; renders the holder of a valid license a legal practitioner of nursing; and provides for the reinstatement of those in an inactive status.

Table 18
Developmental Comparison of Regulations Governing
Licensure of Registered Nurses: 1960-1980

Section	1963	1967	1974	1977	1980
V. LICENSES - REGISTERED NURSES AND RENEWAL	Renewal Beginning in the month of January, 1956 and during the month of January in every second year thereafter, every registered nurse, registered with the Board of Examiners, shall cause his or her certificate to be recorded in the office of the Board of Examiners together with an affidavit or other proof satisfactory to the Board of Examiners of his or her identify as the person to whom the same is issued and of his or her place of residence at the time of such recordation. The registrar shall pay to the Board of Examiners a fee of two dollars ($2.00) for each such recordation. It shall be unlawful for any person to practice nursing as a registered nurse unless his or her certificate has been recorded as provided in this section; provided, however, that the failure to record such certificate shall not be cause for revoca-	Renewal a) The license of every person licensed under the provisions of this subtitle shall be renewed biannually. The fee for renewal shall be as established by the regulations of the Board. b) Such renewal shall render the holder thereof a legal practitioner of nursing for the period stated in the renewal form. c) Any person practicing nursing during the time his or her license has lapsed shall be considered to be practicing without a license and shall be subject to the penalties provided for violations of this subtitle. d) A nurse who ceases to engage in nursing in this state shall not be required to pay the renewal fee as long as he or she remains inactive. Should said nurse wish to resume nursing at some future time he or she shall so notify the Board and remit the renewal fee for the current biennial period.	Renewal - Same Licenses (a)An applicant for a license to practice as a registered nurse shall submit to the Board written evidence, verified by oath, or affirmation, that the applicant: (1) Is of good moral character. (2) Has completed an approved high school course of study or the equivalent thereof as determined by the State Department of Education. (3) Has completed the required State approved registered nursing education program, as defined by the Board, and for the satisfactory completion of which holds a diploma or degree. (b) The applicant is required to pass a written examination in subjects determined by the Board. Upon successfully passing the examination, the Board shall issue to the	Renewal - Same Licenses (a) Qualifications - An applicant for a license to practice registered nursing shall submit to the Board written evidence, verified by oath or affirmation, that the applicant has completed the required State approved registered nursing education program, as defined by the Board, and for the satisfactory completion of which holds a diploma or degree. (b) Examination Generally - The applicant shall pass a written examination in the subjects the Board may determine. Upon successfully passing the examination, the Board shall issue to the applicant a license to practice nursing as a registered nurse. (c)Waiver of Examination - The Board may issue a license to practice	Renewal - Same Licenses Added sub-section. (f) Nurse midwife or certified nurse practitioner. A license issued to any nurse midwife or certified nurse practitioner by the Board shall so indicate in an appropriate space on the license.

Table 18 (continued)

Section	1963	1967	1974	1977	1980
V. LICENSES - REGISTERED NURSES AND RENEWAL	tion by the Board of Examiners of such certificate. Anyone who shall fail to re-record his or her certificate as provided by this section shall, notwithstanding such failure to record, remain eligible for recordation at any time thereafter without examination, upon application for re-recordation and payment of the fees therefor. Licenses It shall be the duty of said Board of Examiners of Nurses to meet not less frequently than once in every year, notice of which meeting shall be given in the public press and in one nursing journal one month previous to the meeting. At this meeting it shall be their duty to examine all applicants for registration under this subtitle, to determine their fitness and ability to give efficient care to the sick. Upon filing application for examination and registration each applicant shall pay a fee of twenty dollars ($20.00).	Licenses (a) An applicant for a license to practice professional nursing shall submit to the Board written evidence, verified by oath, or affirmation, that the applicant: (1) Is of good moral character. (2) Has completed an approved high school course of study or the equivalent thereof as determined by the State Department of Education. (3) Has completed the required State approved pro-fessional nursing education program, as defined by the Board, and for the satisfactory completion of which holds a diploma or degree. (b) The applicant shall be required to pass a written examination in such subjects as the Board may determine. Upon successfully passing such examination, the Board shall issue to the applicant a license to practice professional nursing as a registered nurse	applicant a license to practice as a registered nurse. (c) The Board may issue a license to practice as a registered nurse without examination by endorsement to an applicant who has been duly licensed as a registered nurse under the laws of another state, territory or foreign country, if, in the opinion of the Board, the applicant's educational qualifications at the time of his or her graduation fulfilled the requirements of this State. (d) The applicant applying for a license to practice as a registered nurse shall pay the fee established by the regulations of the Board. An additional fee, as established by the regulations, shall be required for each re-examination. (e) Any person who holds a license to practice as a registered nurse in this State has the right to use the title "Registered Nurse" and the abbreviation "R.N." No	nursing as a registered nurse without examination by endorsement to an applicant who has been duly licensed as a registered nurse under the laws of another state, territory or foreign country, if, in the opinion of the Board the applicant's educational qualifications at the time of the applicant's graduation fulfilled the requirements of this State. (d) Fee - The applicant applying for a license to practice as a registered nurse shall pay the fee established by the regulations of the Board. An additional fee as established by the regulations, is required for each re-examination. (e) Use of Title "Registered Nurse" or abbreviation "R.N." - Any person who holds a license to practice as a registered nurse in this State has the right to use the title "registered nurse" and the abbreviation "R.N." No other person may assume this title or use the abbre-	

Table 18 (continued)

Section	1963	1967	1974	1977	1980
V. LICENSES - REGISTERED NURSES AND RENEWAL	It shall be the duty of the Board of Examiners to determine and it is hereby empowered in its sound discretion to determine, the qualification of all applicants for registration; and each applicant shall furnish evidence satisfactory to the Board of Examiners that he or she is nineteen (19) years of age, is of good moral character, has received the equivalent of a high school education, and has completed the required accredited professional nursing education program as defined by said Board of Examiners and holds a diploma therefrom. It shall be unlawful after June 1, 1955 for any person to practice professional nursing as a graduate, certified or registered nurse without a certificate from said State Board of Examiners. A nurse who has received his or her certificate according to the provisions of this subtitle	(c) The Board may issue a license to practice professional nursing as a registered nurse without examination by endorsement to an applicant who has been duly licensed as a registered nurse under the laws of another state, territory or foreign country, if, in the opinion of the Board, the applicant's educational qualifications at the time of his or her graduation fulfilled the requirements of this State at such time. (d) Application for license under this subsection (d) must be made before June 1, 1968, which time may be extended by the Board in individual cases for good cause. The Board may issue a license to practice as a registered nurse to any person who shall submit to the Board written evidence, verified by oath, that said applicant:	other person may assume this title or use the abbreviation or any other words, letters, signs, or devices to indicate that the person using them is a registered nurse. (f) Any person holding a certificate of registration to practice nursing as a registered nurse issued by the Board and which is valid on June 1, 1967 shall thereafter be deemed to be licensed as a registered nurse under the provisions of this subtitle so long as such certificate is not revoked or suspended as provided herein.	viation or any other words, letters, signs, or devices to indicate that the person using them is a registered nurse.	

Table 18 (continued)

Section	1963	1967	1974	1977	1980
V. LICENSES - REGISTERED NURSES AND RENEWAL	shall be styled and known as a "Registered Nurse." No other person shall assume such title or use the abbreviation R.N., or any other letters or figures to indicate that he or she is a graduate, certified or registered nurse. The Board of Examiners shall have the power, in the exercise of its sound discretion, to issue a certificate of registration, without examination, to any applicant who has been duly registered as a registered nurse under the laws of another state; provided the Board of Examiners shall determine that such applicant possesses qualifications which are the equivalent to those required under Section 293; and provided further that such applicant shall file a written application for registration and pay the registration fee provided for by Section 292.	(1) Is of good moral character. (2) Has practiced professional nursing in this State for at least two years within the five-year period immediately preceding June 1, 1967. (3) Has completed a professional nursing education program which is acceptable to the Board and which would have enabled such person to take an examination and be licensed as a registered nurse under any act relating to nursing heretofore passed by the General Assembly provided such person passes a written examination administered by the Board. (e) The applicant applying for a license to practice as a registered nurse shall pay the fee established by the regulations of the Board. An additional fee, as established by such regulations, shall be required for each re-examination.			

Table 18 (continued)

Section	1963	1967	1974	1977	1980
V. LICENSES - REGISTERED NURSES AND RENEWAL		(f) Any person who holds a license to practice professional nursing in this State shall have the right to use the title "Registered Nurse" and the abbreviation "R.N." No other person shall assume such title or use such abbreviation or any other words, letters, signs, or devices to indicate that the person using them is a registered nurse. (g) Any person holding a certificate of registration to practice nursing as a registered nurse issued by the Board and which is valid on June 1, 1967 shall thereafter be deemed to be licensed as a registered nurse under the provisions of this subtitle so long as such certificate is not revoked or suspended as provided herein.			

The remaining legislation related to licenses provides for licensure by endorsement. Generally speaking, these applicants must meet the same requirements as those who receive their initial license in the state, but it is not necessary to retake the licensure examination. Finally, the 1980 version of this subtitle is exactly as the 1977 legislation, with one notable change. The law now recognizes nurse midwives and certified nurse practitioners, by providing for their licensure by the Board, and specific identification of same on the face of their license.

Section VI - Nursing Education Programs (Table 19). The first part specifically addressing nursing education appears in the 1967 act. With the exception of one addition in 1977, the subsection remains unchanged. The 1967 legislation calls for the Board to survey any program designed to prepare graduates for the registered nurse licensure exam. The survey is undertaken in order to ascertain if a program is in compliance with established standards included in the practice act and developed by the Board. In 1977, the Board is additionally charged with the responsibility evaluating the desirability/need for the type of nursing education program requesting initial accreditation.

Section VII - Denial, Revocation or Suspension of License; Hearing (Table 20). A section devoted to this content area is found in the act throughout the twenty year period. In 1963 the statute speaks only to license revocation, denial and suspension

Table 19
Comparison of Nurse Practice Act Legislation
Governing Regulation of Nursing Education Programs - 1960-1980

Section	1963	1967	1974	1977	1980
VI. NURSING EDUCATION PROGRAMS	This act does not include any section or subsection on the regulation of any form of nursing education program.	a) An institution desiring to conduct a nursing education program to prepare professional or practical nurses shall apply to the State Board of Education for approval to do so and subsequently submit evidence to the State Board of Examiners of Nurses that: (1) It is prepared to carry out a program in professional nursing education or a program in practical nursing education, as the case may be. (2) It is prepared to meet such standards as shall be established by this subtitle and by the Board. (b) A survey of the entire nursing education program shall be made by persons authorized by the Board, who shall submit a written report of the survey to the Board. If, in the opinion of the Board, the requirements for a nursing education program are met, such program shall be listed as a nursing education program for the preparation of practitioners of	Same	Except for the addition of one sub-section*, remained unchanged. *(b) the Board shall evaluate the proposals of institutions desiring to conduct a nursing program for registered or licensed practical nurses as to the need in that area for the type of nursing program the institution wishes to conduct.	Same

Table 19 (continued)

Section	1963	1967	1974	1977	1980
VI. NURSING EDUCATION PROGRAMS		professional or practical nursing; as the case may be. (c) From time to time as deemed necessary by the Board, it shall be the duty of the Board, through its authorized representatives to survey all nursing education programs in the state. Written reports of such surveys shall be submitted to the Board. If the Board shall determine that any nursing education program is not maintaining the standards required by the statutes and by the Board, it shall immediately give notice thereof in writing to the institution conducting the program specifying the defect or defects found by the Board. (d) If the defects specified by the Board are not corrected within a reasonable time to the satisfaction of the Board, the Board may, after an opportunity for a hearing remove the institution from the list of acceptable nursing education programs.			

Table 20
Developmental Comparison of Legislation Regulating the
Denial, Revocation, or Suspension of Licenses; Hearing - 1970-1980

Section	1963	1967	1974	1977	1980
VII. DENIAL, REVOCATION OR SUSPENSION OF LICENSE: HEARING.	"The State Board of Examiners of Nurses may revoke any certificate for sufficient cause, but before this is done the holder of said certificate shall have thirty days notice, and after a full and fair hearing of the charges made, by a majority vote of the whole Board, the certificate may be revoked."	The Board shall have the power to deny, revoke, or suspend any license to practice nursing upon proof that the person: (1) Is guilty of fraud or deceit in procurring or attempting to procure a license to practice nursing. (2) Is guilty of a crime involving moral terpitude related to practice of nursing. (3) Is unfit by reason of incompetence or habitual negligence. (4) Is an habitual or chronic alcholic or is addicted to the use of habit-forming drugs. (5) Is adjudged by a court to be mentally incompetent. (6) Has willfully violated any of the provisions of this subtitle. b) Upon filing a complaint under oath or affirmation with the Board, charging any licensee with having been guilty of any of the actions specified as a ground for disciplinary action, the Board or its authorized representa-	Unchanged	The Board may withhold, deny, revoke, suspend, or refuse to renew any license of a nurse, or applicant or to issue a reprimand upon proof that the person: (1) Same (2) Has had a nuring license denied, suspended, or revoked in another jurisdiction. (3) Has willfully or knowingly filed false reports or records of persons under his care. (4) Has willfully and knowingly given or filed any false or misleading information regarding material matters in an application for employment. (5) Has willfully and knowingly omitted to file on record, obstructed or induced another person to omit to file or record health records required by law. (6) Is guilty of gross negligence in the performance of acts of nursing. (7) Has engaged in any act inconsistent with generally accepted professional standards of good nursing practice.	Same

Table 20 (continued)

Section	1963	1967	1974	1977	1980
VII. DENIAL, REVOCATION OR SUSPENSION OF LICENSE; HEARING.		tive shall fix a time and place for a hearing and shall cause a copy of the charges, together with a notice of the time and place fixed for the hearing to be served on the accused at least thirty days prior thereto. c) At the hearing the accused shall have the right to appear either personally or by counsel or both, to produce witnesses and evidence on his or her own behalf, and to cross-examine witnesses. If the accused shall be found guilty of the charges, the Board may refuse to issue a license to the applicant or may revoke or suspend a license. A revoked or suspended license may be reinstatedafter one year, in the discretion of the Board.		(8) Has knowingly engaged in any act, which before it was committed, had been determined to be beyond the scope of that person's nursing practice by regulations under this subtitle. (9) Has rendered nursing services to a patient while intoxicated or under the influence of drugs. (10) Has been convicted of a felony. (11) Is guilty of a crime involving moral terpitude if the nature of the offense bears directly on the persons fitness to practice nursing. (12) Has violated any provision of this subtitle. (b) same meaning and intent as 1967, 6b. (c) Hearings and judicial review of Board decisions shall be in accordance with the states' "Administrative Procedure Act" of this Code. In addition, parties complained against are entitled to be represented by counsel.	

Table 20 (continued)

Section	1963	1967	1974	1977	1980
VII. DENIAL, REVOCATION OR SUSPENSION OF LICENSE: HEARING.				d) If the license has been revoked or suspended the original license and current license to practice shall be returned to the Board. If the revoked or suspended license has been lost, a statement under oath to the effect shall be filed with the Board. e) A revoked or suspended license may be reinstated after one year, at the discretion of the Board.	

are introduced as options in 1967. The circumstances surrounding the denial, revocation or suspension of a license are more fully delineated in the 1967 and 1977 acts. From its inception as a portion of the act procedural due process is granted.

In 1967, six circumstances are identified as probable cause for administrative action by the Board: 1) fraud or deceit in attempting to gain a nursing license; 2) moral terpitude related to the practice of nursing; 3) incompetence or habitual negligence; 4) chronic alcoholism or drug addiction; 5) legally established mental incompetence; 6) willful violation of any portion of the act.

In 1977, eleven criteria are set forth as probably cause: 1) same as above; 2) license denied, suspended or revoked in another jurisdiction; 3) deliberate filing of false reports or records in patient care activities; 4) willfully giving false or misleading information on an employment application; 5) willful omission or obstruction to file health records required by law; 6) gross negligence in nursing practice; 7) acts inconsistent with practice standards; 8) engaging in activities previously determined beyond the scope of nursing practice; 9) practicing while under the influence of alcohol or drugs; 10) conviction of a felony; 11) found guilty of a crime involving moral terpitude if said offense bears directly on practice fitness; and 12) violation of any subtitle of the act. The 1980 act is unchanged in this area.

Section VIII - Certain Conduct Not Prohibited - Unlawful Practice (Table 21). The major legislative activity in this subtitle takes place in 1967. It establishes that good samaritan acts, student nursing, federal nursing employees, and Christian Science nurses are protected in the practice act. Gratuitous nursing of the sick is excluded from regulation in 1963. These standards remain constant through subsequent revisions.

In 1967, unlawful practice are established and undergo little change over the succeeding years. As might be expected, practicing without a license, facilitating the fradulent acquisition of academic credentials and/or a practice license, and inappropriate use of the term 'nurse' or R.N. are specifically identified as unlawful.

In 1977, the willful employment of unlicensed individuals to practice nursing is included, as is, failure to periodically report those employed in the practice of Nursing. In 1980 a subsection is added to this portion of the act regarding nurse midwives. It calls for a peer review committee to oversee health insurance and medical assistance benefit utilization by nurse midwives.

Analysis

An evaluation of the practice act appears directly related to several characteristics commonly associated with the process of professionalization. In order to identify the nature of these alterations and advances, analysis will be structured around the categories/sections.

Table 21
Comparison of Legislation Governing Certain Conduct and Unlawful Practices: 1960-1980

Section	1963	1967	1974	1977	1980
VIII. CERTAIN CONDUCT NOT PROHIBITED UNLAWFUL PRACTICES	This act does not contain sections titled in the manner of those from 1967-1980. There are two sections, however, which appear related to subsequent content, and may represent the first developmental material. 43:297 This subtitle shall not be construed to effect or apply to gratuitous nursing of the sick by friends or members of the family, and also it shall not apply to any person nursing the sick for hire, who does not advertise, solicit employment or hold himself or herself out as a graduate, certified or registered nurse. 43:298 Any person violating any of the provisions of this subtitle, or who shall willfully make any false representation to the Board of Examiners in applying for a certificate, shall be guilty of a misdemeanor, and upon conviction be punished by a fine or not more than five hundred dollars (500.00).	Certain conduct not prohibited This subtitle does not prohibit: (a) The furnishing of nursing assistance in an emergency. (b) The practice of nursing which is incidental to their program of study by students enrolled in nursing education programs approved by the Board. (c) The practice of any legally qualified nurse of another state, district or territory of the United States who is employed by the United States who is employed by the United States Government or any bureau, division or agency thereof, while in the discharge of his or her official duty. (d) The performance of selected acts of nursing as authorized in Section 291(d) of this article. (refers to delegation of acts by nurses, physicians and dentists to individuals directly under their supervision)	Certain conduct not prohibited Same Unlawful practices Same	Certain conduct not prohibited Same Unlawful practices Same with following additions: (6) Knowingly employ unlicensed persons in the practice of nursing. (7) Failure to report as required in section 294 (a) (17). (requires employers to periodically report names and recordation numbers of persons employed in the practice of nursing)	Same, except Subtitle 301A added: 301-A. Peer review committee (a)(1) In this subsection "nurse midwife" means a licensed registered nurse who has been certified by the American College of Nurse Midwives as a nurse midwife. (2) The State Board of Examiners of Nurses shall appoint a peer review committee to provide for oversight of health insurance and medical assistance benefit utilization by nurse midwives. (b)(1) In this subsection "certified nurse practitioner" means a licensed registered nurse who has completed a nurse practitioner program approved by the State Board of Examiners of Nurses and who has passed a board approved examination.

Table 21 (continued)

Section	1963	1967	1974	1977	1980
VIII. CERTAIN CONDUCT NOT PROHIBITED UNLAWFUL PRACTICES		(e) Care of the ill, injured or infirm by a Christian Science nurse, listed in the Christian Science Journal, provided he or she administers no medians or drugs, internal or external. <u>Unlawful Practices</u> It shall be a misdemeanor for any person to (1) Sell or fraudulently obtain or furnish any nursing diploma, license, renewal or record, or aid or abet such activity. (2) Practice nursing as defined by this subtitle under color of any diploma, license, or record illegally or fraudulently obtained or signed or issued unlawfully or under fraudulent representation. (3) Practice professional nursing or practical nursing as defined by this subtitle unless duly licensed to do so under the provisions of this subtitle. (4) Use in connection with his or her name the			

Table 21 (continued)

Section	1963	1967	1974	1977	1980
VIII. CERTAIN CONDUCT NOT PROHIBITED UNLAWFUL PRACTICES		designation "nurse" or any other designation tending to imply that he or she is a licensed registered nurse or a licensed practical nurse unless duly licensed so to practice under the provisions of this subtitle; provided, however, that until June, 1969, nothing in this subtitle shall prevent unlicensed persons from using the designation "nurse" or "practical nurse". (5) Practice professional nursing or practical nursing during the time his or her license issued under the provisions of this subtitle shall be lapsed, suspended or revoked. (6) Any person convicted of violating this subtitle shall be fined not more than one hundred dollars for the first offense. Each subsequent offense shall be punishable by a fine of not more than five hundred dollars or by imprisonment of not more than six months or by both such fine and imprisonment			

The inclusion of a purpose statement (Section I) in the 1967 act is meaningful. It establishes the state's fundamental belief that the well-being of its citizens is enhanced by limiting the practice of nursing to those who have met the preliminary requirements inherent in the licensure procedure. Although the 1963 act provided for licensure in order to utilize the designation, R.N. (registered nurse), the rationale for this allocation of state recourses was not established in law. The purpose statement formally establishes society's dependence on nursing and thus restricts delegating its fullfillment service to only those who successfully meet the requirements tested by the licensure exam. It is tangible recognition of the states beliefs regarding nursing's value. (Greenwood, 1957).

It is interesting to note that the name of the act changes over time. The title "Nurse Practice Act" is first incorporated in 1974. Previously, the act is referred to as the "Nursing Licensing Act" (1967) and the "Registration of Nurses and Licensed Practical Nurses" (1963). A number of subjective interpretations could be made regarding this change. An act governing the practice of an occupational group seems somewhat more substantive and comprehensive than one which merely regulates a licensure procedure.

The inclusion of the purpose statement in the act and the incorporation of a definition of nursing practice both occur in 1967. The 1967 definition of nursing practice (Section II) precludes independent, autonomous acts, placing total responsibility for

patient care with the physician. Thus, although skill and a substantial scientific knowledge base to practice nursing are recognized, as well as settings appropriate for practice, the role described is a dependent one, requiring physician direction and diagnosis prior to the lawful utilization of knowledge and skills.

The 1974 act substantially alters the dependent, subordinate relationship. Recognition of independent as well as delegated/dependent functions is established. Further, it is clearly stated that independent or delegated functions may be performed autonomously, as well as in collaboration with others.

References to diagnosis and prescription in nursing practice are not explicitly addressed in the 1974 legislation. Section IIb, however, (See Table 15) does speak to the identification of additional practice functions jointly recognized by medicine and nursing. This section refers to acts such as electrocardiogram interpretation. It recognizes that the nurse is responsible for interpretation of such data which may indicate that a patient has had a heart attack. At the very least, Section IIb provides an expanded role potential.

One additional change should be noted between the 1967 and 1974 acts. Specialized knowledge, judgment and skill continue to be recognized, as well as the role of the biological, physiological, behavioral and social sciences in nursing practice. In the 1974 legislation, however, knowledge, skill and judgment are identified as being utilized in the assessment, problem identification, implementation and evaluation of client health care needs. This section

seems to point towards a specific analytical process utilized in discharging practice responsibilities, thus, supporting independent activities of an analytical nature and further verifying practice of a less subordinate nature.

The alterations made in the 1977 practice act seem more directed at refining existing legislation than underlying substantive change. The inclusion of the "planning" activity in Section IIa, further elevates the analytical aspect of nursing practice as meaningful and worthy of recognition.

One additional modification should be noted. In 1967, the "practice of professional nursing" is defined. In 1974, the "practice of registered nursing" is defined. This change in wording seems directly related to the baccalaureate entry into practice issue. Three basic educational programs are preparing candidates for registration. The implication could be drawn that "professional" nursing is seen as above and beyond those acts and requirements of all registered nurses. This analysis is speculative at best.

In summary, over the twenty year period, 1960-1980, the section on definitions changes in several areas that can be associated with professional evolution. Increasingly, the acquisition and application of knowledge in client care is recognized on a more sophisticated level. Furthermore, changes are seen in nursing practice. The superior-subordinate relationship between physician and nurse is altered, and independent, autonomous, and collaborative relationships

emerge. These alterations are reflections of professional attributes of professional autonomy, authority over client, recognition by the community and the identification of a systematic knowledge base.

The State Board of Examiners of Nurses (Section III) is delegated responsibility by the State to regulate nursing activities and interests on behalf of society. Although established prior to 1960, the manner in which potential Board members are selected should be noted. The State relies on the professional association to guide this process. This delegation of responsibility reflects the dependence of the State on the association for sound appointment decisions.

In the thirteen year period between 1967 and 1980, rather specific criteria are developed to guide the Board selection and appointment process. The criteria recognize academic achievement and practice specialization in the clinical, administrative and educational domains. In short, it would seem that the state has recognized the need for nurses with advanced academic preparation to lead this body. Finally, it should be noted that representation is not provided for diploma schools of nursing as of 1977. This exclusion is consistent with the ANA goal of housing nursing education in the higher education setting.

Throughout the twenty year span of this study the nursing Board is delegated the responsibility for evaluation of practitioners who seek practice privileges, as well as those in practice, rather than judgment by an occupational group or body external to nursing.

This self-regulating posture remains throughout the twenty year period with refinement and clarification of expectations and procedure.

The Board, in general, is delegated responsibility for the regulation of practice, education and licensure. These three areas are consistent with those established by Reiss (1955) as areas over which occupational groups seek control. The primary advance during the 1960-1980 period seems to be in the area of practice definition and regulation. Duties and responsibilities in the area were established in 1967, and advanced in 1977 with the recognition that nursing practice may require the performance of additional acts previously housed in the medical domain.

Finally, in 1977 the Board was accorded the responsibility of adopting and revising nursing practice standards, in addition to the rules authorizing practice. This marks the first mention of standard setting and as such reflects a more autonomous and expanded role in the health care system.

Modifications in the sub-section on licenses are subtle, yet meaningful. In 1963, an applicant for licensure had to be 19 years of age, of good moral character, hold the equivalent of a high school education, and have completed an accredited professional nursing education program. By 1977, the age and moral character requirements have been deleted. Through the years, the high school equivalency requirement is upgraded. In 1977, reference to this requirement disappears. It would seem plausible to assume that high

school graduation has been established as an entrance requirement in basic programs, and/or may be regulated by the authority granted to accredit nursing programs.

One of the more interesting changes occurs in 1974, when the language of the statute is altered to indicate that graduates of state approved registered nursing education programs are eligible for licensure, rather than graduates of an approved professional nursing education program. This change in wording from professional to registered marks the second (See Section II) such change in legislative language of this nature. It seems a deliberate attempt to deny graduates of associate or diploma programs, the "professional" designation.

In summary, this aspect of the law deals with the process by which licenses to practice nursing are awarded and renewed. It seems clear that nursing has been accorded control of the licensure process. Educational standards for students entering basic programs appear to have been advanced, and subtle reference is made to the entry into issue by a change in statute language. Finally, for the first time, licensure for specialty nursing practice is recognized in relation to midwifery and nurse practitioners. This marks a major change in authority relationships, in that the practice of midwives and nurse practitioners was previously under direct scrutiny of the medical board.

Section VI (Nursing Education) further defines the Board's responsibilities for nursing education programs. The initial legis-

lation, established in 1967, remains unchanged until 1977. The 1977 change allows the Board to make judgments regarding the need for new nursing programs, not simply programatic compliance with educational standards. This authority, if exercised, could limit the growth of associate degree and diploma programs. It seems unlikely that a Board primarily composed of nurses with advanced degrees, would be disposed to limit growth in baccalaureate and higher degree programs.

Regulations governing denial, suspension and revocation (Section VII) of the practice license are defined and refined during the 1960-1980 time span. The 1977 criteria are more specifically related to practice infractions than the general character of the individual. In essence, the 1977 statute accepts that a nurse may be an alcoholic, a drug addict, or emotionally unstable, as long as the condition does not directly affect patient care activities.

The 1977 legislation also inaugurates accepted performance standards, or peer evaluation, as an appropriate judgment scheme. Further, emphasis is placed on the willful or deliberate intent of the practitioner to violate the law, as opposed to error based on ignorance. In sum, the 1977 criteria are more specific in nature, than those previously developed.

The most significant change occurring in the legislation on conduct or unlawful practices (Section VIII) during the span of this study involves nurse practitioners and midwives. The inclusion of

midwives as a specific responsibility of the Board is significant, for supervision of their practice has previously been shared with the medical board. This subsection clearly assigns credentialing to the American College of Nurse Midwives, and practice evaluation to a group of peers.

The passage of the subsection indicates a higher level, independent practice, free of direct physician supervision. Furthermore, it also establishes that the Board will accredit educational programs designed to prepare nurse practitioners, and license these practitioners utilizing a Board approved examination.

The advances made by the midwives are consistent with a more professionalized practice, featuring the attributes of client authority, autonomy, and recognition by society. It may further be argued that both the nurse practitioners and the midwives have sought and are providing services needed by society. These activities are entirely consistent with a community service interest; as opposed to one of a self-serving nature.

Summary

The practice act governing nursing is one tangible manifestation of the groups contract with society, and as such provides a vehicle for assessment of professionalization. The review of these statutes from 1960-1980 indicates modifications in recognition by the community, acknowledgement of the knowledge base required in practice, advances in professional autonomy and authority over client relationships.

Although recognition of a practice based on principles in the sociological, physiological and behavioral sciences is affirmed, a clear commitment to two levels of practice (technical and professional) is not delineated, nor is the need for a baccalaureate degree as a professional entry level credential.

Matrix Cell - Six: Appointment, Promotion and Tenure Criteria

This data was gathered in order to determine whether criteria used to make decisions regarding faculty competence are changing (research question four). Society grants the professional group the authority to judge and sanction the practice of the individual professional (Greenwood, 1957). In developing appointment, promotion and tenure (APT) criteria faculty set standards by which decisions regarding their competency are made. Thus, such criteria can reflect the evolution of higher performance standards.

Four documents were utilized to chronicle the evolution of APT criteria at the institutional site. They receive major emphasis in the following data report. These documents include faculty handbooks, policy memoranda, and archival records/reports. An interview with the APT Committee Chairperson at the institutional site was helpful in identifying and collecting the documents.

The university policy which covered APT criteria in 1960 was developed, adopted, and distributed to all academic units in 1957. The criteria were initially formulated by a university committee of eleven members. The school of nursing had a representative on this committee. Policy recommended by the committee was

adopted by the university senate within a month of its submission. Excerpts of this policy follow.

Procedures and Principles

1. The administrative responsibility for recommending all faculty appointments and promotions to the President rests with department heads, directors and deans, but, in order to take advantage of the University's collective wisdom, faculty participation should be sought in all recommended appointments and promotions (including department heads, directors and deans) and faculty review is required for all recommendations of appointments or promotions to positions of permanent tenure.

2. Minimum qualifications for the several academic ranks will be adhered to in making future appointments and promotions to the extent permitted by fairness to existing faculty members, available candidates, available funds, and other equitable and practical considerations, all to be considered with a view to accomplishment of the stated University purposes, and with proper weight to stated criteria for judging merit.

3. All appointments and promotions shall be based on merit with proper weight given to: a) teaching skill; b) research, publications, and/or other professional achievement; and c) University service.

Procedures for Appointments and Promotions

Official responsibility for recommending appointments and promotions in rank rests with heads of departments, directors and deans of colleges. Authority to appoint, advance and promote resides in the President. It follows that the quality of the faculty of a department, or college, will reflect the judgment, industry and determination of its head, director or dean as applied to building and maintaining a strong department, or college.

Clearly, heads of departments, directors and deans should be persons of recognized achievement and leadership in their respective professional and scholarly fields. It is the responsibility of the University administration to insure that these positions are always held by well qualified persons who fully accept the challenge of the administrative responsibilities which accompany the honor and dignity of being a department head,

director or dean. To bring the collective wisdom which resides in the University to bear on these critical decisions, final appointments of deans, directors and department heads should be made only after consultation with senior faculty members of the department, school, or college involved and of related departments or schools, and preferably only after report and recommendations from a faculty committee including at least three faculty members of tenure rank from the department, college, or school where the appointment is to be made.

Department heads, directors and/or deans should seek the advice and counsel of their faculty colleagues and work in close cooperation with the, as well as with administrative officials, in building and retaining outstanding departments. Faculty members should not only have the privilege of being consulted but should assume responsibility for giving advice. This faculty responsibility should normally increase with rank, but the advice and counsel of younger men should also be invited. All faculty members, and especially senior members, should constantly bear in mind the needs of their department. In the normal pursuit of scholarly activities, including the reading of professional journals and in correspondence and discussion with friends and acquaintances in the profession faculty members have opportunity to familiarize themselves with the names of talented men and women in their fields, including the most able young people in graduate schools, and should feel free to suggest such names to the department heads, director or dean, for consideration for future appointments. Through such concerted and collective enterprise the University will be better able to realize the great promise which its resources and other favorable circumstances hold in store for it.

Each college and school of the University shall work out and state in writing a definite procedure for faculty participation in, or review of, appointments.

Minimum Qualifications for Original Appointment to the Several Academic Ranks

Certain minimum qualifications shall be required for appointment or promotion to the several academic ranks. These follow closely, but not exactly, the recommendations made by a special committee of the Administrative Board, dated January 1952.

Instructor. Appointees to the rank of instructor ordinarily shall hold the highest earned degree normally associated with

this rank in the field of specialization, or have relatively comparable experience. Unless otherwise specified in writing, instructors are appointed for a term not to exceed the fiscal year during which the appointment becomes effective, and may be reappointed one or more times.

Assistant Professor. In addition to having the qualifications required of an instructor, ordinarily the appointee should have demonstrated superior teaching ability in the departmental field and superior teaching or research ability in some sub-division of this field. In most fields the doctorate will be a normal requirement for appointment to an Assistant Professorship. Unless otherwise specified in writing, Assistant Professors are on three year appointments and may be reappointed one or more times. One year prior to the end of each term of appointment evidence shall be reviewed by the departmental head, director and/or dean with the objective of recommending promotion, continuance at the same rank, or termination.

Associate Professor. In addition to having the qualifications required of an assistant professor, ordinarily the appointee shall have had extensive successful experience in teaching and research work and be competent to direct the work of major sub-divisions of the department and to offer graduate instruction and direct graduate research therein. Since this position may carry permanent tenure, academic competence shall have been deomonstrated by outstanding teaching performance scholarly production, or other distinguished professional achievement, all as defined more particularly herein under Criteria for Appointments and Promotions.

Professor. In addition to having the qualifications of an associate professor, ordinarily the appointee shall have demonstrated a degree of proficiency in teaching and research sufficient to establish an excellent reputation among regional and national colleagues and tangible evidence of sound scholarly production should be found in the research, publications, professional achievements or other distinguished and creative activity before appointment to this position of permanent tenure.

Assistant Research Professor, Associate Research Professor, Research Professor. Qualifications for appointment to these ranks are the same as those set forth above for the corresponding ranks. The only difference is that the duties of research appointees lie in the research field, with limited or no teaching assignment. They should be scholars capable of conducting

intensive research in a given area and should possess the highest academic attainment in the chosen field.

In addition to the foregoing academic ranks, the following positions shall normally require the qualifications indicated.

Graduate Assistant and Fellow. The appointee should hold an appropriate baccalaureate degree from an accredited institution and should have shown superior aptitude and excellent promise as an undergraduate in his chosen field.

Research Assistant. The appointee should be capable of assisting in research under the direction of the head of a research project and should have ability and training adequate to the carrying out of the particular techniques required, the assembling of data, and the use and care of any specialized apparatus.

Research Associate. The appointee should be capable of carrying out individual research or collaborating in group research at the advanced level, should be trained in research procedures, and should have had the experience and specialized training necessary to develop and interpret data required for success in such research projects as may be undertaken.

Assistant Instructor. The appointee should be competent to fill a specific position in an acceptable manner, but he is not required to meet all of the requirements for an instructor. He should normally hold at least the appropriate baccalaureate degree.

Lecturer. The title "lecturer" may be used to designate temporary appointments, at any salary and experience level, of persons who are serving for a limited time or part-time, and normally are not in line for academic promotion.

Visiting Appointments. The prefix "Visiting" before an academic title, e.g. Visiting Professor, may be used to designate appointments wihtout tenure. These titles may also be used as an emergency procedure when there has not been time to complete a thorough review of qualifications, in anticipation of a regular academic appointment.

Criteria for Appointments and Promotions

Certain general criteria shall govern all appointments and promotions in academic rank. Every effort should be made to fill vacancies with persons of the highest qualifications. It is the special responsibility of those in charge of recommending appointments to make a thorough search of all available talent before recommending appointees. Personal interviews when feasible, letters of recommendation, publications, and other criteria of ability should be secured and evaluated before recommending appointment. Promotion in rank should in no case be autonomatic, but should be based squarely on merit.

Teaching, research, publications, professional achievement and University service should all be taken into account in the determination of merit for appointment or promotion. The weight to be given each one of these factors will naturally be determined by what will best maintain the highest academic or professional standing of the department, college, school, or other subdivision of the University. All recommendations for appointment or promotion, shall include a brief but clear and complete statement of the reasons for the recommended appointment or promotion.

1. Teaching Performance. Teaching is a primary function of the University, and superior teaching performance (or reasonable promise thereof in the case of initial appointments) is an important criterion in appointment and promotion. Although productive scholarship and service to the University are frequently thought to be more readily measured and appraised, every effort should be made to recognize and emphasize excellence in teaching. Among the factors to be considered are: a) ability to lecture and lead discussion in the classroom, seminar, or any area of teaching activity; b) ability to draw out students and arouse curiosity in beginners and to stimulate advanced students to creative work; c) ability to organize logically and realistically courses in one's field of specialization and to evaluate critically the content of courses related to one's specialy; d) ability to evaluate student performance; e) effort and skill in guiding and advising students; f) contribution to student welfare by participation in faculty-student relations which contribute to education; g) the development of teaching aids such as textbooks, syllabi, charts, visual and audio aids, and laboratory facilities for classroom demonstrations; h) the clarity and simplicity of published writing as indicia of ability to organize material in understandable form.

Routine classroom performance and acceptable teaching of itself may justify (particularly in time of shortage of teachers) appointment and promotion in non-tenure positions; but, only superlative teaching, evidenced beyond cavil; should justify appointment or promotion to the ranks of Associate Professor or Professor in the absence of other scholarly achievements or university service.

The recognition of good (or bad) teaching rests squarely on the department, or school; and, each department, or school, assumes the responsibility for devising measures suitable to its individual needs for the determination of the teaching performance of its members. Methods which might be considered are: a) an accepted procedure for visiting each other's classes; b) a regular procedure under which the senior staff visits the classes of junior staff; c) self-appraisal through teaching appraisal questionnaires answered by students for the teacher's use only.

2. Research, Publication and/or Professional Achievements. An important factor in determining a faculty member's merit for appointment or promotion shall be his contributions in the form of research, publication, and other professional or artistic activities. The nature of the performance will vary from one academic field to another; but the general test to be applied is that the faculty member be engaged continuously and effectively in creative activity of high quality and significance. Capacity for intellectual development, especially at junior ranks, and demonstrated creative imagination, especially at senior ranks, are prime considerations to be applied across the board.

Publication in professional journal and books is the normal expression of research activity and will be the primary measure of achievement. Recognized standing as attested by fellow scholars outside the University should be a major consideration, especially for appointments and promotion to tenure positions. Appraisals in the form of book reviews or otherwise shall be considered important evidence. Textbooks and similar publications, normally considered evidence of teaching ability, shall count as creative work if they present new approaches and manifest scholarly research.

In the professional schools, contributions to professional literature and to professional practice may be judged creative if they demonstrate new ideas and scholarly activity, and in fields such as art, music, drama, extension and speech, distinguished performance shall be judged as creative activity.

> In agriculture, the sciences and engineering, inventions and discoveries used in industry, or otherwise may, according to their nature, evidence the kind of creative work that in other areas goes into scholarly publications.
>
> Recognition will naturally be given to participation in the activities of professional and learned societies in the form of papers presented at annual meetings, membership on committees, and the holding of office in regional, national and international professional and learned societies.
>
> 3. University Service. Every member of the faculty should participate in the conduct of his department, college, and university. Such participation should increase with rank. This service may be recognized as a factor leading to advancement and promotion, but primarily to the extent that it is above average in quality, or in the amount of time consumed, and with consideration of the extent it contributes to the advancement of the department, college, school or university.

During the years in which this policy was in effect, its application by the APT Committee of the nursing school was consistent with its stipulations. In a report prepared for an accreditation visit by the National League for Nursing in 1969, APT considerations are addressed.

The report indicates that the APT policies in effect for faculty members of the nursing school are those in effect for faculty members throughout the institution. Excerpts from the report which specifically address APT procedures follow.

> The faculty members are appointed to academic ranks that are appropriate to their respective qualifications and functions, and the promotion and tenure policies are consistent with those of other units in the institution.
>
> Tenure accompanies the rank of Associate or full Professor. Assistant Professors may be recommended for tenure at the completion of a sixth year of service without advancement in rank. The University's policy states firmly, "In no case is promotion (or tenure) automatic, but must be based squarely on merit."

> Faculty in nursing holding the academic rank of instructor or above have a minimal preparation of a master's degree. This is in keeping with the University requirements for faculty appointment.
>
> The School of Nursing, as is apt to be the case in collegiate education for nursing, has problems in interpreting or exemplifying the "onward and upward" type of motivation which is a characteristic of higher education in general. It is our hope that eventually the School's criteria for promotion will give full recognition to expert teaching and clinical practice as well as to an increasing amount of research.

The 1975 faculty handbook at the institutional site includes three sections which are germane to this data base. The first section (See Appendix D) outlines the APT procedures for the school of nursing. This material is substantially similar to that found in the 1957 university policy statement previously reviewed. It should be noted however, that the 1975 service definition has been expanded to include professional, civic, and educational activities, as well as those related to the university service.

The other sections of the faculty handbook are entitled "Position Descriptions for Academic Ranks as Defined By the Faculty on Appointments, Promotions and Tenure in 1974-1975 and Criteria for Evaluation of Faculty for Promotion and/or Tenure." The criteria for appointment and promotion appear to be fundamentally unchanged from those identified in the university policy statement (1957), and those mentioned in the 1969 report by the NLN. The 1980 Faculty Handbook criteria on appointment, promotion and tenure are unchanged from those of the 1975 handbook.

Analysis

During the twenty year span of this study, appointment, promotion and tenure criteria remain substantially unchanged in the school of nursing. The nursing school criteria generally conform to the policy established by the university in 1957. This policy is in effect during the entire period of this study.

The element of the APT procedure which remains somewhat vague is the tenure process. Although it is clear that throughout the university the ranks of Associate Professor and Professor carry tenure, the Assistant Professor/tenure relationship is left unspecified in the policy. Senior faculty rank requires an earned doctorate at the institutional level and the school level. The rank of Assistant Professor requires a master's degree. Thus, in relation to the 1957 policy statement, the norm for appointment in most fields (doctoral preparation) is not attained between 1960 and 1980 at the nursing school. Further, it appears that tenure at the nursing school is granted to Assistant Professors without doctorates at the conclusion of six years of satisfactory service in the school. In the fall of 1981, the chairperson of the school of nursing APT committee reported to this investigator that the university policy regarding tenure had been changed so as to require an earned doctorate for tenure application. This change in policy will dictate profound change at the nursing school.

Data Matrix Cell - Nine: Control/Site

The data reported for this matrix cell addresses how programs/curriculum offerings have developed during the study's twenty year period at the institutional site.

As previously reviewed in Chapter 2, a professional group is oriented toward public need, serving the needs of society ahead of their own (Ritzer, 1972). Since World War II, changes in the knowledge base and technological development have promoted an enlarged and sophisticated health care system designed to meet the needs of society through specialization. Educational programs designed to prepare practitioners for these specialized services should emerge as part of an occupational groups' development.

The catalogs of the school of nursing were reviewed, beginning in 1960 and ending in 1980, in five year increments for educational programs offered and the curriculum structure of those identified programs. Table 22 summarizes the program commitments undertaken by the school from 1960-1980. Four distinct educational programs are identified in this summary: generic undergraduate baccalaureate education; registered nurse baccalaureate education; graduate education at the master's and doctoral levels; and a program in continuing education. The findings will be reported by program area.

Generic Baccalaureate Program

Initiated in 1952, and continuing through 1980, only two major changes in this program are evident. At the inception of the

four year program, students were admitted directly from high school. By 1970, this structure is altered so that admission to the generic nursing program is restricted until the student completed approximately 59-60 credits of pre-professional course work. This change to a lower-division/upper-division framework somewhat altered course requirements (See Tables 23-27).

The second major change was initiated with the class of 1973, and entailed an entire revision of the curriculum. The traditional medical model, around which the undergraduate curriculum was designed, gave way to an integrated curriculum structure which emphasized concepts and principles. The actual curriculum content was, generally speaking, not dramatically altered.

R.N. Baccalaureate Program

Change in registered nurse baccalaureate program generally parallels that of the basic generic program. Tables 28 through 32 outline the complete curriculum requirements of this program. They are substantially the same as those required of the generic student.

Allowances are made for the possible maturity of the registered nurse student. Beginning with the 1970 curriculum outline, references are made to establishing credit by examination. Information regarding this opportunity is expanded in the 1975 and 1980 catalogs. In addition, CLEP (College Level Examination Program) examinations are listed as a means of establishing lower-division

Table 22
Summary of Program/Curriculum Offerings at the Institutional Site: 1960-1980

	1960	1965	1970	1975	1980
OUTLINE OF PROGRAM/ CURRICULUM OFFERINGS	1. Undergraduate Generic Baccalaureate Program a) Described as the basic professional nursing program. First two years spent in the main campus; third and fourth years on the campus housing schools of medicine, law, pharmacy, etc. b) Curriculum designed on the basis of the traditional medical education model: medical nursing, surgical nursing pediatric nursing, obstetric nursing, psychiatric nursing, community health nursing (initiated-1952) 2. Registered Nurse Baccalaureate Program a) Designed to bring to full collegiate levels including public health nursing, the preparation of graduates of hospital based diploma schools. To supply the general education courses considered desirable as a basis for further cultural and professional education. 3. Graduate Program: Master of Science	1. Undergraduate Generic Baccalaureate Program Continues unchanged. 2. Registered Nurse Baccalaureate Program Continues unchanged. 3. Graduate Program: Master of Science a) Change noted in graduate program philosophy and purpose statements, in that reference to the preparation of clinical specialists appears for the first time. Philosophy and Purpose: The Master of Science degree program in nursing is designed to prepare qualified registered nurses with baccalaureate degrees for high professional leadership as administrators of nursing education or nursing service; clinical specialists in maternal and child nursing, medical-surgical nursing, general psychiatric nursing, nursing of children with psychiatric disorders, and public health nursing; and	1. Undergraduate Generic Baccalaureate Program a) Upper division/lower division structure now complete.' b) Contract arrangement with one institution now operative. c) Major curricular change affecting class of 1973 announced. 2. Registered Nurse Baccalaureate Program Continues 3. Graduate Program: Master of Science Program offerings remain constant.	1. Undergraduate Generic Baccalaureate Program a) Contract with two other institutions now available. 2. Registered Nurse Baccalaureate Program a) An off-campus program for registered nurses in remote areas of the state was initiated. 3. Graduate Program: Master of Science a) Major in Nursing Service/Education is no longer offered. b) Course outline no longer provided for each program area. c) Five majors and three areas of role preparation. 4. Continuing Education Program a) First mention of offering-workshops, seminars, and short courses-programs to enhance or update knowledge and professional competency.	1. Undergraduate Generic Baccalaureate Program a) Contract programs no longer available. 2. Registered Nurse Baccalaureate Program a) Outreach program continues in remote areas of thestate. 3. Graduate Program a) Master of Science (1) Twelve areas of concentration (major) now offered, and seven areas of role preparation. (see curriculum design) b) Doctor of Philosophy (1) Catalog states that the program is based on the belief that nursing has a distinct body of knowledge which can and must be extended, verified and revised using the methods of scholarily inquiry. (2) Two areas of concentration: (a) Direct nursing-the study of health needs of clients and of nursing action directly provided to clients in a variety of settings.

Source: Institutional Site School Catalogs

Table 22 (continued)

	1960	1965	1970	1975	1980
OUTLINE OF PROGRAM/ CURRICULUM OFFERINGS	a)Designed primarily to prepare nurses in the administration of nursing service and education, and as teachers and nursing service heads in the areas of maternal child, medical-surgical and psychiatric nursing. (graduate program initiated in 1954) b) Five majors offered; 2 areas of role preparation.	teachers or supervisors of the above mentioned clinical specialists. b) Programs in child psychiatric nursing and public health nursing appear. c) Programs for preparation of service and education administrators more highly delineated. d) Seven majors offered and four areas of role preparation.			(b) Indirect Nursing- study of nursing systems and educational and administrative nursing action which promotes clinical nursing practice 4. Continuing Education Program Emphasis unchanged.

Source: Institutional Site School Catalogs

Table 23
Curriculum Outline for Generic Baccalaureate Program - 1960

Curriculum	Semester I	Semester II
Freshman Year		
Eng. 1, 2 Composition and American Literature	3	3
Soc. 1 Sociology of American Life	3	-
G & P 1 American Government	-	3
Zool. 1 General Zoology	4	-
Chem. 11, 13 General Chemistry	3	3
Sp. 18, 19 Introductory Speech	1	1
Nurs. 8 Nursing I	-	2
Physical Activities	1	1
Math. 10 Algebra	-	3
Total	15	16
Sophomore Year		
Eng. 3, 4, or 5, 6 Composition and World or English Literature	3	3
H. 5, 6 History of American Civilization	3	3
Psych. 1 Introduction to Psychology	3	-
Microb. 1 General Microbiology	-	4
Zool. 14, 15 Human Anatomy and Physiology	4	4
Nut. 110 Nutrition	-	3
Nurs. 9 Nursing in Child Health	2	-
Physical Activities	1	1
Total	16	18
Summer Session		
Bio-Chem. 1 Bio Chemistry	4	-
Nurs. 7 Nursing II	2	-
Junior Year		
Nurs. 102 Medical and Surgical Nursing I	10	-
Nurs. 105 Maternal and Child Health	-	10
Ed. 90 Development and Learning	3	-
Nurs. 103 Pharmacology	3	-
P.E. 160 Theory of Exercise	-	3
Nurs. 108 Applied Psychology	2	-
Soc. 164 Family and Society	-	3
Total	18	16
Senior Year		
Nurs. 150 Medical and Surgical Nursing II	5	-
Nurs. 152 Psychiatric Nursing	4	-
Nurs. 153 Public Health	2	-
Nurs. 154 Principles of Management of a Nursing Unit	-	2
Nurs. 155 Survey of Professional Nursing	2	-
Nurs. 156 Public Health Nursing I	-	2
Nurs. 157 Public Health Nursing II	-	4
Nurs. 158 Bio-Statistics	-	3
Hea. 120 Teaching Health	-	3
Total	13	14

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Table 24

Curriculum Outline for Generic Baccalaureate Program - 1965

	Semester I	Semester II
Freshman Year		
Eng. 1 Composition	3	-
Soc. 1 Introduction to Sociology	3	-
Zool. 1 General Zoology	4	-
Chem. 1, 3 General Chemistry	4	4
Sp. 7 Public Speaking	2	-
Hea. 5 Science and Theory of Health	-	2
Math. 10 Introduction to Mathematics	-	3
Psych. 1 Introduction to Psychology	-	3
*Fine Arts or Philosophy	-	3
Nurs. 7 Nursing I	-	1
Physical Activities	1	1
Total	17	17
Sophomore Year		
Eng. 3, 4 World Literature	3	3
**Hist. History (Non-U.S.)	3	-
***Hist. History (United States)	-	3
Zool. 14, 15 Human Anatomy and Physiology	4	4
Micro. 1 General Microbiology	-	4
Nut. 121 Science of Nutrition	3	-
H.D. Ed. 107 Growth and Development in Early Childhood	-	3
Phys. 3 Introduction to Physics	4	-
Total	17	17

*Courses in five departments are available: Art 10, 60, 61, 65, 66, 67 68, 70, 71, or 80; Dance 32, 182 or 184; Music 20, Speech 16 or 114; or Phil. 1, 41, 45, 52, 53, 147, 152 or 154.

**Recommended courses are: Hist. 31, 32, 41, 42, 51, 52, 53, 54, 61, 62 71, 72.

***Recommended courses are: Hist. 21, 22, 23, 24 or 29.

Summer Session		
Bio. Chem. 1 Biochemistry	4	-
Nurs. 103 Pharmacology	3	
Nurs. 8 Nursing II	1	
Total	8	
Junior Year		
Nurs. 102 Medical-Surgical Nursing I	10	-
Nurs. 105 Maternal and Child Nursing	-	10
Anthrop. 105 Cultural Anthropology	3	-
Psych. 110 Educational Psychology	-	3
P.E. 160 Theory of Exercise	-	3
Elective	3	-
Total	16	16

Table 24 (continued)

	Semester I	Semester II
Senior Year		
Nurs. 150 Medical Surgical Nursing II	5	-
Nurs. 152 Psychiatric Nursing	-	5
Nurs. 153 Public Health	2	-
Nurs. 154 Principles of Management of a Nursing Unit	2	-
Nurs. 155 Survey of Professional Nursing	-	2
Nurs. 156 Public Health Nursing	-	5
Soc. 164 Family and Society	3	-
Nurs. 158 Biostatistics	-	3
Elective	3	-
Total	15	15
Total		138

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Table 25

Curriculum Outline for Generic Baccalaureate Program - 1970

Standard Curriculum

Junior and Senior Year Courses
For Classes of 1970, 1971, 1972*

		Credits
Junior Year		
Nursing 008	Nursing II	1
Nursing 102	Medical-Surgical Nursing I	10
Nursing 105	Maternal and Newborn Nursing	5
Nursing 106	Maternal and Child Nursing	5
Biochem. 001	Biochemistry	3
Nursing 103	Pharmacology	3
Elective		3
	Total	30
Senior Year		
Nursing 150	Medical-Surgical Nursing II	5
Nursing 189	Seminar	3
Nursing 152	Psychiatric Nursing	5
Nursing 153	Public Health	2
Nursing 154	Principles of Management of a Nursing Unit	2
Nursing 155	Survey of Professional Nursing	2
Nursing 156	Public Health Nursing	5
Sociology 164	Family and Society	3
Prev. Med. 158	Biostatistics	3
	Total	30

*Freshman and Sophomore curriculum: See Chart on Generic Entrance Requirements, 1970.

Revised Curriculum

Junior Year		
Nursing 120	Concepts of Wellness-Illness	4
Nursing 121	Concepts of Nursing I	6
Nursing 122	Human Development	4
Nursing 123	Medicinal Therapeutics	2
Nursing 124	Concepts of Nursing II (Winter Session)	4
Nursing 126	Concepts of Nursing III	3
Nursing 132	Maternal Newborn Nursing	4
Nursing 134	Nursing of Children	4
Elective		3
	Total	34
Senior Year		
Nursing 128	Concepts of Nursing IV	3
Nursing 136	Psychiatric Nursing	4
Nursing 138	Medical-Surgical Nursing	6
Prev. Med. 158	Biostatistics	3
	Total	16

Table 25 (continued)

		Credits
Nursing 162	Survey of Professional Nursing (Winter Session)	2
Elective	(Winter Session)	2
	Total	4
Nursing 164	Community Health Nursing	4
Nursing 166	Clinical Nursing Elective	4
Nursing 168	Leadership in Clinical Nursing	4
Elective		3
	Total	15

*Freshman and Sophomore curriculum: See Chart on Generic Entrance Requirements, 1970.

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Table 26
Curriculum Outline for Generic Baccalaureate Program - 1975**

Junior Year

		Credits
Fall Semester		
*NURS 314	Concepts of Nursing I	9
NURS 318	Health Elective	3
*NURS 316	Human Growth and Development	3
	Total	15
Winter Session		
*NURS 317	Deviations in Human Growth and Development	2
*NURS 320	Introduction to the Administration of Medications	1
	Total	3
Spring Semester		
*NURS 315	Concepts of Nursing II	9
*NURS 310	Pathophysiology and its Pharmacological Implications	4
NURS 321	Introduction to Organizational Behavior	3
	Total	16

*These courses may be challenged by R.N. students after being admitted to the upper division.

Senior Year

Fall Semester		
NURS 324-325	Concepts of Nursing III A or B	9
NURS 322	Nursing in Society	3
NURS 410	Survey of Research and Statistics	3
	Total	15
Winter Session		
NURS 326	Clinical Nursing Elective	3
	Total	3
Spring Semester		
NURS 324-325	Concepts of Nursing III A or B	9
NURS 418	Health Elective	2-3
	Total	11-12

** See, Generic Program Admission Requirements Chart for information on Freshmen and Sophomore curriculum requirements.

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Table 27

Curriculum Outline for Generic Baccalaureate Program - 1980

Unique Features of the Curriculum for Generic Students:

Upper Division

The junior and senior year of the Nursing Curriculum are offered at the University. The curriculum is based on an integrative model whereby students are taught by a group of teachers who have specialized knowledge and skills in the area of maternal-child, psychiatric-community mental health, medical-surgical and community health nursing. All students work toward the same course objectives, although the teaching--learning methods may vary among faculty.

A faculty--student ratio of approximately 1:10 creates a learning situation whereby students have sufficient opportunity to learn the clinical skills required of professional nurses. Student placement for the junior year is an administrative decision. A lottery is used to make decisions concerning senior student placements.

The goal of nursing care is to assist man to reach his highest level of functioning compatible with health. Consequently, the curriculum focuses on the development of the requisite interpersonal and cognitive skills such as problem-solving, discriminative thinking and making nursing judgments as well are technical skills. The curriculum is best described as one which emphasizes the psychosocial needs of man without negating the importance of physical and spiritual needs.

A typical plan of study for the upper division nursing major follows:

Junior Year		Credits
Fall Semester		
*NURS 314	Concepts of Nursing I	9
**NURS 318	Special Topics - Electives in Health Related Courses	3
*NURS 316	Human Growth and Development	3
	Total	15
Winter Session (Month of January)		
*NURS 317	Deviations in Human Growth and Development	2
*NURS 320	Introduction to the Administration of Medications and Basic Life Support	1
	Total	3
Spring Semester		
*NURS 315	Concepts of Nursing II	9
*NURS 310	Pathophysiology and its Pharmacological Implications	4
NURS 321	Introduction to Organizational Behavior	3
	Total	16

*These courses are challenged by R.N. students after applying to the upper division (Advanced Placement Examinations Nurs 457, 554 and 503 are equivalent to credits for Nurs 314 and Nurs 315 above)

**Course not required for the registered nurse.

Table 27 (continued)

Senior Year

Fall Semester	Credits
NURS 324 or 325 Concepts of Nursing IIIA or B	9
*NURS 322 Nursing in Society	3
*NURS 410 Survey of Research and Statistics	3
Total	15
Winter Session	
NURS 326 Clinical Nursing Elective	3
Total	3
Spring Semester	
NURS 324 or 325 Concepts of Nursing IIIA or B	9
**NURS 418 Special Topics - Electives in Health - Related Courses	2-3
Total	11-12

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Table 28

Curriculum Outline for R.N. Baccalaureate Program - 1960

Curriculum	Credits
General Requirements	
Eng. 1 Composition and American Literature	3
Eng. 2 Composition and American Literature	3
Eng. 3 and 4 Composition and World Literature	6
or	
Eng. 5 and 6 Composition and English Literature	6
G & P 1 American Government	3
Soc. 1 Sociology of American Life	3
H. 5 History of American Civilization	3
H. 6 History of American Civilization	3
Special Requirements	
Microb. 1 Microbiology	3-4
Microb. 101 Pathogenic Microbiology	3-4
Chem. 1 General Chemistry	4
Chem. 3 General Chemistry	4
or	
Chem. 11 General Chemistry	3
Chem. 13 General Chemistry	3
Zool. 558 Development of the Human Body	2
Nursing Requirements	
Nurs. 9 Nursing in Child Health	2
Nurs. 108 Applied Psychology	2
Program for Registered Nurses	
Nurs. 156 Public Health Nursing I	2
Nurs. 157 Public Health Nursing II	4
Nurs. 154 Principles of Management in a Nursing Unit	2
Nurs. 158 Biostatistics	3
Nurs. 153 Public Health	2
Nurs. 199 Pro-Seminar	2
Nurs. 159 Clinical Practicum	2
Additional Requirements	
Hea. 120 Teaching Health	3
Psych. 1 Introduction to Psychology	3
Sp. 1 Public Speaking	3
Sp. 10 Group Discussion	2
or	
Sp. 103 Speech Composition and Rhetoric	3
Ed. 90 Development and Learning	3
P.E. 160 Theory of Exercise	3
Nut. 114 Nutrition for Health Services	3
Soc. 164 The Family and Society	3
Zool. 55 Development of the Human Body	2
Nursing Electives	
Nurs. 189 Workshops and Institutes	1-6

Electives may be selected, after consultation with the adviser.

Table 28 (continued)

A total of 128 semester credit hours are required for the degree Bachelor of Science in Nursing. A minimum of 30 semester hours must be completed in residence for a baccalaureate degree. Credit earned through the University is residence credit.

Public Health Field Experience

Due to the maturity and background of the registered nurse student, eight weeks of public health field experience is required rather than the thirteen weeks which is required in the basic collegiate program. Registered nurses who have been employed in public health nursing, or have had supervised experience as a student, should submit an official record of this experience for evaluation.

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Table 29

Curriculum Outline for R.N. Baccalaureate Program - 1965

	Credits
General Requirements	
Eng. 1 Composition	3
Eng. 3 & 4 World Literature	6
Soc. 1 Introduction to Sociology	3
*Hist. History (Non-U.S.)	3
**Hist. History (United States)	3

*Recommended courses are: Hist. 31, 32, 41, 42, 51, 52, 53, 54, 61, 62, 71, 72.

**Recommended courses are: Hist. 21, 22, 23, 24, or 29.

Special Requirements	
Microb. 1 General Microbiology	3-4
Microb. 101 Pathogenic Microbiology	3-4
Chem. 1 General Chemistry	4
Chem. 3 General Chemistry	4
Zool. 1 General Zoology	4
Zool. 55 Development of Human Body	2
Phys. 3 Introduction to Physics	4
Nursing Requirements	
Nurs. 153 Public Health	2
Nurs. 154 Principles of Management of a Nursing Unit	2
Nurs. 156 Public Health Nursing	5
Nurs. 158 Biostatistics	3
Nurs. 159 Clinical Practicum	2
Nurs. 160 Comprehensive Nursing Care	5
Nurs. 199 Pro-Seminar	2
Additional Requirements	
H.D. Ed. 107 Growth and Development in Early Childhood	3
Math. 10 Introduction to Mathematics	3
Psych. 1 Introduction to Psychology	3
Sp. 1 Public Speaking	3
Psych. 110 Educational Psychology	3
P.E. 160 Theory of Exercise	3
Nut. 114 Nutrition for Health Services	3
Soc. 164 Family and Society	3
Anthrop. 105 Cultural Anthropology	3
Elective	
Nurs. 189 Electives Workshops and Institutes	1-6

Electives may be selected after consultation with the adviser.

A minimum of 138 semester credits is required for the B.S. in Nursing.

Public Health Field Experience: Due to the maturity and background of the registered nurse student, eight weeks of public health field experience rather than the thirteen weeks which is required in the basic collegiate program. Registered nurses who have been employed in public health nursing or have had supervised experience as a student, should submit an official record of this experience for evaluation.

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Table 30

Curriculum Outline for R.N. Baccalaureate Program - 1970 *

Revised Curriculum

The registered student nurse must complete lower division courses required for freshman and sophomore students through enrollment in day or evening classes or through transfer. Following completion of these requirements with a C or higher average, such students may apply to establish credit for certain nursing courses by examination. Information concerning the procedure is available from the School of Nursing. Prior to the initiation of the clinical portion of the revised baccalaureate curriculum in the fall of 1971 the registered nurse student should complete the following:

	Credits
Social Sciences - (Psychology, Sociology, Anthropology)	9
Electives	12
Nursing 153 - Public Health	2
Nursing 154 - Principles of Management of Nursing Unit	2
Nursing 155 - Survey of Professional Nursing	2
Nursing 156 - Public Health Nursing	5
Nursing 158 - Biostatistics	3
Nursing 159 - Clinical Practicum	2
Nursing 160 - Comprehensive Nursing Care	5
Nursing 199 - Pro-Seminar	2
Total	44

*Standard Curriculum as indicated in 1965 chart.

**See chart on lower division entrance requirements for generic students.

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Table 31

Curriculum Outline for R.N. Baccalaureate Program - 1975**

Establishing credit by examination: After admission to the School of Nursing, registered nurses must establish advanced placement by taking examinations for credit in:

		Credits
NURS 310	Pathophysiology - Pharmacology Implications	4
*NURS 314	Concepts of Nursing I	9
*NURS 315	Concepts of Nursing II	9
NURS 316	Human Growth and Development	3
NURS 317	Deviations in Human Growth and Development	2
NURS 320	Introduction to the Administration of Medications	1

*A minimum grade of "C" is required on each Challenge Examination for Concepts of Nursing courses.

Applications for advancement or transfer to the campus: they must be filed on campus by February 15 for the fall semester. The nature of the curriculum dictates that students, both basic and registered nurse, may enter the junior year in the fall semester only. In all cases, admission to the campus must be restricted to those who can be accommodated by existing clinical facilities and nursing faculty.

Curriculum: the undergraduate program of study for R.N. students who have met the requirements for the preprofessional courses and have established credit through satisfactory completion of challenge examinations follows:

Senior Year

Fall Semester		
NURS 334	Concepts of Nursing IV A	9
NURS 321	Introduction to Organizational Behavior	3
NURS 410	Survey of Research and Statistics	3
	Total	15
Winter Session		
NURS 326	Clinical Nursing Elective	3
	Total	3
Spring Semester		
NURS 335	Concepts of Nursing IV B	9
NURS 418	Health Elective	3
NURS 322	Nursing in Society	3
	Total	15

**See R.N. Baccalaureate Entrance Requirements for Freshmen and Sophomore Curriculum.

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Table 32

Curriculum Outline for R.N. Baccalaureate Program - 1980

Advanced Placement for the Registered Nurse

When the official application for upper division study is received by the School of Nursing, information about the Advanced Placement Examinations is forwarded to the applicant and includes study guides and registration forms for all the examinations. The required advanced placement examination are as follows:

		Credits
NURS 310	Pathophysiology - Pharmacological Implications	4
NURS 316	Human Growth and Development	3
NURS 317	Deviations in Human Growth and Development	2
*NURS 320	Introduction to Administration of Medications and Basic Life Support	1
**NURS 457	Maternal and Child Health Nursing	Total of 18 credits for these three examinations
**NURS 554	Adult Nursing	
**NURS 503	Psychiatric/Mental Health Nursing	

Nurs 310, 316, 317 and 320 are prepared by University faculty members. Nurs 457, 554 and 503 are prepared by the American College Testing Center. Those who would like to contact the Center directly may do so by writing to the following address: ACT PEP
2201 North Dodge Street
P.O. Box 168
Iowa City, Iowa 52243

*A minimum grade of "C" is required on this advanced placement examination.
**A minimum average score of 45 is required on these 3 tests.

If an applicant fails Nurs 310, 316, 317 or 320, he must take the courses after matriculating in the program. Decisions as to when these courses are to be taken are the responsibility of the Director of Admissions and Academic Progressions. Students have two attempts to successfully pass Nurs 457, 554 and 503. Students who fail to pass these tests on the second attempt are allowed to apply to the generic program.

Advanced placement examinations must be retaken if the student does not matriculate in the upper division course of study within two years.

Unique Features of the Curriculum for Registered Nurse Students:

Upper Division

The curriculum developed for the registered nurse is planned to maximize the strengths the registered nurse brings to the baccalaureate program. The registered nurse is viewed as an adult learner who possesses the special characteristics of a diverse life, educational and clinical experiences, and a high level of motivation that fosters independent and collaborative learning.

Table 32 (continued)

Clinical practice areas for the registered nurse are provided through arrangements with a wide variety of hospitals and other health agencies. All clinical coursework is under the supervision of faculty of the School of Nursing. Students are assigned to any one of a number of different agencies for the purpose of accomplishing the course objectives as determined by faculty.

A typical plan of full-time study appears below for R.N. students who have met the requirements for the preprofessional courses and have established credit through satisfactory completion of advanced placement examinations.

		Credits
Fall Semester		
NURS 334	Concepts of Nursing IVA	9
NURS 321	Introduction to Organizational Behavior	3
NURS 410	Survey of Research and Statistics	3
	Total	15
Winter Session (Month of January)		
NURS 326	Clinical Nurse Elective or NURS 348 Seminar, Workshop	3
	Total	3
Spring Semester		
NURS 335	Concepts of Nursing IVB	9
NURS 418	Special Topics - Electives in Health-Related Courses	3
NURS 322	Nursing in Society	3
	Total	15

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credit provided the course challenged and the grade earned are determined acceptable.

Graduate Program - Master's and Doctoral Programs

The graduate school curriculum in 1960 offers five major and two areas of role preparation at the master's level. The five majors are: nursing service administration, nursing education administration, psychiatric nursing, maternal-child nursing, and medical-surgical nursing. When the clinical major is selected by the student, a role preparation track in either administration of education or nursing service is required.

The curriculum calls for the completion of thirty credit hours of graduate work, six of which are for the thesis. Twelve of the twenty-four course work hours must be in the major, and a minimum of eight in the minor or role area of concentration. Thus, if a student majors in administration the minor course work must be taken in a clinical area. On the other hand, should the student elect to major in a clinical area, minor course work would be devoted to administration in either service or education (See Table 33 for full course outline).

A substantial amount of change is seen in the master's program by 1965. It is now advertised as one preparing registered nurses with baccalaureate degrees for professional leadership as administrators in service and education, and as clinical specialists in maternal-child nursing, medical-surgical nursing, general or child psychiatric nursing and public health nursing. The nursing

Table 33

Curriculum Outline for the Master's Program - 1960

Graduate Curricula

Nursing Administration

Major Objective: To develop competence in nursing administration so that selected students following a graduate core of clinical nursing may be prepared as administrators in nursing service and/or nursing education.

Central Objective for Field Experience and Seminars: Ability to administer and direct successfully a nursing service in a hospital and/or an educational program for basic students in a professional school of a university and/or university school.

Psychiatric Nursing

	Credits
Fall Semester	
Nurs. 201 Trends in Higher Education in Nursing	2
Nurs. 202 Interpersonal Interaction	2
Nurs. 204 Psychiatric Nursing	2
Nurs. 214 Application of Principles of Physical and Social Sciences in Nursing	3-4
Nurs. 286 Research Methods and Materials in Nursing	2
Minor Subjects	3-4
Spring Semester	
Nurs. 203 Nursing in Somatic Therapies	2
Nurs. 205 Psychiatric Nursing	2
Nurs. 206 Philosophical Concepts of Health	2
Nurs. 287 Seminar in Nursing (Teaching or Supervision)	2
Minor Subjects	5-6
Summer Session	
Nurs. 399 Research-Thesis	6

Maternal and Child Health

Fall Semester	
Nurs. 201 Trends of Higher Education in Nursing	2
Nurs. 207 Nursing in Child Health Services	2
or	
Nurs. 209 Nursing in Maternal and Newborn Services	2
Nurs. 214 Application of Principles of Physical and Social Science of Nursing	2
Nurs. 286 Research Methods and Materials in Nursing	2
H.D. Ed. 200 Introduction to Human Development and Child Study	3
Minor Subjects	3
Spring Semester	
Nurs. 206 Philosophical Concepts of Health	2
Nurs. 208 Nursing in Child Health Services	2
or	
Nurs. 210 Nursing in Maternal and Newborn Services	2
Nurs. 211 Seminar in Maternal and Child Health Services	2
Nurs. 287 Seminar in Nursing (Teaching or Supervision)	2
Minor Subjects	5-6

Table 33 (continued)

	Credits
Summer Session	
Nurs. 399 Research-Thesis	6
Medical and Surgical Nursing	
Fall Semester	
Nurs. 201 Trends of Higher Education in Nursing	2
Nurs. 212 Medical-Surgical Nursing	2
Nurs. 214 Application of Principles of Physical and Social Science in Nursing	2
Nurs. 286 Research Methods and Materials in Nursing	2
Minor Subjects	6
Spring Semester	
Nurs. 213 Medical-Surgical Nursing	2
Nurs. 206 Philosophical Concepts of Health	2
Nurs. 287 Seminar in Nursing (Teaching or Supervision)	2
Minor Subjects	4
Summer Session	
Nurs. 399 Research-Thesis	6

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service administration and educational minor is still available for clinical majors, in addition to a minor in clinical specialization. Preparation for a career in teaching is also now offered as a minor area of concentration. Thus, seven majors are now available, and four role preparation areas - educational administration, nursing service administration, clinical specialization, and teaching of nursing (See Table 34 for full course outline).

The program areas now vary markedly in terms of course requirements and program length. The curriculum plan for the programs in educational administration and nursing service administration are more highly delineated. These programs are now three semesters in length, requiring 40 credit hours, 34 in course work and 6 in thesis. Twenty-two of the 34 must be in the major and 12 in the minor. Twenty-two hours are required at the 200 level or above.

In the program preparing for practice in general psychiatric nursing, 36 semester hours, 30 in course work and 6 in thesis are expected. Eight semester hours are necessary in the minor field and 20 semester hours at the 200 level or above. The program is planned over three semesters.

The child psychiatry curriculum outline calls for 53 semester hours of academic work over four semesters. No further specific requirements are listed in the catalog. The program in medical-surgical nursing requires 35 semester hours, with a 29 hour course work requirement, 12 semester hours of which

Table 34
Curriculum Outline for the Master's Program - 1965

I. Administration in Nursing Education

A general requirement for graduate students majoring in the area of administration is the completion of three to five years of satisfactory experience in teaching or supervision.

	Credits
First Semester-Fall	
Nurs. 201 Trends of Higher Education in Nursing	2
Nurs. 285 Curriculum Development in Nursing	2
Nurs. 286 Research Methods and Materials in Nursing	2
Nurs. 290 Administration in Nursing	3
Minor Subjects	6
Second Semester-Spring	
Nurs. 203 Nursing in Somatic Therapies	2
Nurs. 287 Seminar in Nursing Administration	2
Nurs. 288 Special Problems in Nursing: Research in Nursing	2
Nurs. 290 Administration in Nursing	3
Minor Subjects	3
Third Semester-Fall	
Nurs. 288 Special Problems in Nursing (Directed Experience)	2
Nurs. 288 Special Problems in Nursing (Clinical Nursing-area of choice)	2
Nurs. 399 Research-Thesis	6
Minor Subjects	3

II. Administration in Nursing Service

A general requirement for graduate students majoring in the area of administration is the completion of three to five years of satisfactory experience in management or supervision in nursing service.

First Semester-Fall	
Nurs. 201 Trends of Higher Education in Nursing	2
Nurs. 285 Curriculum Development in Nursing	2
Nurs. 286 Research Methods and Materials in Nursing	2
Nurs. 290 Administration in Nursing	3
Minor Subjects	6
Second Semester-Spring	
Nurs. 203 Nursing in Somatic Therapies	2
Nurs. 287 Seminar in Nursing (Service)	2
Nurs. 288 Special Problems in Nursing-Research in Nursing	2
Nurs. 290 Administration in Nursing	3
Minor Subjects	3
Third Semester-Fall	
Nurs. 288 Special Problems in Nursing (Directed Experience)	2
Nurs. 288 Special Problems in Nursing (Clinical Nursing-area of choice)	2
Nurs. 399 Research-Theses	6
Minor Subjects	3

Table 34 (continued)

III. Nursing of Children with Psychiatric Disorders-Teaching, Supervision Clinical Specialist

First Year of Program	Credits
Fall Semester	
Nurs. 201 Trends of Higher Education in Nursing	2
Nurs. 202 Interpersonal Interaction	2
Nurs. 204 Psychiatric Nursing	2
Nurs. 288 Special Problems in Nursing-Orientation to Critical Problems in Family-Child Relationships	2
H.D. Ed. 200 Introduction to Human Development and Child Study	3
Minor Subjects	3
Spring Semester	
Nurs. 203 Nursing in Somatic Therapies	2
Nurs. 205 Psychiatric Nursing	2
Nurs. 288 Special Problems in Nursing-Orientation to Critical Problems in Family-Child Relationships	2
Minor Subjects	6
Second Year of Program	
Fall Semester	
Nurs. 250 Comprehensive Care of Children with Psychiatric Disorders	4
Nurs. 285 Curriculum Development in Nursing	2
Nurs. 286 Research Methods and Materials in Nursing	2
Nurs. 399 Research-Thesis	3
H.D. Ed. 208 Self Processes in Human Development I	3
H.D. Ed. 250 Direct Study of Children	1
Spring Semester	
Nurs. 251 Nursing of Pre-School Children with Deviate Behavior	4
Nurs. 252 Nursing of Children with Normal Behavior	2
Nurs. 287 Seminar in Nursing-Teaching or Supervision	2
Nurs. 288 Special Problems in Nursing-Research in Nursing	2
Nurs. 399 Research-Thesis	3

IV. General Psychiatric Nursing-Teaching, Supervision, Clinical Specialist

First Semester-Fall	
Nurs. 201 Trends of Higher Education in Nursing	2
Nurs. 202 Interpersonal Interaction	2
Nurs. 204 Psychiatric Nursing	2
Nurs. 286 Research Methods and Materials in Nursing	2
Soc. 180 Small Group Analysis	3
Minor Subjects	3
Second Semester-Spring	
Nurs. 203 Nursing in Somatic Therapies	2
Nurs. 205 Psychiatric Nursing	2
Nurs. 288 Special Problems in Nursing (Research)	2
Minor Subjects	6

Table 34 (continued)

	Credits
Third Semester-Fall	
Nurs. 285 Curriculum Development in Nursing	2
Nurs. 287 Seminar in Nursing-Teaching or Supervision	2
Nurs. 399 Research-Thesis	6
V. Maternal and Child Nursing-Teaching, Supervision, Clinical Specialist	
Fall Semester	
Nurs. 201 Trends of Higher Education in Nursing	2
Nurs. 207 Nursing in Child Health Services	2
or	
Nurs. 209 Nursing in Maternal and Newborn Services	2
Nurs. 215 Nursing Care of the Emotionally Disturbed Pre-School Child (Concurrent with Nurs. 207)	2
Nurs. 285 Curriculum Development in Nursing	2
Nurs. 286 Research Methods and Materials in Nursing	2
Nurs. 288 Special Problems in Nursing-Core in Maternal and Child Nursing	2
H.D. Ed. 200 Introduction to Human Development and Child Study	3
or	
Soc. 164 The Family and Society	3
Spring Semester	
Nurs. 203 Nursing in Somatic Therapies	2
Nurs. 208 Nursing in Child Health Services	2
or	
Nurs. 210 Nursing in Maternal and Newborn Services	2
Nurs. 211 Seminar in Maternal and Child Health Services	2
Nurs. 287 Seminar in Nursing: Teaching or Supervision	2
Nurs. 288 Special Problems in Nursing-Research	1-2
Minor Subjects	5-6
Summer Session	
Nurs. 399 Research-Thesis	6
VI. Medical and Surgical Nursing-Teaching, Supervision, Clinical Specialist	
Fall Semester	
Nurs. 201 Trends of Higher Education in Nursing	2
Nurs. 212 Medical and Surgical Nursing	2
Nurs. 285 Curriculum Development in Nursing	2
Nurs. 286 Research Methods and Materials in Nursing	2
Nurs. 288 Special Problems in Nursing-Clinical Nursing	2
Minor Subjects	3-5
Spring Semester	
Nurs. 203 Nursing in Somatic Therapies	2
Nurs. 213 Medical-Surgical Nursing	2
Nurs. 287 Seminar in Nursing-Teaching or Supervision	2
Nurs. 288 Special Problems in Nursing-Research	2
Minor Subjects	3-5
Summer Session	
Nurs. 399 Research-Thesis	6

Table 34 (continued)

VII. Public Health Nursing-Teaching or Supervision	Credits
First Semester-Fall	
Nurs. 201 Trends of Higher Education in Nursing	2
Nurs. 220 Public Health Nursing	2
Nurs. 286 Research Methods and Materials in Nursing	2
Nurs. 288 Special Problems in Nursing-Chronic Disease Control and Rehabilitation	2
Nurs. 158 Biostatistics	3
Minor Subjects	3
Second Semester-Spring	
Nurs. 203 Nursing in Somatic Therapies	2
Nurs. 206 Philosophical Concepts of Health-Epidemiology	2
Nurs. 221 Public Health Nursing	2
Nurs. 222 Public Health Administration	2
Nurs. 288 Special Problems in Nursing-Research in Nursing	2
Minor Subjects	3
Third Semester-Fall	
Nurs. 285 Curriculum Development in Nursing	2
Nurs. 287 Seminar in Nursing-Teaching or Supervision	2
Nurs. 288 Special Problems in Nursing: Communicable Diseases and Rehabilitation	2
Nurs. 399 Research-Thesis	6
Minor Subjects	3

Source: Institutional Site Catalog: Reproduced with Permission of the Educational Institution

must be at the 200 level or above. Twelve semester hours are required in the major and 8 in the minor field. Program length is not identified.

The maternal-child offering is also 35 semester hours in length with a 29/6 split between course work and thesis. It's requirements for major/minor and 200 level courses are the same as those expected in medicine-surgery.

The public health program requires 39 semester hours for a 33/6 allocation for course work and thesis. Eight hours are required in the minor, 20 at the 200 level or above, and three semesters for program completion.

In 1970, the school catalog shows no change in the program area offerings. Requirements regarding program length have now stablized at three semesters, with child psychiatric nursing still requiring a four semester commitment. Programs vary in terms of semester hours required due to the introduction of the non-thesis option (See Table 35). Seven major areas of curriculum concentration continue to be offered - administration (service or education), maternal-child, medical-surgical, general or child psychiatry, and public health. Role preparation is now limited to clinical specialization, administration and teaching.

The school catalog indicates that the primary purpose of the graduate program is to prepare nurses for leadership positions. Further, it states that primary emphasis is placed on preparation

Table 35

Curriculum Outline for Master's Program - 1970

Maternal and Child Nursing
Clinical Specialist, Teaching or Administration

First Semester-Fall		Credits
NURS 201	Trends of Higher Education in Nursing	2
NURS 207	Nursing in Child Health	3
	or	
NURS 209	Nursing in Maternal and Newborn Services	3
NURS 231	Scientific Basis for Maternal and Child Nursing (Genetics)	2
NURS 288	Special Problems in Nursing (Physiology)	3
NURS 286	Research Methods and Materials in Nursing	2
EDHD 200	Introduction to Human Development and Child Study	3
	or	
Minor Subjects		3
Second Semester-Spring		
NURS 285	Curriculum Development in Nursing	2
NURS 208	Nursing in Child Health	3
	or	
NURS 210	Nursing in Material and Newborn Services	3
NURS 211	Seminar in Maternal and Child Health Services	3
NURS 288	Special Problems in Nursing (Physiology)	3
Minor Subjects		3-6
Third Semester-Fall		
NURS 287	Seminar in Nursing-Clinical Specialty, Teaching or Administration	2
NURS 399	Research-Thesis	6
	or	
Minor Subjects for those electing non-thesis option		3-6

Medical and Surgical Nursing
Clinical Specialist, Teaching or Administration

First Semester-Fall		
NURS 201	Trends of Higher Education in Nursing	2
NURS 212	Medical and Surgical Nursing	2
NURS 288	Special Problems in Nursing (Physiology)	3
NURS 286	Research and Materials in Nursing	2
Minor Subjects		3-6
Second Semester-Spring		
NURS 285	Curriculum and Development in Nursing	2
NURS 213	Medical and Surgical Nursing	2
NURS 288	Special Problems in Nursing (Physiology)	3
NURS 202	Interpersonal Interaction	2
Minor Subjects		3-6
Third Semester-Fall		
NURS 287	Seminar in Nursing-Clinical Specialist, Teaching, Administration.	2
NURS 214	Application of Principles from Biological and Social Sciences to Nursing	2
NURS 289	Process of Administration in Nursing	3
NURS 399	Research-Thesis	6
	or	
Minor Subjects for those electing non-thesis option		3-6

Table 35 (continued)

Child Psychiatric Nursing
Clinical Specialist, Teaching or Administration

	Credits
First Semester-Fall	
NURS 201 Trends of Higher Education in Nursing	2
NURS 202 Interpersonal Interactions	2
NURS 204 Psychiatric Nursing	2
NURS 247 Orientation to Critical Problems in Family-Child Relationships	2
EDHD 200 Introduction to Human Development and Child Study	3
Minor Subject	3
Second Semester-Spring	
NURS 205 Psychiatric Nursing	2
NURS 288 Special Problems in Nursing-Family Therapy	2
NURS 248 Orientation to Critical Problems in Family-Child Relationships II	2
NURS 249 Nursing of Pre-school Children with Deviate Behavior	2
Minor Subjects	3-6
Third Semester-Fall	
NURS 286 Research Methods and Materials in Nursing	2
NURS 250 Comprehensive Child Psychiatric Nursing	4
NURS 287 Seminar in Nursing-Clinical Specialist, Teaching or Administration.	2
Minor Subjects	3-6
Fourth Semester-Spring	
NURS 285 Curriculum Development in Nursing	2
NURS 251 Comprehensive Child Psychiatric Nursing II	4
NURS 399 Research-Thesis	6
or	
Minor Subjects for those electing non-thesis option	3-6

General Psychiatric Nursing
Clinical Specialist, Teaching or Administration

First Semester-Fall	
NURS 201 Trends of Higher Education in Nursing	2
NURS 202 Interpersonal Interactions	2
NURS 204 Psychiatric Nursing	2
NURS 286 Research Methods and Materials in Nursing	2
SOCY 180 Small Group Analysis	3
or	
NURS 289 Process of Administration in Nursing	3
Minor Subject	3
Second Semester-Spring	
NURS 285 Cucciculum Development in Nursing	2
NURS 205 Psychiatric Nursing	2
NURS 288 Special Problems in Nursing-Family Therapy	2
Minor Subjects	3-6

Table 35 (continued)

	Credits
Public Health Nursing	
Clinical Specialist, Teaching or Administration	
First Semester-Fall	
NURS 201 Trends of Higher Education in Nursing	2
NURS 220 Public Health Nursing	2
NURS 286 Research Methods and Materials in Nursing	2
PREV MED 158 Biostatistics	3
NURS 288 Special Problems in Nursing-Communication in Community Health Nursing	2
Minor Subjects	3
Second Semester-Spring	
NURS 285 Curriculum Development in Nursing	2
NURS 206 Philsophical Concepts of Health-Epidemiology	2
NURS 221 Public Health Nursing	2
Minor Subjects	3-6
Third Semester-Fall	
NURS 288 Special Problems in Nursing-Contemporary Issues in Community Health Nursing	2
NURS 287 Seminar in Nursing-Clinical Specialist, Teaching or Administration.	2
NURS 399 Research-Thesis	6
or	
Minor Subjects for those electing non-thesis option	3-6

Table 35 (continued)

	Credits
Third Semester-Fall	
NURS 287 Seminar in Nursing-Clinical Specialist, Teaching or Administration	2
NURS 288 Special Problems in Nursing-Practicum in Teaching or Clinical Specialty	4
NURS 290 Practicum in Administration in Nursing	
NURS 399 Research-Thesis	6
or	
Minor Subjects for those electing non-thesis option	3-6
Administration of Nursing Service or Education	
First Semester-Fall	
NURS 201 Trends of Higher Education in Nursing	2
NURS 286 Research Methods and Materials in Nursing	2
NURS 289 Process of Administration	3
*NURS 204 or NURS 207 or NURS 209 or NURS 212	
Minor Subjects	3-6
Second Semester-Spring	
NURS 285 Curriculum Development in Nursing	2
NURS 290 Administration of Nursing	3
*NURS 205 or NURS 208 or NURS 210 or NURS 213	
Minor Subjects	3-6
Third Semester-Fall	
NURS 291 Practicum in Administration of Nursing	4
NURS 399 Research-Thesis	6
or	
Minor Subjects for those electing non-thesis option	6

*Clinical courses in medical-surgical, maternal-child, and psychiatric nursing. Credit hours vary accordingly.

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for advanced clinical practice. The major in administration is not mentioned in this narrative sequence.

As previously indicated the non-thesis option appears in the 1970 catalog. Students electing this option are required to take 3-6 additional semester hours of elective course work. Further, they submit to their major advisor two scholarly seminar papers. The catalog indicates that one of these papers may be an extensive review of literature. The other must be a report of research in nursing undertaken by the student. Finally, a comprehensive examination is now required of all students during the semester in which degree award is anticipated.

In 1975, graduate curriculum includes, five majors in clinical nursing and three areas for role or career development. The majors are in child psychiatric or general psychiatric nursing, maternal-child nursing, medical-surgical nursing and community (public health) nursing. Role tracks are offered in administration, teaching and clinical specialization. The administration major in service and education has been discontinued (See Table 36).

Program requirements are not specifically identified in the 1975 school catalog. Rather, the narrative indicates that the student's courses must constitute a unified program approved by the major advisor and the Graduate School. Completion of a basic course in statistics is now required prior to admission, and beginning competence in research is promoted through the inclusion of courses in research and statistics.

Table 36
Curriculum Outline for Master's Program - 1975

Clinical Areas of Emphasis

Child Psychiatric Nursing
Community Health Nursing
General Psychiatric Nursing
Maternal and Child Health Nursing
Medical-Surgical Nursing

Career Development

Administration of Nursing
Clinical Specialization
Teaching of Nursing

Program Requirements

The entire course of study must constitute a unified program approved by the student's major adviser and by the Graduate School. Nursing faculty in each department provide individualized guidance in the selection of courses based upon guidelines and policies approved by the Graduate Curriculum Committee and the Graduate School.

Considerable flexibility is possible within the framework of a student's clinical area of interest and specific career goals. Beginning competence in research is provided by inclusion of courses in research and statistics. Basic statistics is prerequisite to the program.

Inasmuch as possible, clinical theory and practice are integrated. Each student completes a functional practicum designed cooperatively by the student and faculty members. Support courses are recommended not only for the clinical areas of emphasis but also for career development and research.

All students must successfully pass a comprehensive written examination. Additional regulations and requirements may be found in the campus bulletin of the Graduate School and in Important Dates for Advisers and Students, issued each year by the Graduate School.

Students may elect either a thesis or non-thesis option. A decision should be made rather early in the program to assist with curricular planning.

Source: Institutional Site Catalog: Reproduced with Permission of the Educational Institution

A comprehensive examination is still required of all students, and the non-thesis option continues. One change in this area is noted. Six semester hours of additional electives are required and one scholarly seminar paper which may be orally defended. This fixes the elective requirement for the first time (previously 3-6), and reduces the scholarly papers from two to one. The possibility of oral defense is mentioned.

In 1980, the programs leading to the Master of Science degree are listed as requiring three semesters for completion of 41-45 credits. Those clinical areas (medicine-surgery, maternal-child) offering primary care as a major require four semesters for completion.

Ten major areas of study are now offered (See Table 37). Maternal-child nursing further subdivides their specialization into pediatrics or obstetrical nursing, thus, twelve majors are possible. For those students electing to major in administration, education or health policy, a clinical concentration must also be identified. Further, students must select a functional role track from a total of seven options. The possible combinations (major/minor/role) are markedly expanded over those previously cited. Majors in administration, education, gerentology nursing, primary care nursing, and nursing health policy are new curriculum options in this year. Administration in education and service reappear as functional preparatory options, and teaching is broken down to focus on associate degree, baccalaureate and staff development education. Nursing health policy also emerges as a functional preparation track.

Table 37

Curriculum Outline for the Masters Program - 1980

Curriculum: Master of Science Degree

The nursing program leading to a Master of Science degree is three semesters and a mini-semester in length and requires the completion of 41-45 credits. The two exceptions are the Primary Care Nursing specialties requiring 54 credits and four semesters.

Starting on the first day of matriculation, a time limit of a maximum of five years is allowed for the completion of graduate degree requirements. This applies to part-time and full-time students.

Areas of Concentration

Each student selects a clinical practice area and a functional role area. The student then chooses either one of these as the area of concentration (major).

The students selects one area of concentration (major) from the following:

Administration
Child Psychiatric Nursing
Community Health Nursing
Education
General Psychiatric Nursing
Gerontological Nursing
Maternal and Child Health Nursing (Nursing of Children or Maternal-Infant Nursing)
Medical-Surgical Nursing
Nursing Health Policy
Primary Care Nursing (Adult or Pediatric)

For those choosing to major in administration, education or nursing health policy, a clinical practice area must also be selected from one of the following:

Community Health Nursing
Maternal and Child Health Nursing
Medical-Surgical Nursing
Psychiatric Nursing or Child Psychiatric Nursing

In addition, all students select a functional role track from one of the following:

Administration of Nursing Service
Administration of Nursing Education
Teaching in Associate Degree Program
Teaching in Baccalaureate Degree Program
Teaching in Staff Development
Clinical Nurse Specialization
Nursing Health Policy

Table 37 (continued)

Curriculum Design

In summary, the curriculum design contains the following components:

1. Core courses required of all graduate students regardless of the area of concentration.
2. Clinical courses required of students in their chosen clinical area (i.e., Community Health, Gerontological, Psychiatric, Child Psychiatric, Medical-Surgical, Maternal and Child or Primary Care Nursing). All students take a designated number of these courses regardless of whether their area of concentration is in clinical practice or role specialization.
3. Functional role track courses required of students in their chosen functional role (i.e., Administration in Nursing Service, Administration in Nursing Education, Teaching in A.D. Program, Teaching in B.S. Program, Teaching in Staff Development, Clinical Nurse Specialization and Nursing Health Policy). All students take a designated number of these courses regardless of their area of concentration.
4. Research courses required of all graduate nursing students.
5. Support courses vary according to the student's area of concentration. These might include non-nursing courses.

Summary of Design

	Credits	
General Plan:		
Core	10	
Clinical	6	
Role	6	
Support	8-12	
Research	5	
Thesis/Electives	6	
Total	41-45	
Gerontological Nursing:		
Core	10	
Clinical	6	
Role	6	
Support	11-12	(includes 6 credits for second clinical area)
Research	5	
Thesis/Electives	6	
Total	44-45	
Primary Care Nursing:		
Core	10	
Clinical	15	
Role	6	
Support	9	
Research	5	
Thesis/Electives	6	
Elective-Role Prerequisite	3	
Total	54	

Table 37 (continued)

Thesis/Non-Thesis Option

A student may elect either a thesis or a non-thesis option, depending on the nature of the problem she/he wishes to investigate and her/his career goals; six credits are earned for either option. In addition, all students must successfully pass a written comprehensive examination.

Thesis: Under the guidance of a committee, the student designs, implements evaluates and orally defends a research project.
Non-Thesis: Under the guidance of the adviser, the student takes six credits of electives and submits one scholarly seminar paper.

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The curriculum design is now shaped around five components: 1) core courses required of all students; 2) courses germane to the students clinical area of interest; 3) functional role track courses; 4) research courses, and 5) support courses according to student need and interest. The 1980 catalog lists a general curriculum plan with the above structure in mind, as well as that required for primary care (54 semester hours).

All students are required to successfully pass a written comprehensive exam. The thesis/non-thesis option remains unchanged from 1975, except that all reference to an oral defense of the seminar paper has disappeared.

The major new addition to the school's curriculum in 1980 is a doctoral program designed to grant the Doctor of Philosophy degree. The program design incorporates four major components, for a total of 60 credits beyond the master's degree. The four components of the curriculum are: nursing theory (14 semester hours), research and statistics (16 semester hours), elective courses (18 semester hours), and dissertation research (12 semester hours) (See Table 38 for details).

In addition to course requirements, each student completes a preliminary exam after two semesters of full-time study, a comprehensive exam (oral and written) after the completion of 42 semester hours of course work, and a final oral defense of the dissertation. The curriculum provides for a focus on either the direct (clinical) or indirect (administration, education) spheres of nursing. In-

Table 38
Curriculum Outline for Doctoral Program - 1980

Curriculum: Doctor of Philosophy Degree

The program of study leading to the Doctor of Philosophy degree includes a minimum of 60 semester credits beyond the master's degree. The curriculum design includes a required core of nursing courses which incorporate study of Man, study of nursing action, study of the environments in which nursing is practiced and study of the principles and methods of scientific inquiry. Throughout the required core courses an integrative focus is maintained whereby theoretical and methodological approaches of the biophysical and behavioral-social sciences are selectively applied from the perspective of nursing.

Within the core courses opportunity is provided for students to build upon their educational and experiential backgrounds through a variety of individually selected learning experiences. Elective courses provide additional flexibility to plan a course of study supportive to individual research interests and career goals.

The program design allows students to specialize in either the direct or the indirect sphere of nursing. Depth of knowledge in the specialty area is developed through required course work and related clinical laboratory experience, selection of supportive electives, independent study and the dissertation research.

The program design incorporates four major components, totaling 60 credits, as detailed below.

Nursing Theory 14 Credits

This component addresses the theoretical basis for nursing practice and the analysis and development of nursing theory. Included are the study and development of key concepts in nursing, the selection and integration of knowledge from nursing and other disciplines, and the study of techniques for constructing nursing theory using both inductive and deductive approaches. A highly individualized clinical laboratory experience provides the opportunity to pursue theoretical aspects of specialized areas of nursing selected by the student.

Research and Statistics 16 Credits

This component addresses the techniques of measurement, design, advanced data analysis and evaluation essential to the conduct of nursing research. Students apply these techniques in developing measurement tools and conducting research projects specific to their own interests. Opportunity is provided for each student to work closely with a faculty member engaged in an ongoing research project.

Elective Courses 18 Credits

This component allows each student to pursue an individualized plan of study supportive to his/her research interests and career goals. A portion of the elective courses are chosen from basic sciences which contribute to the development of nursing knowledge through their theoretical and methodological approaches.

Table 38 (continued)

Dissertation Research 12 Credits

Each student must complete an independent original research project to be communicated in a written dissertation. The research must address questions of significance to the discipline of nursing.

Summary of Design:	Credits
Nursing Theory (required core courses)	14
Nursing Research & Statistics (required core courses)	16
Electives	18
Dissertation Research	12
Total	60

In addition to the course requirements, each student must successfully complete the preliminary, comprehensive and final oral examinations. The written preliminary examination, which is taken upon completion of two semesters of full-time study (or the equivalent), tests knowledge in the areas of general nursing theory, analysis and construction of nursing theory, measurement, research design and statistics. The comprehensive examination is taken upon completion of all required nursing courses and a minimum of 42 credit hours of course work. The examination has written and oral components and is an integrative experience which allows evaluation of the student's mastery of the chosen area of specialization and of advanced nursing theory and research. The final oral examination is an oral defense of the completed dissertation.

In accord with Graduate School policy, the student must be admitted to candidacy for the degree of Doctor of Philosophy at least one year prior to graduation. The student may apply for admission to candidacy for the doctoral degree following successful completion (with a grade point average of 3.0 or above) of at least 42 credits of course work, including all required courses; and successful completion of preliminary and comprehensive examinations.

Source: Institutional Site Catalog: Reproduced with Permission of the Educational Institution

dividualized laboratory or practicum experiences are emphasized, and the student is promised a close working relationship with faculty engaged in ongoing research.

In summary, the catalog states that the doctoral program is based on the belief that nursing has a distinct body of knowledge which can and must be extended, verified and revised, utilizing methods of scholarly inquiry.

Continuing Education

In the 1975 catalog a program for continuing education is presented. The narrative indicates that the program is designed to facilitate the life-long learning process of nurses. It offers workshops, short courses, and seminars to build on the basic preparation of the nurse and update knowledge and professional competence in health care delivery.

Analysis

Two major changes are seen in the undergraduate baccalaureate program from 1960-1980. First, a lower-division/upper-division structure is implemented and the medical model curriculum is abandoned in favor of an integrated approach.

The integrated curriculum appears to reflect the realization that the educational process requires more than the transmission of information. Indeed, the school catalog (1970) describes the curriculum as follows:

> The curriculum focuses on cognitive skills such as problem-solving, critical thinking, making nursing judgments, interpersonal skills as well as technical skills. Indeed, the curriculum is best described as one in which emphasis is given to the psychosocial need of man without negating the importance of his physical and spiritual needs.

The curriculum seems to reflect a need to prepare students for continuing change in knowledge and technology, while retaining a humanistic orientation to client need. The registered nurse baccalaureate program changes parallel those of the basic academic program in terms of curriculum, but also acknowledge the maturity students bring to the educational process. Opportunities increase for advanced academic standing, as well as recognition for professional and personal life experiences.

A major change is seen in the program/curriculum offerings in the graduate school program. The opportunities to prepare for specialized nursing practice in 1980 are vastly different than those available in 1960. In 1960, administration and education are the only recognized role specializations in the clinical area of medicine-surgery, maternal-child, and psychiatry. By 1980, twelve major areas of specialization are offered at the master's level, and seven functional role tracks. Nursing practice indirectly related to patient care, previously deleted from the curriculum, reappears in programs for the preparation of administrators, educators, and nursing health policy analysts.

Finally, a doctor in philosophy program, with direct and indirect tracks are developed and implemented between 1975 and 1980. The curriculum speaks heavily to the preparation of nurse researchers.

Data Profile - Control

Control content areas were drawn from findings at the institutional site, archives and public literature. Public literature reported an analysis of the nurse practice act in the state of the institutional site. Archival data referred to appointment, promotion and tenure criteria at the site, and institutional data looked at changes in program and curriculum offerings. Matrix cells three, six and nine are included within the control area. The objective of this profile is to emphasize themes/changes which emerge over time within the control area matrix cells.

The most striking change noted in this content area is the development of specialized roles in the practice of nursing. Both the nurse practice act and the program/curricular changes at the institutional site reveal recognition for and evolution of specialization.

Further, alterations in generic curriculum (as well as others) which emphasized cognitive, analytical skill development in students are seen in the practice act as recognition that nursing is scientifically based, and has the responsibility and ability to make independent judgments, collaborative judgments and act responsibly in dependent or delegated functional areas.

These changes or data themes are not readily demonstrated in the APT data, although the academic credentials, of faculty members do show the evolution of higher standards. The implementation of higher levels of preparation by faculty, did not occur during the

study's time span, but did occur early in 1981. Academic nurses seem to be playing a leadership role in the advancement of nursing. The APT criteria change may herald a new round of escalation activity.

This concludes the report for data gathered in the beliefs, attributes and control content areas. The chapter will conclude with an analysis of data across sources for internal consistency.

Data Profile - Public Literature

Data matrix cells, one, two and three were related to the public literature information source. Addresses by presidents of the ANA, dictionaries, three historical nursing texts and the nurse practice act from the state of the institutional site were utilized in gathering data.

One of the primary findings in the historical nursing texts was a report of studies acknowledging two levels of nursing practice - technical and professional. The Brown Study in 1948 and "An Abstract for Action" (1970) further recommended the implementation of these two levels. It seems clear from the review of ANA presidential addresses that two levels of practice are fully supported by this organization. Further, the 1977 edition of Taber's medical dictionary defines nursing as having two levels of practice - technical and professional.

Even if two levels of practice are recognized, their formal implementation has yet to be achieved. Two factors appear responsible for this situation. The intragroup struggle over the entry issue

among nurses, and the intergroup conflict with others such as physicians, the American Hospital Association and the National League for Nursing among others. Resistance from outside might be overcome if the nursing community could reach consensus, but when resistance from within the occupational group is significant the objective is far less likely to be reached.

The major block that will have to be overcome in establishing two levels of practice is formal recognition in law of the nurse practice act. Currently, the graduates of three different educational programs are all accorded the right to sit for the licensure exam in order to practice nursing. This statute is not likely to change without the support and acceptance by society that such levels exist. To the extent that the dictionary data reflects the views of society, the differences in nursing education programs and the differences in practice are not recognized by society, nor in the case of Duncan by nursing. Thus, it would seem that while progress has been made in some quarters towards recognizing a professional level of nursing practice, society and many nurses have not accepted its existence.

There does, however, appear to be some evidence in the practice act examined herein that a level of awareness is present. The credentials required of Board members and the exclusion of a representative on that body for the diploma sector of the educational system have been realized. Further, the recent acknowledgement that midwives and nurse practitioners fall under the jurisdiction of

the Board does speak to the recognition of a specialized level of practice, as well as advances in self-determination.

Modifications to the act also recognize that a knowledge base is required for practice, and that the practice of nursing includes high level judgment and skill. Further, in 1974 the act did acknowledge that nursing involves independent, as well as dependent acts. This alteration in nursing's contract with society marked the first recognition of independent function. As such, it reflects the views of ANA presidents and Taber's definition. The recognition, however, of two practice levels has not been realized. These changes were not achieved without a high degree of political activity. This activity is in keeping with the views of ANA presidents who proposed that a high level of political activity is required to shape the health care system toward nursing's interests.

Both the presidential addresses and the historical texts supported and reported the movement of nursing education into higher education. Neither the dictionary definitions nor the practice act speak to this issue. It is interesting to note however that Board membership requirements do speak to the need for academic credentials in order to serve.

It should be noted that the issue raised by ANA presidents in their address referring to collective bargaining was not seen in other data from the public literature source. A wellness orientation, however, as an aspect of nursing's role in the health care system was not only found in presidential speeches and nursing

texts, but it was also recognized in the 1974 practice act when the nursing process (assessment, problem identification, implementation and evaluation) was defined as being utilized for purposes of maintaining health and preventing illness.

Direct reimbursement for nursing care, a major thrust in early presidential addresses, was secured by nurse midwives in the nurse practice act reviewed. In the 1980 practice act a committee was provided for oversight of nurse midwife health insurance matters. This issue was not addressed in the historical texts reviewed.

Finally, the strong support for research in nursing found in the inaugural addresses was supported in the texts reviewed. Although not mentioned in nurse practice act legislation there seems little chance that it would be formerly reflected in a state statute. On the other hand, it might proposed that Board membership requirements should call for doctoral preparation by some of its members. Perhaps this requirement will be realized when the number of nurses who earn the credential increase.

Data Profile - Archives

Data cells four, five and six are those related to archival information. These cells were designed to investigate certain characteristics in classified ads, academic credentials earned by faculty at the institutional site and nationally, and review appointment, promotion and tenure criteria at the institutional site.

The preference for academic credentials in Nursing Outlook, a journal primarily directed at the academic nursing community,

showed an almost relentless emphasis on credentials, even in the face of major educational expansion. In 1960, 63.3 percent of the ads stated a requirement or preference for specific degrees; in 1980, 90.4 percent required or expressed a preference for specific credentials. In 1980, only slightly more than half of the ads expressed a desire for experienced personnel.

It should be noted that not only was there an increase in the requirement or preference for academic credentials, but a striking escalation in the type of credentials sought. In the early years, 1960 and 1965, a baccalaureate degree was required and master's preparation preferred. By 1970, preference for doctoral degrees begins to surface, with master's work becoming a requirement. In 1980, the pendulum swung and from 37 to 67 percent of the ads indicate a preference for an earned doctorate.

The effect of this "credential fever" is not directly reflected in the national statistics of full and part time faculty. Only a five percent increase in earned doctorates among faculty in the baccalaureate and higher degree sector is achived during the 1965-1980 period (.065 to .118), and master's degrees only increased from .782 to .803. It is important to remember, however, that these seemingly meager advances were realized during a period of tremendous growth in nursing education programs, when the need for well prepared faculty was understandably high.

Institutional site data does afford another viewpoint, which serves to inform the area of advancing academic preparation for

nursing education. Progress at the institutional site is significant. Not only is a high level of faculty academic preparation maintained during a period of marked growth, but significant advances achieved. Faculty prepared at the doctoral level increased from .089 in 1965 to .026 in 1980.

Unfortunately, credential data from free-standing generic baccalaureate programs is reported with that from institutions featuring specialized master's education and doctoral program, thus comparison with other like institutions in not possible. It seems reasonable to propose that schools with graduate programs are more likely to demonstrate the effects of credentialing pressure. Knowledge regarding this sector of nursing education and their credentials would be informative when viewed within the context of professionalization. On the other hand, an educational institution at the cutting edge might well be expected to show such advances.

Appointment, promotion and tenure criteria at the institutional site were not altered during the study's time span. A university appointment, promotion and tenure policy promulgated in 1957 was not revised until early in 1981. During the 1960 to 1980 period the school of nursing was in compliance with the university policy. An earned doctorate was not required for tenure application during this time, however, early in 1981 this policy was altered. The doctorate is now a tenure requirement at the institutional site. During the 1960-1980 period, appointments at the assistant professor level generally reflected master's preparation, whereas in other

disciplines a doctorate is the norm. Alterations in the APT policy promises profound change at the institutional site.

Two additional findings bear directly on the process of professionalization. First, the classified ads changed substantially in terms of specialization. Educational positions, as well as those in the service sector, reflected the development of specialties in clinical practice and nursing education. Appendix C contains an alphabetical listing of position titles. The specialization change in education precedes that in service.

Secondly, a comparison of those classified ads primarily directed at educators and those directed at the service sector points toward a differing value system in these two sectors. While the need for academic preparation dominates in the academy, experience is the treasured commodity in nursing service. Only 21.1 percent of the ads in The Washington Post specified credentials, during the twenty year span of this study, while almost half of the ads (43.4) in 1980 expressed the need for experienced personnel. This difference in value orientation is also evidenced in the entry into practice issue.

Data Profile - Institutional Site

A profile of data gathered at the institutional site involves cells seven, eight and nine. Since the object of this exercise is to examine data sources for internal consistency, only that information gathered through interviews that is directly related to entrance/graduation requirements and program and curricular changes will be addressed.

The integrated curriculum model adopted early in the 1970's does seem to support belief in a holistic orientation toward patient care, rather than the illness oriented mode of the medical model. The implementation of a lower-division/upper-division curriculum structure does allow for more fully informed admission decisions regarding applicant ability. It thereby provides the faculty with an opportunity to select more highly qualified applicants. This supports the faculty's perspective that nursing requires "thinkers" not just "doers."

Two profound changes in the curriculum, the development of the master's program and the initiation of the Ph.D. speak to the faculty's recognition and belief in advanced preparation, and the movement of nursing into institutions of higher learning. The development of these programs also recognizes nursing's increased knowledge base, an expanded role, the changing needs of nursing and society, and the need to further develop the knowledge base through the preparation of nurse researchers. The inaguration of a continuing program reflects the expansion of knowledge and technology and the need for practitioners to rectify knowledge deficiencies.

The faculty did express in their interviews a substantial belief in the quality of their nursing programs. Entrance requirements in the generic baccalaureate program change during the period of the study so as to reflect higher level standards. More stringent requirements governing laboratory courses, computation of the admission GPA, restrictions on pass-fail courses among others testify to the implementation of more stringent entrance requirements.

When considering entrance requirements for the graduate program a similar pattern emerges. The tightening of provisional admission standards, the utilization of objective tests, interviews and recommendations in decision-making, among others, give evidence of higher level requirements. Although not directly identified in faculty interviews these changes indicate more stringent requirements in order to admit students with higher level potential, and reflect the need for students who have the ability to develop high level analytical skills.

In summary, entrance requirements for the baccalaureate and master's programs reflect change over time that is consistent with nursing's belief system and higher level standards. In addition, the program development and curriculum changes in the school reflect the emergence of specialization and recognition of changes in client care needs and nursing's role.

Conclusion

This concludes the data report. The fifth chapter utilizes this information to present a condensed list of findings, answer the research questions, and make recommendations.

Chapter 5

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

"Professions occupy an important position in American society. The performance of necessary services . . . and the well-being of society are greatly dependent on the activities of professional groups" (Stuart, 1981, p. 18). In order to attain this prized status groups engage in activities designed to bring them prestige, status, and respectability. The process of professionalization requires group commitment, the passage of time, and an environment conducive to its development.

The American health care system has changed radically since World War II. Knowledge, both theoretical and technical, has proliferated through the expansion of biomedical research. The goal of meeting the care needs of all Americans initiated a marked expansion of the access system. As the cost of care began to rise relentlessly, emphasis turned to preventing illness and the need for hospitalization. In addition, the growth of specialty medical practice created a vacuum for basic health care services directed at keeping people well. Nursing has an opportunity to fill this need, thus, potentially gaining in its desire to advance. It is important, therefore, to ask questions about nursing's professional status.

This study was undertaken in order to describe and document how nursing is changing and if it is changing with respect to the

process of professionalization. Utilizing a grounded field theory methodology attributes, commonly associated with professional status, were operationally defined as measurable constructs by the development of research questions. Data triangulation was achieved through the investigation of a social unit, public literature and credential archives. The ultimate purpose of this activity was to generate information about nursing's professional evolution for future investigation. A gounded field theory methodology was utilized due to its inductive process of discovery. This element, discovery, was facilitated by the development of a matrix designed to gather information from three data sources.

At the institutional site, a school offering baccalaureate and higher degrees in nursing, school catalogs, internal memoranda, university policies, faculty handbooks, and twenty-five interviews with faculty were used to generate data. Historical texts, classified ads, state statutes, dictionaries, addresses by nursing leaders and national statistics reported by the NLN were used as archival and public literature data sources. Through these sources, information was gathered regarding nursing's process of professionalization. The data generated from these sources were reported in Chapter 4.

The primary purpose of this fifth and concluding chapter is to present condensed tables of findings, answer the research questions, present conclusions and make recommendations regarding nursing's professionalization process.

Findings

Condensed tables of findings are presented for each research question. Each of the tables are divided into three sections. The first section contains the research question; the second column data sources, and the third lists findings/changes found within each of the sources. The tables support the following section which answers the study's research questions.

Research Questions

1. Have the number and type of academic credentials earned by faculty changed over time?

On the national scene, there has been a change in the number and type of earned academic credentials. There was, however, a major expansion in the nursing education system, and academic preparation was not sacrificed in the face of growth.

In 1965-1966 there were 4,532 full and part time faculty employed in baccalaureate and higher degree nursing schools; in 1980-1981 that figure had risen to 11,639 (NLN Data Book, 1981). During this growth period, the percentage of faculty with master's degrees rose from .782 (1965-1966) to .803. In the same time frame, doctoral preparation rose 5.3% and the utilization of faculty prepared at the baccalaureate level was cut in half (.149 to .078).

At the institutional site, however, substantial progress is evident. Between 1960 and 1980 there was a net increase of 118 faculty. During this period, the number of faculty with earned doctorates increased by 17%, and the employment of faculty with preparation at the baccalaureate level was eliminated.

Table 39

Summary of Findings - Question One

Question	Data Source	Findings/Change
Have the number and type of academic credentials earned by faculty changed over time?	Public Literature	1. Nursing is not a fully accepted member of the academic community. 2. Doctoral level education for academic nurses has developed.
	Credential Archives	1. The preparation of academic nurses has been maintained and in some cases substantially advanced, even in the face of marked sector growth. 2. Increasing emphasis has been placed on higher level credentials for nursing educators.
	Institutional Site	1. Academic credentials required of faculty have become more stringent during the past twenty years.

Table 40

Summary of Findings - Question Two

Question	Data Source	Findings/Change
Are the entry and certification requirements established by faculty for students in baccalaureate and higher degree settings changing?	Public Literature	1. The quality of nursing education has been upgraded and now requires biological, sociological and physiological preparation, for a highly skilled practice.
	Institutional Site	1. Admission requirements for the generic baccalaureate nursing program have been refined and upgraded. 2. Admission requirements for graduate study have been refined and upgraded. 3. Graduation requirements in the generic baccalaureate and graduate programs have been refined.

Table 41

Summary of Findings - Question Three

Question	Data Source	Findings/Change
Are educational programs designed to prepare nurse specialists being developed in baccalaureate and higher degree schools?	Public Literature	1. Specialization in nursing education and practice has emerged, continues to develop, and is reflected in curriculum development.
	Credential Archives	1. Specialization in the teaching and clinical practice of nursing has emerged.
	Institutional Site	1. There has been substantial growth in educational programs designed to prepare nurse specialists in administration, education and clinical practice. 2. Doctoral education, designed to prepare nurse reseachers, has been initiated. 3. Specialization has emerged in nursing practice.

Table 42

Summary of Findings - Question Four

Question	Data Source	Findings/Change
Have the criteria by which decisions are made regarding the competence of faculty changed? More specifically, do the appointment, promotion and tenure (APT) criteria developed by faculty for peer review reflect the evolution of higher performance standards?	Credential Archives	1. There were no alterations in APT criteria at the institutional site from 1960-1980. 2. Academic nurses did not demonstrate acceptance of the same criteria for APT as the other disciplines.

Table 43

Summary of Findings - Question Five

Question	Data Source	Findings/Change
Has society changed its view regarding the role of nursing in providing health care service?	Public Literature	1. Society has formally recognized its need and value for nursing service. 2. Independent, autonomous, collaborative and dependent nursing functions are now recognized by society. 3. Knowledge, judgment and specialized skill are now recognized as necessary to meet the health care needs of society. 4. Society has delegated nursing the responsibility for evaluating/accrediting nursing education programs. 5. Society has delegated nursing the responsibility for adopting and revising practice standards. 6. Nursing has gained the right to regulate specialized nursing practice-nurse midwives, nurse practitioners. 7. Some sectors in society see nursing as a subordinate subservient occupation, supervised by physicians.

Table 43 (continued)

Question	Data Source	Findings/Change
Has society changed its view regarding the role of nursing in providing health care service?	Credential Archives	1. Society's need for nursing educators and clinicians with advanced preparation has developed over the years.
	Institutional Site	1. Academic nurses are divided as to how society views nursing. 2. Some academic nurses believe that nursing's image is changing from that of an assistant to physicians toward a more independent autonomous practitioner; others do not see this change.

Table 44

Summary of Findings - Question Six

Question	Data Source	Findings/Change
Does nursing demonstrate a shared and consistent system of beliefs?	Public Literature	1. Nursing educators believe that the baccalaureate degree is requisite for professional practice. 2. Nursing must move its basic educational process into institutions of higher learning in order to provide a foundation for higher level clinical practice. 3. Nursing must seek to meet the health care needs of society. 4. A direct fee-for-service needs to be established for primary health care by nurses. 5. Intergroup and intragroup disagreement exists regarding nursing's role in the health care system. 6. Collective bargaining is a tool which can be used to shape an acceptable working environment. 7. Nursing research is required to advance practice and develop a body of knowledge.

Table 44 (continued)

Question	Data Source	Findings/Change
Does nursing demonstrate a shared and consistent system of beliefs?	Public Literature	8. Continuing education programs have developed in order to meet the need for continued professional development. 9. The need for two levels of nursing practice has developed-a technical practice founded on a community college educational experience and a professional practice requiring a baccalaureate in nursing. 10. Nursing has developed an awareness of the need for political activity in order to shape public health care policy. 11. Some believe that nursing practice is independent, highly specialized and theoretically based; others see it as requiring special training for a practice supervised by physicians.
	Credential Archives	1. Clinical nurses place a high value on experience; nursing educators place high value on academic preparation.

Table 44 (continued)

Question	Data Source	Findings/Change
Does nursing demonstrate a shared and consistent system of beliefs?	Institutional Site	1. A holistic approach toward curriculum development has emerged which emphasizes principles and concepts. 2. Nurses are not adequately compensated for the services they provide. 3. Nursing's relationship with physicians is changing from one featuring subservience and dependency to one reflecting cooperation and collaboration. 4. The association of nursing service and nursing service has been altered from one of unity and consensus to one of separation and conflict. 5. The preparation of nurses has moved from the service based setting into higher education institutions. 6. Baccalaureate nursing education has improved over the years by stressing concepts and principles rather than emphasizing technical performance.

Table 44 (continued)

Question	Data Source	Findings/Change
Does nursing demonstrate a shared and consistent system of beliefs?	Institutional Site	7. Nursing's professional role in the health care system lacks resolution and definition. 8. Nurses now participate in the development of public health care policy, and must continue to do so in order to shape policy toward client need. 9. Collective bargaining by nursing has developed and academic nurses disagree as to its value and appropriateness. 10. Nursing research has been initiated. 11. Clinical nursing research is valued by nursing educators. 12. Educators believe that the baccalaureate degree is required for professional nursing practice, but they do not see this view shared by those outside education. 13. Academic nurses believe that advanced nursing practice must be predicated on the acquisition of higher level academic credentials.

Ritzer (1972) asserts that as occupational group members advance by earning advanced degrees, the more professional the individual and, hence, the group becomes. The nursing education community has been able to maintain preparation and in some cases advance even in the face of marked expansion.

Comparisons between these two data bases are tentative at best, as like entities are not being compared. The credentials of faculty in schools with only a generic program are reported with those offering graduate programs we well. These statistics would be more meaningful if these two sectors could be reported separately and compared. The change is recent, but evident.

2. Are the entry and certification requirements established by faculty for students in baccalaureate and higher degree settings changing?

The entrance and graduation requirements for four academic programs at the institutional site were reviewed. Comparisons across time for change in the doctoral program requirements was not possible; however, the requirements appear similar to those in other disciplines.

Standards for the generic and R.N. programs varied primarily in recognition of the possible maturity registered nurses bring to the academic setting. The entrance requirements for the baccalaureate program did demonstrate substantial change, particularly those of the generic program. As such, they indicate more stringent criteria by which the aspiring nursing student is judged.

The implementation of a lower-division/upper-division framework allowed admission decisions on a broader and more comprehensive data base. Two years of pre-professional college level work promises higher level discrimination than that connected with high school data only.

Requiring the completion of chemistry, microbiology, and anatomy and physiology prior to upper-division application reflects a more stringent perspective, in that these courses are more demanding than those in other areas, and are also fundamental in understanding health, as well as alterations in health. Additionally, admission policies required that these courses have a laboratory component and be those taken by majors in the field. The tightening of "studio" course credits, prerequisites in nutrition, pass-fail remedial work, GPA computation, and the inclusion of objective test data in admission decisions all speak to more stringent standards.

A similar pattern is also evident in admission decisions for the master's program. The specification of GPA requirements, tightening of provisional admission standards, the utilization of objective test data, personal interviews and practice experience are changes realized in the graduate admissions process. The exclusion of candidates without a baccalaureate degree in nursing further attests to changing standards. These changes do represent the elevation of admission requirements, though they are less pronounced than those in the baccalaureate sector.

Graduation standards in both the baccalaureate and master's programs do not appear to change substantially. In the baccalaureate setting, a 2.0 GPA requirement per semester is imposed, and both clinical and didactic portions of nursing courses are required to have a minimum grade of "C". The graduate program certification standards show some alteration but not substantial change. Grades of "C" are eliminated for credit, and nursing courses must have a "B" or better. The thesis requirement is dropped and an alterative is established.

In summary, while admission standards are refined and upgraded, graduation criteria undergo little substantive alteration in the basic and graduate nursing programs over the twenty year period. Rather than representing a lack of development, the graduation standards appear consistent with those in other disciplines, however, further study would be required to substantiate such a statement.

3. Are educational programs designed to prepare nurse specialists being developed in baccalaureate and higher degree schools?

Substantial change is obvious in the area of nurse specialist preparation. Significant alterations in program/curricular offerings at the institutional site can be seen in the development of the graduate program. In 1960, clinical majors were available in psychiatric, medical-surgical and maternal-child nursing with role preparation as teachers and administrators. By 1980, numerous op-

tions are available. For example, education is offered as a major concentration with role preparation in instruction and administration in associate degree education, baccalaureate education, or staff development settings.

Administration continues as a specialty across the twenty year period with functional specialization developing in education, as well as service. The initiation of clinical majors in community health, child psychiatry, gerontology, pediatrics and mothers and infants are seen. Role or functional preparation as a clinical specialist is also offered. The evolution of the clinician role was also revealed in Taber's 1977 definition of nurse. In addition, programs which prepared primary health care providers (nurse practitioners) in adult and pediatric nursing appear in 1980.

The development of primary care programs represents a major change in nursing's role in the health care system. The products of these programs are knowledgeable, skilled, scientifically based health care providers, whose primary aim is to keep people well. They are able to diagnose and prescribe without direct physician supervision. In short, they represent the type of practitioner necessary to fill the need which developed with the expansion of the health care system. The emergence of this specialty practice was also recognized in the historical texts and the nurse practice act.

Two other changes in curriculum reflect substantial change. The education of health policy analysts at the master's level

reflects the widening interest of nurses and nursing in the process of shaping health care policy. The development of this program seemingly acknowledges a level of awareness and sophistication among the occupational group heretofore not recognized.

The second change is the development of a doctoral program to prepare researchers in clinical, academic, and administrative nursing. The evolution of a knowledge base requires research skills, and the academic preparation of researchers in schools of nursing should promote its development.

4. Have the criteria by which decisions are made regarding the competence of faculty changed? More specifically, do the appointment, promotion and tenure criteria developed by faculty for peer review reflect the evaluation of higher performance standards?

During the 1960-1980 period appointment, promotion and tenure criteria at the institutional site and within it's parent university are unchanged. A 1957 APT university policy was in effect for the duration of the study. The appointment and tenure standards for assistant professor at the nursing school were found to be somewhat lower than those of the other disciplines. Practices in the other disciplines regarding appointment, promotion and tenure have yet to develop in this particular setting.

A report on this research question would not be complete if the 1981 alteration in criteria reported by the chair of the APT committee at the institutional site were not noted. She reported that tenure application in the future would require an earned

doctoral degree. This policy promises to promote profound change at the institutional site, since tenure has been granted in the past to those without the doctorate at the assistant professor level.

5. Has society changed its view regarding the role of nursing in providing health care service?

The answer to this question was primarily sought by reviewing the development of a nurse practice act. Dictionary definitions and classified ad data were also obtained as a reflection of societal perspective.

Society's perspective regarding the role of nursing does not seem to reflect substantial change between 1960 and 1980. The nurse practice act does reflect advances in its recognition that nursing is theoretically based in the biological, physiological and social sciences. Statutory language does give credence to the premise that some nursing judgments and actions are independent of physician control, as well as the fact that others continue in a delegated or supervised manner. Further, the regulation of nurse practitioners and nurse midwives was secured by nursing, and some refinements obtained in the regulation of licensure, education and peer review.

On the other hand, the levels of practice - technical and professional - proposed by the national organization and supported by others are not seen in the evolution of the practice act, the classified ads, nor in the dictionary (Webster's) which seemingly best reflects the views of society at large. Indeed, there seems

substantial doubt in ANA presidential speeches and interview data that two levels of practice are recognized by the body politic.

Thus, it would seem that at this point in time, a professional independent level of nursing practice is not recognized, and that from the viewpoint of society three educational programs (associate degree, diploma, baccalaureate) are accepted for the most part as equal in value.

6. Does nursing demonstrate a shared and consistent system of beliefs?

Without equivocation, the answer to this question is no. In fact, there seems to be more disagreement than agreement. In reading the answer to this question it should benoted that representatives from the service sector were not included in gathering data about nursing's belief system. They may have views which vary from those expressed by the educators. This area was not considered within the purview of this study. From another perspective however some indications of consistent ideological orientation do appear, when multiple sources are considered.

The escalation of educational requirements in practice and education drew heavy support as part of a developing ideology. The movement from service based programs to nursing education in higher education institutions was strongly supported. The manner of expressing the belief, attitude or value varied, but the idea remained constant. Nursing must house its educational function in higher education. The emphasis was directed at the need for professional baccalaureate education.

Substantial belief was also expressed in the development of educational quality. This expression specifically referred to nurses being taught the "why" of patient care, rather than "how" to execute physician orders. A theoretical emphasis, rather than a technical emphasis, received strong support. This orientation was also reflected in data from the nurse practice act, convention addresses by ANA presidents and aspects of definitions found in Taber's dictionary.

On the other hand, respondents did report differing values in service and education for theoretical and technical functions. Educators feel that service values technical achivement, and education values theoretical advancement. These orientations seem supported by the addresses of ANA presidents and by the classified ads for service.

Higher level educational expectations for faculty teaching in baccalaureate and higher degree programs also received support, but not as firmly as those for basic preparation. Faced with the prospect of having to earn doctorates for tenure consideration, faculty acknowledged the need for such standards, but some reported that they did not support doctoral preparation as necessary for clinical supervision of students. Although the ideal is supported, not all intend to support its achivement.

Varying opinions were expressed regarding the separation of service and education. Some accepted the separation as fact, while others saw the need to mend the breech. Consensus was not evident on this issue.

There was strong support for implementing the baccalaureate degree as a professional entry level credential, but significant frustration was expressed with regard to the rank and file in understanding the importance of such a move. The bottom line was that agreement on this matter is far from resolution.

Another change identified by faculty referred to the development of research in nursing. While a developing research ideal did seem apparent, concern was expressed as to how and when faculty could conduct ongoing research, particularly clinical research. This value identification was strongly supported by ANA presidents, but it seems doubtful given their remarks and those of the faculty that substantial amounts of research are being completed.

On economic and general welfare issues - in general, compensation was not seen as adequate, although an expression of progress was articulated along with a future need for fee-for-service. Collective bargaining generated the most substantial level of disagreement among respondents. Some saw it as highly desirable, some as a necessary evil, and some as totally objectionable.

The highest number of unique expressions regarding nursing ideology had to do with the role of nursing in health care. The responses also generated the highest degree of diversity. Some respondents expressed beliefs that nursing had taken on a much more active practice role in the community, while others emphasized a future practice emphasizing preventive care rather than acute care. This orientation is not in keeping with beliefs expressed in de-

finitions, the positions sought in classified ads, nor is it consistent with the fact that more registered nurses are employed in acute care hospitals than in any other sector. There was agreement, however, that specialization had emerged.

The independence/dependence conflict, particularly related to physicians, received attention. Some faculty felt that substantial progress had been made and would continue to be made in achieving independence and in attaining positive relationships with physicians. Others saw any talk of a more independent role as lacking in reality, and felt that physician/nurse relationships were at an all time low.

The need for political activity by nurses was verbalized. This seems supported in curriculum changes at the institutional site and in ANA presidential remarks. Activity levels of rank and file nurses in the national organization were criticized by interview subjects. This view was also supported by ANA presidents.

In summary, there appears to be substantial evidence to support the view that nursing has two conflicting ideological orientations. One that sees the nurse as a superior technician practicing in a subordinate role to physicians, and another that envisions an independent, autonomous, health care provider that operates in a primary care mode.

Conclusions

Professionalization is a long process, usually requiring group commitment, an environment conducive to its development, and

the passage of time. Vollmer and Mills (1966) conceptualize a profession as an abstract form, nonexistent in reality. This view offers the opportunity of conceptualizing the development of an occupational group towards professional status as a dynamic process "whereby many occupations can be observed to change" (Vollmer and Mills, 1966, p. vii) with respect to certain characteristics in the direction of the abstract ideal type. Thus, this study did not seek to determine whether nursing is or is not a profession, but rather how and if it is changing relative to the characteristics associated with professional status.

Nursing has changed in the past twenty years, however, the change process has been uneven and restricted in nature. The advances made by nursing education and academic nurses should not be overlooked. The mainstream of nursing education is housed in higher education institutions, and faculty have been able to maintain academic preparation, and in some cases move markedly ahead, even in the face of substantial expansion of nursing education programs. Now that the educational growth rate appears to be leveling off, an environment which promotes marked advancement, as opposed to maintenance, may be at hand.

Academic nurses are, however, not moving as rapidly as they might to assimilate and incorporate higher education peer review characteristics in their practice. Their active participation in curriculum development, however, to meet the needs of society; the influence they exercise in the development of program requirements; and their belief in the academy's knowledge production function does attest to the initiation of some newly discovered behaviors.

The evolution of clinical nurses has been slow to develop. The value of academic preparation particularly at the baccalaureate level for practice, does not seem as readily accepted in this cohort of nurses. A far greater value seems to have been placed on experience in clinical practice rather than an appropriate level of academic preparation.

The recognition that nursing practice involves independent and collaborative functions as well as dependent functions appears to be gathering support, as does a theoretically based practice. These characteristics seem more evident in those nurses who have specialized as well as those who are not institutionally based, such as nurse midwives and nurse practitioners. Once again the process is uneven and episodic.

Is nursing moving towards professional status? On one hand, the educational advances that support professional evolution do appear to be developing. Marked support of specialization at the graduate level, beginning production of nurse researchers, and the establishment of generic preparation at the baccalaureate level are all indicators of advancement.

On the other hand, the proliferation of nursing education at the associate degree level; the licensure of associate degree graduates via the same mechnism as baccalaureate graduates; the inability of academic nurses to embrace the same peer review expectations as the other disciplines; all speak to a lack of consensus on what constitutes a professional nurse, academic or otherwise.

The clinical practice of nursing continues to be predominantly institutionally based and therefore less likely to advance in power and prestige, primarily because of the influence exercised by physicians and administration in such an environment. From another perspective, however, clinical practice in areas such as intensive care units, psychiatry and obstetrics, clearly reflect the independent diagnosis and treatment of alterations in the patient's health care status.

The professionalization of nurses and nursing is proceeding, but at a slow rate. The changes realized over the past twenty years are not substantial in terms of the ultimate goal, however, when one considers them within the context of changes in our social environment, they deserve recognition.

The desire for professional status among nurses and nursing and its concomitant rewards does not appear to be diminishing in intensity. The decreased production of nurses prepared in service based institutions is already operative, and the decline of their influence in the nursing community should decrease the disparity in ideological orientation which currently divides those within nursing and those outside nursing. The proliferation of associate degree nurses, however, may, quite simply, exchange on disperate group for another.

The cost of health care continues to rise. The role that economic factors will play in the shaping of the health care system promises to take on added emphasis. In such an environment the

future of nursing is speculative at best. Nurse practitioners and nurse midwives could provide basic health care services in an efficient, effective cost-savings environment, but, physicians, and those who depend on the acute care faculty for their livelihood, are not likely to promote the development of independent nurse practitioners whose shingles hang along side their own. Should such an alteration take place, it would require a ground swell of support from the community and a clear commitment from nursing to support such a move. A major change in the nurse practice act will be essential in promoting an environment for nursingpractice which features professional autonomy and authority over client. The willingness of the nursing community to develop knowledge and skills, and actively engage in the political process is fundamental if advancement of the group is realized.

In summary, the professionalization and professionalism of nursing is proceeding, but at a very slow rate. The changes which have been realized were achieved during an era of marked change, socially, economically, politically, and technologically. The fact that nursing has been able to advance at all in such an environment deserves credit. Further, as might be expected the advances are uneven and episodic, some groups making great strides while others experience difficulty maintaining their current position.

One of the principle reasons for undertaken this study of the professionalization and professionalism of nursing was the opportunity

presented for occupational advancement in today's health care system. Although nursing has progressed during this study's twenty year period the words of Hildegard Peplau at the ANA convention in 1972, still seem to ring true:

> Or, to put it another way, the power of the forward thrust of the profession, and the counterpulls upon it at this time, seem roughly equal. And this is the test: Whether or not the will and the energy of nurses can be mobilized sufficiently to meet the new challenges now on the horizon . . . . (One Strong Voice, 1976, pp. 585-586).

Recommendations

The completion of this study represents a beginning in research designed to gain knowledge in the professionalization and professionalism of nursing. It's findings and conclusions are tentative and general at best. An indepth and comprehensive understanding of status changes in different nurse groups in varying locations is evident but not definitely documented. For example, although progress was identified in nursing gaining control over and advancing the practice of nurse midwives and nurse practitioners what is the professional status of these nurses and other groups in other settings? What factors have promoted their advancement or retarded their progress? How can such information be used to influence nursing's development?

Although the development of a systematic knowledge base was identified as a professional characteristics and reflected in the research questions, a heavier emphasis might have been placed in this study on gathering data regarding nursing's research and publication activities. Although belief statements seem to support

the need for nursing research there is currently little evidence that those expressing the beliefs and those with the skills are actively producing research and publications. The data did report concern that nursing's research activities are more oriented towards non-clinical matters. Further research should address to what extent this viewpoint is accurate and how clinical research might be promoted. Would it be beneficial to re-orient and re-socialize the research skills of those in nursing who were doctorally prepared in other disciplines?

The acquisition of doctoral degrees by nurses should be documented and evaluated. This study reported substantial advancement in doctoral preparation at the institutional site. What factors promoted such a change? Could the change have been more pronounced? Are there factors constraining development that could be altered?

Also, it seems advisable for the NLNto separate statistics on academic preparation for faculty in isolated generic programs, and those of faculty in schools with both generic and graduate programs. The academic development of all faculty is an essential aspect of professionalism, however, the advance of those faculty preparing specialists and researchers is paramount.

The continuing development of programs in nursing, particularly the admission and certification standards, will require continuing research. Some concern is already being expressed that the retrenchment of higher education, primarily due to declining enrollments, and the women's movement will have a negative effect on

nursing enrollments. The pressure to maintain enrollments could have a detrimental effect on admission standards and the quality of nursing education. The effect of such environmental changes could have a significant impact on long term development.

Nurse practice acts also provide broad based research opportunities. Only one act was reviewed in this study, and significant question could appropriately be raised as to whether it represents the cutting edge in nursing's contract with society. Comparative studies of acts based on the characteristics of professional evolution, should reveal sectors or groups substantially advanced, or substantially behind, as well as identifying environmental factors which promote/retard the development of nursing's contract with society.

There is much research yet to be done on documenting the role of society in the development of nursing and the beliefs of society about nurses and nursing. What does the average citizen believe or know about the role of midwives or nurse practitioners? How might nursing influence support in society for practice in an expanded role at the expense of physicians? Does society support/want expanded health maintenance services by nursing, or does it support the continued practice of physicians as primary care providers in an illness oriented environment?

The need for continuing research in the professionalization and professionalism of nursing is essential. In the final analysis, it is difficult to predict the evolution a social movement because it is not based on any one single factor, but the constant altera-

tion of multiple social, economic and political factors. The formula for success is dependent on a mixture of variables. An ongoing evaluation of the environment is mandatory to facilitate appropriate and meaningful decisions in the future.

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APPENDIX A

INTERVIEW SCHEDULE

Questions:

1. How do you believe nursing has changed over the past twenty years, 1960 - 1980?

2. To what extent does your nursing school reflect these changes?

3. How do you believe the education of nurses has changed in this twenty year span?

4. How will nursing change in the next ten years?

5. In what way will your school participate in these changes?

6. What role do you believe the nursing education community plays in these changes?

Professional issues which may have to be prompted:

1. How have nurse/client relationships changed over this twenty year period? Nurse/Physician relationships?

2. How has the nursing education system changed during this twenty year period?

3. Has the fact that nursing is predominately female affected its occupational development?

4. Has the clinical setting in which nursing is practiced changed over the years?

5. How has nursing's collective bargaining activity changed over this time span?

6. How has nursing's service to society changed during this twenty year period?

Dear

I am a doctoral candidate engaged in nursing research. The purpose of this letter is to request your help in the completion of my doctoral dissertation. Specifically, I would like to interview you regarding your views on how nurses, nursing, and nursing education have changed over the last twenty years. Administration has reviewed my proposal and is aware that I will be contacting randomly selected members of the faculty.

I have enclosed an interview scheduling sheet and a stamped self-addressed envelope for its return. Please indicate your decision regarding the interview on the form and return it to me at your earliest convenience. Should you elect to help me, your participation will be held in confidence.

I look forward to receiving your completed form and thank you for your assistance.

Sincerely,

Mary S. Tilbury R.N., M.S.

Enclosures: As Above

Dear

Thank you for favorably responding to my request. I have scheduled your interview for at in your office.

It would be helpful to me in gathering demographic data about my interview sample if you could provide me with a copy of your curriculum vitae when we meet. I will, of course, reimburse you for the cost of its duplication.

If you should need to reach me, my phone number is . I look forward to our meeting.

Sincerely,

Mary S. Tilbury, R.N., M.S.

APPENDIX B

Duncan's Dictionary for Nurses

nurse: 1. One who cares for the sick, wounded or helpless, under the direction of a physician; usually implies one specially trained to give such care. 2. To care for the sick, wounded or helpless. 3. To feed an infant at the breast. Graduate N., one who has graduated from a professional school of nursing. Practical N., one who cares for the sick, under the direction of a graduate N., but is not a graduate of a professional school of nursing. Registered N., a graduate N. who has been registered and licensed to practice nursing by a Board of Examiners for the state in which she lives or works. Occupational Health N., one who works in a factory, mill, department store, office, hotel, or other place of employment; her function is to give immediate and expert care to injuries received by employees or others in these places, to follow up on sick and injured employees, and to help develop accident prevention programs. Private Duty N., one who cares for a single patient in his home or the hospital. Public Health N., one who performs her services for patients in their homes, schools or outpatient clinics; works for an agency and is not self-employed; works with other health workers on community health programs; is concerned with keeping the people of the country physically and mentally healthy. Also called community nurse. Visiting nurses function in public health capacities. School N., one employed by the school to participate in health programs for school children. Staff N., one who gives bedside care to patients in a hospital.

nursing: Strictly, the activities that are involved in giving physical and emotional care to the sick, wounded, and helpless. Broadly, all activities performed by nurses and that are concerned with restoration or maintenance of community health as well as personal physical and mental health.

Duncan, H. A. Duncan's Dictionary for Nurses. New York: Springer Publishing Co. Inc. 1971, pp. 243-244.

Webster's Third New International Dictionary

[1]nurse \ 'ners, 'nes, 'neis\ *n*-s *often attrib* [ME *nurse, norse, nurice,* fr. OF *norrice, nurice,* fr. LL *nutricia,* fr. L. fem. of *nutricius, nutritius* nourishing- more at NUTRITIOUS] 1a: a woman who suckles and takes care of an infant that is not her own: wet nurse b: a woman who takes care of a young child: dry nurse 2a: a person who looks after or gives advice to another b: something that serves as a fostering agency or influence <time is a ~ and breeder of all good - Shak.> 3a: a person skilled in caring for and waiting on the infirm, the injured, or the sick; *specif*: one esp. trained to carry out such duties under the supervision of a physician b: a person esp. trained to assist a physician or dentist (as in an operating room) 4: Nurse Tree 5a: a worker form of a social insect (as an ant or bee) that cares for the young b: an asexual oozooid that produces and carries the blastozooids in some ascidians (as of the genus *Doliolum*) c: a female mammal used to suckle the young of another female usu, of her own kind - usu, used with following noun <~ doe> <~ cow> <~ mare> 6: the act of nursing the balls in billiards - to nurse *adv* 1 *or* at nurse: under the care of a nurse <would send for the baby, though I entreated him... to put it out to *nurse* - Charlotte Brontë> 2: under the control of trustees <put his estate *to nurse* - Tobias Smollett>

[2]nurse \"\ *vb*-ED/-ING/-s [alter. (influenced by [1]*nurse*) of ME *nurshen* to nourish, contr. of *nurishen* - more at nourish] *vt* 1a: to nourish at the brest: suckle <four women were unable to ~ their infants - J.P. Greenhill> <keep the kittens alive till the mother can ~ them - Eleanor B. Simmons> b: to take nourishment from the breast of: suck milk from <possible for a baby to contract tuberculosis from *nursing* its mother - L.H. Brevard> <the foal should

not be permitted to ~ the mare when she is hot and sweating - James Law & M.S. Shahan> 2: to bring up: rear, educate <for we were *nursed* upon the selfsame hill - John Milton> 3a: to promote the growth, development, or progress of <anything to ~ the arts and bring them into the homes of the ...people - M.R. Cohen> <the policy of attracting original work and *nursing* authors of promise - Times Lit. Supp.> b: to cultivate (a plant) with care <*nursed* the long rows of vines that were their livelihood - Margaret Evans> c: to manage (as a business) with care or economy <on his hundreds of thousands of dollars - *nursed* into millions - a substantial Boston family had been built - J.A. Michener> d: to take charge of and watch over in the manner of a nurse <to ensure that performers arrive on time he ~s them from show to show - Don Everitt> <trout are hatched and *nursed* to planting age - *Amer. Guide Series: Wash.*> e: to cause to develop <fancied it to be their interest ...to ~ the embers of the old enmity into a flame - Edward Edwards> 4a: to care for and wait on (as an injured or infirm person) : Attend <great-grandfather was bedridden...and my mother *nursed* him Ellen Glasgow> b: to attempt a cure of (as an ailment) by care and treatment <would stay in her room and ~ a sick headache - Louis Auchincloss> <had been pitched against a bridge ... and was *nursing* a painfully bruised arm - Llewellyn Howland> 5: to hold in one's heart or mind: keep in memory or consideration <had spent the night watches in *nursing* his wrath - John Buchan > <did not ~ the idea that her life was at an end - Arnold Bennett> <*nursed* a plan to invade the South and forcibly liberate the slaves - B.B. Stutler> 6: to hold or grasp carefully or firmly < ~ my fat briefcase on my knees and go through my papers - Christopher Morley>

<took her hands again and *nursed* them against my cheek - Mary Austin> 7a: to use, handle, or drive carefully so as to conserve energy or avoid injury <trying to ~ a gigantic crippled plane back over many hundreds of miles of open ocean - J.A. Michener> b: to use with forethought and care so as to conserve or stretch out < ~*s* his time so that he may keep his brain in rested condition for decisions - *Atlantic*> c: to consume slowly so as to conserve or stretch out <like to a drink ... and watch the people around us - Dwight Taylor > <~ *s* a cup of coffee and a doughnut until it is morning - Norman Mailer> 8 *chiefly Brit*: to attract or sustain the favorable attention of usu. by personal contacts and the dispensing of favors in order to sustain electoral support <is busy *nursing* his constituency and calculating how he can be reelected - W.E. Binkley> 9: to keep (billiard balls) close together and in good position for a series of caroms ~ *vi* 1A: to give suck b: to feed at the breast: suck 2: to act or serve as a nurse

syn Cultivate, Nurture, Foster, Cherish: Nurse implies careful sustaining of an infant, person, thing, or notion. Cultivate is likely to differ from Nurse in suggesting methods of sustaining and protecting the useful in the plant world; it implies sedulous and steady care but lacks the human warmth suggested in many of the other words in this group <spinning theories of fiction is my favorite amusement...a good habit to *cultivate* - Ellen Glasgow> <whatever physical gifts she may have are carefully *cultivated* Lafcadio Hearn> <the morbid curiosity *cultivated* in Browning by his father's tasks and inclinations - Ruth R. Chapman> Nuture places stress on giving that which sustains and affording a safe environment pointing toward a certain development or course

<men who have not been *nutured* in dissecting rooms and other laboratories - C.S. Peirce> <had been *nutured* in sentiments opposed to the institution of human servitude - R.P. Warren > Foster may suggest the relationship of foster parent to child in implying caring for, encouraging, sustaining, and maintaining growth <such a sentiment is *fostered* by all those agencies of the mind and spirit which may serve to gather up the traditions of the people - Felix Frankfurter> <the pope...used his powers to *foster* abuses that brought wealth to the Roman court - G.M. Trevelyan> <we must *foster* on every campus the principle of individualism as contrasted with docile receptivity - C.M. Fuess> Cherish implies fondness or love for something with incidental nurturing of it <a cause which is embraced and *cherished* by so vast a portion of American society - Kenneth Roberts>

nursing *n* *-s* [fr. gerund of ^{2}*nurse*] 1: the profession of a nurse <modern schools of > 2: the varied activities that constitute the duties of a nurse <proper is no easy job>

Gove, P. B. (Ed.). Webster's Third New International Dictionary. Springfield, Massachusetts: G & C Merriam Company, 1976, pp. 1151-1152.

nurse (ners) [L. *nutrix*, a nurse]. One who cares for the sick or wounded, esp. a registered nurse. See: *nutrix*.
n., charge. One in charge of a single hospital ward.
n., community; n., district. A visiting nurse.
n., dry. An infant's nurse who does not suckle the child.
n., general duty. One not specializing.
n., graduate. One who is a graduate of an accredited school of nursing.
n., head. A supervisor at the head of a hospital nursing staff.
n., health. A community nurse.
n., practical. One with experience in nursing but who is not a graduate of a school of nursing.
n., private. A nurse in charge of a single patient.
n., private duty. One not a member of a hospital staff who is called in to care for an individual patient in the hospital.
n., probationer. One under observation in a nursing school before being admitted as a student.
n., public health. A graduate nurse employed by a Board of Health.
n., registered. A graduate nurse who has been registered and legally licensed to practice by state authority.
n., school. A registered nurse whose duties are to supplement the work of the physician in medical inspection of pupils.
n., scrub. N. who is a member of an operating team being surgically clean in order to be able to assist the surgeon.
n., special. A private nurse taking special care of one patient or one who specializes in the care of certain types of patients.
n., student. A girl who is enrolled as a school of nursing.
n., trained. A registered nurse.
n., visiting. A registered nurse, employed by an association to care for the sick poor in their homes.
n., wet. A woman who gives suck to infants of others.

nur´sing [L. *nutrix*]. 1. Scientific care of the sick by a graduate, registered nurse. 2. Loosely applied to all care of the sick. 3. Suckling at the female breast, as an infant. 4. Lactation.

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n., charge. One in charge of a single hospital ward.

n., community, n., district. A visiting nurse.

n., dry. An infant's nurse who does not suckle the child.

n., flight. N. who cares for patients being transported in airplanes.

n., general duty. One not specializing.

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n., probationer. A student nurse during the first part of training.

n., public health. A graduate nurse employed by a Board of Health.

n., registered. A graduate nurse who has been registered and legally licensed to practice by state authority. ABBR: R.N.

n., school. A registered nurse whose duties are to supplement the work of the physician in medical inspection of pupils.

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n., head. A supervisor at the head of a hospital nursing staff.

n., health. A community or visiting nurse.

n., practical. One who is licensed to administer care, usually working under direction of a licensed physician or a registered nurse. May be a graduate of an accredited school for practical nursing or one who has practical experience only.

n., private. A nurse in charge of a single patient.

n., private duty. One not a member of a hospital staff who is called in to care for an individual patient in the hospital.

n., probationer. A student nurse during the first part of training.

n., public health. A graduate nurse employed by a Board of Health.

n., registered. A graduate nurse who has been registered and legally licensed to practice by state authority. ABBR: R.N.

n., school. A registered nurse whose duties are to supplement the work of the physician in medical inspection of pupils.

n., scrub. N. who is a member of an operating team being surgically clean in order to be able to assist the surgeon.

n., special. A private nurse taking special care of one patient or one who specializes in the care of certain types of patients.

n., student. An individual who is enrolled in a school of nursing.
n., trained. A registered nurse.
n., visiting. A registered nurse, employed by an association to care for the sick poor in their homes.
n., wet. A woman who breast-feeds the infants of others.

nur´sing [L. *nutrix*, nurse]. 1. Scientific care of the sick by a graduate, registered nurse. 2. Loosely applied to any care of the sick. 3. Breast-feeding. 4. Lactation.

Taber, C. (Ed.). Taber's Cyclopedic Medical Dictionary. (11th ed.). Philadelphia: F. A. Davis, 1970, pp. N-33-34.

Taber's Cyclopedic Medical Dictionary

nurse [L. *nutrix*, nurse]. 1. One who cares for the sick, wounded, or feeble, esp. one who makes a profession of it after successfully completing a prescribed course in a school of nursing. 2. To feed an infant at the breast. 3. To perform the duties of caring for an invalid. 4. To care for a young child.

n. charge. One in charge of a hospital ward.

n. clinician. A registered nurse with general knowledge of nursing theory and practice, esp. skilled in the clinical specialty in which he or she works. This nurse is capable of working independently in solving patient-care problems and is able to teach and work successfully with others on the medical-care team. Term first used by Frances Reiter. R.N., M.A., Dean, Graduate School of Nursing, New York Medical College.

n. community, n., district. A visiting nurse whose duties are limited to a certain community or district.

n., dry. An infant's nurse who does not suckle the child.

n., flight. N. who cares for patients being transported in airplanes.

n., general duty. One not specializing in a particular field of nursing, but available for any duty.

n., graduate. One who is a graduate of an accredited school of nursing.

n., head. A supervisor at the head of a hospital nursing staff.

n., health. A community or visiting nurse whose duty is to give information on hygiene and prevention of disease. SEE: n., public health.

n., practical. One who is licensed to administer care, usually working under direction of a licensed physician or a registered nurse. May be a graduate of an accredited school for practical nursing or one who has practical experience only.

n., private. A nurse who cares for a single patient.

n., private duty. One who is not a member of the hospital staff but is called upon to care for an individual patient in the hospital.
n., probationer. A student nurse who during the first part of training is under observation.
n., public health. A graduate nurse who has had additional training in the methods of promoting health and preventing disease. SEE: n., health.
n., registered. A graduate nurse who has been registered and legally licensed to practicie by state authority. ABBR: R.N.
n., school. A registered nurse whose duties are to supplement the work of the physician in providing for the medical needs of students while they are in school.
n., scrub. N. who is a member of the surgical team in an operating room. She has prepared for the procedure by scrubbing just as the physicians have. She is gowned and wears sterile gloves. Her duty is to hand instruments to the surgeon and assist in any other way necessary.
n., special. A private nurse taking special care of one patient or one who specializes in the care of certain types of diseases.
n., student. An individual who is enrolled in a school of nursing.
n., trained. A registered nurse.
n., visiting. A registered nurse, employed by an association to care for the sick poor in their homes.
n., wet. A woman who breast feeds the infants of others.

nur´sing [L. *nutrix*, nurse]. 1. Scientific care of the sick by a graduate, registered nurse. 2. Loosely applied to any care of the sick. 3. Breast feeding. 4. Lactation.

Thomas, C. (Ed.). Taber's Cyclopedic Medical Dictionary. (12th ed.). Philadelphia: F. A. Davis, 1973, p. N-43

Taber's Cyclopedic Medical Dictionary

nurse [L. *nutrix*, nurse]. 1. An individual who is professionally trained to be a member of the health care team. The extent of participation varies from simple patient-care tasks to the most expert professional techniques necessary in acute life-threatening situations. The ability of a nurse to function in making self-directed judgments and to act independently will depend on his or her professional background, motivation, and opportunity for professional development. The health care team includes the technical nurse who is technique oriented and deals with the commonly recurring nursing problems and knows standardized procedures and medically delegated techniques. Also included in the team is the professional nurse who is prepared to assume responsibility for the care of individuals and groups through a colleague relationship with a physician. The roles of nurses constantly change in response to the growth of biomedical knowledge, changes in patterns of demand for health services, and the evolution of professional relationships among nurses, physicians, and other health professionals. 2. To feed an infant at the breast. 3. To perform the duties of caring for an invalid. 4. To care for a young child.

n., charge. Nurses in charge of a hospital ward.

n. clinician. A registered nurse with general knowledge of nursing theory and practice, esp. skilled in the clinical specialty in which he or she works. This nurse is capable of working independently in solving patient-care problems and is able to teach and work successfully with others on the medical care team. Term first used by Frances Reiter, R.N., M.A., Dean, Graduate School of Nursing, New York Medical College.

n., community. A visiting nurse whose duties are limited to a certain community or district. SYN: *district n.*

n., district. SEE: *n., community.*

n., dry. An infant's nurse who does not suckle the child.
n., flight. Nurse who cares for patients being transported in airplanes.
n., general duty. One not specializing in a particular field of nursing but available for any duty.
n., graduate. One who is a graduate of an accredited school of nursing.
n., head. A supervisor at the head of a hospital nursing staff.
n., health. A community or visiting nurse whose duty is to give information on hygiene and prevention of disease. SEE: *n., public health.*
n., practical. One who is licensed to administer care, usually working under direction of a licensed physician or a registered nurse. May be a graduate of an accredited school for practical nursing or one who has practical experience only.
n. practitioner. SEE: *n. clinician.*
n., private. A nurse who cares for a single patient.
n., private duty. One who is not a member of the hospital staff but is called upon to care for an individual patient in the hospital.
n., probationer. A student nurse who during the first part of training is under observation.
n., public health. A graduate nurse who has had additional training in the methods of promoting health and preventing disease. SEE: *n. health.*
n., registered. A graduate nurse who has been registered and legally licensed to practice by state authority. ABBR: R.N.
n., school. A registered nurse whose duties are to supplement the work of the physician in providing for the medical needs of students while they are in school.
n., scrub. Nurse who is a member of the surgical team in an operating room. She has prepared for the procedure by scrubbing just as the physicians have. She is gowned and wears sterile gloves. Her duty is to hand instruments to the surgeon and assist in any other way necessary.

n., special. A private nurse taking special care of one patient or one who specializes in the care of certain types of diseases.
n., student. An individual who is enrolled in a school of nursing.
n., trained. N., registered, q.v.
n., visiting. A registered nurse, employed by an association to care for the sick, elderly, and poor in their homes.
n., wet. A woman who breast feeds the infants of others.

nur´sing 1. Scientific care of the sick by a graduate, registered nurse. 2. Loosely applied to any care of the sick. 3. Breast feeding. 4. Lactation.

Thomas, C. (Ed.). Taber's Cyclopedic Medical Dictionary. (13th ed.). Philadelphia: F. A. Davis, 1977, pp. N-42-43.

APPENDIX C

Washington Post - 1960

Operating Room
Public Health

Washington Post - 1965

Intensive Care
Operating Room
Public Health

Washington Post - 1970

Assistant Director of Nursing
Assistant Head Nurse
Associate Director of Nursing
Director of Nursing
Head Nurse
ICU
Instructor, Nursing
Intensive Care
Operating Room
Public Health
Supervisor

Washington Post - 1975

Administrative Supervisor
Assistant Director of Nursing
Clinical Nurse Expert - Eye
Clinical Specialist
Clinical Specialist - Maternal Child Nursing, Intensive Care Unit
Clinical Specialist - Psychiatry
Director of Nursing Service
Emergency Room
Faculty Position

Head Nurse
Intensive Care Unit
Inservice Instructor
Instructor
Intensive Care
Nurse Anesthetist
Nursing Director
Operating Room
Psychiatric Nurse Clinician
Supervisor

Washington Post - 1980

Adolescent Psychiatry
Alcoholic Rehabilitation Nurse
Antepartum Nurse
Assistant Director of Nursing
Cardiac Rehabilitation Nurse
Cardiovascular Nurse
Clinical Specialist - Medical-Surgery
Community Health Nurse
Coronary Care Unit
Critical Care Clinical
Critical Care Director
Critical Care Instructor
Dialysis Nurse
Director of Nursing
Educational Clinical Specialist
Emergency Room
Enterstomal Therapist
Geriatric Nurse
Head Nurse
House Supervisor
Instructor
Intensive Care Unit
IV Therapy Nurse
Labor and Delivery
Maternal - Child Clinical
Maternal Infant Specialist
Medical Intensive Care
Mental Health Center
Neonatal Intensive Care Unit
Neurology
Neurosurgical Nurse
Nurse Practitioner

Nursing Outlook - 1960

Administrative Maternity Nurse
Assistant Director, Diploma School
Assistant Director for Psychiatric Nursing
Assistant Director of Inservice Education
Assistant Director of Nursing
Assistant Director of Nursing Education (Diploma)
Assistant Director of Nursing Service
Assistant Professor, Medical-Surgical
Assistant State Director, Diploma School of Nursing
Assistant State Director for Public Health Nursing
Associate Director of Nursing
Certified Public Health Nurse
Clinical Instructor - Public Health, Obstetrics, Psychiatry, Operating Room, Pediatrics, Medical-Surgical, fundamentals, Maternity, Maternal-Child, Nursing Arts, (Bachelor of Science in Nursing and Diploma)
Director of Education
Director of Nursing Education - Diploma
Director of Inservice Education
Director of Nursing
Director of Nursing, Diploma School
Director of Nursing Services
Director of Public Health Nursing
Director of Visiting Nurses Association
Educational Director
Emergency Room Supervisor
Executive Director, Public Health Agency
Executive Director - Visiting Nurses Association
Evening Supervisor
General House Supervisor
Head Nurse - Operating Room
Head Nurse - Psychiatry
Inservice Education Instructor
Instructors - Bachelor of Science in Nursing Program
Junior Public Health Nurse
Maternal-Child Instructor - Bachelor of Science in Nursing Program
Maternity Nursing Supervisor
Nurse Anesthetist
Nursing Supervisor
Obstetrical Supervisor
Operating Room Head Nurse
Operating Room Nurses
Operating Room Supervisor

Nurse Specialist
Occupational Health Nurse
Oncology Research
Open Heart Nurse
Operating Room
Orthopedic Nurse
Patient Care Supervisor
Pediatric Nurse
Post Partum
Psychiatric Clinical Specialist
Psychiatric Nurse
Rehabilitation Specialist
Renal Transplant
Shock-Trauma
Staff Development Instructor

Pediatric Instructor
Public Health Nurses
Public Health Nurse I
Public Health Nurse III
Public Health Nurse Supervisor
Public Health Nursing Consultant
School of Nursing Director - Diploma
Supervisor - Metabolism and Research Unit

Nursing Outlook - 1965

Assistant Director - Child Psychiatry
Assistant Director - Diploma Program
Assistant Director - Diploma School of Nursing
Assistant Director - Nursing Education
Assistant Director - Nursing Education - Diploma
Assistant Director - Nursing
Assistant Director - Nursing Services
Assistant Director - Psychiatric Nursing Services
Assistant Director, Staff Development
Assistant Director - Visiting Nurses Association
Associate Director - Nursing Services
Associate Director - School of Nursing - Diploma
Associate Professor
Chronic Illness and Geratric Consultant
Clinical Instructor
Clinical Instructor - Medical-Surgical, Pediatrics, Fundamentals, Obstetrics, Public Health
Consultant - State Department of Mental Hygiene
Curriculum Coordinator
Director of Diploma School
Director of Inservice Education
Director of Nursing
Director of Nursing - Associate Degree Program
Director of Nursing Education
Director of Nursing Education - Diploma
Director of Nursing Service
Director of Practical Nursing Program
Director of Psychiatric Nursing Service
Educational Director - Diploma
Executive Director - Public Health Agency
Executive Director - State Board of Nursing
Executive Director - Visiting Nurses Association
Executive Secretary - Board of Nursing

Faculty Appointments
Faculty Positions - NCH, Medical-Surigical
Head Nurse - Gereatric Rehabilitation
Head Nurse - Intensive Care Unit
Home Care Administrator
Intensive Care Unit Nurses
Inservice Education Instructor
Inservice Instructor
Instructor - Pediatrics, Fundamentals, Maternal-Child Health, Medical-Surgical, Obstetrics, Psychiatry, Public Health, Operating Room, Maternity
Intensive Care Nurses
Maternity Supervisor
Medical Nursing Supervisor
Medical - Surgical Coordinator
Medical - Surgical Nursing Supervisor
NCH Nursing Supervisor
Nurse Consultant
Nursing Home Consultant
Nursing Service Administrator
Nursing Service Director
Nursing Supervisor
Obstetrics Supervisor
Operating Room Nurses
Operating Room Supervisor
Pediatric Nurse Specialist
Pediatric Rehabilitation Coordinator
Pediatric Supervisor
Psychiatric Nurse
Psychiatric Nursing Supervisor
Public Health Assistant Director
Public Health Nurse
Public Health Consultant
Public Health Nurse Supervisor
Public Health Nursing Director

Nursing Outlook - 1970

Administrative Supervisor
Assistant Director - Community Health Agency
Assistant Director - Diploma School
Assistant Director of Nursing
Assistant Director of Nursing Education
Assistant Director of Nursing - Operating Room
Assistant Director of Nursing - Psychiatry
Assistant Director - School of Nursing

Assistant Educational Administrator
Assistant Instructors
Assistant Professor - Medical-Surgical
Assistant Professor - Psychiatric Nursing
Associate Dean
Associate Degree Faculty
Associate Director of Nursing
Associate Director of Nursing Education
Associate Director of Nursing Services
Cardiovascular Instructor
Chairman - Associate Degree Program
CCU Nurse Specialist
Chairman - Associate Degree in Nursing Program
Chairman - Advanced Medical-Surgical Nursing
Chairman - Bachelor of Science in Nursing Program
Chairman - Fundamentals of Nursing
Chairman - Medical-Surgical Nursing
Child Health Nurse Consultant
Clinical Instructor - Diploma Program
Clinical Instructor - Medical-Surgical, Bachelor of Science in Nursing by Clinical Area
Clinical Nursing Coordinator - Medical-Surgical, Obstetrics, Gynecology, Medicine
Clinical Specialist - Medical-Surgical, Neurological, Rehabilitation, Pediatrics, Newborns
College Faculty - Bachelor of Science in Nursing, Associate Degree, Pediatrics, Obstetrics, Psychiatry, Medical-Surgical Maternal-Child Nursing, Public Health
Coordinator - Bachelor of Science in Nursing Program
Coordinator - Nurse Internship Program
Department Head - Medical-Surgical Nursing
Director - Associate Degree in Nursing Program
Director - Associate Degree Program
Director - Bachelor of Science in Nursing Program
Director - Home Care Service
Director - Home Health Agency
Director of Nursing Education
Director of Nursing Education - Diploma
Director of Nursing Services
Director of Nursing - Visiting Nurses Association
Director, Medical-Surgical Nursing
Director, School of Nursing
Director, Visiting Nurses Association
Educational Coordinator
Executive Director - Illinois League of Nursing
Executive Secretary - Nursing Association
Faculty - Maternal-Child Nursing, Psychiatric, Medical-Surgical Pediatrics, Associate Degree in Nursing, Public Health Nurse, Fundamentals

Head Nurse - Emergency Room, Psychiatry
Head Nurse (various clinical units)
Inservice Instructor
Instructors - Pediatric, Medical-Surgical, Obstetrics, Fundamentals, Psychiatry
Medical-Surgical Nursing Coordinator
Nurse Administrator
Nurse Consultant - Extended Care
Nurse Coordinator
Nursing Supervisor - Medical-Surgical, Public Health, Operating Room, Psychiatry
Pediatric - Clinical Specialist
Pediatric Nursing Instructor
Psychiatric Clinical Specialist
Psychiatric Nursing Instructor
Public Health Nurse
Public Health Consultant
Supervisor - Central Service, Operating Room, Visiting Nurses Association, Medical Units, Obstetrics, Community Health
Supervisor, Nursing Service - Operating Room, Outpatient Clinics, O, A, UNA, Public Health Nurse

Nursing Outlook - 1975

Administrative Director - Home Health Agency
Assistant Dean - Assistant Director of Nursing
Assistant Dean for Continuing Education
Assistant Dean, Graduate Program
Assistant Dean, Media Coordinator
Assistant Director, Medical Nursing
Assistant Director of Nursing - Staff Development
Assistant Director, School of Nursing
Assistant Professor of Nursing
Associate Dean, College of Nursing
Associate Dean of Nursing
Associate Dean for Undergraduate Studies
Associate Director of Nursing Education
Associate Professor of Nursing
Chairman and Professorship - Bachelor of Science in Nursing Program
Chairman - Assistant Director of Nursing
Chairman - Department of Nursing
Chairman - Graduate Studies
Child Health Nurse Consultant
Clinical Director - Oncology Nursing

Clinical Specialist, Emergency Room, Pediatrics, Critical Care
Co-Director - Pediatric Nurse Practitioner Program
Community Health Nurse Supervisor
Consultant in Administration and Curriculum Development
Coordinator, Adult Nursing
Coordinator, Bachelor of Science in Nursing Program
Coordinator - Maternal Child Health - Graduate Program
Curriculum Coordinator - Bachelor of Science in Nursing
Dean, College of Nursing
Dean, School of Nursing
Department Chairman - Bachelor of Science in Nursing
Director, Assistant Director of Nursing Program
Director, Family Nurse Practitioner Program
Director - Graduate Program
Director, Graduate Studies
Director - Inservice Education
Director of Continuing Education
Director of Nursing
Director, School of Nursing
Executive Director, Visiting Nurses Association
Faculty - Maternal Child Health, Community Health, Psychiatry, Obstetrics, Pediatric Rehabilitation, Gereatrics, Medical-Surgical, Primary Nursing
Family Nurse Practitioner
Family Planning Nurse Specialist
Graduate Nursing Faculty - Primary Care, Research, Administration, Education
Instructor of Nursing
Mental Health Nurse Consultant
Nursing Chairman - Bachelor of Science in Nursing Program
Nursing Education Consultant
Nurse Researchers
Obstetric Supervisor
Program Director - Bachelor of Science in Nursing Program
Program Director - Nurse Midwifery
Public Health Nurse Advisory Specialist for TB Control
Public Health Nurse Consultant
Public Health Nurse Consultant - Crippled Children's Bureau
Public Health Nurse Supervisor

Nursing Outlook - 1980

Assistant Dean - Bachelor of Science in Nursing Program
Assistant Dean for Graduate Studies

Assistant Dean - Undergraduate Program
Assistant Director of Nursing for Peminology
Assistant Director, School of Nursing
Assistant Professor - Graduate Nursing Program
Associate Dean
Associate Dean for Academic Affairs
Associate Dean - Graduate Program
Associate Dean - Master's Program
Associate Professor - Professor and Coordinator, Interdisciplinary Study
Chairperson - Associate Degree in Nursing Program
Chairperson - Bachelor of Science in Nursing Program
Chairperson - Department of Nursing
Chairperson - Department of Psychosocial Nursing
Chairperson - Family Health Care Nursing
Chairperson - Mental Health Nursing Program
Chairperson - Nursing
Community Health Nurse Clinician
Dean, School of Nursing
Director of Bachelor of Science in Nursing Program
Director of Continuing Education
Director of Inservice Education
Director of Nursing - Faculty
Director of Outreach Programs and Continuing Education
Director of Student Affairs
Director - Visiting Nu°Ses Association
Executive Director - Board of Nursing
Executive Director - Home Health Agency
Executive Director - Visiting Nurses Association
Executive Secretary, State Board of Nursing
Faculty - All Clinical Programs, Adult Health Nurse Practitioner Program, Oncology, Primary, Ambulatory Care, Administration
Faculty - Associate Degree, Bachelor of Science in Nursing, all Clinical Areas, Adolescent Nursing
Family Nurse Clinician
Graduate Faculty - Adult Health
Graduate Faculty - Maternal Child Health, Research
Graduate Faculty - Maternity Nursing
Graduate Faculty - Rural Family Health
Graduate Nursing Faculty
Inservice Education Instructor
Instructors - All Clinical Areas
Lecturer, Community Health Nursing
Midwifery Education Coordinator
Nurse Physiologist
Nursing Department Chairperson
Nursing Education Consultant
Nursing Instructor

Occupational Health Nursing Coordinator
Professor and Dean
Public Health Nurse

APPENDIX D

FACULTY POLICIES AND PROCEDURES - 1975
APPOINTMENTS, PROMOTION AND TENURE PROCEDURES

I. Minimum Qualifications for the Original Appointment to the Academic Ranks*

Certain minimum qualifications shall be required for appointment or promotion to the several academic ranks.

A. Instructor. An appointee to the rank of instructor ordinarily shall hold the highest earned degree normally associated with the rank in his field of specialization, or have relatively comparable experience.

B. Assistant Professor. In addition to having the qualifications required of an instructor, ordinarily the appointee should have indicated promise of a high level of teaching ability in the departmental field and the potential for superior teaching, research or creative ability in some sub-division of this field. In most fields the doctorate will be normal requirement for appointment to an Assistant Professorship.

C. Associate Professor. In addition to having the qualifications required of an assistant professor, ordinarily the appointee shall have had extensive successful experience in teaching, research or creative performance and be competent to direct work of major sub-divisions of the department and to offer graduate instruction and direct graduate research therein. Since this position carries permanent tenure, academic competence in teaching, scholarly production or other professional achievement should be thoroughly documented.

D. Professor. In addition to having the qualifications of an associate professor, ordinarily the appointee shall have demonstrated a degree of proficiency in teaching sufficient performance and a degree of proficiency in research or creative performance to establish an excellent national reputation. Appointment to this rank carries tenure.

E. Research Assistant Professor, Research Associate Professor, Research Professor. The duties of research appointees lie in the research field, with limited teaching assignment. These appointees should therefore be scholars capable of conducting intensive research in a given area and should possess the highest academic attainment in the field.

*Also see Position Description for Academic Ranks as Defined by Faculty Committee of the School of Nursing.

F. Graduate Assistant. The appointee should normally hold an appropriate baccalaureate degree from an accredited institution and should have shown superior aptitude and excellent promise as an undergraduate in his/her field.

G. Faculty Research Assistant. The appointee should be capable of assisting in research under the direction of the head of a research project and should have ability and training adequate to the carrying out of the particular techniques required, the assembling of data, and the use and care of any specialized apparatus. A baccalaureate degree shall be the minimum requirement.

H. Research Associate. The appointee should be capable of carrying out individual research or collaborating in group research at the advanced level, should be trained in research procedures, and should have had the experience and specialized training necessary to develop and interpret data required for success in such research projects as may be undertaken. An earned doctorate shall normally be a minimum requirement.

I. Assistant Instructor. The appointee should be competent to fill a specific position in an acceptable manner, but he/she is not required to meet all the requirements for an instructor. He/she should normally hold at least the appropriate baccalaureate degree.

J. Lecturer. The title Lecturer may be used to designate temporary appointments, at any salary and experience level, of persons who are serving for a limited time or part-time, and normally are not in line for academic promotion.

K. Visiting Appointments. The prefix Visiting before an academic title, e.g., Visiting Professor, may be used to designate a short term, full-time appointment without tenure of a person who is normally permanently employed elsewhere.

L. Adjunct Assistant Professor, Adjunct Associate Professor, Adjunct Professor. This title is to be used in the appointment of outstanding persons employed elsewhere in the metropolitan area and not holding another academic appointment. The appointee would be associated with a departmental faculty, but would not be essential to the development of the department's program. This title does not carry tenure, and the appointee would not be a member of the College Park Faculty Assembly. The appointee should have such expertise in his/her discipline and be so well regarded that his/her appointment would have the endorsement of the preponderance of the members

of the departmental faculty. Any department may recommend to the administration persons of this rank; the number of adjunct appointments may not normally exceed ten percent of the number of professors and associate professors on the departmental faculty. Appointments to this rank shall not extend beyond the end of the fiscal year during which the appointment becomes effective and may be renewed.

M. Other Titles. Professorial titles should be granted only to teaching and research personnel who are associated with teaching departments, colleges or divisions. No new titles or designations should be employed for appointees to faculty status without prior recommendation by the appropriate committee and approval by the campus senate.

II. Criteria for Appointment and Promotion

Certain general criteria shall govern all appointments and promotions to academic rank. In the case of both appointment and promotion every effort should be made to fill positions with persons of the highest qualifications and in conformity with affirmative action guidelines.

It is the special responsibility of those in charge of recommending appointments to make a thorough search of all available talent before recommending appointees. At a minimum the search must include the advertisement of available positions in the appropriate professional journals. Personal interviews, letters of recommendation, and publications should be secured and evaluated for a potential appointee is recommended for appointment. Upon appointment each new faculty member shall receive comprehensive information concerning criteria and procedures used in decisions on his/her promotion or tenure. All faculty members shall be notified in writing of any changes in criteria or procedures used in decisions on his or her promotion or tenure.

Promotion in rank and the award of tenure should in no case be automatic but should be based on merit, and on the academic needs of the department, college, division and campus.

The factors to be considered in appointment and promotions fall into three general categories: A. Teaching and Advisement; B. Research and Professional Achievement; C. Service.

A. Teaching and Advisement. Teaching and academic advisement are primary functions of the University and superior teaching performance at all levels (or reasonable promise thereof in the case of initial appointments) is an important criterion

an appointment and promotion. Although productive scholarship and service to the University are frequently thought to be more readily measured and appraised, every effort should be made to recognize and emphasize excellence in teaching.

The responsibility for the evaluation of teaching performance rests on the primary academic unit of the faculty member. Each such unit shall develop appropriate criteria for the evaluation of the teaching performance of its members and disseminate them. The procedures for evaluation should include input from students and departmental colleagues.

B. Research and Professional Achievement. An important factor in determining a faculty member's merit for appointment or promotion shall be his/her contributions in the form of research and other professional or artistic activities. The nature of the performance will vary from one academic or professional field to another; but the general test to be applied is that the faculty member be engaged continuously and effectively in creative activities of high quality and significance. In some fields the communication of research through oral and/or written presentation is the usual expression of research activity. The quality of such efforts should be the primary measure of achievement. Capacity for intellectual development, especially at junior ranks, and demonstrated creative imagination, especially at senior ranks, are prime considerations to be applied across the board. In the professional schools, contributions to professional literature and to professional practice may be judged creative if they demonstrate new ideas and scholarly activity. In fields such as art, music, dance, drama, and speech, distinguished performance shall be judged as creative activity. In agriculture, the sciences, and engineering, patented inventions and discoveries may evidence the kind of creative work that in other areas goes into scholarly publications.

Research or other activity which for one reason or another cannot be made available to members of the University community shall not be considered in weighing an individual's case for appointment or promotion.

C. Service. In addition to a proven aptitude for teaching and for research and publications, a candidate for promotion should have demonstrated a commitment to the University through participation in service activities. Such participation may take several different forms:

1. Campus and University Service

   a. Committee and Organization Service. Since the committee system is integral to the governance and to the formulation of policy of the University, it is vitally important that every member of the faculty consider service on departmental, college, divisional, campus, and University committees as an essential aspect of his/her total professional responsibility.

   b. Administrative Service. The complex structure of the University requires that some faculty devote part of their time to administrative activity. Many administrative activities are better done by a faculty member with a scholarly background in the discipline of the unit which he/she serves, than by a person who has no such experience. Such part-time administration by faculty should be viewed, then, as necessary, valuable service and should be regarded as comparable to any of the other forms of service to the University.

2. Professional Service. Each member of the faculty should be encouraged to work within the professional societies of his/her discipline, in order to maintain and strengthen the standards of that discipline. Such activities as election to office of a professional organization, editorship of a journal, membership on a board of readers or board of directors, are forms of professional service.

3. Civic and Educational Service. Frequently the professional and scholarly background of a member of the faculty enables him/her to be uniquely qualified contributor to a local, state or national civic or educational activity, and she/he should be encouraged to engage in such activity as part of his/her non-University responsibility.

In summary, service activity is expected of the successful faculty member, but no form of service shall be a substitute for teaching and research achievement. Nor should service activity be expected or required of younger faculty to the point that it interferes with the continued development of their teaching and research.

SCHOOL OF NURSING

POSITION DESCRIPTIONS FOR ACADEMIC RANKS

AS DEFINED BY

THE FACULTY ON APPOINTMENTS, PROMOTIONS AND TENURE IN 1974-75

CONFIRMED BY THE FACULTY COUNCIL OF THE SCHOOL OF NURSING IN FEBRUARY, 1975

These descriptions are presently utlized by administrative personnel within the School of Nursing in considering appointments and promotions of faculty. When decisions for appointment or promotion are made, they are forwarded by the Dean to the Chancellor for final approval.

Appointments at the rank of associate professor or above, or promotions to those ranks also must have the approval of the Board of Regents and the President of the University.

INSTRUCTOR

Position Title:	Instructor*
Responsible To:	Department Chairman or Designated Representative
Position Description:	Plans, implements and evaluate learning experiences of students in both clinical and classroom settings.

QUALIFICATIONS

Academic Preparation:	A master's degree with graduate courses in nursing and teaching**
	Non-nurse faculty shall have a master's degree appropriate to the teaching responsibilities.
Experience:	Teaching: prior teaching experience is preferred.**
	Clinical practice: evidence of demonstrated competence in providing nursing care.
	Leadership: evidence of potential for leadership.

*NOTE: According to University policy, appointments to the rank of instructor are for a term not to exceed the fiscal year during which the appointment becomes effective. An instructor's appointment will be automatically renewed for the second and succeeding years unless the appointee is notified in writing to the contrary by April 1 during the first year of service and by December 15 during the second and succeeding years.

**The following recommendation related to academic preparation and teaching experience was approved by the Faculty Assembly in May, 1974:

1. Teacher preparation should be specified as required for appointment to the undergraduate or graduate faculty.

2. Successful teaching experience may be substituted (particularly at the graduate level), but references should be required as validation before an appointment is made.

3. No faculty member should be hired without (1) or (2).

4. Where exceptions are made to this policy, it is the responsibility of the school to provide assistance in preparation for teaching.

5. Promotion from Instructor to Assistant Professor should be, in part, contingent upon making up deficits in teaching preparation.

Professional:	Licensure: currently licensed as a Registered Nurse.
	Organization: current membership in ANA and other appropriate organizations.
	Malpractice insurance: the amount deemed appropriate by School of Nursing policy.
Health:	Health status permits successful execution of the responsibilities of the position.
	Faculty members who are not nurses should meet comparable professional qualifications.

ASSISTANT PROFESSOR

Position Title:	Assistant Professor*
Responsible To:	Department Chairman or Designated Representative
Position Description:	Provide leadership in the planning, guidance, implementation and evaluation of the learning experience of students in both classroom and clinical settings.

QUALIFICATIONS

Academic Preparation:	A master's degree in the field to which appointed. Documented evidence of professional growth and/or planned, advanced study in an institution of higher learning.
Experience:	Teaching: documented evidence of teaching ability and competence through experience in an institution of higher learning.** Clinical practice: evidence of expertise in practice related to the field of specialization. Leadership: demonstrated competency and leadership ability in above and related experience.
Professional:	Same as for Instructor.
Health:	Same as for Instructor.

*NOTE: According to University policy, full-time appointments to the rank of Assistant Professor shall be for an initial term of three years, which appointment may be revewed for an additional three-year term. The first year of the initial appointment shall be a probationary year and may be terminated at the end of that fiscal year if the appointee is so notified by March 1. The appointee shall be notified at least one year in advance of the expiration of any three-year term if it is the intention of the University not to renew the appointment.

**NOTE: Institution of higher learning has been operationally defined as the Junior or Community College, the Senior College (baccalaureate level), and the Graduate School.

ASSOCIATE PROFESSOR

Position Title:	Associate Professor
Responsible To:	Person Designated by Dean
Position Description:	Provides leadership within a clinical department or a functional program. Assume responsibility for working with faculty and/or students in the planning, guidance, implementation and evaluation of learning experiences of students.

QUALIFICATIONS

Academic Preparation:	The doctoral degree is required.
Experience:	". . . academic competence in teaching, scholarly production, or other professional achievement should be thoroughly documented." Faculty Handbook
Professional:	Same as for Instructor.
Health:	Same as for Instructor.

PROFESSOR

Position Title:	Professor
Responsible To:	Person Designated by Dean
Position Description:	Provides scholarly nursing leadership within the School of Nursing and in the University.

QUALIFICATIONS

Academic Preparation:	The doctoral degree is required.
Experience:	The individual has established a scholarly reputation among regional and national colleagues as a leader in the field of nursing education.
Professional:	Same as for Instructor.
Health:	Same as for Instructor.

***NOTE: The qualifications for each succeeding rank assume that the qualifications for the previous rank have been met.

***NOTE: The following recommendation was approved by the Faculty Assembly in December, 1975.

Faculty who have not been employed one full academic year (or the quivalent for part-time faculty) are not eligible to apply for promotion and/or tenure.

CRITERIA FOR EVALUATION OF FACULTY FOR PROMOTION AND/OR TENURE

Rank: Instructor

a. Demonstrates skill as a clinical practitioner.

b. Participates actively in curriculum planning, development and revision within the department or program to which appointed.

c. Utilizes effectively, contemporary and innovative teaching methodologies in formal, informal and clinical settings.

d. Provides for an environment conducive to learning: provides for the development of a teacher-learning relationship which enhances learning.

e. Services as an academic advisor to assigned students.

f. Communicates effectively with personnel utilizing appropriate channels.

g. Supports and participates active in on-going research within the faculty or department and/or initiates studies as an individual or as a member of a research team.

h. Participates in School of Nursing activities, serves on School of Nursing committees.

i. Represents the School of Nursing in appropriate University activities.

j. Participates actively in local and state professional organizations.

Rank: Assistant Professor

Same as for Instructor, and in addition:

a. Demonstrates increased skill as a clinical practitioner.

b. Demonstrates increased skill as a teacher.

c. Assumes responsibility in clinical settings for increased collaboration with colleagues in nursing and other disciplines.

d. Demonstrates leadership through increased participation in University and School of Nursing activities and committees.

e. Assumes increased responsibility in state and local professional organizations.

f. Contributes to nursing literature.

g. Participates in activities to improve the quality of nursing care to the consumer.

h. May serve as member of thesis or dissertation committees.

Rank: Associate Professor

Same as for Assistant Professor, and in addition:

a. Directs and participates in research.

b. Guides and directs junior faculty in the instructive process.

c. May serve as nursing consultant in regional and national situations.

d. May assume leadership in regional and national organizations.

e. May serve as chairman or member of thesis and dissertation committees.

Rank: Professor

Same as for Associate Professor, and in addition:

a. Utilizes scholarly depth of knowledge and specialized expertise to project types of nursing service required to meet the changing needs of society.

b. Establishes a scholarly reputation among regional and national colleagues as a leader in the field of nursing education.

c. Provides tangible evidence of continuing scholarly production in research, publications, and other creative activities.

d. Contributes significantly in a high level position within the University.

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A STUDY OF THE PROFESSIONALIZATION AND PROFESSIONALISM OF NURSING: 1960-1980

by

Mary S. Tilbury

(ABSTRACT)

The purpose of this study was to describe and document how nursing is changing and if it is changing in keeping with the process of professionalization.

The purpose was addressed through a grounded field methodology which defined attributes commonly associated with professions into measurable constructs; documented evidence of these characteristics by triangulating data sources; and explored the ideology of academic nurses through twenty-five interviews. The study generated hypotheses regarding nursing's professional evolution for future investigation.

The characteristics commonly associated with professional groups were identified through an extensive review of the literature on professionalism and professionalization. Six research questions were developed from the literature to guide the study. As formulated, the questions reflect change over time. The study's basic

premise is that occupational groups change with regard to specific characteristics during the process of professional development, and that the conceptualization of a profession is an abstract, ideal form, non-existent is reality. The study views the development of an occupational group towards professional status as a dynamic process. Therefore, it does not seek to ask if nursing is or is not a profession, but how it is developing with respect to characteristics commonly accepted as those associated with professions.

Public literature, archival data, and a baccalaureate and higher degree nursing school are used to achieve data triangulation. The addresses of ANA presidents, historical texts, a nurse practice act, classified ads, dictionary definitions, faculty credentials , appointment, promotion and tenure criteria, entrance/certification requirements, curricular development and twenty-five semi-structured interviews with baccalaureate and higher degree faculty serve as data sources. These data sources are explored through inductive analysis for evidence of developing attributes and the evolution of a professional culture, defined as a shared and consistent system of beliefs.

The study reveals that nursing's professionalization is incomplete, episodic and uneven in nature. Two conflicting ideologies are identified as limiting changes between nursing and society. Recommendations are made for further study of this social movement.