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EDUCATION FOR NURSING PRACTICE; REPORT OF THE NEW YORK STATE NURSES ASSOCIATION 1966 ARDEN HOUSE CONFERENCE.

New York State Nurses Association, Albany, N.Y.

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Ninety-six nursing leaders participated in the conference to discuss nursing education, nursing service, and the role of the professional association. It was hoped that similar discussions on the local level would result. Speeches included "The Case for Creativity in Nursing" by Apollinia O. Adams and "Education for ????" separate presentations by Eleanor C. Lambertsen and Jean Campbell. Each of 10 discussion groups considered the overall question: How do we move in an orderly fashion from the present situation to that outlined in the American Nurses Association Position Paper on Education? In addition, each group was assigned one of the following topics and presented pertinent recommendations: (1) Cooperation of nursing education and nursing service in the preparation of the practitioner, (2) more effective control of nursing by the nursing profession, (3) joint responsibility of education and service for the stimulation of research, (4) expectations and responsibility of nursing service in the preparation of the practitioner, (5) preparation and role of the clinical specialist, (6) planning between education and service for staff development, (7) dual responsibility of education and service in developing leaders, (8) achievement of a professional level of nursing practice, (9) analysis and promotion of quality patient care, and (10) joint planning for maximum use of clinical and educational facilities. (JK)

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Education for Nursing Practice

REPORT

of

THE NEW YORK STATE NURSES ASSOCIATION

1966 Arden House Conference

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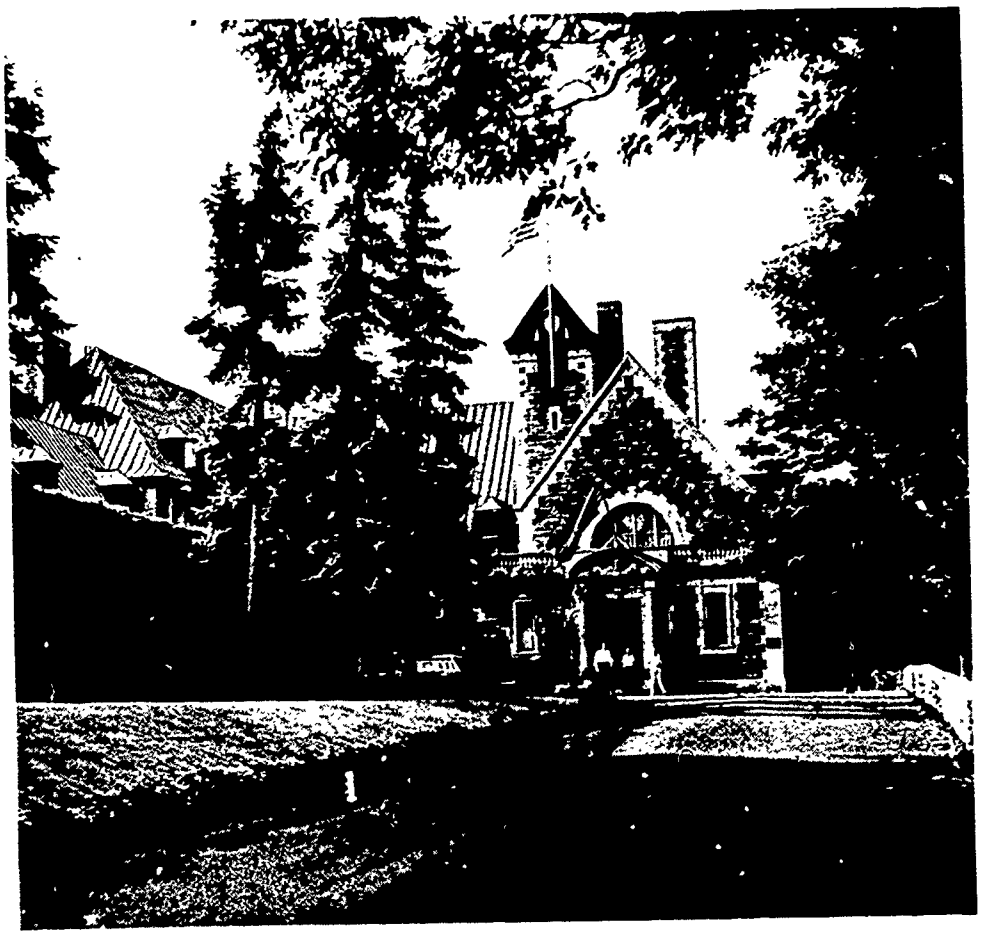

Arden House, on the Harriman Campus of Columbia University, site of the 1966 conference, "Education for Nursing Practice," sponsored by The New York State Nurses Association.

PROLOGUE

"Imagination is more important than knowledge, for knowledge is limited, whereas imagination embraces the entire world — stimulating progress, giving birth to evaluation" . . . these words of Albert Einstein might well have been written about The New York State Nurses Association Conference held at Arden House, March 4-6, 1966. During these two days ninety-six registered professional nurses, leaders in nursing service and in nursing education in New York State, directed their most serious attention to the conference theme, "Education for Nursing Practice". In the realities of every day, this theme is not just a subject for a conference but a matter of intense importance and concern to the nursing profession.

The premise of the Arden House Conference was that forward movement in the resolution of problems can best be achieved if an early diagnosis is made If this conference served to raise questions, to sharpen issues, to clarify problems, and to supply at least some of the answers, then it was a success. We believe it did do these things.

The 1966 Arden House Conference was neither a spontaneous nor an isolated incident, but rather one activity of committee work tracing back to 1962.

In 1962 the American Nurses' Association added to its functions "to initiate standards for nursing education and to implement them through appropriate channels." Criteria for appointment to an ANA Committee on Education were developed and the membership of the committee appointed in late 1962.

In December 1962 the Board of Directors of The New York State Nurses Association appointed a special committee and assigned to it the function of devising ways to promote study and understanding of Goal III of the American Nurses' Association. This special committee was the precursor of the present NYSNA Committee on Education. It began its intensive work in 1963 by sponsoring the Sagamore Conference and a follow-up in Albany in early 1964. Shortly thereafter it became apparent that a broader-based Committee on Education was necessary, and the special Committee to study Goal III was replaced by a Committee

on Education. Among its assigned functions was one charging it with recommending to the Board of Directors action which might be desirable for The New York State Nurses Association to initiate in connection with nursing education. The establishment of the committee and the assignment to it of this specific function reflected the belief of the NYSNA Board of Directors that the professional association *must* be concerned continuingly with the the education of the future practitioner and *must* take action to properly direct that educational process.

Beginning early in 1965, the NYSNA Committee on Education gave lengthy consideration to the specific roles and responsibilities of nursing service and nursing education in preparing nurse practitioners, recognizing fully that professional education is a continuing process. In the spring of 1965 the committee recommended to the NYSNA Board that a special conference be held which would enable nursing leaders to discuss, in depth, nursing education and nursing service and the role of the professional association. This recommendation, approved by the Board of Directors, led to the 1966 Arden House Conference on "Education for Nursing Practice". The conference in turn will guide much of the committee's thinking during the coming biennium. Hopefully, it will also serve to stimulate similar discussions and study on a local level in order to involve many nurses in considerations vital to the profession.

Shortly after the Board of Directors approved the Committee on Education's recommendation for an Arden House Conference the ANA Position Paper on Educational Preparation for Nurse Practitioners and Assistants to Nurses was published. This timing proved to be most fortunate because it provided an opportunity for the conferees to examine and discuss freely the professional association's Statement of Position on Education for Nursing.

This report on the 1966 Arden House Conference is presented in an effort to provide the conference participants, and others, with a record of some of the many thoughts, ideas and questions expressed during those two days spent on top of the mountain. Reducing the substance of a dynamic group discussion to mere words on paper imposes limitations. The true flavor and depth of the discussion cannot be captured nor can the interaction of the group process be recorded. It is important to remember this when reading the published reports of the group discussions.

We are indebted to all the conference participants for giving so freely of their time and talents. The value of this will accrue to all nurses in the Empire State.

Esther M. Thompson, R.N.
Chairman
NYSNA Committee on Education

"Re-Marriage - Education and Service"

QUOTES OF NOTE BY PANELISTS

Frances Reiter

. . . Our very name comes from the source "nutrients" — the nutrients of health, the nutrients of family, the integrity of the family and giving of care during periods of dependence . . .

. . . We need constructive ideas, knowing our problems are monumental, knowing those of us in education are caught in a system that prepares for what we "think" our social values are, as best we can identify these, but from our heritage, have put a value upon the academic — which may, for the moment, seem to be outweighing the clinical — the direct patient contact. And those of us who are in service, are caught in another kind of closed system that has made us accountable to both hospital administrators and the medical — giving us almost no room to assert our own control of our personal, human. care of patients. . .

. . . With modern trends — rapid change — it is possible we could be submerged in these changes. It is possible that the half million aides that we have brought in to give care are beginning to say "The care of the patient is ours and you have no right to this care" — we need to face this . . .

Sister Mary John Baptist

. . . The elements of a good marriage are the elements we look for in nursing and may have lost — giving — generosity — kindness — thoroughbredness — these all build up to love . . .

. . . How many of us are really secure in giving care to patients; secure in extending ourselves; secure in committing ourselves to what we've promised to do — give care . . .

Ruth E. Simpson

. . . A student who comes to us has many virtues — ideals — she wants to help people. She has within her heart a willingness to give . . .

. . . In education we try to help them. We give them tools to develop abilities so they can perform and give what they say they want to give . . .

. . . My concern is that, once they have the tools and once they get into a situation, our responsibility is to continue to nurture these ideals . . .

Claire E. O'Neil

. . . I am concerned over the fact that a new graduate, when placed in a hospital situation, is unable to personally sustain her aims and ideals. She doesn't graduate with the ego strength she needs. We need to constantly bolster their ego . . .

Frances Purdy

. . . A young graduate is taught and impressed more by the crowd around her — at coffee break, lunch, etc. . . .

. . . Each one of us had our own reasons for becoming a nurse. Whether we wear a uniform or not, we still respect it for what it stands for . . .

. . . There is a practical place for a marriage between education and service. The teaching should be more realistic, and there should be more hands and bridges across to the work situation . . .

Lydia Hall

. . . What is missing in the education of the nurse is the education of her *person,* and understanding of self . . .

. . . It is a privilege and a responsibility for nurses to do patient teaching . . .

Dorothy T. White

. . . We talk in nursing service and education about how we are going to prepare a graduate. The graduate then goes into a work situation in which there isn't a place for her . . .

. . . The position which the hospital says it has is not the position for which the graduate was prepared in her educational program . . .

The Case For Creativity in Nursing

Apollonia O. Adams, R.N.

Currently there is competition for the very minds of men. Among these factors which will determine the outcome of that competition, creativity is one of the most important. In fact, it is the hope of mankind. As in all professions, the case for creativity in nursing is today's challenge. Because of the rapid pace of scientific knowledge in this changing world, we can no longer rely with security on present "basic principles" as a means of educating for the future. No system of education that we now have can prepare for the "unknowns" that science will bring tomorrow or late this afternoon. In preparation for tomorrow we must find and nurture our most creative nurses. We must stimulate creative action in the solution of problems, for meeting the day to day crises that are ever with us. We must reward creative thought and action, not destroy it.

With what and where do we need creativity in nursing? It seems to me that we will need the most creative approaches possible:

(1) *to attain quality nursing care and services;*

(2) *in redesigning and developing all levels of nursing educational programs, the basic, the graduate, and continuing education;*

(3) *to stimulate, permit and nurture the creative skills and talents of all nursing personnel in all work situations.*

We need more creative ways to teach better observation. We need more creative ways to prevent the dulling or withering of that skill.

In the re-arrangements and shifting of emphasis that is predicted in nursing education, we need a brave new approach to the evaluation of the skills and knowledge of the diploma graduate who applies for academic preparation. We must not destroy the potentials of that group. We need creative thinking and action for best utilization of all nursing personnel, including those in nursing education as well as in nursing service.

The nursing profession accepts change slowly and the public's image of the nurse's role in the healing team changes even more slowly. For recruiting men and women into nursing, we must demonstrate that we encourage bold, imaginative thinking and that a career in nursing can be an exciting and rewarding adventure with great opportunity for originality of thought and action. We must see that this is possible.

There will be many obstacles in the path to creative action. Every adventurous person has had to struggle with reactionaries. Mythology is full of tales of boldly creative beings like Prometheus, who was tortured; Talos, who was destroyed for daring to explore the edges and depths of wisdom. Creating means change, and change as we all know can be frustrating, disturbing and painful. It can also be exciting, stimulating and inspiring.

If we are truly to attain quality care - comprehensive care - we must be unafraid to change outdated staffing patterns.

Too often we have conformed to the desires of employees rather than patients and therefore, earned the respect of neither. We talk about the lack of "dedication" in nursing. I do not believe that we need to worry about dedication or enthusiam, if we use creative approaches to patient care. Enthusiam of this kind is quite contagious. We must be willing to select our leaders, or take the ideas of the leaders, or support or re-enforce our struggle for status and over-desired self-image; but because they will lead us, painful though the way may be, to quality care and services for Mankind.

As I looked over the reference list given to you for this meeting and thought of still other materials, books, articles, I realized that we have a wealth of ideas, suggestions which we read, probably agree to and then never use, or put very many of them into action. Do we discipline ourselves enough to schedule time for creative thinking? Do we encourage and allow others around us to do this? Or do we tend to say that because of pressures of work this is impossible? How do we react to the nonconformist?

The 17th Century philosopher, Roger Bacon's "Four Stumbling Blocks to Truth" might well apply now to creativity in nursing. They are:

1) *The influence of fragile or unworthy authority. (None of you have probably ever experienced that!)*

2) *Custom - (How heavily are we burdened with this in nursing??) (Yet to give the word a different meaning — how creative could our approaches to care be if we considered the customs of the people to whom we give care?)*

3) *The imperfections of undisciplined senses. (How does this relate to observation? Relat to sufficient scientific knowledge?)*

4) *The concealment of ignorance by ostentation of seeming wisdom. (I'll let you silently pick your own examples of this).*

Not only will we meet with resistance in nursing and from nurses, but the very society we operate in will make the creative process progressively more difficult. Yet, it is from this society that we must recruit our future nurses and their leaders.

However, all is not dark and hopeless. We do have an example in nursing of an approach to patient care which shows great promise. The development of the clinical specialist has been the most creative step we've taken in years. Also, we can by looking at what is preventing or defeating creativity, work to remove those causes - to nurture creativity in nursing.

We have at this meeting some of your most creative people to stimulate you. We have at this meeting an opportunity to spend time together, away from turmoil to try to think big - think new. "They build too low, who build beneath the stars" is an inscription over one of the doors at the Library of Congress, a doorway to knowledge.

This work we are to do — this challenge we are to meet — will be very difficult for as Adlai Stevenson said, "In this new twilight of power, there is no quick path to a convenient light switch."

As we begin to work together, these next two days, I am reminded of Huxley's advice on how to approach such an opportunity. We must sit down before a fact as a child and be prepared to give up every preconceived notion, and follow it wherever and to whatever abyss it leads us, or we shall accomplish nothing.

EDUCATION FOR ? ? ? ?

Eleanor C. Lambertsen, R.N., Ed.D.

> *If anything significant is to be accomplished, leaders must understand the social institutions and processes through which action is carried out. And in a society as complex as ours this is no mean achievement. A leader, whether a corporation president, university dean, or labor official knows his organization, understands what makes it move, comprehends its limitations. Every social system or institution has a logic of its own that cannot be ignored. (1)*

It is my premise that the delivery of nursing service will continue to be an increasingly complex social problem, that social pressures, social forces and social legislation have and will continue to result in action programs for health services. Action programs that may or may not be influenced by nurses, physicians and other "vested" interest groups in the health field. It is not necessary with this group to review the federal and state legislative programs currently supporting the preparation of semi-skilled and sub-professional workers for health services. In February the Departments of Labor and Health, Education and Welfare held a conference to study ways in which the government's programs on manpower training, poverty programs and vocational training could best be used to create a pool of a million qualified health service workers in the next ten years. At the conference Mr. Keppel stated:

> *"Medical care has been priced out of the market for many. One way to cut costs and spread available services would be to provide more trained people at the sub-professional level to supplement the work of the physician."*

Is the leadership in nursing aware of the enormous import of the social responsibility inherent in the current legislative programs? Are we capable of coping with the larger questions? Have we abdicated a significant leadership role in shaping public policy?

> *"Leaders have a significant role in creating a state of mind that is the society . . . they can conceive*

and articulate goals that lift people out of their petty preoccupations, carry them above the conflicts that tear a society apart, and unite them in the pursuit and objectives worthy of their best efforts." (2)

I do not believe the issue is that of the system of education for nursing service personnel. For education for nursing - and this is true of education for all occupational groups - is a reflection of social investment in the particular worker. And education for nursing will be influenced by the social values placed upon education for all American youth. A predictable and irreversible trend is increased educational opportunity. There is every evidence that the rapid growth of junior colleges will increase and that increasing numbers of these colleges will offer technical level preparation for nurses and members of other allied health fields. Between 1960 and 1970, the American Council on Education expects college admissions to increase by 150 per cent while the increase in college age population will only be 50 per cent. It is anticipated that all workers in nursing service will be better prepared educationally and that the graduate of the baccalaureate programs will be further challenged in her leadership role in the practice of nursing. I further predict that in the not too distant future the professional nurse practitioner will be prepared at the graduate level, for this too is a social trend for other professional groups.

The role of nursing in this changing social order places increasing responsibility on professional nurse practitioners in case finding, prevention, rehabilitation and supportive services as well as therapeutic services. We cannot continue to place emphasis only upon illness. Certainly we need more nurses, but our desperate need is for professional nurse practitioners who are more broadly prepared than narrowly prepared — nurses who can move effectively in nursing services from the variety of settings such as hospitals, nursing homes, clinics, ambulatory services, home care programs, homes, schools, etcetra in any cultural environment anywhere in the world. We cannot afford to continue to prepare leaders in nursing who are bound by the routines, mores and traditions of one or two employment situations or even one particular country.

In the decade ahead technological advances and resulting changes in health institutions and agencies will require a liberally educated nurse with the capacity for professional judgment and professional action as yet undefined in our professional literature or our research.

We must recognize that a set of skills, accepted as professional when just developed, may become so routine that they can be taught to or "caught" by other individuals through the use of concise directional statements or through advances in educational

technology. Knowledge has a similar filtering process. Recall if you will the newspaper accounts of the physiological and psychological status of the astronauts; of the increased numbers of scientific articles in magazines such as *Life*, *Saturday Review*, *Time*, etcetra.

One of the most significant areas of social development which will have a direct affect on nursing is the changing nature of the patient population. A better informed public and an increasing number of prepayment plans and other means of financing health services has resulted and will continue to result in an increased number of people availing themselves of health care services. The increases will be in the "high use" groups: the old, the young, the "therapeutically well" who previously would not have been expected to survive. This informed public will increasingly demand quality as well as quantity of health care services.

The patient's relationships with physicians, nurses, administrators of health service agencies and other members of the therapeutic team will change as he is expected to make more decisions about seeking and using care and as he becomes more involved with decisions about the therapeutic measures to be taken. He will also be cooperating in his own therapy to an unprecedented degree.

Patients' problems will be more complex as chronic illness increases and multiple problems of patients and families come into focus. Today a significant gap exists between the best kind of health care we can provide and that which is available to many of our people. In spite of our efforts to date, there remain substantial groups of people who do not benefit from the assumption that health is a basic human right — these groups are the economically, culturally and physically disadvantaged. Major federal and state legislative programs in health are attempting to resolve these problems.

Dr. Leona Baumgartner in the White House Conference on Health held November, 1965 stated:

> *"The web of social and physical chaos, which is largely the product of our amazing successes in a free society of expanding science and technology, is the part of health about which the least is known. We are victims, as it were, of a "mindless power system" . . . pollution, pesticides, drugs, new tensions, more leisure, foods, new ways to protect against disease, powerful machines that change our landscape and our lives . . . changes that affect each of us whether we know it or not. How are we to live healthy in this new world? Herein lie the problems for which there are few definitive answers and for which*

we need to invent solutions; problems which involve a vast array of fiercely conflicting economic, social, and political interests; problems that are constantly changing with new scientific discoveries." (3)

In this same conference the participants agreed that the role of the health team requires better definition. There is an urgent need for a careful analysis of the skills and knowledge needed by each allied health worker.

The roles of the physician and nurse will change substantially. The upgrading of nursing education and the resulting competence will equip nurses for increased responsibility for independent action and decisions. A need was expressed at the White House Conference to expand the concept of the physician-assistant, health visitor or community health aide. Is this to be a new member of the health team or an extension or redefinition of professional nursing? This is an issue we must be aware of, and we must be prepared to take an active part in the deliberations. It is my strong belief that there has been all too much emphasis upon role definition in isolation on the part of all of the health professions. Dr. Lowell T. Coggeshall recently asked:

"Are Health professionals being trained so narrowly that they are merely acquiring an encyclopedic knowledge rather than acquiring the ability to make appropriate decisions for broader medical services or as leaders of future health teams?"

Is this a danger in nursing? The issue in specialization is not that of denying the need for expertness but rather that of specialization in proper perspective. Specialization must reflect a social consciousness of relationships and responsibility. It is this approach to specialization which is essential and safeguards coordination in the multi-disciplined approach to problems and needs of the clients served by the specialists. Nursing exists and functions in a society geared to specialization; in a society geared to specialization in health services. The paradox is that these same social forces which tend to create more and more specialists in the health services tend to reinforce the generalist's concept in the profession of nursing at the time nursing leaders are promoting the concept of the clinical nurse specialist.

Dr. Edmund D. Pellegrino, a leader in medical education has succinctly stated:

"The resolution of the question of the optimum relationship between all those who contribute to patient care remains as one of the more crucial problems facing the health professions in the years ahead." (4)

How much longer will society continue to tolerate the diffusion of functions and dilution of nursing services? Granted anxiety will be created in older practitioners and there will be difficulty and disagreement about relocation of functions. But the longer we delay clarifying the function of the professional practitioner in nursing the greater will be the problem and the more serious the nature of the quality of nursing services.

The professional practitioner of nursing will be competent in the techniques of critical inquiry, decision-making and therapeutic action. This competence will be assured if the practitioner is knowledgeable in the techniques of securing pertinent information at the time it is indicated. Since professional roles will become increasingly blurred she will be capable of defining the significant contribution of nursing. She will be an effective member of the therapeutic team and assume responsibility for leadership of the nursing team.

Technological developments as well as scientific developments in health services will continue to influence the role and function of the nurse practitioner.

Significant changes are already occurring in the delivery of health services. Jack C. Haldeman, M.D., President of the Hospital Review and Planning Council of Southern New York, speaking on the "Hospital of the Future," at an NLN regional conference for consultants predicted the following developments by 1975: we will spend a higher percentage of our resources for health care than we do now; hospitals will become "medical health service centers" doing more in the fields of early diagnosis, health maintenance, and prevention and rehabilitative medicine; and as a result of the differences in emphasis in medical treatment fewer hospital beds will be needed. Programs of post hospital extended care, outpatient diagnostic services, and home care services will provide much of the care now given in hospitals. The development of these services will be hastened by Medicare, which will reimburse those providing the service. Large institutions for the mentally ill and mentally retarded will give way to community health facilities. These will be located closer to the patients' homes and will offer preventive, early diagnostic, outpatient and inpatient care, and traditional and rehabilitative services.

Automation, patient monitoring by television and other electronic devices are and will continue to revolutionize services of health agencies. Edward H. Norian, a hospital administrator at an NLN Regional Conference in 1962 developed a hypothetical model of an automated hospital:

> *"The hypothetical hospital would begin to activate all its records, both accounting and medical,*

and its operations at the moment each patient walked through the doors . . . . For example, when the admitting officer would punch the patient's social security number, this would go into a storage mechanism. Then, as each subsequent test and diagnostic procedure were developed, the result would automatically be lodged against that number . . . . " (5)

In addition, while the patient is in his room physiological data could be produced either continually or randomly, depending upon a desirable mode at the time.

The hospital of the future will eliminate the patient's chart, for information will be available through data processing equipment and retrieved at computer stations which will replace head nurse stations. Closed circuit television will be in every patient's room and facilitate observation and recording of patients' responses on video tape. As a result there will be increasing concern with the depersonalization of patient care and as a consequence with humanizing the environment. The responsibility of nurses for the therapeutic milieu will extend beyond that of the environment of the psychiatric institution. The stress of separation from a normal life situation and adjustment to this complex environment will intensify the needs for nurses skilled in the principles of mental health-psychiatric nursing.

The professional nurse practitioner and those responsible for the administration of nursing services will function in a different world with increasing numbers of complex problems.

In his proposed international health and education acts of 1966 President Johnson has called for a global attack on ignorance and disease. He pointed out that the first requirement of an international health program is trained American manpower. This legislative program complements current legislation and extends our responsibility for the preparation of professional nurses for leadership in international nursing.

What then is the potential role and function of the professional nurse practitioner in this space era? For I envision a practitioner of nursing capable of communicating with practitioners of nursing in other parts of the world. Expert practitioners of nursing in these United States will be in a position to provide leadership for planning, providing and evaulating nursing care in an international setting as compared now to one patient unit in a specific hospital or in one local public health setting. Through the mechanism of television and the satellite we are now able to establish visual and auditory communication between people of different continents or countries. Is it not feasible to consider the extension of this facility to the health field?

Universities and leading medical centers will contract for services with other developing countries and maintain communication through high power satellites. Plans of nursing care will be developed with a team in another part of the world; evaluated in conference, be translated into any language and put into effect under the "direct" supervision of the nursing team leader.

Closed circuit television available now in a limited number of hospital settings will be extended to homes in our local communities and to patient-family settings in other parts of the nation or world. Clinical experts in nursing will be readily available for patient-family counseling in quite a different type of community nursing services.

Electronic physiologic measuring devices are already producing diagnostic information for use by the physician. Although the present day patient monitoring systems are cumbersome and complex it is conceivable that it will be possible for ambulatory patients to be monitored through already known devices and that changes in these patients physiological status will be reported and recorded in centralized receiving stations. For telemetering makes possible the transmission of information by radio, rather than by wire, from the transmitting source to a receiving source.

We can get fully automatic operation of machines doing routine work; we can get decision making by machines; we can store vast amounts of information and have rapid access to the information when we want it; and we can get feedback - that important factor which alerts human beings or other machines to the fact that something is wrong and requires correction. This does not mean that the nurse can delegate to the machine responsibility for supervision of patient care services. The machines will be called upon to provide the observer with additional information and then move in a program which the observer has already scheduled for it to carry on. The dimension of planning and programing for nursing care will have very different meanings. Responsibility for decision making on the basis of scientific principles will be an absolute requirement.

Our success with the "man in space" will in the not too distant future be reflected by the "nurse in space." Do you recall that it took all of 18 minutes for the astronauts to rocket from Florida to Africa? What will be the concept of home visitation or even staffing for community nursing services in the not too distant future? What will the nursing service community consist of in this emerging space era? Nurses in university medical centers must be capable of asserting leadership in the preparation of nurses for their changing roles and function.

In this projection of scientific advances the College of Nursing of the Air will become commonplace. Students of nursing will be brought together in international, national or regional schools

through educational television, rapid transportation and as yet other unexplored communication media. Expert teachers of nursing will be available to untold numbers of students in an extended campus. The development of computers which can "memorize" entire libraries and recall appropriate information almost as fast as a question is asked will revolutionize education and the practice of nursing.

Certainly with this audience it is not necessary to elaborate upon equally explosive developments in health and health services. But the concept of nursing services and nursing education for a world community implies competence in planning, providing and evaluating nursing care of patients and families regardless of the nature of the health problem and regardless of the culture or language.

Although the emphasis for the preparation of leadership for professional nursing practice today is upon critical thinking, reasoning and decision-making we must continue to redefine the knowledge, judgment and skills essential for an elite leadership in a not always predictable and changing future. The students of today are this leadership group, for in their professional lifetime what in nursing today may be thought of as a flight from reality will *become* reality. In my professional career, I have experienced revolutionary changes which today we take for granted. But I have faith in the leadership of the future for I believe that with the emphasis in professional education today our graduates will be capable of predicting and purposeful planning for change and increased responsibility.

FOOTNOTES

1. John W. Gardner, "The Antileadership Vaccine." Annual Report of the Carnegie Corporation of New York, 1965.
2. Committee on Perspectives. **Perspectives for Nursing.** New York: National League for Nursing, 1965.
3. The White House Conference on Health. **Panel Summaries.** 1965.
4. Edmund D. Pellegrino, M.D. "Medical Service and Patient Care," **Hospital Progress,** November 1963, pp. 79-84
5. Edward H. Norian. **The Challenge of Automation,** Blueprint for Progress in Nursing. New York: National League for Nursing. pp. 37-40.

EDUCATION FOR ? ? ? ?

Jean Campbell, R.N., Ed.D.

The Fall 1964 issue of *Daedaleus* carried an article by Clark Kerr titled "The Frantic Race to Remain Contemporary". (1) Currently it is contemporary to emphasize creativity, the new, the different. The result of this emphasis may be a major cultural change or merely another fad. Kerr identifies the quality of self discipline as the attribute that distinguishes between the scholar and the top-of-the-head idea man. It is this quality, he says, that will make the difference between what could be an essential contribution to the general body of knowledge and just an interesting hypothesis. It is possible to shift the context of this idea a bit and say that the essential difference between top-of-the-head ideas in nursing and actual contribution to progress in nursing depends upon the amount of self-disipline all of us are willing to endure.

Over the past 25 years we have had many serious discussions of educational needs in nursing. A criticism one might make of many of these explorations is that they focused mainly on how to get more of what we already had. Not all were so limited, however. The idea of the nurse clinician was envisioned 23 years ago (2); *Nursing For The Future* (3), concerned with the education needed for the responsibilities to be carried, was published 18 years ago; *The Education of Nursing Technicians* (4), 15 years ago; *Collegiate Education In Nursing* (5), which interpreted essential characteristics for nursing education in a college setting, 13 years ago. (As we think of these time spans we certainly cannot be accused of being flighty.)

These writers focused not on more of what we have but on discovering and making available to greater numbers the kind of preparation relevant to the world in which they live and to the society which they serve. We have been very slow in picking up the really creative ideas they expressed. In some situations, unfortunately, we picked them up to distort them out of all real semblance to that which was proposed - developing the facade but not the substance.

The ANA statement on education is a new attempt to present a realistic appraisal of educational needs for nursing developed in the light of the responsibilities carried by nurse practi-

tioners, licensed and registered. It has been developed in recognition also of the groundwork of the past and of the many present forces in our society that make this a likely time for redirection

The statement itself identified some forces operating in our environment which suggest that current educational patterns for nursing need change, that they are not in tune with our time. You probably already have considered many of these; yet, I doubt that they can be emphasized too much.

We have a population whose members increasingly hold the expectation that college - not secondary school - represents the satisfactory minimum level of education. Given this, it is absurd to say that those who work with people in times of their greatest stress do not need to be as well educated.

We have a rapid development of state systems for public education beyond the high school. Given these, it is foolish to say we will not use them.

We have an increasingly industrialized society with its problems of dislocation and alienation. Given this, it is preposterous to say we do not need people in nursing whose education is humanely focused.

We have such extensive scientific developments in the health care field that to continue just to supply more of what we have smacks of the immoral - wrong to both the student and the society that is to be served.

This conference has been struggling with the problem of how to overcome inertia, to redirect movement. The question has been phrased as "how do we move in an orderly fashion from where we are to the position outlined in the paper?" First of course, we must want to move. Then we must also recognize that whatever the process, that it will be orderly is a most unlikely occurrence.

In our society change in human affairs is rarely the result of action growing out of reasoned judgment, thoughtful and logical analysis, and concensus among diverse groups. Hopefully some degree of each of these is present. However a realistic appraisal of forces that will encourage or retard action is crucial to any attempt to redirect movement. We have identified forces in our society whose presence indicates that change is necessary and that education for nursing is out of date. These forces are available for use in bringing about change.

Within nursing itself, however, are the forces that will determine how rapidly and in what directions change will occur. The ANA statement focuses solely on nursing practice and on the educational needs of those who work in nursing to the end that their performances will meet the needs of people for nursing. Because the statement is comprehensive it identifies changes related not only to present but to future needs. It proposes changes for educational bases that few practitioners today possess. Few

practitioners licensed for nursing are prepared in associate degree programs. Few practitioners registered as nurses are prepared at the baccalaureate level. Heavy responsibilities for patient care are carried currently by practitioners with neither background. Because of this, it is obvious that a major factor encouraging or hindering change will be the quality of the human relations we are able to develop. We may be as strong as any other group in this area, but we are not very good. It is unfortunate that variety in nursing background tends to be appraised as good or bad on some mythical continuum of quality rather than as differences in kind or type.

It seems to me that there are two major commitments which must be made and kept. These commitments are crucial for developing the kind of human relationship among practitioners that will encourage change. They are essential for accomplishing the goals outlined in the position paper. They can be simply stated.

First, commitment to the belief that the *quality* of nursing practice is the overwhelming concern for *all* who work in nursing.

Second, commitment to the belief that the preparation of *all* future practitioners is the rightful concern and responsibility of *all* who work in nursing.

I should like to consider some of the implications present.

Everyone involved in nursing must be more concerned with the practice of future graduates than with the numbers of students currently enrolled. That this is the present concern is, I believe, debatable. New programs, baccalaureate and associate degree, are opened in spite of limited members of qualified faculty members and, in some instances, inadequate clinical facilities. Diploma programs suddenly find it possible to reduce length in order to remain competitively attractive, or attempt to ape other types of programs for the same reason. Actions such as these support a theory that school existence and students are of greater importance to nurses than future graduates and their competence.

Everyone involved in nursing must be concerned that programs in existence provide proof that they are developing soundly or else that they go out of existence. The ability to obtain accreditation or Reasonable Assurance of Accreditation provides evidence of some quality even though accreditation standards today are minimum. In New York State in 1963, 58 of the 126 programs in existence were not accredited. As of October 15, 1965, 66 of the 136 programs were accredited and 70 were not (7). The major causes for lack of accreditation are lack of qualified faculty or lack of willingness to hazard the judgment of peers. When other reasons are given, I believe they are rationalizations. It is the present practice of the SNA to contribute to recruitment for non-accredited programs by publicizing these in its published list of nursing schools. Such action denies commitment to the idea

that the quality of nursing practice is the fundamental concern of all who work in nursing.

Each practitioner, registered or licensed, each nurse assistant, must be individually militant in representing the patient or family interest. Rarely does one read that a situation in that hospital or this community was changed because nurses said that good care demanded it. There is no d[illegible]hat it is easier to argue words as "professional", "practica[illegible]chnical", etc., among ourselves that it is to go to city hall, the local newspaper, the medical board, etc., in a battle for opportunity to provide better patient care. It is easier to criticize the performance of othe[illegible] than to participate in establishing criteria for care, to test these, and to act upon the results. A good beginning for each practitioner would be the observation and analysis of his own practice. This analysis would require prior clarification of areas of practice and scope of responsibility in each. This in itself could be a most enlightening activity.

Practitioners of nursing cannot be prepared without clin[illegible] tings, in which to learn. As long as attitudes are caught it will be the observations of those already practicing nursing that for many *learners* will control their concepts of real nursing practice. As role models *all* practitioners in nursing have a common responsibility for the preparation of future practitioners. All nursing practice has a common goal: representing the patient's and family's interests and, as Weidenbach phrases it, working within the patient's and family's perception of illness. Although the goal is common, the interests and perceptions are varied, and the needs are varied. Nursing practice, therefore, while it constitutes a unity is a unity of that which is varied or diverse rather than uniform in its elements. As a unity it is a oneness that is "gained by the interdependence of parts or individuals and of the cooperation of all so that each within its proper limits helps in effecting the end of the whole". (9)

Only as learners have opportunity to observe respect for differing skills, and acceptance of varying abilities as needed and responsible parts effecting the end of the whole that is nursing practice, will they learn to participate effectively in their roles. As future practitioners have opportunity to observe individuals practicing various roles, each gains a concept of the expectations that he will face. Only as he has opportunity to observe individuals practicing in diverse roles will he gain a concept of the totality we call nursing practice. Therefore, all practitioners of nursing have a common responsibility for the preparation of future practitioners.

Years ago we separated teaching and service functions in order to define the areas of responsibility of each and to focus on each more clearly. I doubt if we should have progressed as far as we have in both service and education had this not happened.

My observation of areas where dual responsibility still exists supports my belief in the desirability of separate role responsibilities. When separation is carried to the extreme however, it becomes mutual isolation and the sense of mutual responsibility for future practitioners as well as for present service is lost. To regain it is not easy.

A few weeks ago an instructor asked a trained baby nurse if it would be possible to have a student observe as she bathed, fed, and cuddled her charges. The response was — "Say, who the hell is the teacher around here?" Very crude, you say? You need to know that the charge nurse on this unit did not want practical nurses. Before the students came to the unit she had said, "These are college students and you are not to interfere with them in any way." Small wonder that the hurt and resentment came out as it did against the instructor.

Before we are going to progress very far in educational change in nursing, we must mend some fences among nurses, licensed and registered.

"Getting to know you" constitutes an immediate first step in all settings used for student experiences. Agency and faculty staff in each setting need to develop a plan whereby some of each attend each other's conferences as practitioners concerned with nursing, not as representatives of problems. This isn't new or creative - it's old stuff - it's also something that across the board is not done on the area levels on which it needs to be done. There may be great understanding on the so-called upper levels, but too often this doesn't filter into patient care units. The interchanges I am suggesting need to be at the area levels. These are the levels where agency people constitute role models for students and where students and faculty make some contribution to patient care. This is where learners either become aware, or fail to, of the competence possessed by people with varying backgrounds. It is where respect is learned. It is where the future practitioner gains, or fails to gain, ideas on how to practice more effectively.

"Getting to know you" demands acquaintance on the human social level as well as the work level. Both service and faculty staffs can arrange such situations, and need to do so. I'm not recommending overwhelming togetherness, merely suggesting two ways in which better acquaintance might lead to better practice and better education for future practitioners.

Improvement of relationship *within* nursing is, I believe, the key to effective utilization of social forces that encourage attainment of the ANA position on education. The need for improvement can be documented further by reading the letters in *NO* and *AJN* listening to discussion at any council meeting, or noting comments on associate degree programs made by nurses and reported recently in some newspapers and in hospital journals.

We cannot expect militancy from the individual when

those of us who purport to be leaders are not seen as militant in our representations of patient interest. As long as other allegiances are primary to us we shall not identify clearly enough the scope of activity that is nursing practice - its responsibilities and its authority. This clarity is essential. To date what is nursing is determined primarily by expediency, history, and status, not study and analysis. Study and analysis need to be ongoing among staff in the area levels of agencies and among faculty in schools. Practitioners must continue to study the needs of the patient and how to meet them more effectively or nursing will cease to be the care of people. This is no idle fear. Nursing has gone far toward becoming what no one else in the setting is available to do. There is pressure for nurses to become medical assistants and even machines are competing for attention.

A recent advertisement in one of our periodicals called attention to a workshop in physiotherapy. It noted that emphasis would be on what the nurse could do when a physiotherapist was not available. It did not say emphasis is on how the nurse can use the physiotherapist if one is available.

There is too much of this. The nurse who is substitute administrator when the administrator is away leaves her nursing function.

The nurse who is the pharmacist when the pharmacist is not present leaves her nursing function.

The nurse who terminates IV's or does blood work because the doctor is not there leaves her nursing functions.

The primary function of people in nursing is not to pinch hit for other staff. It is the responsibility of nurses to identify the scope and responsibility of nursing and to insist that other people whose functions also require 24-hour or weekend attention assume their own responsibilities.

Nursing practice is a social service; it is service to the patient or family. Nursing education, however, is not a social service although it prepares for such. Only as educational needs of learners are met will future service needs of society for nursing be met. The Position Paper on Education outlines reasonable, attainable, desirable goals for preparation for nursing. The process of transition to these educational patterns will document the quality of self-discipline that is present in nursing today.

FOOTNOTES

1. p. 1051 — 1057
2. AJN. Feb. 1966 p. 274
3. Esther Lucile Brown, N.Y. Russell Sage Foundation 1948
4. Mildred L. Montag, N.Y. G.P. Putnam's Sons 1951
5. Margaret Bridgman, N.Y. Russell Sage Foundation 1953
6. Facts About Nursing, A.N.A. N.Y. 1964 p. 112
7. N.L.N. Researched Studies Unit. Unpublished
8. Clinical Nursing, A Helping Art. N.Y. Springer Publishing Co. p. 12
9. Websters's Dictionary of Synonyms. Mass., G&C Meriam Co. Publ. 1942 p. 858.

QUESTIONS FOR GROUP DISCUSSION

Overall question to all groups: **How do we move in an orderly fashion from the present situation to that outlined in the ANA Position Paper on Education?**

QUESTIONS FOR

Considered by	QUESTION
Group I page 26	How can nursing education and nursing service cooperatively and creatively prepare the practitioner to practice more effectively in terms of: a. New demands b. Acquisition of new knowledge and skills c. Trends in education and health care
Group II page 29	Control of nursing is vested in a number of sources: nursing service, nursing education, medical practice, statutory regulations, and social forces. a. How can the profession of nursing exercise more effective control of nursing? b. What additional measures are possible to control more effectively nursing practice to the end that nursing care may be improved?
Group III page 30	Experimentation, studies, and research must be stimulated. Both education and service have a joint responsibility. How can this be promoted? a. Who should do it? b. How can knowledge gained in research be implemented and disseminated? c. How can the blocks in the use of research findings be eliminated?
Group IV page 32	What does nursing service expect of the new graduate? a. What are the specific areas of competence? b. Which abilities are found infrequently? c. Is education able to assume the full responsibility for preparation of the practitioner and should it do this? d. What responsibility should nursing service accept? e. How can joint planning serve to minimize the problem?
Group V page 34	How does nursing service envision the role of the clinical specialist in nursing services? a. What is the realism of this concept? b. How can education begin to support the preparation of the clinical specialists in numbers sufficient to meet the demand? c. What should be the preparation of the clinical specialists? d. What other methods can be used pending availability of the clinical specialist?

GROUP DISCUSSION

Group VI
page 37

Staff development is a continuous process. Joint planning between education and service are essential if this is to be most effective. How can we:

a. Foster joint planning in this area
b. Delineate areas of responsibility between service and education
c. Improve programs
d. Bridge the gap between the role of student and that of practitioner
e. Promote clinical competence

Group VII
page 39

Leadership in nursing is of paramount importance. Nursing education and nursing service have a dual responsibility in fostering leadership.

a. What specific measures are indicated to promote recognition of ability and stimulate the development of the future leader?
b. Leadership demands creativity. How can this aspect of leadership be fostered?

Group VIII
page 41

Have we achieved a professional level of nursing practice?

a. If so, in what areas of specialization are we successful and where are we unsuccessful or less successful?
b. How can we achieve or promote professional practice?

Group IX
page 44

Promotion of quality care in nursing service is essential.

a. What are the components of quality care?
b. How can nursing service be organized to promote this aspect of patient care?

Group X
page 45

Joint planning between nursing service and education is necessary if there is to be maximum use of available clinical and educational facilities for the preparation of future practitioners in New York State?

a. How can this joint planning be facilitated?
b. Is regional planning realistic and practical?
c. Who should take the leadership role in this endeavor?
d. How can it be initiated in the interest of promoting effective nursing education?

Group i

Leader: **Helen F. Pettit**
Recorder: **Sister Marie Michael**
Members: **Janet M. Day**
Claire E. O'Neil
Rosemary Pellegrino
Frances Purdy
Mildred S. Schmidt
Margaret P. Sydow
Margaret H. Wells

QUESTION:

How can nursing education and nursing service cooperatively and creatively prepare the practitioner to practice more effectively in terms of:

a. New demands
b. Acquisition of new knowledge and skills
c. Trends in education and health care

We support the ANA Position Paper and the philosophy of nursing practice implied by the description of the nursing roles (professional and technical).

We believe the principles stated are needed to assure optimal nursing care of the patient and preparation of students of nursing both for today and tomorrow.

We understand the separate and distinct objectives of nursing educational and service programs and the immediacy for better understanding and interaction to be developed between the two groups.

We are well aware of the present situation in preparatory programs and nursing services and recognize the imperative need of careful planning on a regional basis to insure sound standards of nursing education and nursing care.

RECOMMENDATION 1:

We recommend that wise and seasoned nurses, without further delay, assume the initiative in community planning for sound programs of professional nursing education and preventive and therapeutic nursing services.

In order to provide an orderly transition from what we have to what we need, we believe nurses must take the initiative for cooperative planning in each community to meet the health needs of the public and provide for the educa-

tional needs of those wanting to enter the occupation of nursing and those wanting to continue their preparation in nursing.

We urge that all of the educational resources of the region be studied. This should include the long term plans already laid down by the State University system and the City University of New York as well as those of other educational institutions.

Health care agencies should be considered in a similar manner in relation to their purpose, contribution to the health needs of the region and their appropriate future role.

We envision core health centers (hospitals, public health agencies, or university medical centers) focusing on a broad spectrum of health needs, combining patient care, teaching and research. Around the hub or core of central services, we envision a group of satellite agencies and schools sharing knowledge and certain personnel.

The interrelationships of these groups must also be studied since their interdependence is obvious and essential. For example, education must have a practice setting for laboratory and field work that demonstrates sound care and in which the student will find a role model. Nursing studies and research must be made and tested in suitable clinical settings. Patient care and staff development within agencies should expect the attention, experience and knowledge of well prepared practitioners within educational settings and these individuals need to continue to practice.

In the immediate future in order to provide essential nursing education and nursing service a region may need to continue sound NLN-accredited diploma programs. Present planning however should include a blueprint for movement toward the educational programs recommended in the Position Paper.

It is our belief that present administrative and nursing service patterns militate against the practice of professional nursing as we know it should be and/or should become.

RECOMMENDATION 2:

To implement the care we envision, the structure within which nursing is practiced must be modified. Health care services will need to be organized through a multidisciplinary group of

which the Chief of Professional Nursing Services would be a signal member or Chairman. Her preparation would be at the Masters or Doctoral degree level depending on the scope of care, teaching and research responsibilities of the entire setting and its relationship to satellite institutions. Her responsibilities will relate to all purposes of

She will promote the broad scope of care envisioned in the Position Paper through an appropriate number of clinical nursing specialists prepared at the master's level. The graduates of baccalaureate programs will be leaders of nursing care teams composed of technical nurses and nursing assistants prepared through vocational education. Supervision of the planning, giving and evaluating of care will be the responsibility of the clinical nursing specialist. Her primary role will be the care of the patient.
the setting.

This implies that the nurse at all levels will be a practitioner. An attempt was not made to outline responsibilities for persons in institutional administration but these responsibilities were considered to be outside of the scope of nursing practice.

We believe that there must be planning at institutional, local, and regional level. Pilot studies should be developed in various kinds of settings for appropriate utilization of all resources. Those who have experimented with new types of staffing patterns, such as the use of the clinical specialist, should share their experiences by writing articles for journals and by encouraging observation visits.

RECOMMENDATION 3:

Nurses in positions of responsibility need to be knowledgeable about the legislation affecting the health occupations and implications for nursing practice. They ought to assume leadership in supporting the ANA legislation program and support proper standards of preparation and performance for those they engage for care of patients.

RECOMMENDATION 4:

Conferences, such as the present one, should be held for the same or similar individuals (preferably the former) so that progress reports can be made and future action determined.

Group II

Leader: **William Obermeyer**
Recorder: **M. June Simpson**
Members: **Gladys Olmsted**
Frances Reiter
Sister Mary Alice
Margaret S. Tully
Alice O. Vana
Catherine Voetsch
Dorothy M. Whittingham

QUESTION:

Control of nursing is vested in a number of sources: nursing service, nursing education, medical practice, statutory regulations, and social forces.

a. How can the profession of nursing exercise more effective control of nursing?
b. What additional measures are possible to control more effectively nursing practice to the end that nursing care may be improved?

This group attempted to identify the internal and external controls of nursing.

Some of the controls explored by the group were the social mandate, budget, hospital administration, medical groups, tradition, federal financing, automation and statutory control. We moved from this to concentrate upon recommendations concerning how we might better exercise control in nursing.

Some of these recommendations are as follows:

1. We urge that nursing service and education work together to develop strong leadership in nursing. We need those who will speak up for nursing, for nursing must prove productive in a rapidly moving society.
2. We encourage the utilization of the nurse clinician in service institutions. Preparation should be made in universities for programs for nurses to become clinical specialists. In the meantime perhaps we can encourage those nurses already in the ranks, who are interested and see the value of this endeavor. We can gain more control of nursing if through practice we implement the nurse clinician.
3. It is urged that the professional organization consider specialty boards or possibly an academy of nursing within its scope. In view

bership be broadened to include other nursing groups?
of these possible developments might mem-

4. We suggest that two examinations for the two levels of nurse practitioner be considered. For further maintenance of standards should we have examination for those beyond these levels?
5. There needs to be a clearly established guideline as to the functions and responsibilities of The American Nurses' Association and National League for Nursing so that the professional organization controls, maintains and enforces curriculum standards for the various levels of practicing nurses. We suggest that NLN and ANA work toward this.
6. Nursing service needs to provide the positions for the levels of nursing with clearly defined roles. In view of the paper, and in the interest of the patient it is necessary to implement two levels of practice as soon as possible.

Group III

		QUESTION:
Leader:	**Lorraine Wallenborn**	Experimentation, studies, and research must be stimulated. Both education and service have a joint responsibility. How can this be promoted. Clinical nursing research should take priority. How can it be promoted? a. Who should do it? b. How can the knowledge gained in research be implemented and disseminated? c. How can the blocks in the use of research findings be eliminated?
Recorder:	**Laura Simms**	
Members:	**Hazel Harvey**	
	Robert Harvey	
	Jeanne Hess	
	Louise M. Pan	
	Evelyn M. Peck	
	Sister Mary John Baptist	
	Judith G. Whitaker	

HOW DO WE MOVE IN AN ORDERLY FASHION?

A. Identify groups (and vested interests) most affected:

1. The greatest bulk of nursing education today,

the diploma programs and the hospitals which support them

2. Institutions of higher education — the general system of education into which these programs must move
3. Baccalaureate educational programs and higher degree programs which now exist. They need to examine their position on the numbers of students they can accept as well as the provision of excellence in clinical laboratories — our service agencies
4. The service agencies which distribute nursing practice to the public — the utilizers
5. The rank and file of practicing nurses, many of whom will seek continuing educational opportunities

B. What Channels Can We Use?

1. The feeling that there is an urgency — New York State must take the initiative
2. The move cannot take place piecemeal — school by school
3. Rather, there must be an organized effort — This must be through the *New York State Nurses Association,* involving leaders from related organized groups as needed

The specific group task was the question stated above: experimentation, studies, research, a joint responsibility of nursing service and nursing education, giving priority to clinical nursing research. How can this be promoted?

1. The mutual concern of nursing education and nursing service may be regarded as the nature of *nursing practice* as distinct from the old cliche: *the patient.*
2. The need for two types of practice in the Nursing Department becomes more apparent:

The Organized Staff	**The Independent Practitioner**
Floor Staff — Management of the technical and institutional activities	Nurse Clinicians — Who move about more freely in the organization.
3. Clinician I Clinician II Clinician III	Progression, as a result of practice, in: a) Competence b) Sphere of Influence (Spreads services to a wider population)

Clinical studies begin as empirical in nature. They use the steps of systematic problem solving.

THE CLINICIAN:

1. Assesses specific nursing needs of the patients
2. Formulates a plan of action in terms of these needs
3. Implements the plan with the available personnel and material resources
4. Evaluates the outcome (patient oriented)
5. Reports in a systematic manner the outcome, which through accumulated practice and reporting
6. Adds to knowledge about clinical practice.

While this type of empirical study is needed it does not take the place of true research which must come through a new discipline acquired at the graduate level of education.

Group IV

		QUESTION:
Leader:	**Beatrice Latremore**	What does nursing service expect of the new graduate?
Recorder:	**Edith Roberts**	a. What are the specific areas of competence?
Members:	**Rowena Dutcher**	b. Which abilities are found infrequently?
	Eleanor Hall	c. Is education able to assume the full responsibility for preparation of the practitioner and should it do this?
	Sister Mary Robert	d. What responsibility should nursing service accept?
	Larry Spooner	e. How can joint planning serve to minimize the problem?
	Rosemary Sullivan	
	Enid Williams	

OVERALL QUESTION —

Two topics pertaining to this question were discussed: How do we move in an orderly fashion and in what educational setting should baccalaureate nursing education be given. The group reccognized the importance of having this level of education in a setting that provided the crossfertilization with other health groups. This would not be offered in a college program.

RECOMMENDATION

That there is a need for study of whether education on the baccalaureate level should be given in university or college programs.

GROUP QUESTION

SUMMARY OF DISCUSSIONS —

In recognition of the different programs of education for nursing and the increasing complexity of health care, agencies must find ways to more effectively place the beginning nurse practitioner.

There is need to study the factors which have created the present situation which many times requires the agencies to place new graduates in positions which require highly developed judgment.

The group felt that they could not give the specific areas of competence and the infrequently found abilities of the new graduates until the present situation was carefully studied.

Is education able to assume the full responsibility for preparation of the practitioner, and should it do this?

What responsibility should nursing service accept?

RECOMMENDATION

1) Full responsibility should be assumed by nursing education; at the same time, nursing service should be involved in the implementation of the teaching.
2) More imaginative ways need to be developed to involve the present nurse practitioner in the educational process of the new practitioners.
3) The professional nurse practitioner in all settings should assume the responsibility for the direct care of patients.

DISCUSSION

Use of clinical specialists who would be responsible for the quality of nursing care in the hospital, could allow them to serve as role-models for students, in a positive and planned way. This would give nursing service recognition and involvement in upgrading its own practice.

Nursing service needs to find more effective ways of utilizing the present practitioner instead of asking for more nurses.

Experiences should be provided to facilitate change of attitude of present work force so that they can more willingly accept the direct care of patients and work with other health groups in developing more satisfactory methods of care.

Establish procedures for rewarding the nurse practitioner who assumes direct patient care.

Provide the opportunity and the mobility for the nurse practitioner to follow the patient throughout his illness.

Secure the cooperation of hospital administration in the development and changes of nursing practice.

How can joint planning serve to minimize the problems?

RECOMMENDATION

1) There is merit if educators and practitioners discuss together the preparation of the graduate on national, state and local levels.
2) Work conferences in depth, at all levels, should be promoted by the organization to study the contributions that nursing can make to the health care of people.

DISCUSSION

There are dangers in perpetuating present haphazard use of personnel who are not prepared to do the required care.

A value of joint planning would be that service and education might be more aware of each other's role and responsibilities. Service would pick up its responsibilities if assured that education would let graduates know the realities of work situations.

In relation to work conferences, it was felt that service and education operate within highly organized systems and spend an inordinate amount of time in management and do not devote as much time to our real purpose.

There would be merit if service and education could come together to talk about ways of bringing this about. They need to find ways of collecting and recording data to begin forming a body of information to use in improving care and in developing methods of teaching others to improve care.

Group V

Leader: **Katherine C. Neill**
Recorder: **Ruth W. Harper**
Members: **Iris Brice**
Marion Crotty
Georgia E. Hudson
Shirley M. Kane
Ruth P. Ogden
Sister Victoria
Gladys Weber

QUESTION:

How does nursing service envision the role of the clinical specialist in nursing services?

a. What is the realism of this concept?
b. How can education begin to support the preparation of the clinical specialists in numbers sufficient to meet the demand?
c. What should be the preparation of the clinical specialist?
d. What other methods can be used pending availability of the clinical specialist?

The assignment of this group: to discuss question #4 pertaining to the clinical specialist, in no way indicates the wide

scope of topics discussed during the sessions.

The composition of the 9-member group was:

2 in public health nursing administration
3 in dual position of director of hospital nursing service and school of nursing
2 in diploma school of nursing education
1 in hospital in-service education
1 in professional organization

The variety of topics discussed included what the sick person wants; what the nurse should be and do; the image of the nurse as seen by patients, doctors and co-workers; factors affecting the nurse's ability and availability to give good patient care; the dilution of quality of care through the increasing numbers of less well-prepared assistants, and, of course, the effect of ANA's Position Paper on Education at the present time and in the future.

Each member of the group participated quite actively and constructively in exploring these issues; only the limitations of the time schedule kept us to the task of considering the "clinical specialist".

It was necessary first for the group to define for itself the term "clinical specialist".

DEFINITION: The clinical specialist is a professional nurse, prepared in the psycho-biological sciences and the art of nursing, with a deep perception of medical and therapeutic goals.

The clinical specialist functions in a specific area of nursing practice and uses skills in preventive, restorative and rehabilitative care; may function outside of traditional staffing patterns; and cares for patients and their families; relates skillfully to colleagues in the nursing profession as well as to members of other health professions.

The group then went on to derive several conclusions and to make recommendations.

The group saw the clinical specialist making a significant contribution to the improvement of the quality of patient care, functioning in a variety of settings ranging from hospital to community health and nursing agencies. They envisioned the clinical specialist as being available for demonstration, conferring and coordination of patient care.

The introduction of clinical specialists into the hospital nursing service might lead to a reorganization of nursing service structure and staffing patterns.

In the public health agency the clinical specialist might strengthen the process of supervision and staff development.

Recommendation 1. Therefore the group *recommends* that *organized nursing services utilize the services of clinical specialists as an integral part of their staff.*

The preparation of the clinical specialist which is required to enable fulfillment of the responsibilities indicated in the definition and examples just given was:

Recommendation 2. The *clinical specialist shall be a highly competent nurse practitioner prepared in a clinical speciality at the master's level.*

In consideration of the role of the university in this preparation of clinical specialists, the group recommends and urges that the university:

Recommendation 3. (1.) offer more programs preparing clinical specialists.
(2.) stress the importance and value of the clinical specialist as a career opportunity in nursing services.

Until such time as there are sufficient clinical specialists to serve both on faculties of schools and on nursing service staffs, the group recommends:

Recommendation 4. (1.) *that faculties of schools of nursing and nursing service agency staffs explore ways in which instructors in clinical specialties may be helpful to the nursing staff.*
(2.) *that agencies which have clinical specialist programs collaborate and cooperate with other health agencies in the establishment of similar programs;*
(3.) *that universities assume their responsibilities for helping nursing service staffs, particularly in outlying communities far from centers of learning, by such means as providing consultation service, workshops and extension courses.* This is viewed as contributing to the upgrading of the level of nursing practice.

In regard to the Position Paper, some members of the group expressed concern about the apparent lack of planning for provision of nursing personnel in terms of sufficient quantity as well as quality during the period of transition, if the Position Paper of the Committee on Education is accepted without reservation.

Group VI

Leader: **Sister Margaret Marie**
Recorder: **Martha E. Rogers**
Members: **Hildegarde Eagan**
Florence S. Ehlers
Marion Hazard
Pauline Keefe
Helen E. Middleworth
Cora E. Pike
Mary K. Pillepich

QUESTION:

Staff development is a continuous process. Joint planning between education and service are essential if this is to be most effective. How can we:

a. Foster joint planning in this area
b. Delineate areas of responsibility between service and education
c. Improve programs
d. Bridge the gap between the role of student and that of practitioner
e. Promote clinical competence

GENERAL GROUP DISCUSSION —

Staff development is a continuous process. Joint planning between education and service are essential if this is to be most effective.

Our group explored the concept involved in staff and development as a continuous process. We accepted and recognized staff development as the employer's responsibility to the nurse practitioner and to the patient as a means to provide safe and quality patient care. We admitted staff development embraces all levels of personnel within the framework of nursing; however, we felt that if we could think of large concepts in staff development plans for the Registered Nurse, these same concepts could be used in the development of all. Elements considered in the broad conceptualizing of staff development utilized orientation of the nurse practitioner from where she is when employed to where we must bring her for effective practice.

MAJOR IMPEDIMENTS TO OVERCOME EXISTING ATTITUDES AND VALUE SYSTEMS:

Our group envisions active participation of nurses in the learning process through programmed instruction; video tape; closed-circuit TV; film identification. We think that continuous education can be achieved through both in-service programs to meet the nurses immediate needs in use of electronic devices and specialized advanced techniques. Adult Education programs offered by university and community college programs can provide these as well as interchange and exchange of knowledge between

nurse educators and nurse practitioners in service, i. e., nursing service may utilize the Instructor of Physiology to ready practitioners to understand what action occurs in defibrillation of cardiac muscle.

We know joint planning between education and service will improve the climate in nursing for both students and practitioners and remove barriers which prevent mutual respect and mutual sharing at the operational level of function — patient care. The group recognized the need for role identification in nursing by both nursing education and by nursing service, but cannot identify the common denominators that should be utilized by both in the continuous education process to bridge the gap and facilitate transition from student to practitioner and vice versa.

The use of weekly buzz sessions, "teach ins", unit library resources, the self evaluation and promotional evaluation forms as tools for improving clinical competence through promoting values that are meaningful to the nurse's self image and self acceptance were identified.

The group explored the need for staff development in the leadership, R.N. level in nursing as a means for developing flexibility, freedom to investigate, developing the ego strengths to bring about change where needed and re-education of colleagues in the related interdisciplinary health fields. Nurse leaders through process of continuous education need to set the stage within the agency through a planned program of information released to the press; and to official literature which will reach the administrators, medical staffs and other groups in the health field; they can no longer afford to work in a vacuum or think in isolation away from the reality of the patient environment.

CONCLUSIONS — CONTINUING STAFF DEVELOPMENT SHOULD:

1. provide opportunity for staff participation in planning and free sharing of ideas.
2. be geared according to respective levels of preparation.
3. provide information-giving, new knowledge, training and re-training according to level of preparation.
4. provide opportunity for self-learning through programmed instruction, video tape, closed T.V., library resources, etc.
5. develop community college and other resources for extra-mural offerings for continued education to get up to date, keep up to date, and provide tools and knowledges for rapid change.
6. provide opportunity for revising attitudes and values consistent with changing times and directed toward developing a positive concept of self-worth and responsible action within the scope of each person's preparation and ability; i.e., learning, flexibility, tolerance.

7. provide a climate in which all nurses will be stimulated to seek learning and re-learning and to strive for excellence and respect for differences — encourage curiosity.
8. enable personnel to develop responsible self-direction and ego-strength in promoting health services and community understanding.
9. assist staff in understanding position paper and to participate in interpretation to other health personnel and the public.
10. promote growth through continuing evaluation by self and others.
11. promote identification with nursing and the utilization of nursing channels between education and service.
12. promote role concept toward supervision and guidance of nursing as differentiated from present patterns of supervision of things, activities, etcetera.
13. promote human welfare as the center of nursing's purpose.

RECOMMENDATIONS:

1. Ask ANA or NLN to develop evaluation tools and evaluation source materials.
2. Ask NYSNA to initiate major publicity campaign to transmit information on ANA position paper and NYSNA proposals to implement.

Group VII

Leader: **Stiversa Bethel**
Recorder: **Mary E. Conway**
Members: **Ruth H. Buchholz**
Jean Campbell
June Clermont
Katherine M. Disosway
Sister M. Amata
Mary Ellen Warstler
William J. Wood

QUESTION:

Leadership in nursing is of paramount importance. Nursing education and nursing service have a dual responsibility in fostering leadership.

a. What specific measures are indicated to promote recognition of ability and stimulate the development of the future leader?
b. Leadership demands creativity. How can this aspect of leadership be fostered?

The group addressed itself to the following detailed questions:

a) What specific measures are indicated to promote recognition of ability and stimulate the development of the future leader?

b) Admitting that leadership demands creativity, how can *this* aspect of leadership be fostered?

We accept the premise that we are dissatisfied with the present situation that obtains in many service organizations today. We recognize that the situation the new practitioner finds himself (or herself) in today more often than not stifles creativity. The authority structure is such that this practitioner often finds himself or herself a threat to the person in authority — this person frequently having had less formal educational preparation than the young practitioner. In effect, by the very structure and social patterns of our health agencies we're failing to stimulate creativity.

REPORT OF GROUP VII

We asked ourselves:

If this, then, is the situation, what can we do to change it? A member of the group cited an example of how industry actively cultivates creativity in its initial orientation of employees. During the orientation period an effort is made to identify potential leaders. We asked ourselves if this is a process nursing could and should adopt? We examined briefly the present system of recognition and reward for excellence within organized nursing services; we find that promotion upward and away from the patient continues to be the pattern. We grappled with the problem of how to reward excellence in the practitioner who chooses to remain close to the patient. We concluded that more than financial reward is involved. A whole value system is involved.

Early in its discussion the group agreed that it would be helpful to think what might be accomplished if the entire nursing service organization in a healthy agency were to be re-structured. Some of the ideas suggested to be tried in relation to re-structuring were:

(a) have the supervisor be concerned only with identifying patient care needs;
(b) assign a non-nurse to handle all allocation of staff;
(c) conduct an on-going program of leadership training;
(d) encourage leadership at all levels;
(e) bring together nursing service administrators in the area, including those whose facilities are not used for student education, and directors of nursing education in that area for regular informational and planning sessions.

There was total agreement within the group that the single most important prerequisite for any attempts at re-structuring is the establishment of the kinds of climate within which change *can* take place. This climate must be consciously cultivated and well established before attempting an experiment in re-structuring.

Having reached these basic agreements the group now offers as its answer to the questions asked, the following:

RECOMMENDATIONS TO NYSNA COMMITTEE ON EDUCATION

1. That Nursing Practice be accepted as the *area for leadership;*

   (We accept the definition of nursing practice as contained in *A Position Paper On Education* published by *American Nurses' Association* in ANA December 1965. These elements are involved: "promotion of health and healing; the use of clinical nursing judgment in determining, on the basis of patients' reactions, whether the plan for care needs to be changed or maintained; it is asking questions and seeking answers")*
2. That a climate be prepared in which creativity can take place.
3. That structuring of the organization for Nursing Practice be attempted; the *following steps* must be taken:

a. Eliminate from consideration all previously defined functions and qualifications of personnel
b. Look at every job in terms of its contributions to nursing practice
c. Develop guidelines by which to judge whether a particular item in a job *is* or *is not* nursing practice
d. Analyze information gained
e. Try one plan in an area where there seems a reasonable chance of success
f. Evaluate what was tried
g. Implement further.

The ultimate goal for the re-structuring of the nursing service organization is to have nursing personnel involved solely with the nursing care of patients.

Group VIII

Leader: **Esther Charnes**
Recorder: **Marian Hosford**
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Mathilda Haga
Eleanor Lambertsen
Ralph Patrick
Myrtle Rathmann
Sr. Bernard of the Cross
Joan Tompkins
Mary Helen Wood

QUESTION:

Have we achieved a professional level of nursing practice?

a. If so, in what areas of specialization are we successful and where are we unsuccessful or less successful?
b. How can we achieve or promote professional nursing practice?

To establish direction for deliberation the following broad

*See statement for further elaboration.

questions were raised within the framework of the Position Paper:

1. Where are we headed?
2. Where do *we want* to head?
3. What are the major social forces underlying the Position Paper?
4. What can we do about these?

The group believed that for the first time in the history of organized nursing a reasonable educational system appropriate to our time and society was proposed by the ANA with the goal of achieving acceptance within the mainstream of American education. However, several dynamic social forces were further implied which aided or hindered this movement. They are the distinctive values and goals of higher education; the utilization of nursing personnel; the distinctive goals of pre-service; in-service, and continuing education; the relationship between quality of practice and education for each level of practice; a moral commitment regarding recruitment and admittance into professional nursing practice; the rights of society for quality nursing care; and the relationship of society's present value system to the concept of "patient side" nursing.

The functions to diagnose, prescribe, and treat are inherent within every profession. However, these constantly evolve and change within a dynamic society. If we accept these assumptions at this point in time, nursing has not generally reached a professional level of practice.

Some of the components of professional nursing practice were further defined. These imply a theory rather than a skill orientation accompanied by deep social conciousness and responsibility. Likewise, these assume the ablity to take preventive and therapeutic nursing action based upon the interpersonal skills for listening, observing, and interpreting in the patient teaching — learning situation. In addition, the professional practitioner resorts to the library and laboratory to do research on her own practice. Philosophically, this person is prepared "to become", not "to be" which necessitates a commitment to a professional lifetime of learning.

In a consideration of those impediments to professional practice such factors as a failure to recognize an elite leadership group, poor economic remuneration when compared to the costs of high level professional preparation, a lack of intellectual challenge and the inability to get away from the lockstep "of covering time and space" were considered. Perhaps the greatest block at the present time is the traditional hospital setting bogged down by institutional arrangements as a result of an historical past.

While this new professional product is yet to be created or yet in the experimental stage, we do know that the professional practitioner of the future will be more broadly prepared to func-

tion in any environment with the ability to reason and make major professional nursing decisions with an inherent responsibility for these decisions.

In the light of this discussion, the following recommendations are made to the NYSNA:

1. Define two kinds of nursing practice; recognize the grandfather clause in its implementation.
2. Define nursing functionally; i.e. general practitioner, team leader, clinical practitioner. Eliminate the semantics which have splintered nursing.
3. Establish a system of rewards for professional practice beyond the minimal practice — Speciality Boards, Academy of Nursing.
4. Clearly distinguish between pre-service education and continuing education for these two specific levels; spell out the roles of the educational institution and service in continuing education.
5. Demonstrate how these two functional groups described can be utilized properly.
6. Endorse research to test and retest conceptual models for nursing practice at these levels.
7. Examine and utilize existing social tools to reach our goals — legislation, licensing, licensing boards, etc.
8. Encourage young practitioners to assume responsibility for leadership early.
9. Recognize and accept responsibility for shaping public policy.
10. Experiment with changes within the institutional framework to break the lockstep of time and place.
11. Establish a dialogue with other professions — eliminate provincialism in nursing.
12. Recommend that the Position Paper be implemented immediately through appropriate channels.
13. Utilize all facilities within the district associations for the continuing education of the nursing practitioner (include the use of modern educational technology).

While our discussion group has made no profound proposals, we were able to establish trust in each other and to share our mutual concerns about education for nursing practice.

Until this is accomplished in the districts, implementation of the Position Paper will not become a reality in our time. Consequently, we recommend that the Proceedings of this Conference be published and distributed immediately for discussion and planning at the "grass roots" level.

Group IX

Leader: **Albin Gasiorowski**
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Teresa A. Yarwood

QUESTION:

Promotion of quality care in nursing service is essential.

a. What are the components of quality care?
b. How can nursing service be organized to promote this aspect of patient care?

In regard to the overall question it appeared to be the group feeling that this is a positive step and one which should be implemented but that there should be an orderly change which would not cause injurious confusion.

First — we must accept our responsibility which is — "Nursing is responsible for Nursing." Will we as a group take a stand to insure quality care through control of all those who perform patient care? Unless we do we must be willing to accept continual interference in and infringements on our profession.

WE DEFINED AND RECOMMENDED AS THE COMPONENTS OF QUALITY CARE:

1. the fostering of the development of expertness in giving nursing care;
2. understanding of the basic concepts in biological, physiological and behavorial sciences for the technical nurse; and for the professional nurse, depth in the understanding and utilization of the knowledge of these sciences in the planning for nursing care;
3. understanding, appreciating and accepting the sociological, economic, ecological and cultural differences; and the effect these have on the nurse's approach to the patient;
4. the development of an awareness of the significance of the reactions of patients and families to living, wellness, illness and dying;
5. the ability to differentiate between the patient's concerns (including the family's) and the nurse's concerns in formulating a care plan;
6. the ability to communicate, verbally and non-verbally;
7. a philosophy of nursing care should be developed and written in each hospital and should be made available to and accepted by each person involved;
8. *written* nursing care plans should be developed for each patient to insure continuity and consistency of care; incorporated in this plan the utilization of a multidisciplinary approach as indicated;

9. concern for quality care must extend beyond the hospital to the nursing home, to all other agencies and to the home;
10. provision for systematic clinical studies (or resea. for and of quality nursing care.

THUS IF QUALITY CARE IS TO BE ACHIEVED WE MU. RECOGNIZE:

a) the needs and potentials of the individual nurse;
b) that education is an on-going process and must be planned for through a well organized in-service program under a capable director;
c) that each group must have the privilege to participate in the formulation of its goals.

We are encouraged to know that in some of our hospitals steps are being taken by our forward-looking directors to improve staffing patterns.

It is concluded that with interest, effort and determination on the part of all concerned improvements can be implemented.

Group X

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Members: **Aileen L. Carroll**
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Laura D. Roper
Barbara G. Schutt
Grace Sease
Florence Shumway
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QUESTION:

Joint planning between nursing service and education is necessary if there is to be maximum use of available clinical and educational facilities for the preparation of future practitioners in New York State.

a. How can this joint planning be facilitated?
b. Is regional planning realistic and practical?
c. Who should take the leadership role in this endeavor?
d. How can it be initiated in the interest of promoting effective nursing education?

At the first meeting, we arrived at a concensus to work together and look objectively at the social and economic forces affecting nursing, and to determine how nursing can best meet the needs of individuals and families in need of our service.

This could be achieved in terms of joint planning between nursing service and nursing education. As we worked together in this mature relationship, we further identified the need to participate, collaborate and cooperate with other organized groups whom we identified in the following categories:

Higher education — national, state, local and the State Education Department
Secondary education — from which we draw our applicants.
The discipline of medicine — utilizing organized and unorganized groups, as well as the women's medical auxiliary groups

HOSPITALS

Hospital Administration — national, state and local
Boards of Trustees
Advisory Committees

HEALTH DISCIPLINES

Organized Labor — international, national, state and local
Official and Non-official Agencies

PARAMEDICAL GROUPS

Pharmacists
Social Workers and other professional groups
The whole range of Therapists, dietitians, etcetra.

LEGISLATIVE BODIES

FEDERAL AGENCIES

United States Public Health Service
Armed Forces, etc.

GENERAL PUBLIC

Lay Organizations, Labor Unions, etc.
Persons involved in Communication Media
Foundations
Patient Groups, Colostomy Clubs, Emotionally Disturbed
Volunteers

We believe that nurses cannot plan alone, that it is imperative that we work with the above-mentioned groups at the appropriate time and in a suitable manner.

We proceed to identify how nursing service and nursing education achieve the common goal of quality patient care, each focusing on the inherent responsibility and authority which has been delegated to it in the role in which it functions.

Nursing education must assume responsibility for the education of the student and contribute to the continuing education and professional development of the nursing practitioners in the health agencies.

Nursing service on the other hand has as its major responsibility the care of patients but has an added responsibility to

participate actively in the education of students, serve as role models for the students and as resource persons to the educators because of their degree of expertness in their particular aspect of nursing.

FIRST RECOMMENDATION

In this mature partnership, personnel in nursing service and faculty in educational institutions recognize the interdependent relationship between the groups.

This partnership can be enhanced when there is formal agreement on the area of responsibility, identified by written contractual agreement.

The second step is the identification of the process through which interdependency is achieved.

The third step is the need for interpretation of the goals, and involvement and commitment to the goals by all nursing service personnel, nursing educators and students.

SECOND RECOMMENDATION

Whereas, the NYSNA is the official spokesman for nursing in New York State, we, therefore, recommend the NYSNA assume responsibility for spearheading and coordinating state and regional planning to meet the nursing needs of people in the State.

The New York State Nurses Association must utilize the organized related groups to facilitate the process of state and regional planning. Whereas, other groups are involved in planning to meet health needs, individual nurses must become actively involved at the policy-making level of these groups whether they be at the local, regional or state level.

There is a need to identify regions in the state that lend themselves to organized planning. Within these regions, we need to identify institutions of higher learning, schools of nursing that might lend themselves to incorporation within the formal educational structure, and clinical facilities that could be used appropriately for education of students including a wide range of facilities, etc., some of which have already been identified, such as day hospitals, home care programs, etc., and others that have not been but may be identified in the future.

The rationale to support this recommendation is that planning is an absolute necessity. The process must be determined by nurses in the particular locale and they must utilize whatever resources are available. Flexibility, creativity and imagination must be utilized if the goals in planning are to be achieved.

THIRD RECOMMENDATION

We further recommend that nursing education programs cooperate and utilize all of the innovations developed through educational media for the enhancement of the educational process. New and creative methods must be found so as to provide quality education for an increasing number of students required as health care facilities expand.

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NYSNA CONFERENCE ON EDUCATION FOR NURSING PRACTICE

MARCH 4-6, 1966

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SELECTED READINGS

Miel, Alice (Ed.) *Creativity in Teaching.* Belmont, California: Wadsworth, 1961.

Taylor, C. W. (Ed.) Creativity: *Progress and Potential.* New York: McGraw Hill, 1964.

Taylor, C. W. (Ed.) *Widening Horizons in Creativity.* Wiley & Sons Inc. 1964.

"A Position Paper", *ANA,* December, 1965 (monograph)

"Standards for Organized Nursing Services", *ANA,* February, 1965 (monograph)

Brown, Esther Lucile, "Preparation for Nursing," *American Journal of Nursing,* Vol. 65 No. 9, September, 1965 pp. 70-73 (reprint)

Hassenplug, Lulu Wolf, "Going on for a Bachelor's Degree", *American Journal of Nursing,* Vol. 66 No. 1, January 1966 pp. 83-85 (reprint)

Johnson, Dorothy E., "Today's Action Will Determine Tomorrow's Nursing", *Nursing Outlook,* Vol. 13 No. 9, September, 1965 pp. 38-41 (reprint)

Lambertsen, Eleanor C., "Who Is the Nurse; Who Are the Others?", *New York State Nurse,* Vol. XXXVIII No. 2, March, 1966 pp. 6-9 (reprint)

Reiter, Frances, "The Nurse-Clinician", *American Journal of Nursing,* Vol. 66 No. 2, February, 1966 pp. 274-280 (reprint)

Epilogue

The 1966 Arden House conference was the beginning of continuing activity to achieve a goal now established. The realization of that goal can only be brought about when nursing leaders who participated in the conference stimulate a concern about education for nursing practice at the local level, and initiate action. New York State is once again in the position of taking a leadership role for the profession.

Education for Nursing Practice

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