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AUTHOR	Cooper, Signe S., Ed.
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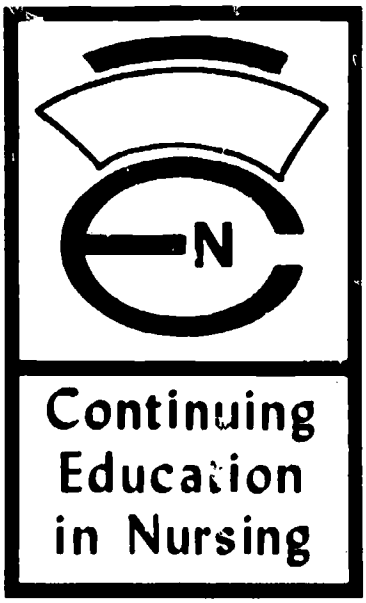
ABSTRACT

The National Conference provides continuing education for nurse educators who are responsible for providing continuing nursing education. Papers presented at the conference are: Philosophies of Continuing Education, Theodore J. Shannon; Philosophies of Education--Implications for Continuing Education in Nursing, Edith V. Olson; Developing a Model for Consumer Health Education, William L. Blockstein; The Adult Educator as a Change Agent, Burton W. Kreitlow; Competencies Expected of the Teacher in Continuing Nursing Education, Signe S. Cooper; The American Nurses' Association (ANA) and continuing Education, Audrey F. Spector; ANA Special Project in Continuing Education, Sister Jeanne Margaret McNally; Continuing Education as a Requirement for Relicensure: What Are the Issues? Maura Carroll; Introducing the Continuing Education Unit, Paul Grogan; Exploring the Federal Scene, Mary Hill; Continuing Education--A Western Council on Higher Education for Nursing (WCHEN) Seminar, G. Marjorie Squaires; Continuing Education Activities of the Southern Regional Education Board (SREB) Project in Nursing Education, Helen C. Belcher; Regional Approach to Continuing Education for Nurses in New England, Eileen Ryan; Regional Planning in the Midwest; Emily Tait; North Central States Planning Project, Signe S. Cooper. References, resources persons, and conference participants are listed. (NH)

CRITICAL ISSUES IN CONTINUING EDUCATION IN NURSING



Report of a National Conference on Continuing Education in Nursing, October 19–21, 1971

Department of Nursing
Health Science Unit
University of Wisconsin-Extension
Madison, Wisconsin

1972

PREFACE

The National Conference on Continuing Education in Nursing held in Madison, Wisconsin, October 18-22, 1971, followed the precedent set by previous conferences. These were held in 1970 at the Sagamore Conference Center of Syracuse University, and in 1969 at Williamsburg, Virginia, sponsored by the Medical College of Virginia.

The National Conference is designed to provide a continuing education opportunity for those nurse educators who are themselves responsible for providing continuing nursing education. The content of the conference is useful as a review for those who attended; it is also useful to those who were unable to attend.

New positions for nurses in continuing education are being established as more universities and other institutions are accepting greater responsibility for this educational endeavor. As is often the case with nursing positions, the constant turnover of personnel may result in the entry of inexperienced nurses into the field. These Proceedings will serve as a useful reference to these nurses as they begin a career in continuing education in nursing.

The rapid changes in society and in health care will lead to increasing demands for continuing education for the practitioner. These Proceedings are presented as a contribution to the nursing literature on continuing education.

Signe Skott Cooper

Signe S. Cooper

Editor
and Chairman
Faculty Planning Committee

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NATIONAL CONFERENCE ON CONTINUING EDUCATION IN NURSING

Purpose and Objectives

The conference is designed for registered nurses whose major responsibilities are in continuing education. It is planned to provide an opportunity for these nurse educators to discuss issues and concerns, to share ideas and knowledge, and to learn about the new developments in the field.

Specific Objectives:

1. To learn about current developments in adult and continuing education
2. To explore various aspects of major issues in continuing education in nursing
3. To become more familiar with resources available to the nurse in continuing education
4. To share ideas and common concerns relating to continuing nursing education

PHILOSOPHIES OF CONTINUING EDUCATION

Theodore J. Shannon
Professor of Education, University of Wisconsin-Extension

Introduction

It is amusing to note the contradictory views which people have toward philosophy as a subject of study on the one hand, and as a guide to action in the work-a-day world on the other. Most of us have been raised to think of it as the queen of all subjects, the love of wisdom, the utmost application of the mind and intelligence to the problems of man and the universe - a real heavyweight among the fields of study. "Doing your damndest with your mind", as one philosopher described it.

Contrasted with this outlook, and equally prevalent, is the one contained in the advice so often given to people: "Be philosophic about it. Don't give it a thought!"

People in our work probably tend more toward the latter view than the first, not because we believe that philosophy is a thoughtless endeavor, of course, but rather that many of the old issues which preoccupied the traditional philosophers in the past have been bypassed by events. Or, to put it differently, we may think that many of the older branches of philosophy - e.g. metaphysics, ontology, epistemology - have been dealt with more directly and convincingly by science rather than philosophy - by the physical sciences, the life sciences and the social sciences.

I don't find that so difficult either to comprehend or to accept. The sciences are, after all, the natural and direct descendants of general philosophy (natural philosophy) representing its differentiation over the last two or three centuries into countless parts, branches, fields, and specializations which flew off inevitably under the impact of the knowledge growth triggered by the Reformation. Once knowledge began to burgeon, no single discipline could contain it.

And people in the health sciences whose very professional being derives from the application of science don't need to be convinced of its value, or to be reminded of the primitivism, pestilence and deprivations that would befall us if scientific advances were curtailed, or if the specializations and technologies which grow out of the sciences were submerged.

What we can deplore, nonetheless, is the loss of comprehensiveness, the loss of humanity, of meaning, of priorities, of universality, which sometimes accompanies specialization. It is here that philosophy

and philosophers should come to our aid, not as substitutes for, but as complements to, our professional endeavors. For broadly speaking, the difference between philosophy and science in my mind is not one of kind but of degree. They represent opposite ends of a continuum. Science deals with the finite, the particular, the discrete, the more limited and controlled aspects of inquiry, decision-making or practice, while philosophical deliberations on the other hand attempt to encompass greater and greater scope, to take into consideration a larger number and variety of factors - to see the thing as a whole, or the person as a whole, so to speak.

For those of us working in the various fields of Continuing Education surely there is usefulness in this philosophic emphasis on generalizations and comprehensiveness. As operational people always on the run we are subject to the hazard of running thin, of doing things for the sake of doing - or for the sake of reporting our doings. Priorities, meanings, values and objectives may begin to elude us in the press of meeting clientele needs. Philosophy should help us to construct frames of reference; also to evaluate.

I note that one of the issues of this conference is the Inter-Professional Approach to Continuing Education in the Health Sciences. Commendably this reflects a recognition of the shortcomings - even the dangers - of exclusivity, of fragmented approaches to the health sciences – and implies a team effort to overcome these. I wonder whether it might not be useful to incorporate into such team endeavors professional people from outside the health sciences, yes even philosophers who have given thought to adult education and continuing education, or perhaps political philosophers, or economic and social theorists.

Another issue of this conference is the one dealing with Determining Needs and Priorities. One of the papers calls for "periodic retreats to allow time for examination of the current and emerging social, political and professional forces affecting the needs of society, and for creative thinking about how new needs and priorities should be determined." Philosophers might help in this examination.

Lest there be any misunderstanding on the point, let me say that I mean this notion to apply to all fields of continuing education, not just to Nursing. Neither nurses nor continuing educationists are expected also to be philosophers. Philosophy is a specialty like any other and should be called upon as others are.

I should add that of all the health professionals, nurses may need this admonition least. The public record of your profession speaks for itself. It reflects comprehensiveness in your concern for human beings, and your concern for reordering the national priorities to provide better health care for all Americans. It's as if you have been philosophizing -

attending to the bigger questions all along. "History", as one Greek put it, "is philosophy lived."

The literature of philosophy is too voluminous and too diverse to review in the time available this morning. Not only is time a constraining factor, but in addition there is not always a one-to-one correspondence between a general philosophy and its educational counterpart. That is, some schools of thought have been enlisted to justify quite disparate educational practices, just as several philosophies may converge commonly on a specific educational practice.

Another constraint is that Continuing Education, like its cousin Adult Education, is not yet characterized by full, consistent, and systematic philosophical treatment in the research and literature. Both of these are still in an emerging stage, and those of us who are their practitioners are by our daily actions contributing to the construction of rationales to support them.

While almost every issue of an adult education publication addresses itself somewhere to the "philosophy" of Adult Education (or of Continuing Education), precious little comes through in the way of hard results. Typically the articles wind up stating a need for more attention to goals or philosophies, or exhorting adult educators to be more philosophical, but seldom are real bridges built between general philosophy and adult education. Occasionally, an *educational* philosopher makes a contribution.

When pedagogy languished for lack of consistent philosophic attention, a whole field of educational philosophy emerged and grew, starting about the turn of this century. Androgogy, as some people are now calling Adult Education to differentiate it from the education-of-the-young, has not yet been so favored. Processes and methods of Adult and Continuing Education have been much more researched and refined than have philosophies.

Immediately you can see that it's going to be difficult for you to implement the earlier suggestion that you invite adult education philosophers into your councils. They're scarce commodities. Yet, you should do your bit to aid the profession by trying to entice potential contributors to enter the field.

The American Educational Scene

Therefore in view of these constraints I shall need to deal with the subject of my talk more from the side of the *operations* of Continuing Education than the Philosophy, but to do so hopefully in a manner that sheds light on certain issues and provides some policy guidance to the practitioner.

A practical way to do this is to take a look at the American

educational enterprise as a whole, including a look at the way it developed historically. One reason this examination may be fruitful is that education in our country - the whole business of schooling - has been a major instrumentality of society for implementing those radical philosophical assumptions about man, freedom and government that made the American Revolution a true revolution and not merely a military rebellion. Looking backward over time we can discern in the struggles to establish, enlarge, and enhance educational opportunities, a steadfast, pragmatic, continuous working-out of the basic philosophies which set us apart as a unique experiment in the history of mankind. Parenthetically, I should note that soon to come on the market is a book *Without Marx or Jesus* by *Jean-Francois Revel,* a French author not usually given to commending Americans and things American, whose basic thesis is that ours is still the only true revolution in the world today, and that upon our success in perfecting this revolution rests the transformation of societies around the globe.

Another reason for looking at American education is that this is the only way to put in clear perspective Continuing Education which, as its name implies, is that education which builds on previous education. It is therefore necessary both at the micro level of the individual and at the macro level of the whole movement to take into account the base from which Continuing Education proceeds. There are two curricular implications here for Continuing Education.

The first is that the teacher or administrator preparing educational fare for an individual student cannot do so effectively without taking into account the previous education or experience of the student - cannot do so in a vacuum so to speak. Cannot, that is, *unless* the *student himself* is enough aware of his needs to choose wisely from among alternatives. How many teachers study students as well as subject matter? Or for that matter, how many students have been taught to learn in this manner (to learn to learn, to discriminate among alternatives?)

The second implication grows out of the first. Continuing educators cannot be indifferent to the educational systems which produce their clientele, for these systems determine their starting points, and preordain their subject matter and methodology. Again, how many continuing educators are in a position either to study or influence professional - or earlier - educational programs?

We have an expression in the United States which we apply to children to excuse some behavior which doesn't meet our approval: "What can you expect?" we ask. "They don't *know* any better." Note that the emphasis is on the word "know", meaning that a person needs to know better in order to perform better, that he cannot perform any better than he knows how. Or contrarily, by implication, when a person

knows better he performs more reasonably. The key word is "know". "To know" and "knowledge", we assume, underlie reasonable, or intelligent, behavior.

Understanding this linkage of knowledge with behavior (performance) is critical to understanding the spectacular flowering of education in the United States. For this linkage derives from a radical assumption about man. That assumption is that man is or can be a rational being, if he is given the chance. What is the chance? The chance to know better—to be educated. We are not depraved. Just deprived. "Ye shall know the truth and the truth shall make you free." That New Testament expression is carved on the oldest building of this campus, converted we may assume from theological purposes to educational ones—a sort of dignified professorial pep-slogan. "Knowledge is power" is a variation of the same theme.

Who shall have this power? Our answer is "everyone". Since Government derives its power from the consent of the governed, *i.e.* since *everyman* is in on the act of governing, then if he is to perform that act wisely - rationally - he needs to be educated.

While there were many people who didn't accept that view - and there are still some among us here and abroad - many of our most influential early statesmen were enthusiastic proponents of it. In fact, so many stated the case for widespread education so well that I had trouble selecting quotations from among them. Noah Webster felt that whereas despotic governments might fear that enlightenment would corrode their own power, in our kind of government, corrosion would set in *unless* public enlightenment was widely diffused. A hundred years later Daniel Webster said that on the diffusion of education among the people rests the preservation and perpetuation of our free institutions. Thomas Jefferson believed that freedom must not be at the mercy of the opinion of an ignorant multitude. Madison and the Adamses were others who promoted support for education. There's no need to belabor the point. You've heard these quotations, and others, many times before.

We all know the up-shot of this belief in education in this country. Its fruits are among us in the form of thousands of schools within the reach of every child and youth of the land. Ours is not a national *system* of education but rather one of national patterns: The familiar educational ladder with rungs or grades starting at the bottom with an elementary system, from nursery school or kindergarten to the eighth grade, then up through the high school for four years—sometimes divided into junior and senior high—or even a middle school—and then two or four years of college on top of that. Finally a superstructure added to all of that for professional or graduate education.

Of course this pattern didn't emerge full-blown, but developed,

rather, gradually and logically step by step in the same upward direction. By shortly after the Civil War, the graded elementary school was emerging out of the common school and spreading rapidly. In 1874 the Kalamazoo case ensured the spread of public high schools - which thereafter doubled their enrollments every 10 years until about the middle of this century. Today high school graduation is not only taken for granted but is even discounted as sufficient preparation for many endeavors.

Schools are everywhere. They are public and private; there are similarities among them, and also differences. Some are specialized, some are comprehensive. Some are vocational, some academic. Some are sponsored by churches, some--like many nursing schools--are sponsored by hospitals - and so forth. To a foreigner accustomed to a fixed national pattern, the variety here is bewildering. Incidentally, we should remember that the Federal government doesn't run the schools. Rather, education is the responsibility of the several States, which invariably have delegated their authority to communities and districts.

Another critical difference between us and other countries is that in many foreign lands - most, in fact, - it is terribly difficult to get into school - or to stay in, at least. Formidable national competitive examinations at successive levels rigorously stop off the upward flow until there is only a trickle at higher levels. Over here it's not only *not* difficult to get into school - that's mandatory. What's difficult is to get out.

Thus far what has been said about education applies to children and youth and not to adults. And that's an accurate reflection of reality. Our major energies, monies and attentions were, and are today, directed toward educating the young and not the adults.

Yet, paralleling this massive frontal children's movement has been a modest but steady stream of educational programs for adults from very early times. Benjamin Franklin's Junta, the American Lyceum, Mechanics' Institutes, societies for the improvement of agriculture, Chatauqua and correspondence schools - these are some examples. But such enterprises never represented the main show; none were supported with public funds. They were, instead, private, voluntary, and self-supporting. Not until the turn of this century did the public purse get tapped for any such activities, and then only slightly. And the beginning of what might be called an adult education *movement* traces back only to the 1920s. Yet even without public funds to support them, they accomplished much. They lent mighty support to the creation of our public schools, for example. And, more relevant to our topic today, they were forerunners of Continuing Education. The pace of Adult Education is picking up now of course, via evening schools, vocational and technical schools, community colleges, public school

adult education, professional associations, government agencies and industries - not to mention the several agencies of the university.

In other words, all age groups are about to be swept up in this forward thrust of education which seems to be so characteristic of our times both at home and abroad.

Before getting too far from this section some questions relevant to Continuing Professional Education should be asked:

We have accepted a responsibility to tax ourselves in order to provide knowledge, upon which rational behavior depends. Indeed, for children and youth we have made schooling compulsory. Thus far, adults, by and large, are exempt both from the compulsion of schooling and the privilege of public funds for schooling.

Question: In the practice of a profession, isn't competent performance the same as rational behavior? If it is, and if we insist that some amount of continuing education is essential to competent performance, may we make continuing education compulsory? Is the answer influenced by the provision of public funds?

I don't have ready answers to these questions but I have some views about them. I believe that as a society we are not far from accepting that Continuing Education *is* essential to professional competence. Furthermore, I foresee in the near future a radical enlargement and transformation of the health sciences delivery system as a result of massive federal intervention. Evaluating and enforcing competent performance in the new era will become major public issues and will be undertaken by public bodies unless the professions can present convincing evidence that they can continue to police themselves as they are doing today.

Some special words about *higher* education are appropriate now to describe three other paths leading to Continuing Education.

All of us are familiar with the phenomenal growth that has taken place in college education in our own lifetime as a consequence of the fact that the rate of growth itself has been growing. That is, population growth alone hasn't accounted for enrollment growth; the percentage of the population desiring collegiate education also has been increasing step by step. When I was in high school, some 10% went on to college. Today around 50% go on to some form of higher education. Most of us can remember when college education was not particularly popular. It is worth noting that while our generation did *not* witness the actual development of the elementary and high schools in this country, we have been witnesses to the real expansion of collegiate education, and now, hard on its heels, the development of continuing education.

Like the elementary and secondary schools, the 2500 institutions of higher education present a quite varied panorama, tracing their new world ancestry to colonial days, and their forms and traditions to

England and the Continent. Created by private and sectarian forces and emphasizing fixed formal, classical and humanistic studies, early colleges were clearly not designed to serve either many persons or many ends. "Elitist" is the word used today to characterize their exclusiveness; some haven't yet completely shaken that connotation.

A big breakthrough in altering these restrictive characteristics of our colleges occurred in the midst of the Civil War with the passage of the Morrill Act which provided Federal subsidies to each State (in the form of grants of land from the public domain) to set up colleges of agricultural and mechanical arts (A & M). Some States, like Iowa and Michigan, created new land-grant institutions, as they have since been called. Others, like Wisconsin and Ohio, combined them with their State universities.

Whatever their form, these colleges enlarged and democratized higher education in at least two ways: First, by incorporating into the curriculum the various work-a-day subjects of agriculture and engineering which heretofore had been excluded, i.e. by providing a choice between the esoteric and classical subjects, and the more mundane and practical ones; and next, by opening college doors to a larger segment of the population, notably the children of farmers and workers. The way this simple Federal involvement in Higher Education led inevitably to a nation-wide system of Continuing Education - with the Federal Government continuing to pay the bills - may be worth noting.

After these new colleges were established by the States, new monies, of course, were required to sustain them. Some State funds were forthcoming but not in sufficient amounts. In time the question was asked: "Since Washington had prompted the creation of these new colleges, didn't it also have an obligation to help with their support?" The answer came in the form of a Second Morrill Act which provided (and still provides) money to sustain the teaching in these colleges.

Another question was, "What on earth do you teach in this new field of Agriculture? Farmers are faced with plenty of problems, but where will the inexperienced professors get the answers?" Obviously, from Research. But since Research costs are high, shouldn't Washington help here also? So still another act was passed, the Hatch Act, providing research funds to these colleges.

The final question was what to do with this vast reservoir of data and knowledge about Agriculture which the busy researchers began to grind out and which could do so much to improve the production of food and fiber? The inevitable answer was: Give it out to the farmer to put to practice. Set up machinery to extend it freely to him and to his family. So in 1912 the Smith-Lever Act established Agricultural Extension, and thus institutionalized Continuing Education for this sector of society. These developments occured over a period when

farmers comprised a sizeable segment of the population. Today they make up only a minor fraction of our numbers. Yet the flow of funds continues. Nurses and other health science continuing educators should study that success story and apply its lessons.

Changes in one institution have a way of influencing other institutions, and so the impact of the land-grant idea was felt in all universities, private and public, alike. Similarly, changes begun in private universities came to bear on the public ones. Three such democratizing changes are worth noting because of their direct relevance for Continuing Education. These are: the strengthening and proliferation of Professional Studies; the burgeoning of research; and the creation of university extension - all of which occurred around the end of the last century and the beginning of this one.

Education in the professions of medicine, law and theology, of course, had been long established as a function of the university, but not so some of the other occupational fields. It was in this period that business, architecture, education, journalism and library science began to assume full professional status. At the same time, the older professional fields were strengthened, particularly by the introduction and build-up of scientific teaching.

It was at this time that the German ideal of a large free university, where research could be carried on, as well as instruction, began to replace the British-inspired small, undergraduate collegiate pattern. The laboratory and the lecture hall came to compete with small sessions as methods of instruction. The technological needs of the Federal Government during World War I helped entrench research as the second function of the university - second that is to the teaching function. World War II converted universities into the predominate research agencies of the nation.

We should pause to note the impact these two developments made on the emergence of Continuing Education. Stated very simplistically (in the interest of time), it is this: The growth of research in the universities immensely supported the growth of professional studies. Most importantly, the *quality* of the curricular offerings was improved by the infusion of the new knowledge and findings of the laboratories. We may assume therefore that with the advancement of knowledge via research, each succeeding generation of graduates is qualitatively better prepared than its predecessors. This would seem to be a success story for *both* research and professional education.

But the corollary of that, naturally, is that with each passing year *after* graduation the practitioner falls *behind* incrementally, i.e. he obsolesces. I don't know how to measure such things, but I've seen figures indicating that engineers can be half out-of-date in five years' time.

In one of your previous conferences Malcolm Knowles pointed out that the research-stimulated knowledge-explosion, converted into technological applications, (which we're very good at doing) is now causing radical transformations within a single life-span. Only a generation or two ago a person could live out his entire life with the same stock of information he graduated with; i.e. serious changes in the world took longer than a normal life time to occur. Children and grandchildren had to do the adjusting, but the process was slow and easy.

Now, changes come so fast that we must run to stay in place. A person may be obliged (or privileged, depending upon your viewpoint) to *change* careers in life as old ones fade into newer ones. The role and status of a profession may undergo major transformation. Medicine is an excellent case in point. Not long ago the most familiar physician was the family doctor. He had stature, breadth, preeminence in the community. He was thought of as a learned man (he wrote Latin; he had a mystery). His counsel was sought out on all important topics, public and private.

Except for people in our generation and older, who would recognize that description of a physician today? Now he's known as a highly-honed specialist whose competence may be superior in one field - and abysmal in the rest: who may save your life up in surgery and snuff it out in the voting booth. High school kids may know more molecular biology and new math - and may have more political savvy.

And why should that surprise us? Knowledge moves on apace ushering in change. *All* our roles change now. Is the nurse providing the interface with the public which the physician once did? If so, that's a role shift requiring changes in training.

Forty percent of the labor force is female. Generally, women perform lower skilled work, receiving lower wages and recognition than men. Few are in policy-making or decision-making positions. If our friends in the "women's movement" succeed, that will all go. We shall set in motion a nation-wide exchange of roles. Moreover, we shall begin a process which allows *continuous* exchanges of roles and functions. Then we will all need to keep learning to perform them. Learning throughout life.

That brings me to university extension, the third democratizing innovation in universities, in which the phrase "lifelong learning" has now become a by-word. Interestingly enough, extension got its start not in some "peoples" university in the U.S. but rather in the hallowed halls of Cambridge and Oxford, where in the last quarter of the 19th Century, there was a push to provide the benefits of general and humanistic studies to a population generally cut off from widespread educational opportunities. I have always thought of that as a

highminded sort of missionary effort to remedy an imbalanced educational equation. As a scheme for diffusing knowledge, however, it appealed to the American democratic temper of the times and was imported almost immediately into this country. Here it spread like wildfire for a while, in private as well as public institutions, whose professors were dispatched hither and yon to lecture to the various publics interested in hearing their words of wisdom. Without going into detail about its sudden demise - and later revival in a new form (here at Wisconsin) - I should make two points of interest to continuing educators. The first is that this new idea of public service, of carrying information out to the people, extending knowledge, popularizing instruction - whatever you call it - was much more appealing to people and organizations *outside* the university than it was to most academicians inside it. That is, the potential clientele was more aware of its need and more receptive to being educated, than the professors were willing to accommodate them. This accounts in part for the separateness of extension agencies within universities. Recognizing that the regular departments didn't value the Extension function equally with teaching the young and, later, with performing research, proponents of extension agencies set them up a safe distance away. It also accounts for your findings two or more doors to the university when you seek its help and resources.

Some professional schools, when they awakened to their responsibilities to educate their alumni, created their own machinery for the purpose. Others worked out collaboration with extension agencies as transmittal belts. Some merged their interests into one, taking joint actions on program and management. And some, of course, haven't come to yet.

The other point about Extension relates to the financing of its programs. One reason that regular departments and schools eschewed the public service function was fear that their normal resources of funds and personnel would be quickly exhausted by the demands of the public. Thus they sought to husband what they had. Extension had to scratch for their own. Some extension operations are therefore entirely self-supporting, some receive partial public subsidies, and some even return a profit to the institution. It's interesting to hear academicians argue that *their* spendings are actually investments in the larger social good. They fall silent when the same principle is applied to Continuing Education.

Is the continuing education of nurses, and other health professionals, an investment in social advancement more than in private gain?

On the whole this brief review of American education would appear to add up to a happy state of affairs. Certainly in quantitive terms it seems to do that. Year by year over the decades, increasing

percentages of our young people have attended school. More than that, the number of years students spend in school has increased - by compulsion at one level and voluntarily at the other. In addition, school opportunities are now extended to adults as well as to children via formal and informal programs of adult and continuing education. In short, schooling is available to all people who want it and who can make provision to accept it. We seem, then, to be meeting *that* test with respect to the range of choices, of subjects of study, and professional career training.

Or are we? Yes, if a person is white, middle-class, Protestant, Anglo Saxon - even a Catholic or Jew, now - he's home safe. But what have been his chances of scoring if he's Black, Indian, Chicano or Poor? With some exceptions, pretty slim - just to read the headlines. And pretty grim if we read beyond. What about equal treatment for women? How does all that square with our beliefs in a pluralistic society, the value of shared diversity, the protection of minorities?

If Continuing Education is merely an extension of what has gone before, then it will accept these inequities as they appear at its doors. On the other hand, if it is, instead, to be a force in the reconstruction of society, it will need to take explicit and positive steps - very likely unpopular ones - to correct the deficiencies.

Of course, we must not discount our accomplishments. Creating the first true mass-education system for a whole nation has to rank as a high water mark of civilization. But it is not in keeping with the traditions of that very system to sweep under the rug some very important unfinished business.

Finally what about the qualitative tests? Judging the quality of education is much more difficult than counting heads. Yet we have to try it. Looking backwards first, I think we must get a plus for faith in reason, and in knowledge as the spur to reason. While this is not entirely our invention as educators, we should be credited with keeping and enlarging the faith.

Next, our schools have reflected an abiding faith in the supreme worth of the individual - certainly for children a "recognition of their right to grow and develop physically, intellectually and morally into full and normal adulthood." But now, looking forward, even this qualititative judgment must be qualified Education as a one-shot *preparation* for life is, as we now know, insufficient. To continue to merit a plus in this realm, we must succeed as missioners *and* practitioners of continuing education.

Why missionary work? Because the time of Continuing Education has not yet arrived. We think it has, but that's because we're talking to each other. We're hearing ourselves. A world outside remains to be convinced of it.

How will you know when Millenium has arrived:

1. When the *practitioner* seeks you out - and your services.
2. When the school world, K - through *Professional School*, quits running scared. Scared that they won't cram full all the crannies of the brain with those myriad scraps of data, before graduation - behaving as Woodrow Wilson feared they would, as if the mind is "some prolix gut to be stuffed."

   Professors and administrators of the professional schools must quit viewing the learning curve as a sharp parabola beginning and ending in their own curriculum. They must see it extended out over life. They must value you and accept you as co-workers who are ready to pick up and continue where they leave off. You will have to teach them that.
3. And then when the *student* begins to look forward to working with you, and indeed actually *begins working with you* well before graduation. For we may have let schooling run too long uninterrupted by the corrective influences of work. The youth have been disenfranchised from the world of consequential performance - the world of work which gives us meaning and identity. Disenchantment with a life without purpose projects an image of a purposeless society, the hallmarks of which are instant gratification and anti-group proclivities.

Disillusion mounts among our youth when those boiling energies can't be put to ends beyond themselves. You may be glad to have them with you in the flood-tide of public medicine.

As *practitioners,* when will you rate a plus?

1. When you recognize that education alone will not create the conditions you require in the larger society to operate successfully, and you begin to collaborate with the other forces which are going your way. Don't be afraid of the women's movement. You were there first!
2. When you recognize that Continuing Education is everybody's business, not only yours, and you stop worrying about the competition. How would you do it all, by yourself, anyway? Let your own high standards teach your students to choose with discrimination.
3. When you study the business of teaching and learning until you've quit fearing innovations. The alphabet was only the first teaching aid; don't teach as if it were the last. Remember, if he can be turned on, the student is still his own best teacher.
4. And, finally, when you continue to demonstrate to the others what you are showing here today: that you can take some of your own medicine - and live.

PHILOSOPHIES OF EDUCATION IMPLICATIONS FOR CONTINUING EDUCATION IN NURSING

Edith V. Olson
Nursing Coordinator, Rochester Regional Medical Program

It is indeed a pleasure to participate in this conference to share some of my ideas along with Dr. Shannon's on philosophy and continuing education, and hopefully to challenge us one step further into our discussions about this timely and urgent issue of continuing education in nursing; for you believe, as I do, that it will be the *knowledgeable* nurse who will provide the expert and humanized care needed by patients in our complex world and our complex health care situation. It will also be this nurse who will participate as a knowledgeable member of the interprofessional and interdependent team, planning and providing continuous and comprehensive patient care, equally preventive, curative, and rehabilitative.

I will approach this topic through three different aspects: first, to describe briefly the dynamic, complex, and very fluid setting in which nursing finds itself; second, to state the overall goals toward which we must have purposeful commitment if we are to have any success in coping with today's health care crisis; and, third, to comment on some aspects of philosophy as it influences continuing education in nursing. (Fig. 1)

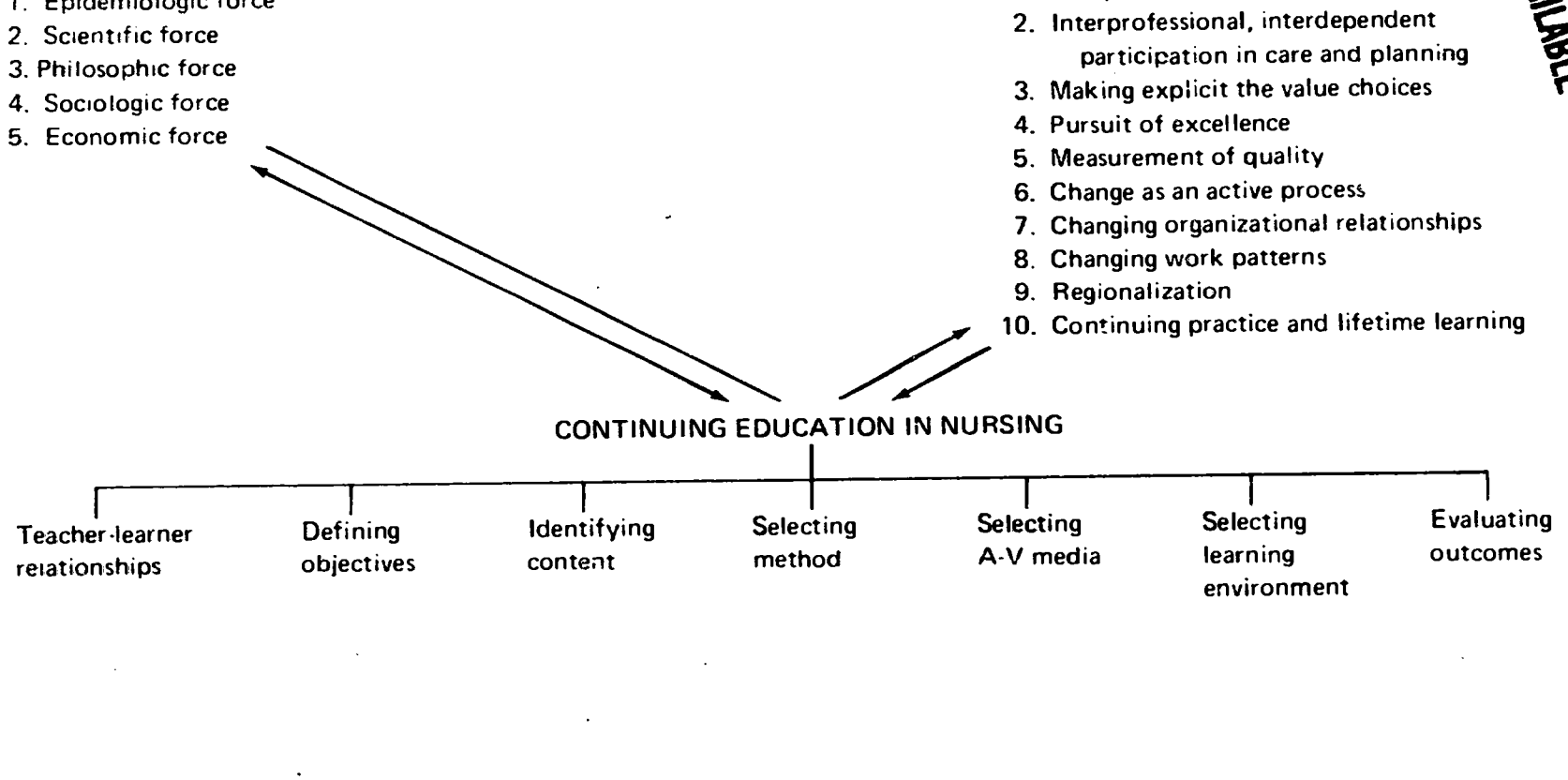
I. The backdrop of dynamic, complex, and very fluid setting

In the opening sentence of the critically acclaimed book, *Future Shock*, Alvin Toffler prophesies that "In the three short decades between now and the twenty-first century, millions of ordinary, psychologically normal people will face an abrupt collision with the future." Toffler's theory is that the rapid acceleration of change is forcing us to live at a faster tempo than our nervous systems can tolerate. He predicts that we will succumb to the disease, future shock, which is manifested by a "dizzying disorientation brought on by the premature arrival of the future."

Certainly, today our society is rampant with external and internal forces that threaten to crush or shatter it. Everyone and everything seem to be either exploding or being affected by an explosion.

Such precipitous collisions with explosions and the relevancy of time can engage one in long thoughts and fear if we allow it. It seems

Fig. 1 **PHILOSOPHIES OF EDUCATION: IMPLICATIONS FOR CONTINUING EDUCATION IN NURSING**



to me that a spectre is haunting nursing · the spectre of failure, the fear of falling short of professional goals and public expectations. The size and speed of the new challenges, the expectations of prompt and high quality results, and the chronic shortages of personnel are well-founded reasons for this fear · present, paradoxically, in a society that is technically developed, relatively affluent, and generally rational in its administrative process.

How will nursing evolve in the decades ahead? Will it find a deeper dimension of practice? Or will nursing as we know it become extinct? By understanding more about the directions of our world and our beliefs in relation to them, we can have meaningful participation in shaping nursing in it.

In other words, philosophy's business is all of life. And if philosophy has an central, guiding purpose, it is to bring thought to bear upon the task of living well. In education, its mission is the same: to bring criticism to the task of educating well.

Therefore, if a study of the philosophy of education is to have any genuine effect, it must terminate in a recognition of how philosophical ideas come to live within us, and how they serve to move and shape our experience.

Great epidemiologic, scientific, social, philosophic, and economic forces are creating unprecedented demands on our health care resources of facilities, manpower, and money.

The epidemiologic force is the population explosion, with its proportionately greater numbers of the young and the old in the age continuum, and, with 80% of this nation's mortality and morbidity from only five major killing and disabling diseases. Especially graphic and tragic are the extent and effect of their functional and social disability.

The scientific force is producing an explosion of knowledge and technology with the potential for more rapidly and efficiently assimilating and evaluating knowledge at the applied level. The quantity and rate of knowledge production have burdened the practitioner to the point where most of his time must be spend going back to school or in "think" sessions just to assimilate applicable research in his field alone, to say nothing of achievements in related fields. Herein lies the paramount danger of becoming so preoccupied with the technologic skills and knowledges that we will become less able to communicate with one another, that both our patients and we health professionals will fall victim to progressive depersonalization. How can the scientific explosion be applied to the health service industry while still maintaining the humanity, individuality, and creativity of man himself?

The philosophic force derives from an increasing concern about the dignity and worth of man. Merely saving lives, adding years to life,

or even reducing the disabling effects of disease, can no longer be our primary concern. A greater responsibility will be to add meaning to added life, not only for our patients and their families, but also for ourselves and the society to which we belong.

The sociologic force - the growing awareness of people demanding human dignity, the right to self-determination, and freedom from want is creating great ideological and political schisms while, simultaneously, producing great striving and anxiety to reach new human values and new utopias. In keeping with contemporary social thought, excellent health care has become a basic human right, evolved from social and political, rather than medical impetus, and bringing a greater demand for and a more critical viewing of health care delivery by the heretofore relatively unsophisticated consumer. We are also coming to realize with such leaders as Dr. George James that health per se is not considered a pure and uncontestable human good but a desirable element in active competition with such other human needs as economic gain, recreation, and just plain pleasurable living.

The economic force is driving us to realize that a quantitative increase in facilities, manpower, and services does not necessarily equate with a *qualitative* increase in health care. It is making us search for new patterns of services, education, and evaluation. In our competitive free enterprise system, the economic force may well be the catalyst toward searching for models to cope with today's health care crisis.

The truly educated health professional will experience the excitement in these five forces and be challenged into full participation.

II. The backdrop of goals

What must be the goals of the health care system for the future? For only as we answer this, will we be purposeful, innovative, bold, and committed in resolving the health care problems. For only as we answer this, will continuing education in nursing be relevant in effecting the maximum benefit to society, as well as a full measure of professional and personal satisfaction. I would suggest ten broad goals toward which we need continuing education, not necessarily a complete list nor in a priority of importance.

Goal 1: Comprehensive health care

Our technology and our know-how provide us with the basic wherewithal to focus on the whole man, to provide the total spectrum from prevention to rehabilitation, to promote the utmost physiological and psychosocial mobility and independence in the patient - a person better educated, better able to pay, and expecting high quality care as

his right; yet our current inability to deliver health care to vast segments of the population results in the awkward situation of not being able to deliver all that is within human capabilities to deliver.

Through cybernetics vast amounts of scientific knowledge can be stored and retrieved for professional problem solving. Perhaps *Fortune* magazine summarized best what the computer has done for us: "A man cannot instruct the computer to perform usefully until he has arduously thought through what he is up to in the first place and where he wants to go from there—the rethinking process gets more difficult as the computer gets better. Wherever the computer is used, it is improving enormously the quantity and quality of human cognition; and it is rapidly becoming a kind of Universal Disciplinarian."

One great potential for development in health services is that of health promotion - not just primary prevention of disease but promotion of positive health. In 1787, Thomas Jefferson wrote that "without health there is no happiness. An attention to health, then, should take the place of every other object." How many nurses are knowledgeable about, or even the least bit interested in, risk factors? Or how many nurses accept risk profiles for their academic interest and practice a kind of living totally inconsistent with their knowledge? The role model health professional will certainly be more able to define the "good" life and to identify the alternatives against which personal choices are made.

Goal 2: Interprofessional - interdependent participation in patient care and health services planning.

That health care covers a wide spectrum of services and that today's patient expects high quality care as a right reinforce the belief that many different health professionals are necessary in today's health care world. Interdependence, rather than independence, is a hallmark of professional maturity. Communicating and contributing with a purposeful, productive focus on patient and health care problems, demands that nursing accept its responsibility in the interdependent role through knowledgeable and skillful practice and through a trusting interprofessional relationship.

Goal 3: Making explicit the value choices.

In our world's dynamic ecosystem, we are faced with making choices about the kind of society and life we want. With the predictive tools of our technology, one leadership function we can perform is to facilitate communications beyond the traditional lines and to present the alternatives our society has in terms of health.

Goal 4: The pursuit of excellence.

The pendulum swing to commitment, involvement, creativity, individuality, zero defects, and excellence is a partial reaction to the pragmatic focus on group behavior, group consensus, and conformity to the group norm. John Gardner in *Excellence* indicated that the pursuit of excellence must be both a right and a responsibility if the social system that values each individual is to survive. De Tocqueville concluded that the state of society became more intolerable the better that it became and that discontent was likely to be highest when an ideal state seemed almost within reach.

Zero Defects, an organized effort to inspire personnel at all levels in an organization to do their jobs right the first time, everytime, makes its appeal to an individual's self interest and pride in workmanship, and is based on the theory that the fastest possible change can occur when there is a meaningful, mutual, positive relationship among the people who must create change - and from this relationship come motivation, commitment, and cyclic award for personal satisfaction or improvement. Since every interaction of a patient with a health agency puts our performance on display to the world, do the concepts of excellence and Zero Defects have importance for the health team? Is the health team any more complex than an industrial team? Is the difference in efficiency due to less clearly defined goals and organization of the health team? If every health agency had to compete for patients in a competitive market, would there perhaps be a substantial increase in quality and quantity of performance?

Goal 5: Measurement of quality

Quality is a vital ingredient of the health care process, with complex interactions between user behaviors and provider behaviors with two results: an intermediate product, the use of a service, and an ultimate product, an outcome definable as the health and welfare of the user. The traditional focus has usually been on provider performance; however, as knowledge advances, standards are redefined by professional determination and with others in a social process. Evaluating the process of health care is just as important as evaluating the outcomes, for it not only provides feedback concerning the performance of the system but also allows for administrative control of quality and for testing the consequences of planned change. The most fundamental and pervasive feature in the ecology of quality control is the nature, degree, and location of social concern and accountability for the quality of professional performance. The creation and perpetuation of a state of tension may be the only way of assuring that the quality of care is maintained and the interests of the user and health professional are equally protected.

In all of this, the informed consumer must be an active and equal participant, and, as a collectivity, must demand that all elements in the health care system remain accountable to him in the discharge of their social functions. The consumer must create the social, political, and administrative mechanisms that implement such accountability in a continuous operation.

Goal 6: Change as a active process

Wallis has stated, "That social change can occur is far more obvious than that man can bring about social change.——There is a great chasm, often overlooked, between demonstrating that things can change and demonstrating that things can be changed." Change is an active process. This rapidly changing world will need people who not only are very highly skilled but have the added qualities of mental flexibility, creative thinking, and a high receptivity to new ideas.

If one believes as Parsons, that the major function of the health care system is social control - that is, controlling the deviant who is socially defined as sick - then the adaptive and reactive pattern of behavior is appropriate. One can then be a passive recipient, or perhaps even a resister, of change, Unwillingness of health professionals to change the patterns of care systems, and unwillingness of patients to change their consumer habits have been identified as a major present day crisis.

On the other hand, if one believes that planning is an intervention process to change current behavior sets to new behavior sets to obtain a desired and rationally planned future - then the health professional becomes a catalyst for change.

Health care is in such a fluid and dynamic state that its leaders must retain a remarkable elasticity lest they fall victim to that dread malady, hardening of the categories, the occupational disease which can destroy both profession and person. For the choice is whether coming changes will be thrust upon community health agencies and health professions ill prepared to absorb or adapt to them, or whether organized health services and professions will seize their opportunities and influence the shape of the future.

Goal 7: Changing organizational relationships.

The use of the computer and cybernetics is challenging our strongly held beliefs about the authority of the hierarchy of position, as seen in traditional organizational charts. Traditional approaches of administration, used largely by non-economists, identify the chronic personnel shortage as a *cause* of administrative deficiency, simply cured by having adequate numbers of trained personnel. The economists suggest that in a market economy the com nunity indicates what is

necessary and desirable within its total resources. From this view, personnel shortages are regarded as a *symptom* of basic derangements in our health systems, and an *output* orientation and the systems analysis approach would move us from inquiry into the current symptomatic problems to the core problems themselves. This approach requires health leaders to examine first the goals and values they seek to achieve, and then to ask whether structures and processes are relevant, adequate, and rational.

Goal 8: Changing work patterns.

Because of an unequally distributed and dysfunctional division of labor, it is more necessary than ever to rethink job functions, professional functions, and our patterns of work. Professional and specialty domains, carved out and often jealously guarded, will need to change. As we learn new skills and take on new functions, we will have to share functions with others who have different kinds of skills, thus breaking down carefully guarded domains of influence. In the health field people are stereotyped by their professions rather than by their individual mix of skills. Although a professional affiliation does give anchor and support, it also tends to place us into a mold from which it is hard to escape. Only when health professionals focus on what patient needs are, and are trusting and understanding of each other's skills, will they be able to decide who is the most appropriate person to care for the patient at a given point in time.

A worsening problem affecting our educational system is the political recognition that too much of our population is out of the economic, occupational, and social mainstream of society. With the growing unemployment of those minimally educated, semiskilled, or in late middle age, the paradox of supposed terrible manpower shortages in the highly skilled and professional occupations exists.

Freed by technology the nurse will have the opportunity to concentrate on what may well be her unique role in the interprofessional team, humanizer for the recipient of the ever expanding health technology - and in giving as a humanizer, she will prevent her own dehumanization.

Goal 9: Regionalization

One trend definitely emerging is regionalization, the cooperation of comprehensive health services on a regional basis. Improving the organization of and the communication between what we already have, as well as bold experimentation, are in order. Some professionals and agencies are dubious of the motives of those who actively sponsor regional changes or experimentation. In reality, cooperation actually enhances individual effort.

The Regional Medical Program, Comprehensive Health Planning, Regional Education Compacts, etc. are dynamic examples of the regional and grassroots approach to cooperative planning and action.

Health care personnel, as professionals and as community citizens, must cast away the fortress of institutionalism and provincial competition. They must become informed about and involved in the social forces shaping regionalization.

Goal 10: Continuing practice and lifetime learning.

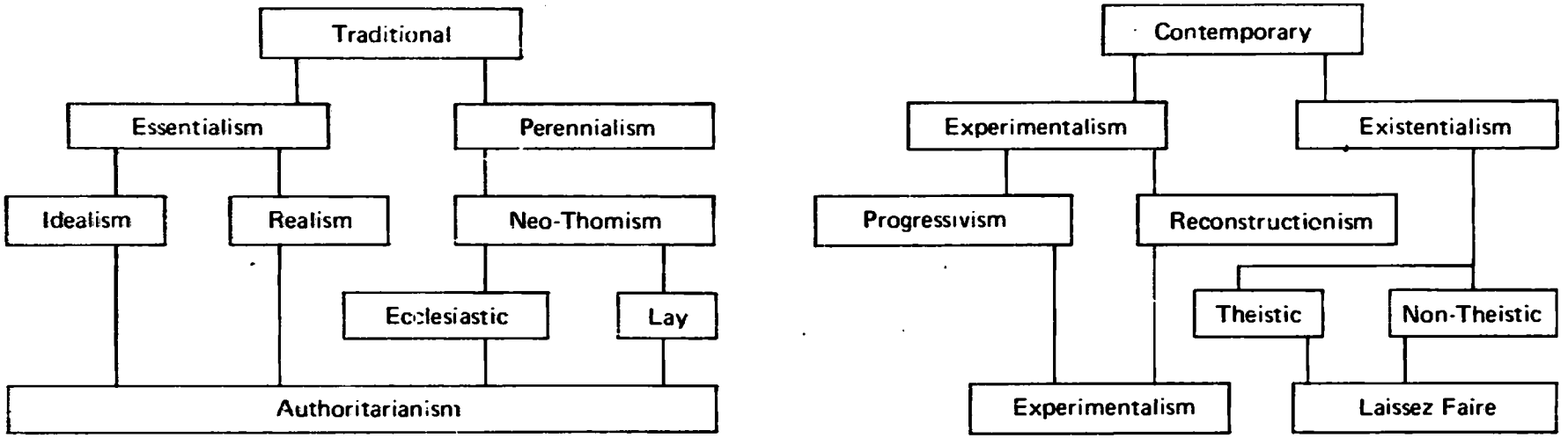
Whatever decisions are reached about educational programs for beginning practice in any of the health professions, two goals must be clear: that each educational program should provide a base for further education, not a completely educated product; and that, through education, men and women must be encouraged to maintain a professional identity even when inactive. Persons of the future will have to have the kind of education that prepares them to continuously learn new and different skills. Continuing professional education is education for practice and is ongoing and lifetime - not just sporadic. Its goal is a changing behavior in the practitioner which contributes to the maintenance and upgrading of quality health care.

The 1966 report of the Interprofessional Task Force on *Continuing Education for the Health Professions* concluded that "in the foreseeable future, it is the interprofessional activity that needs attention, for individual practitioners can hardly escape the flood of information that is about to engulf them", that "the programs should be built on the process of inquiry into patient care in which the professionals are jointly involved"; and that "when the goal is learning to work together, the process of study in itself constitutes the educational program."

The concept of continuing interprofessional learning, in which patient-centered dialogue and study with one's professional colleagues occur, should also result in further individual study. For to contribute to the group, each professional must pursue his own unique knowledges and skills. Thus, health professionals, learning together and questioning each other, will motivate themselves and others to seek new information or new methods of applying old information. Also, they will motivate themselves and one another to learn more about the patient as a person, about his reactions and attitudes toward health care, and about themselves as individuals.

And what of continuing education for the patient and society? When health is defined as a positive state and health care covers the entire spectrum from prevention through restoration, the patient and society must learn their changing roles in this spectrum.

Fig. 2 **PHILOSOPHIES OF EDUCATION**



III. Philosophy applied to continuing education in nursing

With the backdrops of the setting and the overall goals, the clock pushes me on to comment on philosophies of education as applied to continuing education in nursing. Because the complexity of the subject is worthy of at least a ten-credit course, I decided that the only way I could get a handle on it was to prepare these outlines for your use now, and perhaps in the future, and to remark about some contrasts I see in application.

To reiterate - philosophy's business is all of life. If it has any central, guiding purpose, it is to bring thought to bear upon the task of living well. In education, its mission is to bring criticism to the task of educating well. If its study is to have any genuine effect, it must terminate in a recognition of how philosophical ideas come to live within us, and how they serve to move and shape our experience.

The diagram (Fig. 2) merely illustrates the classification of the five major philosophies of education into two periods, traditional and contemporary, with the latter having its ascendency in the early 20th century. Fig. 3 summarize their guiding principles—what is reality, what is truth, and what is good and beautiful. To highlight a few comparisons between the guiding principles:

The idealist believes that he is created in the image of a Greater Being, and that by rendering himself receptive to ideas and symbolic experiences, and by aspiring to a more infinite goodness and love for beauty, he can move up the ladder in becoming more like the Absolute Self.

The realist believes that the real world is the form and matter all about us, that in Nature we can find the laws and principles the stability needed for balance in living. Its world is materialistic. Its perceptions are gained through observation of the world about us.

The pragmatist believes in the world of ordinary human experience, that truth is derived from what works, that what is good and beautiful is determined by the public group, and that the value system is ever changing through pragmatic experience.

The existentialist, perhaps in rebellion against the public norm, believes that each man exists for and in himself, that his is the right to be free from the public value system, that his self must be transcendent over the social system, and that his choices are his own responsibility.

How are these philosophies expressed in education and what importance do they have for continuing education in nursing? The last group of pages summarize this.

A. The teacher-learner relationship (Fig. 3)

1. From the idealist view -

   If the teacher is to be an exemplary role model for the learner to imitate, then who are the role models in nursing? Where should they be based? In university medical centers, the fountain of new knowledge and best practice? Who decides that the role model nurse is such - the nurse herself, the employing agency who assigns a job title and says "develop your own job description", the society to whom the nurse delivers an excellent product, or the learner who decides to be a copy of this role model? What do such titles as "clinical nurse specialist" and "nurse clinician" really mean? If the teacher is a role-model, how can the teacher-learner relationship be best facilitated in continuing education so that the nurse practicing in a different or distant setting can see and know the practice of her role model?

2. From the pragmatist's view -

   If the value system is ever-changing, what can the teacher feel as job satisfaction? Is it the experiencing along with the learner the process of change, the process of problem-solving, the process of group interaction and critical analysis? Is there no "finished end product" which can be defined? Who is to be the ultimate decision maker and the caretaker of responsibility for practice? Does no learning take place, or is it without relevancy, unless it has been experienced by the learner and put to the test against group criteria? How can the continuously learning learner put into practice her learnings against tremendous peer pressures for the status quo?

3. From the existentialist's view -

   In what ways and toward what ends can the teacher awaken the "caring about" component in the nurse learner - caring about her own self-esteem, her continual need to be learning and to be involved, her commitment and her responsibility for her own acts? Is there any predetermined role for the teacher or is this defined at the time and by the expressed needs of the learner?

   A summarizing comment: In our health care system and continuing education system there are many individuals, of different generations and philosophy with differing views about the teacher-learner relationship. Must these differences be in eternal conflict? How can they be channeled into eclectic productive relationships for both teacher and learner?

Fig. 3 OVERVIEW OF PHILOSOPHIES OF EDUCATION

Educational theory	Who?	Ontology What is real?	Epistemology What is true?	Axiology Ethics—what is good? Aesthetics—what is beautiful?
Traditional philosophies				
I Authoritarianism				
A. Essentialism				
1. Idealism	Socrates Plato Georg Hegel Immanuel Kant Herman Harrell Horn Theodore Greene	A world of the mind, of ideas. Two worlds: Microcosmic—self Macrocosmic—Absolute Self. Basis for Protestant conception of life.	Seeing with the "mind's eye"—consistency of ideas. Render ourselves receptive to ideas of the universe. Turn from sensate to symbolic experience.	Imitation of the Absolute Self-infinite goodness in conduct Refection of the "Ideal"—infinite lover of beauty.
2. Realism	Aristotle Comenius John Locke Thomas Jefferson Bertrand Russell Alfred North Whitehead Harry Broudy John Wild	A world of things. Form—matter hypothesis. World is essentially material and mechanistic. Nature contains laws and principles by which its movements and processes may be generalized.	Spectator theory: sensation and correspondence. Perception of the real world will yield true ideas as they correspond with actual facts. Stability and dependability in Nature.	The Law of Nature. Appeal to common sense. Nature contains elements of what is good and right.

Educational theory	Who?	Ontology What is real?	Epistemology What is true?	Axiology Ethics--what is good? Aesthetics--what is beautiful?
B. Perennialism				
1. Ecclesiastic neo-Thomism-classical humanism	St. Augustine St. Thomas Aquinas William Cunningham William McGucken Pope Pius XI Jacques Maritain	A world of reason and Being (God). Potentiality - Actuality Principle. Essence + Existence equals Being. Metaphysical rapport between us and the cosmos.	Intuition, logical reasoning, and revelation--cultivation of logical powers of human mind.	The rational act - what is good conforms to the rational nature of man. Creative intuition. Intellect of man tells him what is beautiful.
2. Lay neo-Th - sm	Robert M. Hutchins Mortimer J. Adler			

Educational theory	Who?	Ontology What is real?	Epistemology What is true?	Axiology Ethics–what is good? Aesthetics–what is beautiful?
Contemporary philosophies I. Experimentalism (Pragmatism) A. Progressivism	Heraclintus Sophists - Protagoras Gorgias Francis Bacon Auguste Comte Charles S. Peirce William James John Dewey Boyd H. Bode William H. Kilpatrick John L. Childs	A world of experience–ordinary human experience.	Testing to see what works–truth derived from the consequences of our experiences. When many individuals in a lab or citizen in a community place themselves in a position to undergo the consequences of certain actions made upon the environment, they arrive at a scientific judgment.	The public test–the law is always changing. never static, always determined through trying out to see what are the ultimate consequences. The public taste–values changing.
B. Reconstructionism	Karl Marx George S. Counts Harold Rugg Theodore Brameld	Not a distinctive philosophy but built on conceptions of experimentalism. Militant formulation of policy.		The "Utopian Future"–teach to reconstruct the social order.

Educational theory	Who?	Ontology What is real?	Epistemology What is true?	Axiology Ethics - what is good? Aesthetics - what is beautiful?
II. Existentialism ("Laissez Faire")	Soren Kierkegaard George Kneller Jean Paul Sartre Friedrich Nietzsche Paul Tillich	A world of existing who am I? What is Man?	Subjective choice personal appropriation. Choice with individual responsibility. Finding the self.	The anguish of freedom Revolt from the public norm Self trancendence over social transcendence

B. Defining objectives (Fig. 4—p. 37)

1. From the traditionalist's view -
   If "teacher knows best", on what basis does she define the real needs of the practitioners "out there" - pre-test, direct observation, peer review performance evaluation, or periodic testing for recertification? If teacher objectives are non congruent with covert or expressed needs of learners, will behavior change in the practice setting occur except under mandate? If continuing education knowledge is the ability to present the latest facts, is practice any different or better with the facts? Are teacher objectives any better than no goals at all?
2. From the pragmatist's view -
   Will the nurse who knows how to think, how to problem-solve, how to create change, be a better practitioner than the one who is trained to follow and perform in a procedural approach? If what is needed via continuing education is a retreading of nurses taught under traditional goals - a retreading to think, to problem-solve, to be a change agent - how do teacher and learner come to terms as to the need for continual learning, as to the congruent goals and the expectations of learner behavior? Merely stating goals in terms of anticipated behaviors does not necessarily guarantee the application of the learned behaviors to practice, if the behavioral objectives are not stated for beyond the learning setting. But how does one expeditiously and with validity evaluate behavioral objectives achieved by continuing education?
3. From the existentialist's view -
   If needs expressed by the learner are the only relevant ones, how can continuing education be carried on in any way except a one-to-one relationship and through self-directed education? In the complex health care system settings, what is the environment of freedom, the environment for individualized choosing? How can congruence be achieved between what the system says it needs in terms of individual and group behaviors and what the learner chooses as his rights and responsibilities - social conformity and group tyranny be damned?

C. Identifying appropriate content (Fig. 4—p. 37)

1. From the traditionalist's view -
   Should the content of continuing education consist primarily of the humanities applied to our practice (eg. the philosophy

of the dignity of man as the core of rehabilitation), or the identification and memorization of facts and patterns with procedural application (e.g. memorizing shapes of arrhythmias and acting on the basis of prescribed standing orders if the nurse observes a certain arrhythmia). But how does one ever know all that is known or will be known?

2. From the pragmatist's view -
   If content is not important except as it is used in the process of problem-solving, should all of continuing education be that of process and group experience, learning retrieval of relevant information for the problem at hand, and learning behavioral sciences through the experience of group dynamics?
3. From the existentialist's view -
   Is there any appropriate content in continuing education to be identified if learning is totally the learner's responsibility? Against what criteria does the learner choose relevant and meaningful content, or even chooses to be motivated toward content? If content is for the individual, is there any unique body of content for a profession?

D. Selecting method (Fig. 4—p. 38)

1. From the traditionalist's view -
   Is the lecture method from an "expert", so much a part of our education for the health professions, a dead method? Or a deadly method? Is there any role for drill in continuing education? If the learner is the only one who can integrate his learning, why are we so dedicated to putting learning activities into sequences - sequences of simple to complex, of scientific facts and principles to specified clinical applications? If continuing education is continual learning, what are the learnings and of what value are they if they result because of actual experience rather than a planned learning experience?
2. From the pragmatist's view -
   Under the stress of time and the need for action how does one justify the cost of continuing education that requires time to problem-solve, to reflect, and to come to a group decision? If learning is living the experience, how can staff development leaders best use the day-to-day practice experiences as continuing education? How do you tell a staff that they need to be problem-solving when they tell you that they want in-service doctors' lectures on the latest drugs and treatments - and on duty time?

3. From the existentialist's view -
   Does Socratic questioning, an integral part of Existential learning and sometimes referred to as grilling by students or staff, have any place in continuing education? If learning is the responsibility of the student, then isn't the method also his responsibility - and taken to its ultimate conclusion, then isn't the cost of continuing education his responsibility and not that of employer, patient, or third party payer? Returning to method, if nursing is an art, then is not the free expression of the individual in nursing as an art the ultimate expression of the self, and the ultimate continuing education experience?

E. Selecting the A-V media (Fig. 4—p. 38)

Are we in continuing education enamored by the media in and of themselves - the programmed instruction manuals and machines, the multi media systems, the closed circuit television and videotapes, etc?

1. From the traditionalist's view -
   Media are developed by experts in the media fields from objectives and content developed by the role model and expert teacher. A video tape of the role model at practice, the sequential and cross reinforcing method of the multi media systems, and the guidelines and workbooks produced even for one day conferences are expressions of the traditionalist's view.
2. From the pragmatist's view -
   Producing the media itself is the learning experience, never mind the amateurish end product. Besides, who is to say what is an amateur or professional production? What degree and kinds of learning occur from being a spectator of professional production or a participant in an amateur production? Which learning evokes the most effective and lasting change of behavior?
3. From the existentialist's view -
   Is not the beauty of a finished nursing art the ultimate A-V media of expression to the self and to others?

F. Selecting the learning environment (Fig. 4—p. 39)

The traditionalist would say that continuing education buildings with lecture halls and laboratories for practice are necessary. The pragmatist believes the problem-solving related to every day practice is best carried out in the practice setting around and with

the patient and in small conference rooms adjacent to the clinical setting. The existentialist doesn't need a learning facility since he will find it if he chooses to need one.

G. Evaluating outcomes (Fig. 4—p. 39)

1. From the traditionalist's view -
   The primary goal of evaluation is to come out with a numerical grade or rank order the group against which to decide certification, seen as the responsibility of the teacher, the profession, and/or the state. The role of the learner is to meet outsider-determined goals for an adequate performance level for certification for something.
2. From the pragmatist's view -
   If evaluation is to be a mutual process by teacher and learner, mutually defined goals and mutually understood criteria for assessment must be developed at the start of a learning experience. If the process of problem-solving is an expectation, how can it be measured with validity—paper problem solving case studies or via observation of problem-solving competency in real life setting? What needs to be the system for developing norms needed for licensure and recertification if the value sets are ever changing?
3. From the existentialist view -
   What is the nature and value of evaluation (from an outsider's view) if goals, process, and evaluation are the sole responsibility of the learner? Is this incompatible with professional standard setting?

IV. Building a personal philosophy.

After a thorough study what remains to be done is just this: to identify some personal set of commitments which you can lay claim to as your own; to extend and enlarge these commitments into a cluster of notions, about the world and about the job of teaching, which fit together and which you can defend; and finally, to arrange those notions into an organic whole, so that they begin to operate in your life and work.

It takes really thorough and rigorous review of all of the aspects of philosophy to come up with the "conceptual tools" for active philosophizing. In addition to analyzing the *lateral* relationships within a philosophy and the *vertical* relationships between philosophies, one can provide examples and illustrations which often help to bring real understanding of difficult ideas.

The business of philosophy - building or developing a systematic

Fig. 4 PHILOSOPHIES OF EDUCATION APPLIED TO CONTINUING EDUCATION IN NURSING

COMPONENT	IDEALISM	REALISM	PERENNIALISM	EXPERIMENTALISM	EXISTENTIALISM
The teacher	As a paradigmatic self, role model and exemplar As a refined, idealistic interpreter of the moral sense of the community.	As a demonstrator and trainer in rules of conduct	As mental disciplinarian and spiritual leader, disciplining behavior to reason	As a research and project director	As provocateur of the self to responsibility, awakening of "caring" in students
The learner	As a microcosmic mind, imitator and exemplars and heroes.	As a sense mechanism.	As a rational and spiritual being.	As an experiencing As involved in group decisions in light of ever-changing consequences.	As the ultimate chooser.
Faculty relations	Discussion of ideas.	Precise chains on command	Separation into policy councils, etc.	Identification of problems in life around which to build projects. Committees galore!	

COMPONENT	IDEALISM	REALISM	PERENNIALISM	EXPERIMENTALISM	EXISTENTIALISM
Defining	Teacher centered *to* student To present knowledge for development of ideas in and for themselves To identify what is good and beautiful. Conserve the heritage.	Teacher centered *to* student. To expose student to to physical reality -- regular, orderly, systematic, and natural reality. Transmit settled knowledge.	Teacher centered *to* student. To train student to love Truth in and for itself To train the intellect	Student centered *with* teacher To provide the environment for ongoing experiences in which ideas and truth are tested in action. Truth sought and reached only because it can be used in our lives, because it is relevant. Teach how to think, not what to think; how to manage change or reconstruct the social order.	Student centered *by* student. To provide the environment of complete freedom - no tyranny of other people's decisions and social conformity. Student has the choosing mechanism.

COMPONENT	IDEALISM	REALISM	PERENNIALISM	EXPERIMENTALISM	EXISTENTIALISM
Identifying appropriate content – curricular emphasis	Subject matter of the mind -literature, intellectual history, philosophy, religion. Literature--deals with permanent and enduring *ideas* of human condition. History--where we have come from, where we are headed. Humanities--awaken us to basic *ideas* of the the cosmos. Emphasis on custom and tradition.	Subject matter of the physical world-mathematics, physical sciences. Study of the world for principles, laws, regularities; then turns understandings into programs for doing things.	Subject matter of intellect and spirit--disciplinary subjects, eg. mathematics, language, Doctrine. Rigorous censorship on learning. No non-intellectual subjects, eg. athletics, crafts, recreation, all extracurricular activities.	Subject matter of social sciences. Sciences studied not for knowledge but for scientific method. Management of change itself. No settled truths--seek open questions. Emphasis on process, not product; on method, not result; on means, not end. No religion because of dogmas.	Subject matter of choice: art, ethics, moral philosophy, religion. No prearranged concepts. Release of human feeling--arts most provocative. Social sciences--seen as studies in human motivation.
Professional emphasis	Liberal arts. History of Nursing.	Biological sciences for understanding of reality of of illness world.		Behavioral sciences for understanding of man in his society.	Psych-mental health for understanding of man as an individual responsible for his own choice, actions.

COMPONENT	IDEALISM	REALISM	PERENNIALISM	EXPERIMENTALISM	EXISTENTIALISM
Selecting method	Absorbing ideas. Teaching for the handling of ideas—lecture with discussion. Symbols—principal medium through which the Mind operates	Mastering facts and information via demonstration and recitation. Systematic, prescribed procedures and routines; sequence of learning activities. Carnegie unit—semester hour. Precise class schedules.	Training the intellect. Disciplining the mind—formal drill. Readying the spirit - Catechism. Rigorous mental discipline forces individual to exercise memory and reason. Distasteful assignments force students to develop inner strength for character.	Problem-solving. Project method—life situations. Group endeavor. "Psychological" method. Learning through living. Learning is a social enterprise. Socialization process negates "homogeneous grouping" of students. Education of the masses.	Finding the self. Arousing personal response. Socratic questioning.
Selecting A-V media	Studying the masterworks.	Studying design in nature. Workbooks. Multi-media systems.	Finding beauty in reason.	Participating in development and production of media and projects.	Composing a personal art work.

COMPONENT	IDEALISM	REALISM	PERENNIALISM	EXPERIMENTALISM	EXISTENTIALISM
Selecting learning environment	Lecture hall. Clinical setting with role models and practice for perfection.	Lecture hall. Clinical setting with ward walks. Field trips as observers.	Recitation assemblies Practice for ritualistic procedures. Laboratories for drill.	Small group sessions with or without leader for conduct of projects and discussions. Field trips as participants	Bull sessions. One to one. Socratic sessions
Evaluating outcomes	Essay tests-open ended questions.	Paper and pencil tests for facts.	Memorization and recitation	Case studies with problem solving Self assessment with teacher.	Self assessment

point of view can be approached using either the deductive method or the inductive method.

In the deductive approach, your first job is to set down as comprehensively and comprehensibly, and as cautiously and rigorously, as you can your personal views on ontology, epistemology, and axiology.

The thoroughness with which you can manage this "I believe" will determine how successful you will be later on. You must stick closely to a logical development of your ideas and, since there is an intimate, mutual interconnection between ontology, epistemology, and axiology, special care must be taken that incompatibilities do not creep in at this point. The second stage is to spell out the kind of educational theory which would seem to follow from these fundamental propositions. In the third step, show how your educational theory would produce certain concrete behavior patterns in a teacher - his instructional purposes, his methods, his ways of evaluating learning. The fourth stage is to rigorously apply criticism and analysis to your own teaching, making clear those points of contact with your own position and how they relate to your own position, drawing a deductive argument *from* your philosophic position *to* your educational theoretical position *to* the kinds of specific behavior patterns you feel a teacher would follow? The final stage or test is to find connections between your deduced pedagogical prescriptions and the way you actually teach. By the time you have criticized and revised your statements and your teaching behaviors you will have put forth a philosophy of education.

In the inductive approach the best place to begin would be your own teaching behavior and, through six succesive steps, ask "how do I teach?"

a. Prepare a general description, without evaluation, of a typical teaching day - how you taught, the methods used, the ends you tried to achieve, the ways you measured learnings.

b. Identify those moments of the day when you felt you were teaching best, when you felt good about what you were doing, when you had the distinct impression that genuine learning was going on.

c. Attempt to specify the educational theory this kind of teaching would seem to indicate, the theory which would seem to be directing the kinds of things that went on in the day.

d. Sketch out the general outlines of what kinds of ontological, epistemological, and axiological views ap-

pear to be operating · try to organize some basic philosophical propositions that you think may be inferred from the procedures you used.

e. Compare and contrast the first four steps with the theories of educational philosophy, explain why one set of ideas rather than another hooks up with your own (and yours with it).

f. Compare all about the way you teach · Do you teach the way your point of view ultimately suggests? If not, are corrections or alterations needed? Or perhaps your teaching is adequate but your statement of philosophy needs changing.

Perhaps you will find from your analysis that, while you fall primarily into one of the philosophies, you really borrow something from all of them · that you are an eclectic, one who draws his basic ideas from several different points of view. There is nothing wrong in being eclectic; most of us are. However, your obligation is to harmonize your selections from the different philosophies into some kind of compatible whole. This is perhaps the most difficult and yet the most decisive stage in building a personal philosophy of education. Only in the degree that you can organize your ideas in a whole will they be clear of inconsistencies and incompatibilities.

An alternative to the deductive or inductive approach, which may have some merit in continuing education in nursing, is called the cultural method. It starts from the question: what is the role of the profession with its educational institutions in an age of cultural change and transition? What should be the educative process in its socio-politico-historical setting in helping to bring about a newer life? What changes in attitude and outlook may we expect in the years and decades ahead? Will the profession of nursing help to bring about these crucial changes or will it leave them to other agencies? Then, working first in the direction of philosophic beliefs, you would specify what you believe should be the ontological, epistemological, and axiological underpinnings of such a social policy. Then, working in the other direction, you would spell out the kinds of curriculums and teaching methods which would seem to satisfy the image you have of the educational program in a period of change. And, as before, you will want to see where you fall in your beliefs as applied to your behaviors, the harmonizing of what you profess with what you actually do.

Perhaps the final word about building a personal philosophy of education should be this: if you never succeed in arriving at a definitive personal philosophy of education in which you can hang

out your intellectual shingle, do not despair. There is no obligation to believe in any one philosophy nor in a wholesome eclecticism. There is only one necessary commitment: to take one's life seriously enough to believe that thought and criticism can be applied to make it better, more intelligent, and more civilized. Furthermore, there is a vibrancy to the continuously inquiring mind. What is important is the constant quest in search of the meaning of life and the way to awaken that meaning in the lives of our students.

John Dewey wrote, "To the being fully alive, the future is not ominous but a promise." How will the magnitude of the problems facing nursing today and projected for tomorrow, the combination of such social ills as poverty, urban decay, drug abuse, population explosion, race relations, as well as the host of ethical and moral dilemmas forecast for a society dominated by rapid technological and bio-genetic innovations - how will the magnitude of these problems affect how and where nurses will practice and under what conditions? Nursing still has manageable jurisdiction over some aspects of how it will evolve, and it also has, within limits, a freedom of choice.

No doubt, as Toffler forecasts, our nervous systems are due for a shaking up as we accelerate our capacity to keep up with the increasing demands of a changing society and a changing world. However, before we plan for the next century, we had better look at the effects of decisions we made yesterday and those we make today, for as Alfred North Whitehead has said, "The future has an objective existence in the present." In other words, tomorrow is what we will make of it. However, if we do not know what we want to make of it there may be no future, for Whitehead also advises us, "How the past perishes is how the future becomes."

Sir Joshua Reynolds has stated, "The mind is but a barren soil - a soil which is soon exhausted, and will produce no crop, or only one, unless it be continually fertilized and enriched with foreign matter."

Thomas Huxley has written, "If a little knowledge is dangerous, where is the man who has so much as to be out of danger?"

In conclusion, you as a nurse and as an educator face the real test of your philosophy of nursing, your philosophy of education, and your philosophy of living in what choices you make in the predicaments of continuing education in nursing and today's crisis in health care delivery.

DEVELOPING A MODEL FOR CONSUMER HEALTH EDUCATION

William L. Blockstein
Professor and Chairman, Health Sciences Unit
University of Wisconsin-Extension

Dr. Jesse Steinfeld, Surgeon General of the United States, speaking at the 24th World Health Assembly in Geneva said,

> The United States has determined that five basic principles must serve as the foundation for the United States' first national health policy to improve our health care system in a coordinated, comprehensive program directed at problems in health education, health research and delivery of health services.
>
> First and foremost, equal access to our health care system is essential. Racial, economic, social, and geographic barriers must be eliminated or minimized.
>
> Second, supply and demand in health resources must be reasonably balanced. An increase in demand that cannot be met by existing or foreseeable resources compounds the problem—a principle that was ignored and has proved costly in our previous experience with Medicaid and Medicare.
>
> Third, the health care system, including health education and health research as well as health services, must be organized efficiently. Placing the burden of greater new demands generated by increased funding on the same old inefficient system is fatal. How much to spend is only part of the question. How to spend it efficiently for a maximum return on the investment is the critical issue.
>
> Fourth, instead of discarding all of the present system, the great strengths of our existing system will be built upon. Nothing could lead to greater chaos than to sacrifice useful

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parts of the system under the misguided concept that we must totally do away with our present system and start anew in order to improve it.

And, fifth, our programs will be based on health—not health care alone. This means that individual citizens will be encouraged to act responsibly in their daily lives through programs of health education, health maintenance and disease prevention.

It is the fifth of Dr. Steinfeld's points above that we will discuss today. In 1970, the National Association of State Universities and Land Grant Colleges had been requested by the Health Services and Mental Health Administration of the Department of Health, Education and Welfare to conduct a study into the potential of building a model or models for Consumer Health Education. In turn, the association approached several university research teams to inquire as to their willingness to conduct the study on behalf of the association for HSMHA. The University of Wisconsin was awarded the study contract in November, 1970.

It is of some interest as we begin this account of our model development to describe the research team. Our membership included: the project director who, by initial training, is a pharmacist and presently a continuing education generalist in the area of Health Sciences. Other team members included: a physician who was in pursuit of his doctorate in medical sociology, a hospital administrator in pursuit of his doctorate in health services administration, a senior student in medical school, a graduate student in political science, a specialist in sociology, a young researcher in health services administration, and a professor in continuing and adult education who had particular strengths in independent study and in program evaluation.

With this team assembled, we began our study of existing programs in citizen health education and began to study the existing activities for the provision of health education through the presently organized systems available in health serving institutions whether academic, governmental, or private. Additionally, we began to study the details of the land grant university systems of cooperative extension and general adult education.

What follows next, is our understanding of the present state of health care in America and our assessment of the role that university extension and health science centers in private and government agencies can play in meeting the objective of Surgeon General Steinfeld's fifth point.

Health care in America is under great pressure. Medicare, medicaid, many private and semi-public health insurance programs, a growing population, new medical technologies and other factors have over-burdened the presently constituted health delivery system which unfortunately has been able to expand only at a very slow pace. Health care has increasingly come to be regarded not only as a necessity but as a basic human right, increasing the public's health care expectations.

Many Americans are not able to obtain badly needed treatment, while at the same time certain scarce medical resources are being used inefficiently. The maldistribution of health personnel and services means quality care and many recent medical advances are not available to all sectors of the general public. In addition, the system of care that has evolved tends to create a degree of dependency or passivity in those people who have become patients or who have sought care.

Historically, our society has been characterized by a do-it--yourself-if-possible philosophy. This developed partially in response to economic need, but is related even more to the satisfaction received from increased self-reliance through informed action. The helplessness and uninformed dependency which attaches to the status of being a patient in the present health care system is a deterrent to the development of a philosophy of self-reliance in health.

The federal government has for many years been involved in attempts to alleviate the shortage of facilities and personnel through such programs as Hill Burton and Health Manpower. More recently, the Regional Medical Programs have attempted to facilitate dissemination of the latest medical knowledge and technology for the good of all people. Likewise, the Office of Economic Opportunity has been involved in outreach programs providing direct care to low income groups and experimentation with consumer control of these same services. Inherent in both these programs is the concept of regional and local responsibility for the health needs of defined geographic populations.

Comprehensive Health Planning is an attempt to bring order to the distribution of medical resources, fill gaps in health care, and hopefully avoid the duplication of services which has occurred in the past. The public is being asked to participate in such planning through membership on boards of local area wide planning agencies.

Most experts generally predict that the next major health role of the federal government will be the encouragement of a broad health insurance system. However, the removal of financial barriers to health care may dramatically increase public demand for services, leading to further strain upon the presently overburdened system.

Gradually medicine is changing from a disease orientation toward one of health maintenance. National morbidity and mortality no longer

concentrate on curable acute illness, but on conditions such as cancer, heart disease, stroke, mental illness, arthritis, diabetes and accidents. There is little evidence that even dramatic increases in the kinds of medical services now available can have any impact on these problems. What is required is a broader health focus, emphasizing preventive, supportive and rehabilitative roles. Health management programs must emphasize personal and family schedules for healthier life styles, preventive health screening, identification of high risk disease groups with a concomitant need to change maladaptive life styles, and chronic disease self management.

No system can possibly furnish all of the above for a population of passive individuals. The greatest untapped manpower resource in this country is the individual consumer. Needed is an informed and "activated" citizen who can take his own initiative in personal health approaching and utilizing the health care system properly for all services required in his personal health management program.

An important and promising avenue for encouraging this appropriate, active response is through a broader program of consumer health education. For such a program to succeed, it must have an appropriate and high quality substantive base. This must be coupled with a pervasive delivery and access system that will assure widespread involvement and methods of effectively dealing with personal motivation.

State universities and land grant colleges are unique in their commitment to public educational service. Problem solving, research and education for all people with the objective of informed consumer action are major missions, not merely by-products of regular academic programs or of individual faculty and student actions. Extension has been the main outreach of these institutions, developing an ability to reach large numbers of people effectively, using the university resources in solving problems. Extension has considerable expertise in packaging information and using multiple teaching techniques. In addition, feedback mechanisms exist to measure the effectiveness of programs and the satisfaction of people being served. Other strengths include the ability to identify problems and needs, organize groups, and work with and through existing local power structures.

University Extension, both cooperative and general, has demonstrated its effectiveness in some areas which contribute to better health—including nutrition, sanitation, homemaking, and pest control. Extension has not been involved directly in issues of health care delivery or access to the system, because it was deemed that this was the exclusive domain of the formal health care delivery systems.

Given the present "crisis" in health care, the need for a major effort directed at consumer health education, and the capability and

capacity of university extension, it is appropriate that health and extension personnel now engage their efforts in a common quest. Together these groups can reach out to include the patient, not as the object of, but as the active subject and participant in health care.

To that end, this report develops a model for designing programs in consumer health education which can be used by extension divisions and health science centers of university land grant institutions to demonstrate the following:

1. Greater concern for personal health.
2. Positive steps to prevent illness occurrence; to prevent progression of minor illnesses; and to prevent dependency through rehabilitation following catastrophic illness.
3. A better understanding of the changing health delivery system and how to obtain access to it most effectively and efficiently.
4. How and what one may accomplish by self help without or prior to calling on the formal health care delivery system.

I. Consumer Health Education Model

A. Definition of Terms. For the purpose of this report certain basic concepts require definition:

1. Consumer. The entire spectrum of citizenry, from the sick through the well; patient through nonpatient, including those in rehabilitative phases.
2. Health. A state of maximal high level wellness characterized by physical, social and mental wellbeing.
3. Education (Activation). A process involving dual components of imparting information plus motivating the learner to use it effectively.
4. Consumer Health Education. Activation of the individual toward the pursuit of greater personal and community health.

Given the rationale for a new approach to improve health through expanded education of the consumer and given the four definitions above, several distinct educational roles of extension emerge:

a. a *motivational* role, helping persons recognize and define their needs, and take appropriate action either outside of or within the formal health care delivery system.
b. an *informational and problem solving* role, serving as an interface between health knowledge resources and the motivated consumer.

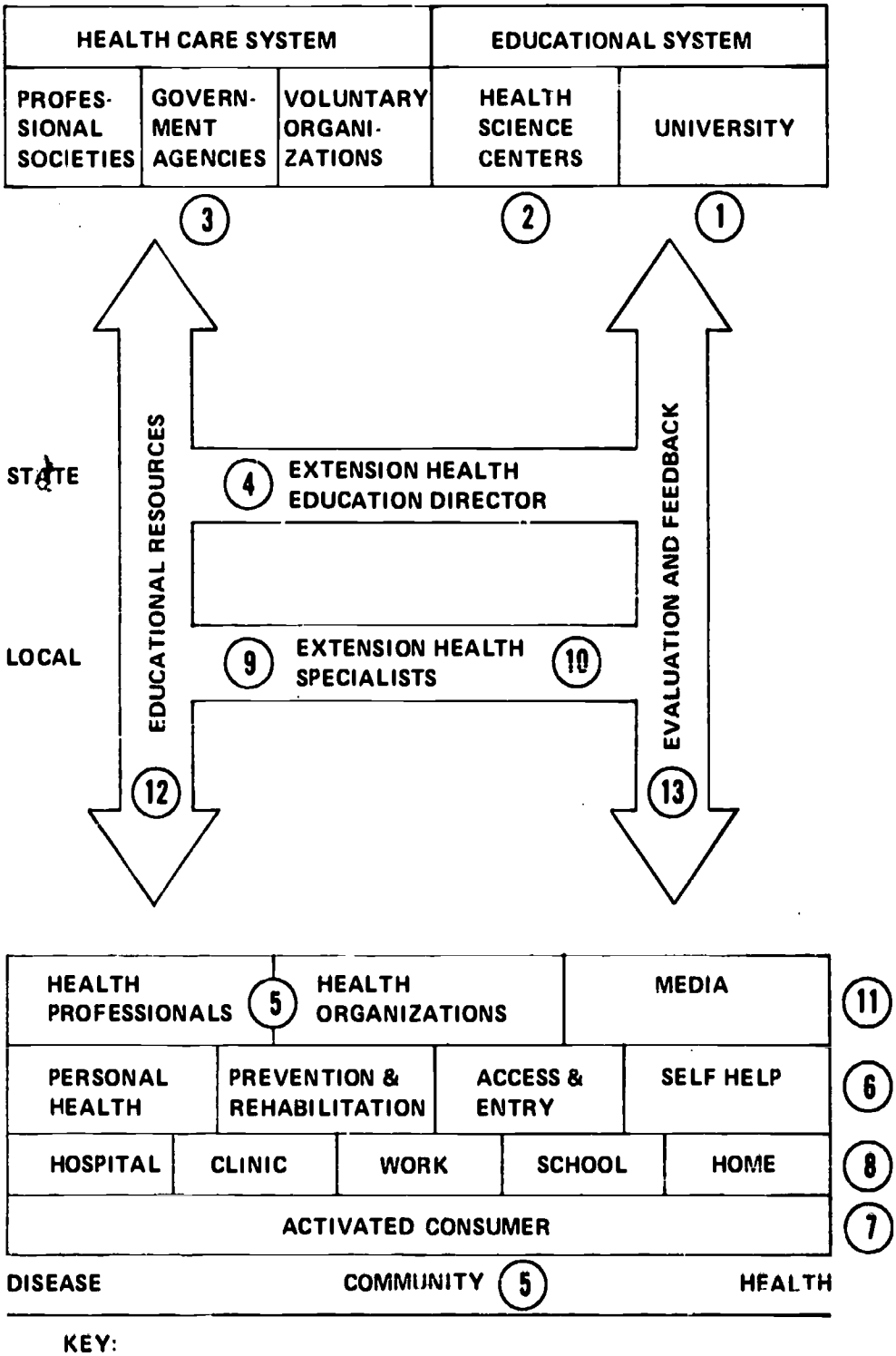
c. a *facilitating* role, bringing together diverse individuals and groups involved with health services in the local community, for communication, community organization and development.

B. **Model.** In order for extension to develop effective demonstration consumer health education programs, a complex series of problems must be addressed, decisions made, and relationships established. A major focus of the demonstration projects will be to develop mechanisms by which information concerning health and the health care system can be related to university extension.

The Extension Health Educational Model (p. 49) should help clarify such mechanisms. After a brief description and summary, a discussion of each numbered element will follow.

This model represents a conceptualization of health education. Components of the health care system are on the left, the educational system on the right. As presently constituted, there is little overlap between them. The top and bottom of the model focus on separate considerations at state and community levels. The two-way arrows indicate the nature of cooperative relationships that must be established through extension, as well as the necessity for constant feedback and evaluation of the system. A disease orientation predominates on the left, a health focus on the right, with personnel and settings following this pattern. A major objective is to build bridges that span the barriers between the two sides for the benefit of the community, the health system and extension. These bridges are shown at both the state and local levels.

C. **Descriptive Summary.** At the state level, an extension division of a state university or land grant college will have to develop administrative capabilities and resources in the health area. It will establish ties with a variety of educational resources in the university, health science (medical) center and elsewhere, and establish communication with health professional societies, private and voluntary health organizations and government agencies.



KEY:

1. University
2. Health Science Centers
3. State Health Organizations
4. Administrative Leadership
5. Community Relations
6. Subject Focus
7. Target Populations
8. Settings
9. Extension Personnel
10. Training Programs
11. Media
12. Educational Resources
13. Evaluation

At a local community level extension will have to select specific health related problems for pilot and demonstration focus. This will mean identifying specific target populations, (a block, a city, a county, or multiple counties), establishing measurable behavioral goals, and developing educational and information systems to help meet these objectives. Decisions will have to be made concerning the setting in which the educational programs will operate, information sources to be developed, and information packages obtained or produced (literature, audiovisual communications or other media).

Since a unique focus and contribution of extension is face-to-face contact, existing agents will have to be selected and retrained or new personnel developed. Establishment of effective relations with local medical practitioners, health workers and agencies is crucial. Finally, methods of continual feedback and evaluation must be an integral part of the program design.

Finally, it is necessary to consider existing and developing capabilities of local community health services. Too often programs have led to the arousal of hopes, expectations, and the activation of the population, only to find these cannot be met. One of the eventual outcomes of consumer activation will be pressure to improve and fill gaps in the existing system, but in the short run, this may arouse antagonism, destroy trust and reduce credibility with all elements of the community.

II. Guidelines

Many steps remain untested and many issues must be resolved before consumer health education can be successfully accomplished by extension. The following discussion emphasizes key issues brought out in a brief planning study conducted by University Extension of The University of Wisconsin. It was felt the study should not attempt to delineate specific models for as yet undetermined institutions, in their highly varied situations and settings. Instead, it emphasizes essential qualifications and necessary decisions. These guidelines are offered, then, as broad suggestions to aid institutions in their preparation of specific action programs in consumer health education.

A. Essentials for Program Development

1. University

   It is understood that the development of consumer health education projects will require university-wide effort involving the capabilities of such departments as communications, education, nutrition, behavioral sciences, or others as needed. This has often been true with other extension programs, but will be especially necessary in the development of new information packages and evaluation schemes for measuring changes in consumer health behavior.

2. Health Science Center

   Formal relationships between extension divisions and health science centers which include schools or colleges of medicine are felt necessary for the success of the initial projects. This will insure a broad knowledge base for health education programs, necessary quality control of information, and provide credibility and legitimacy with health professionals and agencies.

   It will also provide a necessary resource for the development of curricula and training programs for extension health specialists.

   The establishment of these relationships can be accomplished in a number of ways, including joint appointments, advisory committees and agreements with departments (for example, preventive, family or community medicine) or health science center outreach programs (for example, continuing professional education). Exchange of personnel between the health center and extension may be advantageous, or consumer health education programs may be developed within the medical center.

   In the event that extensions and health science centers are administratively separated among institutions, arrangements for consortia or regionalized demonstrations may be submitted.

3. State Health Organizations

   Close and continuing ties should be developed with the state medical society and other professional organizations, the State Department of Health, regional

medical programs, comprehensive health planning and other government agencies, as well as relevant voluntary and private health organizations. These will provide valuable educational resources, advice, possible support, and further credibility to the developing programs.

4. Administrative Leadership

Extension must develop administrative capabilities and resources in the health area including adequate personnel to assure the establishment of effective relationships with the above groups, and to provide adequate coordination and leadership in the development of state programs. A full time director of consumer health education would provide leadership and an identifiable health focus in extension. His functions should include coordination, evaluation, program planning, education and direction of local staff, and development of new health programs.

5. Community Relations

The goal of consumer health education goes beyong merely expanding the health component of existing extension programs. *A key feature is the development of formal linkages with the existing health care system.* A distinct local image or identify within extension will highlight its mission in the eyes of consumers, local health workers and other extension personnel and serve to legitimize its activities.

Formal relations with local division of organizations contacted at the state level should be established (for example, county medical society, county board of health, and voluntary health organizations). Initial and continuing contact with local medical practitioners, public health nurses, pharmacists, social workers and others is crucial to local acceptance. The possibility of local advisory councils and volunteer or part time service of the local health professionals should not be overlooked. The health system needs integration rather than increased fragmentation.

The demonstration projects must identify and deal with key health problems. This may seem initially limiting, especially since categorical programs are not the aim, but limitations of time, funds and experience necessitate sharp focus in the demonstrations.

One important decision will be whether to attack problems in the health field where major resources have already been expended (such as smoking, cancer detection, and diet), but where the extension approach of face to face contact, problem solving, and demonstration focus may markedly further success, or to attack problems which thus far have been largely understressed in the health care system (such as home safety, self medication, and rehabilitation). In either case, problems should be identified which are thought capable of educational solution.

It is sometimes difficult to grasp the core concept of health information, health education or "health activation" as it is called in this proposal, and how it differs from the health component of existing extension activities. This becomes more pronounced from the first to the fourth objective.

a. "Greater concern for personal health"
Extension is experienced in this objective through youth development, family living and other programs which focus upon personal grooming, toothbrushing, cleanliness, diet, nutrition, exercise, etc. Sex education and information about drugs and alcohol could be given greater emphasis. This first step is an essential base for the motivation of the individual to take independent and continuing action. However, the goals of this project should go far beyond this first concern.

b. "Positive steps to prevent illness occurrence; to prevent progression of minor illnesses; to prevent dependency through rehabilitation following catastrophic illness"
An important example is the development of a personal health record--filled in, understood and kept by all families. Lack of such unified information is a major source of time loss, duplication and inefficiency within the health care system and has continually underlined the lack of personal responsibility on the part of patients. Other examples are:
  --poison control in the home, including leaded paint
  --accident control
  *--family planning
  --venereal disease
  --cigarette smoking
  --diet for cardiovascular disease, diabetes, etc.
  *--cancer detection, including the "seven warning signs"
  *--glaucoma screening
  --pre-school visual testing
  --proctoscopic examinations and other aspects of the annual checkup

—immunizations
—after effects of heart attacks, mastectomies, dental surgery, loss of limbs, oral cleft palate, and other medical problems
—diabetic counseling
—bereavement after family death
—rehabilitation after debilitating diseases such as hepatitis, mononeucleosis
*—rehabilitation after mental illness

*Personal health management programs

c. "A better understanding of the health delivery system and how to obtain access to it most effectively and efficiently." This problem has been strangely neglected by the health care system. Efforts should be made to teach the consumer to protect and fend for himself in gaining access and moving through a confusing, uncoordinated, often impersonal system of care. An activated public would better understand the following:
—how to find a doctor
—how to find the right specialist
—selecting health insurance
—accepting a physician assistant
—rights and benefits of government health care programs, e.g. medicare, medicaid, coinsurance, deductibles, etc.
—taking medications property
—when to go to the emergency room
—selecting a nursing home or rehabilitative service
—quackery, health fads and gimmicks
—effective participation on local health councils, health center boards, and other health councils, and other groups involved with health planning
—proper use of the health care system

d. "How and what one may accomplish by self help without or prior to calling on the formal health care delivery system." The health care system has for a number of years advocated certain aspects of self-help and self-treatment. It has been recognized that large segments of the public are already treating themselves, often inappropriately. Program efforts in this area should be aimed at both ends of the spectrum - what can the consumer do for himself and what should he not do, especially in isolated or rural areas?

–emergency first aid, especially in isolated or rural areas
–appropriate use of medical services
–what to do until the doctor comes
–proper use of over-the-counter medication
–self rehabilitation following heart attacks, mastectomies, amputations, etc.
–home care for chronically ill, or those in rehabilitative states
–home treatment of common illnesses, e.g. upper respiratory infections, "flu"
–infant and child care
–cancer screening, including breast self examination, and home Pap test

Clearly, the four broad objectives outlined above are not distinct categories, and most programs would contain elements of all four. One example would be family planning, which would deal with personal health, prevention, gaining access to the health system, and self help. Other programs could specifically focus on one area, such as understanding the changing health care system.

As a part of our research, three of us from the project team were privileged to study health education programs in England, Sweden and Denmark and to review the operations of the World Health Organization in Geneva.

Among each of the countries visited, it was rewarding to observe the utilization of the nurse as primary contact for the health system. Whether called Health Visitor (Great Britain) or District Nurse (Sweden/Denmark) the nurse was labeled the responsible party for home-health education. Pre- and ante-natal care, personal hygiene, general health education, and so on, are among the responsibilities of this field worker. The position of trust and responsibility given this health professional lends strength, we feel, to our proposal that the inactive nurse be considered for extension appointment in consumer health education demonstration projects.

We could share with you many more points from our planning study that led to the model described earlier. Rather than develop all of the details for you, let me close by posing some questions for you as you consider the implications of this new entity in health education.

A. How can the public be most effectively stimulated and motivated? What kinds of worries, symptoms, and illnesses

do people respond to positively and why? What are the "real health needs" as opposed to "perceived needs"? Effective health education will often change the perception of needs, which too frequently relate to symptoms of existing illness, rather than a preventive health focus. The goal of health education is meaningful and effective behavioral change. Changes of knowledge, attitudes, and behavior do not necessarily follow one another.

B. What are potential hazards of health education for the consumer?
—legal
—medical
—demand for services

Will activation of the consumer actually increase demands for service rather than reduce demand? What are the legal implications of teaching consumers self-help and self-treatment? What are the implications for the doctor-patient relationship in creating an informed citizenry that refuses the dependency role and demands a participatory role in health care?

C. What is the unique role extension has to offer in health education? Does it wish to become one more agency dispensing information in the health field? How will it relate programmatically to institutions already involved in health education e.g., public school systems, public health nursing, voluntary organizations? Is extension's most effective role to parallel their activities, or to find some way to inter-relate activities in a meaningful and productive manner?

D. How can coop-extension best project a new image and avoid the agricultural sterotype? It is important that extension recognize its traditional image and how this image may interfere with as well as aid the objectives of this project.

E. How can the initial projects, if successful, be generalized and expanded to the total population? What additional sources of support may be available? What mechanisms are needed to insure inter-extension cooperation in order to avoid duplication of information packaging, curriculum development, and other experience gained from these projects? What form of national leadership would be most effective?

F. As extension and the health system begin to come together, both will be on unfamiliar ground. It is understandable, then, that stresses will be placed on every element of both systems, arousing anxieties and requiring readjustment.

At the local level, stress will be felt by consumers, health workers, new and existing extention agents, and a variety of organizations. What will be the relationship of the extension health specialist to the existing health professional? Can they develop meaningful and useful working relations?

On a state level, health organizations may feel threatened by the appearance of a formidable institution, with a very different educational philosophy and approach. The university medical centers are undergoing change in relationship to the continuing education of professionals and to the community in general. Now, centers will be asked to participate in outreach programs for the general public, expanding their traditional role even further. How can extension avoid being dominated by a medical, disease-oriented model, and become an effective force in its own right?

G. How will changing social policy, such as federal health insurance, affect patient demand and utilization of health services? Will an "educated" public respond differently? When medicare and medicaid were introduced, there were unanswered questions, confusion and unfulfilled expectations. One possible challenge for extension is the establishment of a national health information network, which would be in place and functioning when national health insurance becomes a reality.

We have described an approach to Consumer Health Education that involves the consumer in the process. We have done this by relating extension's great strength of the person-to-person approach to the knowledge base of health professionals and institutions.

Our purpose is simply this—by providing a model for health education operations, and allowing for a variety of approaches in the execution of the model, we feel that it is possible to enable citizens to act responsibly in their daily lives for health maintenance and for disease prevention.

THE ADULT EDUCATOR AS A CHANGE AGENT

Burton W. Kreitlow
Professor, Department of Educational Policy Studies
Agricultural and Extension Education
University of Wisconsin

If there had been any question in anyone's mind about whether or not nurses in leadership roles were involved in education, that doubt should have been dispelled by the nature of the conference up to this point. Those of you who are involved in continuing education for nurses, whether you have a title that says you are a specialist or a professor or a coordinator or a dean or a director or a chairman—are adult educators. As adult educators you are attempting to change people or organizations or both. You have, in your various roles in continuing education, goals for change and as such, it is my conclusion that you indeed are change agents. Thus, in this presentation, although the title says The Adult Educator as a Change Agent, I am really pointing my finger at nurses involved in continuing education and their role as the change agents. As a change agent there are certain responsibilities—practical, theoretical and perhaps moral that each of you have. When you make an effort to change someone you want to know how it proceeds. This takes some specificity in the goals toward which you direct, guide or lead the process of education. It takes various techniques to move that process along, and it takes some real wonderment as to whether or not what you're doing is right.

An adult educator in his role attempts to change another's knowledge, attitudes or physical skills, We have fancy words for that in the field of education. We call these the cognitive, affective and psycho-motor domains. These three words cover just about any potential change that you or your institution may have in mind.

If we take the long view in looking at change, we note that over the years man has adjusted to changes in society. There are things that a changing society demands of him, demands of his resources and he makes his own decisions (I hope) as to what he will do in response. On the other side of the coin, we note that society itself and social organizations and institutions are changed by man. As individuals involved in adult and continuing education, you cannot help but be concerned with both the adjustment to society and the adjusting of that society.

To lay the broad picture in front of you, I'm going to do two things this morning. I'm going to examine some of the data on the way new practices and new ideas are adopted by individuals. This is to help

you become aware of the pattern of individual change and the role of the adult educator as a change agent. Secondly, I'm going to present a theoretical model to demonstrate how new patterns (changes) are adopted by institutions, these institutions being schools, universities, hospitals, nursing associations, what have you.

First, let's look at the way practices are changed by individuals. I am sure that some of you, in your adult education role, focus your efforts on getting individual nurses to change certain behaviors, whether it be in the knowing or "cognitive" realm, the value and attitude or "affective" realm or in the "psycho-motor" realm.

The early investigations on change were associated with the field of agriculture. Here rural sociologists attempted to identify patterns, through which individual farmers progress as they moved from one form of farming behavior to another. We call this the adoption of new practices by farmers. It was relatively easy to see whether or not a new variety (of corn) was grown, just as I expect it has been relatively easy to see whether a nurse adopted a new (nursing) practice. There are a large number of investigators to whom we could refer, but I will limit name calling. Lionberger, after numerous studies, presented a description of the adoption process that went something like this:

Awareness – first knowledge
Interest – active seeking
Evaluation – considering evidence
Trial – tentative trying out
Adoption – full scale integration into the system

As we look at the above, we note the logic of the steps to the agricultural enterprise but we can also see much logic in these steps to almost any enterprise that requires individual decision in what action to take, what materials to buy, what money to spend, or indeed on what to invest in that which we think is a better idea.

One of the other factors that was noted in the early agricultural studies, is the time-lag from the availability of the knowledge or discovery to the adoption of the new practice. The extent of this time-lag tells us something about the adequacies or inadequacies of the adult educators in that field. It was noted, for example, that from the early knowledge of hybrid corn to the point where it was generally adopted took twelve years. From knowledge of the increase of production that came with commercial fertilizers to the general adoption of commercial fertilizers was twenty years. Those who have taken a look at new knowledge in the field of education, elementary and secondary, identify time-lags of from ten to one-hundred years. We should keep in mind that dealing with social ideas and materials is different than dealing with crops. As nurses and adult educators, you are involved in dealing with people. How long then does it take for

something that we know is more effective in the nursing field to gain general adoption? How long? Five years, ten years, twenty years or are there some things that are known now that were known in 1900 and are still not in general use? I'm sure that you know more than I do about this.

Agricultural researchers went on looking at individual adoption processes and summarized what they found. The results could be diagrammed into what we now call an adoption curve. Individuals take their own sweet time to make up their minds as to whether or not to take on the new practice.

Let's assume that there are one hundred people who could adopt a certain practice. Would they all adopt it at once or would it progress over a period of years? Well, as you could guess, there are those who would adopt early and there are some who would be the last of the one hundred to adopt anything new. When it got down to charting this adoption process by groups of individuals, the researchers came up with a kind of an S-shaped curve, which if we're looking at the percent or the number of the one hundred individuals who adopted the practice, we'd find a group of *early adopters* who would carry on for a number of months or a number of years before there would be a real pick up in adoption by the rest of that group. Then there would be a rapid rise in adoption of the practice. From the *early adopters* we move to the *majority.* This would come about rapidly. But this again would not include all of the one hundred cases. There might be anywhere from ten to twenty who would be classified as *late adopters* and again over a period of months and often years, one at a time they would sort of look over their shoulder and pick up the practice. Maybe no researcher has lived long enough to see all one hundred adopt a practice. How about that particular S-shaped curve in nursing? Is yours a profession that moves faster than teachers, faster than farmers, faster than doctors, faster than pharmacists? I think it would be well for each profession to take a long hard look at its own adoption process. Look at it in relation to other fields.

As a summary on individual adoption, I'd like to show the classification that *Rogers* makes in terms of the adoption process. Over the full scale he notes a normal curve and identifies 2½% as innovators 13% as early adopters, 34% as the early majority, 34% as the late majority and 16% as laggards. Any laggards among those with whom you work?

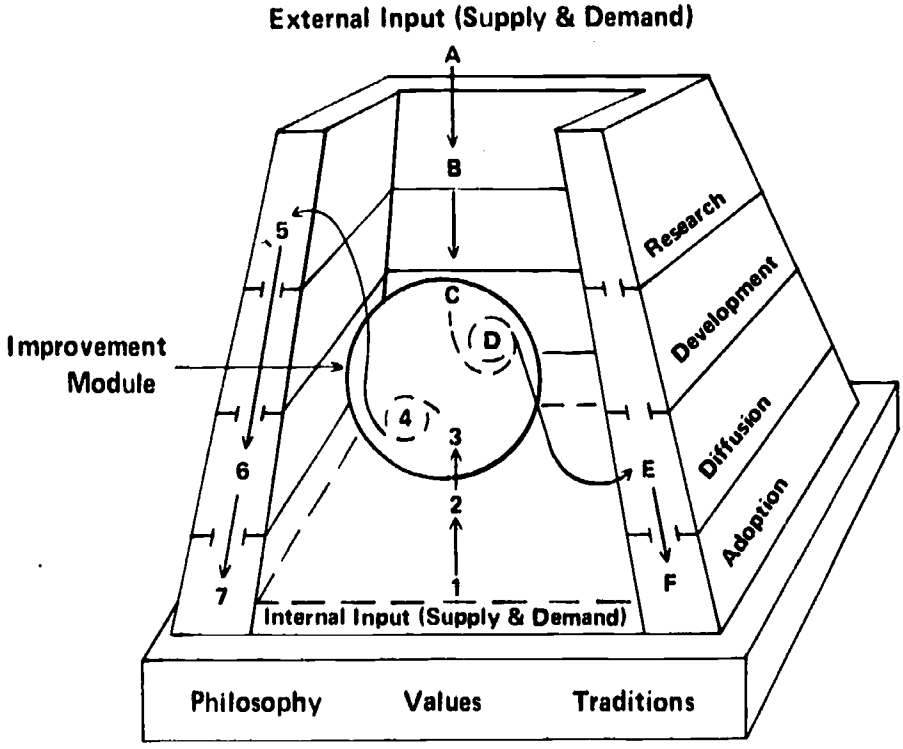
Let's move now from individual adoption to the adoption of new behaviors by institutions and organizations. I should say first that we must recognize if we're trying to change a hospital, a nursing association, a school, or a business organization we're dealing with quite a different entity than if we're trying to make changes in individuals.

The individual can often make up her own mind without reference to those around her. It can be a decision related to her own work. But if you're dealing with an institution or an organization, you'd have large numbers of people involved and the kinds of decisions that are made to adopt some new practice in your organization or in a hospital, are normally not made by one person. We have seen in the research with individuals, that it takes a long time for a practice to be adopted. It is small wonder then that our social organizations and agencies take a longer time to adopt new practices. Quite a bit of work has been done in looking at educational institutions in terms of the patterns of their behavior changes. Some the early work in this was done at Ohio State University by Guba and Clark and their work has been followed up in a number of other places. I have been involved in research on the change, or if you will, the improvement process within educational institutions and it is the model developed from these studies that I would like to present for your consideration and interpretation.

I used as a beginning base some of the ideas of Guba and Clark in which they identified the steps through which an organization goes in adoption. They said it first involved research, then development which included invention and design, then diffusion which included dissemination, and then adoption which meant trial, installation, and institutionalization. Their particular model was two-dimensional and in doing field work with it in the public schools I had a great deal of trouble in fitting observations to a two-dimensional model. I discovered afterwards that by adding a third dimension to the Model, the data collected would fit. After considerable observation and listening to tape recordings of committees involved in school change, I actually built the physical model which is diagrammed below. Two examples of how new ideas proceed through this model are described as they actually occurred in school systems. I trust that you can translate the process into your own terms for organizations you attempt to improve.

The Figure places in a single drawing the total structure and process introduced above. A few words are added to complete the picture. The base of the pyramid includes the philosophy, values, and traditions of the district. These are the long-term stabilizers. The external and internal input is identified as being "supply–" or "demand–" oriented. The use of supply and demand in this context is to indicate whether the solution to a problem is sought (demand) or whether it is available (supply). The results of research by a university or any other agency can provide an external input to a school district by either the "supply" or "demand" route. If the school asks for help, the input is "demand–" oriented. If a university professor disseminates the results of his research in an article and it reaches the school district, it is a "supply–" oriented input.

The process flow of an external input ("supply–" oriented) is demonstrated by letters "A" through "D" in the Figure. In this instance, and on the basis of experience, a professional section within the State Department of Public Instruction believes that rural community schools should work out cooperative arrangements with neighboring districts for the employment of school social workers. A spokesman for the department decides (Point "A") to disseminate (supply) this belief in his monthly newsletter to schools. It is at this point–"B"– that the idea is noticed by the guidance counselor and gets into the school system.



A Model for Educational Improvement

This could be the end of the idea. In this instance it is brought to the attention of several staff members and the administrator. After some informal discussion the administrator decides to turn the suggestion over to the school's committee on improvement (Point "C"). Here it is discussed in detail by all concerned groups (Point "D"). Recommendations and decisions are made to diffuse (Point "E") the idea into the system in order to have the teaching staff become acquainted with its potential. At Point "F" the determination is made to adopt the idea in full and commit the institution to the joint employment of a school social worker in cooperation with a neighboring district.

An example of an internal input (demand-oriented) in the same district is shown by numbers 1 through 7 in the Figure. Beginning near

the bottom of the model at Point 1 is an illustration of an input brought to the system by a teacher. The teacher has a major reading problem in her Fifth Grade. She brings the problem to the attention of her principal (Point 2). On the basis of his contact with the reading problems experienced by other teachers, the principal is convinced that the problem is one that affects the entire school. This being the case, he suggests that it be reviewed by the committee for improvement (Point 3 in the Improvement Module). A search for solutions is made (Point 3 in the Improvement Module). A search for solutions is made (Point 4) by an interacting and concerned group. Help is sought and obtained from many sources both within and outside the system. In the process, information on a non-graded reading program is studied and special committees are established to determine whether a non-graded program would appropriately solve the problem for the district. At one point in discussions a suggestion is made to have the system establish its own research program to test out a non-graded program. Later information received from a research and development center (external input on the basis of demand) convinces the committee that a non-graded program would work if carefully developed to meet the special characteristics of the children in the district. On this basis the committee on improvement proposes and receives administrative sanction to research a few aspects and to develop the overall non graded idea (Points 5 and 6) in the lower grades in 1970-71. If it works well, they will diffuse it throughout the system (Point 7) as soon as possible. If success continues, they would bring the practice to full adoption (Point 8).

I would like to see an example from the field of nursing and walk such an example through the model. To do this, I will need at least one volunteer and preferably two or three who will help me talk and walk it through. Where do I get such an individual? It should be someone who has been involved, either as a participant or a change agent in getting a change adopted in a nursing organization, in a hospital, or in some other institution. Let's have some volunteers.

(At this point there were volunteers and the nursing examples did, indeed, fit the model—the reader may wish to try those within her experience.)

Before we go to the next part of the program, let me just run through a rather quick summary of the high points of this presentation. First, I have assumed that many nurses are adult educators and as adult educators, are change agents and as change agents work in promoting changes among individuals and changes within organizations. With individuals there is an attempt to promote the adoption of new behaviors on the part of those with whom you work, whether it is in the cognitive, the affective, or the psycho-motor domain. With organizations, you try to get them to change their behavior—their

organizational behavior, their educational behavior, their service behavior. When we look at an organization, we ask ourselves the question, "Can a new idea get in?" either from the outside or the inside. Does it get considered? Is there a vehicle through which the nurse adult educator can operate in getting an idea considered? Is there a subsystem within your organization to handle potential improvements? How often in institutional improvement attempts do we end up with a conference that ends where it began—the same problem but no progress or solution?

Conferences are for ideas inputs and developments and adoption. It takes an organization, it takes a system to gain that adoption. I trust that your organization has such a system.

COMPETENCIES EXPECTED OF THE TEACHER IN CONTINUING NURSING EDUCATION

Signe S. Cooper
Professor, Department of Nursing, Health Sciences Unit
University of Wisconsin-Extension

As I prepared for this discussion today, it became apparent that it was difficult to discuss the subject in a way that would be useful to all participants in this conference. Those represented at this conference work in a variety of settings, with varying responsibilities, and thus require different competencies of faculty members. For this reason, it is rather difficult to talk in generalities about competencies of faculty members, but I shall attempt to do so.

It is difficult to talk about competencies without giving serious consideration to characteristics, and as I thought about the subject, it became difficult for me to separate competencies expected of faculty from certain characteristics possessed by the teacher.

(To help the group focus its thinking on the subject, table discussion groups considered briefly the topic, "What do you believe is a major competency or characteristics for a nurse faculty member responsible for continuing nursing education?"

The groups identified these characteristics:

- *Has a variety of experience*
- *Flexible*
- *Able to transfer information into practice*
- *Open-minded; not defensive*
- *Secure*
- *Has confidence in the adult learner*
- *Possesses spirit of inquiry*
- *Ability to "hang loose"; yet can pay attention to details*
- *Innovative*
- *Good interpersonal relationships*
- *Friendly; puts people at ease quickly*
- *Has political savvy and "grantsmanship"*
- *A continuing learner herself*
- *Teaches skillfully; uses variety of approaches*
- *Understands groups as well as individuals*
- *Good moral sense and integrity*
- *Goal-oriented)*

Expectations of the teacher are changing in all areas of education. No longer is the role of the teacher limited to that of being the source

of and dispenser of knowledge. Rather, his role is seen as directing learning, stimulating thought, presenting various points of view, serving as a resource, encouraging creativity and self-discovery. Such a role is a difficult one, but it is necessary to effective learning. For the teacher of adults it is especially important, since these learners come with a variety of life experiences which contribute to and enhance their own learning.

The role of the teacher in adult education has been discussed and studied for some time, but no clear-cut picture emerges. Different competencies are required of the teacher of adults than the teacher of children, yet there are a number of commonalities. The effective teacher—whatever his area of expertise—has the ability to instill in his students a sense of adequacy, a security, a feeling of confidence in themselves. Just how this is accomplished is less easy to identify—and this is one of the challenging aspects of teaching.

It is also obvious that the teacher of today must go beyond the demands of present-day society, and think in terms of the future in a world which is constantly and rapidly changing. Thus, the role of the teacher is to educate for uncertainty.

Who Is The Teacher?

This is an important question, since desirable competencies depend upon responsibilities. In general, I have addressed my comments to teaching and not administrative faculty. In most continuing education programs we depend a great deal upon Ad hoc or part-time faculty, and my comments can be applied to these faculty members as well.

Before identifying specific competencies required of the continuing educator in nursing, it is useful to look a little more at the role of the teacher. Teaching roles are constantly being redefined, and nowhere is this more evident—nor perhaps more needed—than in nursing. Thus, the specific role of the continuing educator may depend very much upon the way that undergraduate students were taught.

To cite an example: reflect on how many of our programs are of the "sit and listen" variety. Traditionally, this is how students were taught in schools of nursing. Because participants in so many of our programs come with this educational background, they are often reluctant to get involved in the learning process. We've had to learn how to use group discussion, role playing, and to encourage the study of supportive materials. Do your enrollees use the bibliographies or read the materials that are sent to them in advance of the program? (DID YOU?)

Learning is often a slow, groping painful process. It requires thought, investigation, exploration, involvement. It is so easy for the

teacher to provide ready-made answers to questions that are raised, or to accept without thought others' answers to our own questions. This is almost an occupational hazard for the educator who moves from teaching in a preparatory nursing program to continuing education.

The continuing educator has a variety of roles to fill: as a guide, and counselor to the learner, an arranger and organizer of learning experience, an encourager and motivator to learners, an evaluator of programs. The teacher may be involved in the production of instructional materials, but he must also evaluate and select materials developed by others. As more and more instructional materials are being produced, the teacher must become ever more sensitive to his responsibility to identify those unique human activities which educational media cannot perform.

In addition to his role as an instructor and counselor, the continuing educator usually has an administrative role in his institution, including a responsibility for participation in policy planning. He shares with his colleagues responsibility for committee assignments and activities related to the functioning of the institution. At the department level, he has a major contribution as a member of the team, working together for the good of the whole.

Educational Background. One of the issues in adult education nationwide is the lack of prepared leadership. This is an issue and concern in all our preparatory nursing programs—it is of no less concern in continuing nursing education.

Selection of faculty members for the teaching of adult nurse learners is rarely easy, since relatively few potential teachers have much formal preparation for their duties. Thus, the selection is often based on other criteria. In an educational institution, the academic requirements for those faculty members whose major responsibility is in continuing education is the same as for any other faculty member. (I support this concept wholeheartedly. In reality, because well-prepared faculty are scarce, we make necessary adjustments, and may weigh experience and creativity more heavily than is true on the resident campus).

In the future, we will no doubt see increasing numbers of faculty members with doctorates in adult education. In the meantime, it's useful if faculty members have had some formal work in the area of adult education, philosophy of education, group work, and related courses. We may need to make adjustments in work loads so that faculty members may fulfill some of these deficits after they have been employed.

Specific Competencies

It is apparent that a variety of skills are required for the teacher in any continuing education program. These skills vary depending upon the content to be taught, the students to be taught, the setting in which the learning occurs, and the specific responsibilities assigned the faculty member.

The Teacher As a Learner. Perhaps one of the mose important criteria to consider is the potential candidate's acceptance of responsibility for his own continued learning. Is that candidate a continuing learner himself? Does he plan for his own continuing learning and, if so, in what way? Is he aware of the many resources available to him? In what area does he do in-depth independent study?

It is a truism that individuals learn at their own pace and in their own way. Some may set aside a definite time for library study; others may find it more stimulating to join a group of colleagues to discuss the nursing literature; still others may find it useful to listen to audiotapes; many learn from all these approaches. Perhaps the most significant point is that a specific plan is made for self-development, and a definite time set aside for learning. In our busy, complex lives, it becomes too easy for other things to take precedence.

It has been said that the teacher's greatest contribution is to instill in students the zest for continuing to learn. The effectiveness of the teacher as a continuing learner role model gets a high priority.

I personally believe that we cannot place too much emphasis on this characteristic of the teacher in continuing nursing education. I also consider this important for all faculty members of schools of nursing—but it is imperative for the continuing education faculty.

Knowledge Of The Subject. Related to the teacher's acceptance of a personal responsibility for his own continued learning, is his knowledge and interest in his subject, and his enthusiasm for his subject. Can he present material in a meaningful way? Does he use humor to add spark to his classes?

For effective teaching in clinical nursing courses, the educator must herself be a skillful nurse practitioner. The statement, "Those who can, do—those who can't, teach" is a sad reflection on the state of some types of education. In continuing education, the teacher is in constant contact with practitioners who can easily identify clinical inadequacies. It is obvious that such an exposure creates a "credibility gap" that can ruin any program.

We recognize that as knowledge advances and as practice changes it becomes increasingly more difficult for teachers to be as knowledge-

able as they would like to be. There will obviously be some situations in which some students in the group know more than the teacher about some things—and the skillful teacher will know how to take advantage of this knowledge for the good of the group.

Relationship To Students. The relationship of the teacher to his students in a way that is conducive to learning is another significant asset. This is difficult to determine, but may be critical.

Is the teacher friendly—but without creating undue dependence? It must be recalled that the aim of education is to help the student become an independent learner. The role of the teacher is to help learners reach their potential and achieve self-fulfillment.

As every experienced educator knows, one of the excitements of teaching are those things you learn from students themselves. You will recall those lines from *the King and I:* "If you become a teacher by your pupils you'll be taught". Because learners come to us with a wide variety of experiences, we can learn much from them.

Broad Understanding Of Health Issues. In addition to clinical competence, the continuing educator needs to be sensitive to current developments in nursing and the broad area of health. Such an awareness includes an understanding of significant social and economic issues, current trends in nursing practice, significant health legislation. Participation in nursing and other professional organizations helps the nurse keep abreast of current developments.

As society becomes ever more complex, as health issues are given a higher priority by that society, nurses must be more involved with and concerned about the broad issues. Thus the educator must have considerable knowledge of these issues.

Creativity. Although identification of creativity is difficult, this attribute ought to have a high priority in the selection of faculty. Faculty members need the opportunity to try out new ideas and to develop imaginative approaches to meeting learning needs. Since continuing education programs in nursing are relatively new, creativity is especially important at this time.

The nurturing of creativity requires an educational setting that is conducive to the encouragement of creativity. Faculty members need a climate that encourages experimentation and the right to fail.

But there is a corollary to creativity. As badly as we need creative faculty, we also need those who recognize that details are important and that every job has certain aspects that are mundane and uncreative, if not downright dull. Persistence, even in the face of obstacles, can be a useful asset.

Flexibility. In addition to being creative, flexibility is a highly desirable trait. Perhaps in no other field is there such diversity in educational background than in nursing, and perhaps in no other area of human endeavor do we expect so much with relatively short periods of training. Program content often must be adjusted to meet the needs of specific learners. The itinerant teacher may not find all the equipment he expected: can he still make his content interesting, even without slides?

Respect for Others. In a recent speech David Carley, Chairman of the Wisconsin Governor's Health Planning and Policy Task Force, said, "It was never right - and it is no longer possible to satisfy Americans with distant, impersonal medical care. The system must respect *everyone's* identity – and sacrifice *no one's* dignity."

It is almost trite to include respect for others as an essential characteristic of the nurse educator, for it seems obvious that any nurse must possess a certain degree of skill in responding sensitively to others. Yet it seems of special significance to the nurse educator. We must be aware of the significance of the concept of the dignity and worth of the individual. If nurses themselves are not given this dignity and aren't valued in the employment setting, are they able to provide this to the patients for whom they are caring? And are there not many implications for continuing education here?

Nursing is a divided profession. For a number of reasons, we have many nurses who are unhappy, sometimes hostile, often insecure. Many are threatened by the changes that are occurring: changes in nursing practice, changes in nursing education, the rise of new health workers, specifically physician assistants.

As educators, we cannot ignore the needs of these nurses. We must develop our listening skills, get our antennae out to identify concerns, learn ways of providing encouragement and support. Above all, we must help them recognize that they have important contributions to make in the area of health care. It may be that continuing education will be the glue that holds the profession together.

Summary

I have discussed the role of the teacher in continuing education and have outlined some specific competencies expected of the teacher. I would remind you that competencies vary from one situation to another, and the ones that I have identified are those that I feel of special significance in our educational setting. Obviously each faculty member possesses different qualities and competencies and the strength of any one faculty may very well rest upon its diversity. Carefully selected, faculty members complement each others' limitations and augment each others' strengths. Is it fair to say that by working in unity, the whole is greater than the sum of its individual parts?

THE AMERICAN NURSES' ASSOCIATION AND CONTINUING EDUCATION

Audrey F. Spector
Coordinator, Continuing Education,
American Nurses' Association

I am happy to discuss with you what the national professional association is doing in continuing education. The news is good: the association is moving in directions that I believe will greatly increase its effectiveness in dealing with issues in continuing education.

Some issues have already been discussed and others will be during the remainder of this week's conference. Rather than dwell on the issues, I will share with you what ANA is doing. I will discuss the Survey of Continuing Education, a Task Force, a "Council" and will mention several other activities that are related to continuing education.

Survey of Continuing Education

The national survey is now underway to find out what continuing education offerings are currently available to nurses over the country. This project, funded by the United States Public Health Service, Division of Nursing, is a one year survey to identify the diversity, subject matter, location and sponsorship of continuing education offerings. Information as to the geographic distribution of programs and the availability of continuing education programs for nurses engaged in various fields of practice is needed by the professional association, at the national, state and district level, by nurse educators, and by individual nurses. This information will be useful to ANA and other health care organizations for proposing state and federal legislation, to nurse educators in planning for new facilities, and to individual practitioners in identifying the sources where they may find continuing education programs that will meet their professional needs.

I would like to point out that it is not the intent of ANA to directly offer courses to meet any gaps in continuing education and that may be evident when the survey is completed. Rather, the intent is to promote the development of continuing education offerings where needs are indicated.

The project director, Sister Jeanne Margaret McNally, is here and will tell you more about the survey in the second part of this presentation about ANA.

Task Force on Continuing Education

The question of continuing education as a voluntary matter and professional responsibility or as a requirement for renewal of license is being studied by ANA. The Task Force on Continuing Education was formed to study the question and to make recommendations concerning it to the ANA Board of Directors.

Members of the Task Force are representatives appointed by the five structural units of ANA that are most concerned with continuing education and five members at large, selected by the five appointed members. The structural units represented are: the Commission on Nursing Education, the Commission on Nursing Service, the Commission on Economic and General Welfare, the Congress for Nursing Practice, and the Council of State Boards of Nursing. Their representatives are: Ella W. Allison, from Pennsylvania, representing the Commission on Nursing Education; Mary E. Macdonald, from Massachusetts, representing the Commission on Nursing Services; Mrs. Mary Munger, from Montana, representing the Commission on Economic and General Welfare; Maura Carroll, from California, representing the Congress for Nursing Practice; and Marguerite Hastings from New Hampshire, representing the Council of State Boards of Nursing. The five members at large are: Signe S. Cooper, the chairman of this week's National Conference in Wisconsin, who was elected chairman of the Task Force; Dr. Erline P. McGriff from New York elected vice-chairman; Mrs. Rebecca Culpepper, Tennessee; Mrs. Elda Popiel, Colorado; and Mrs. Emily Tait, Missouri.

You will see that membership in the Task Force includes several names familiar to the National Conference. Also, it includes persons from different geographic areas and difficult perspectives.

The Task Force expects to hold its final meeting in early January, 1972, at which time it expects to formulate its recommendations to the Board concerning continuing education.

"Council" of Continuing Education

At its first meeting, in August of this year, as the Task Force examined the professional association's responsibilities to assure that every nurse updates and increases her knowledge and skill in health care, it saw the need for an on-going body within the association, t deal with continuing education. The Task Force therefore recommended that a council of continuing education be formed. As an outgrowth of that recommendation, ANA has committed itself to establish a structural unit on continuing education. (I will refer to it as a council of continuing education although its name has not been determined.)

The council is to be established under the aegis of the Commission on Nursing Education, which is the structural unit at ANA which has responsibility for all matters of education.

The Chairman of the Steering Committee of the National Conference, Betty Gwaltney, was invited to meet with the Commission, to share the needs and concerns in continuing education, as seen by the National Conference. Betty's forthright presentation was a valuable contribution to the Commission's meeting and the Commission was most appreciative of her presentation and of the interests of the National Conference.

The Commission delayed formulating detailed plans concerning the council, in order to give the National Conference the opportunity to make recommendations. The only definite decision about the continuing education council at this point is that there is to be a membership group at ANA established by the Commission on Education, to carry out the association's responsibilities in continuing education.

I want to emphasize that the Commission purposefully delayed developing specific plans for formulation of the council in order to incorporate any recommendations that the National Conference might wish to make at this week's meeting. I cordially invite you to give your ideas or recommendations regarding the purposes, functions, criteria for membership, or any other related suggestions you might wish to make.

Presently, the overall purposes of the council are thought of as providing an organizational arrangement at the national level, which further demonstrates ANA's concern for its responsibility in continuing education and as providing for meeting the needs and special interests of nurses with responsibility in continuing education. It is probably worthwhile now to explore some ideas as to how the council could possibly be developed.

In exploring possible membership in the council, the purposes and functions of the council would seem to have a direct bearing on criteria for membership. If one of the functions of the council concerns, for example, establishing standards for continuing education in nursing, the council would need to have as members those nurses who are members of the professional association, who are engaged in continuing education, and who are regarded by their peers as knowledgeable and capable of enunciating standards in continuing education.

If one of the purposes of the council is to meet the special needs and interests of persons in continuing education, it would seem necessary to invite nurses to indicate their interest in becoming members of the council and, at the same time, to indicate their area of special interest. Some special interest groups in continuing education that may need to be provided for within the council might be for

persons with responsibilities for continuing education in universities, inservice, regional medical programs, and on staff for state nurses' associations. It should be possible to make arrangements for such persons to meet with others who are engaged in the same type of continuing education. It should also be possible for the association to look to these specially defined groups within the council for expertize within that specified area of continuing education.

I have dealt with the main purposes of the council. I do, however, see the possibility of the council contributing to ANA's activities in several crucial areas. Our national organization, like every large organization, has many components with overlapping concerns, so I am just speaking to the potential to be explored.

Recommending legislative action in the area of continuing education is one area. ANA is strengthening its government relations activities, adding to its government relations staff and enlarging its office in Washington. A council of continuing education could contribute significantly to strengthening the profession's legislative activities concerning continuing education.

In another area, through the council, the association could increase its ability to assist nurses in acquiring new skills and abilities to cope with changes in the health care delivery system. One current trend in the delivery of health care services is toward community health care centers with emphasis on health maintenance and the prevention of disability. Most practicing nurses are prepared to function in hospitals, in the care of sick people, rather than in preventive health care.

Another example of the council's possible concerns, is in changes that are occurring in abortion laws and in the social climate concerning abortion. Nurses whose basic education occured at a time when the laws and public attitudes were different than they are now, are increasingly challenged by their own feelings, social influences, changes in the laws, and the needs of their patients in this emotionally charged area. Continuing education is an instrument for coping with change. Could the council, in collaboration with the ANA Division on Maternal and Child Health Nursing, assist the association in fulfilling its responsibilities to the public and to practitioners in the changing area of abortion?

Drug abuse is another social and health problem which might be of concern to the council, in that it involves changes in knowledge and attitudes on the part of practicing nurses. Already, the association has a project funded by the United States Public Health Service, to enhance the contribution of professional nurses in the field of drug abuse. It is to begin next month, when the project director is employed. The project is to develop curriculum guidelines which can be modified for use by educators in continuing education (short-term courses and

inservice education, conference groups) as well as all types of basic education programs (associate degree, diploma, baccalaureate) and graduate education. The curriculum guidelines are expected to include objectives, course content, learning experiences, reference lists and resources.

The areas I have mentioned, changes in the delivery of health care services with new emphasis on non-hospital care, abortion, and drug abuse, are concerns of more than one structural unit in ANA. Drug abuse, for example, is obviously a concern of the Divisions on Practice—the Community Health Division, Psychiatric and Mental Health Division, and, considering the effect of drug use on mothers and babies, the Division of Maternal and Child Health Nursing. The Congress for Nursing Practice and the Commission on Nursing Education are obviously involved in the association's activities related to drug abuse. The concerns, communications and ideas from all these units were put together in developing the project on drug abuse, which is administratively the responsibility of continuing education.

Within ANA, consideration will need to be given to various ways in which the council would interact with other structural units. Arrangements for joint meetings of an executive committee of the council with other groups, conferences among chairman and staff, and simultaneous meetings arranged so that certain groups can meet to discuss specific areas of mutual concern appear essential. One possible plan for sharing is for the council and other structural units at ANA to have an annual planning session in which they would inform each other about activities and projects on which their structural units will be working and during which they would agree on a division of labor in such a way that overlapping and conflict can be avoided. The extent of autonomy of each unit, the nature of accountability, the need for organizational cohesiveness and for a unified profession are considerations that will enter into planning for the council of continuing education.

Besides giving consideration to ways in which the structural units of ANA work together, the council must give thought to ways in which it might work with other national organizations. Often, ANA works with other national professional associations on matters involving changes in the practice of both professions. The ANA Division on Maternal and Child Health worked with representatives of the American Academy of Pediatrics for over a year on changing practices in the health care of children. The result was *Guidelines on Short-term Continuing Education Programs for Pediatric Nurse Associates,* issued as a joint statement of the two professional associations. At present, ANA is working with the American College of Obstetrics and Gynecology concerning changing practices in maternity nursing and it

can reasonably be expected that joint efforts with other professional groups will continue to be needed. The association needs guidelines reflecting the professional association's beliefs concerning the development of continuing education programs in nursing, which could be used by ANA representatives in their work with such groups. Had there been a council of continuing education, it might very well have had valuable input into joint plans developed for continuing education of nurses for expanding roles.

Thus far, some basic considerations the association has had in the development of joint statements concerning continuing education are: continuing education programs to prepare nurses to function in expanding ways should take into account national, regional and local needs and resources; the programs should, whenever possible, be established under the aegis of accredited collegiate nursing programs; planning should involve district and state nurses' associations, nursing schools, and state master planning committees; and there should be active participation sought from consumer groups.

Means will need to be provided for the council to be involved as necessary with organizations in adult education, through liaison arrangements, consultation, or invitations to representatives of other organizations to attend meetings relevant to the interests of that organization. ANA does already have relationships established with several groups. For example, through membership in the National Health Council, ANA is a member of that organization's committee on continuing education. I have contacted the National Task Force that is developing a uniform unit of continuing education to explore the relevance of its work to nursing.

Other Activities

To move now from that part of my discussion dealing with the council, I would like to talk about other activities that are most relevant to continuing education.

Other exciting things are happening. The ANA financial situation that caused a temporary postponement of meetings and work on many projects, has now improved, and meetings of structural units have been resumed and much significant work is being accomplished.

The association is defining the scope of nursing practice. The Congress for Nursing Practice expects that a final draft of the statement will be ready for discussion by ANA members at the 1972 convention.

Standards for nursing practice are being developed. There is to be one set of general standards, applicable to all clinical practice. Each division on practice may develop more specific standards if they wish. However, the goal is for ANA to have one set of general standards completed by the end of 1971.

Plans for certification by the professional association are in process. Certification by the nursing profession is defined as the issuance of a statement which attests that a member has attained excellence in clinical nursing practice. Any member of ANA, regardless of the nature of her educational credentials, is to be eligible to apply for certification in a specific area of nursing—for which certification is available—within a division on practice. Certification is not expected to be for a lifetime; it will be for a specific period of years. To renew certification, the applicant will need to provide evidence of having kept up with changes in practice.

Each division on practice is to develop criteria for certifying the excellence of the individual nurse's practice consistent with the basic criteria developed by the Congress for Nursing Practice. It is expected that by the convention, 1972, each division will present criteria for certification in that division to its members for discussion.

The Task Force, which I discussed earlier, dealt with the association's plan for certification for excellence in practice and discussed the confusion that can result when the term certification is applied to other meanings. It is believed that certification in nursing should have a universal meaning within the profession, to the public and to other health professionals. For that reason, it is believed that the term certification should be applied only to recognition by the national professional association for excellence in clinical practice.

The Task Force's recommendation, as applied to my description now of certification for excellence in clinical practice, was that the term certification not be used by state nurses' associations to describe the giving of recognition to members who provide evidence of a certain amount of continuing education. Terms such as recognition or award were suggested for use by those states which plan to give recognition for continuing education.

The Task Force noted that when the professional association was restructured, each of the divisions on practice was given the responsibility for recognizing professional achievement and excellence in its area of concern and provision was made for a certification board in each division (ANA bylaws, 1966). Time has been required for the association to develop plans for certification and the time factor is believed to have contributed to the development of plans for "certification" by some state nurses' associations.

Now to another development: there is to be a council of nurse researchers. Plans for that council are being developed by the Commission on Nursing Research. Criteria for membership has been defined and applicants are now invited for membership. While this new council of nurse researchers was planned for purposes and functions that differ from those of a council of continuing education, some of the

mechanics of developing this council of researchers may well be useful to planning for the council of continuing education.

At the convention of 1972, there will be an informative meeting about the council of nurse researchers and I hope a similar meeting about the council of continuing education.

As long as I have mentioned plans for the ANA Convention of 1972, I want to say here that there will be a variety of programs of interest to continuing education.

Thus far, I have not discussed issues except as they relate to activities I have described. However, there is one issue that I must speak to briefly: what is the most effective approach to assure that nurses practice in a safe and effective manner? The need for every professional person to continually update and expand his professional knowledge and skills is unquestioned. The national professional association is concerned with finding the best method to promote continuing education in nursing in a way that will be in the best interests of nurses and of the public. Considerations include: the need to avoid placing barriers to the interstate movement of nurses or in any way reducing the number of nurses available to practice; the need for the profession itself to demonstrate it is capable of determining its own destiny rather than looking to outside bodies; and the costs to the public as well as to nurses.

The chief consideration, however, is that the purpose of continuing education in nursing is to improve nursing practice. With this in mind, I am suggesting that there is a connection between the profession's plan to certify individuals for excellence in practice, and continuing education. I believe certification is a goal to which members will strive, and continuing education would logically be one avenue by which nurses will seek to enlarge their knowledge and skills so that they may demonstrate excellence in practice.

Now in summary, ANA is conducting several activities to carry out its responsibilities in continuing education. One is the survey of continuing education. Another is the Task Force which is to make recommendations concerning the question of continuing education as a requirement for renewal of license or as a voluntary matter and professional responsibility. Plans for certification for excellence in practice, defining the scope of practice and establishing standards for practice are all activities that have implications for educators in continuing education in nursing. Finally, the ANA Board of Directors and the Commission on Nursing Education are committed to the establishment of a membership group which I have referred to as a Council of Continuing Education. Again, I invite the National Conference to make such recommendations as it may wish, to the end that the ANA Council of Continuing Education may be a viable body to carry out the professional association's responsibilities in continuing education.

ANA SPECIAL PROJECT IN CONTINUING EDUCATION

Sister Jeanne Margaret McNally
Project Director, American Nurses' Association
ANA Special Project in Continuing Education

I am pleased to have the opportunity to meet with you and to tell you about the American Nurses' Association study on continuing education.

The purpose of the study, "Identification of Need for Continuing Education for Nurses by the National Professional Organization" is to conduct a survey of the programs and the resources currently available to registered nurses, and to determine a plan of action for the ANA to fulfill its responsibilities for updating nursing practice.

It is appropriate for the ANA to be involved in such a study. It is a well-known fact that the ANA has been committed to continuing education for the profession; many practicing nurses look to the ANA for information and direction; and the ANA should assume some leadership at the national level in defining and solving inherent problems relative to the direction continuing education should take.

For the purpose of this study, continuing education is defined as educational programs with formal learning experiences to assist registered nurses to update and enlarge their knowledge and skills in health care. It includes short-term courses, conferences, seminars, institutes, workshops, clinical sessions, and programs using other media, as telephone dial access and conference, and television.

While the study does not consider inservice education programs, degree granting programs, or self study programs, it certainly does not negate the importance and necessity of this type of learning as a form of continuing education.

The descriptive survey research method is used for this study. This method is designed to describe the existing state of continuing education for nurses. The data are being collected primarily by asking structured questions of the respondents with closed data collection to permit rapid tabulation of data and to provide standardization. This method of data collection includes simultaneous consideration of the variables relevant to the study.

A questionnaire will be sent through the mail to be answered as specified in a cover letter. Prior to this mailing a pilot study of fifty respondents will be conducted to test the questionnaire. Questions which do not draw forth consistent definite responses will be revised.

Follow up communication will attempt to reduce non-respondents to the minimum.

Data being considered includes: title of course, place conducted, sponsors, funding, fees, financial aid to participant, length of course, teaching methodology, eligibility for enrollment, and multidisciplinary planning and attendance.

Several (25) other groups are involved in studies concerned with continuing education for nurses at the present time. It is my hope that whenever possible we may share data to avoid costly and unnecessary duplication. I have been in touch with the project directors of these studies and have had responses from several concerning the purposes and designs of their studies. Since several of these studies are being conducted concurrently with the ANA study, we may request to include some of these findings or recommendations, whichever is more appropriate, of the state studies in the national study to illustrate the total picture. Particularly in the area of resources, I would hope we can share data collection as much as possible rather than repeat the process.

There will be consultants to the study. These consultants will represent the areas of adult education and of continuing education for nurses. I am also involved in making site visits to certain ongoing continuing education programs and in having consultative conferences with persons concerned in these programs.

The population to be surveyed is purposive, selected on the assumption that they are the providers of continuing education for nurses. This population totals approximately 4,000 and includes: schools of nursing, hospitals, public health departments, professional organizations in nursing and allied health organizations, regional medical programs, voluntary health associations, regional education groups, and federal government programs.

The data will be analyzed with primary, content analysis for systematic, objective and quantitative description of the data. After the data are tabulated and analyzed a report will be written with implications of the findings and suggesting areas of need in continuing education. This report will be presented to a committee representing all the organizational units of the American Nurses' Association and selected consultants to determine the need for ANA action, to consider a mechanism by which ANA can provide current information on continuing education on offerings nationally, and to recommend the direction for continuing education for nurses to meet emerging needs and changes in health care delivery.

The report in its final form should be ready in one year and will be distributed to state nurses' associations and to those others involved in planning the activities initiated as an outcome of this project.

CONTINUING EDUCATION AS A REQUIREMENT FOR RELICENSURE: WHAT ARE THE ISSUES?

Maura Carroll
Chairman, Continuing Education in Nursing
University of California, San Francisco

I stand before you this morning as a classic example of ambivalence. It is my personal belief, as a life-long educator, that each person is responsible for his own continued learning; that each one of us continues to grow and seek every opportunity for expansion; that there is an internal force which propels one to satisfy a curiosity about learning, which is really insatiable. On the other hand, realistic observation and experience force me to conclude that such a belief is not a universal truth. The cold reality is (and I dislike sounding cynical) that, at least at this point in time, most people in nursing are not self-motivated and do indeed seem to need a force from the outside to move them toward the notion of continued learning.

Herein lies my ambivalence. I now stand as an advocate of legislation which requires evidence of continuing education as a factor in maintaining licensure. It took me a while to reach this point. I am still not certain that it is the best route. However, there is the history of regulatory bodies and their role in bringing about change and improvement in the professions they controlled. Standards set were always minimum, but adequate, to ensure safe practice. Even at minimum, such regulations were superior to the then current practice. I believe we can project such an outcome for legislation relative to continuing education.

Obsolescence is a fact of life. It is invidious and pervasive so that the signs may be missed. Practice may become outdated by the practitioner who is unaware. The rut becomes increasingly comfortable so that she continues to practice in the same way, day after day, year after year, until one day she discovers the world has passed her by and she wonders why. (I say practitioner, but I am referring to all groups in the profession.) Such unawareness and outdated practice are impossible to survival in the present age of swiftness. They lead to the need for insistence by an outside agent (outside the person) that currency in practice is a must—there is no escape from this fact. There is no such thing as safe practice if its knowledge base is obsolescent.

There are several avenues to implementation of the idea of mandatory continuing education—one of these is through legislation. Let me call attention to the fact that any continuing education which is

required of practitioners by any group is mandatory. This is important to keep in mind as a way of balancing negative attitudes toward legislation.

The idea of mandatory continuing education by legislation is controversial. It does not have universal acceptance. As with any mandatory plan, it highlights issues which already exist and which would pertain in any program which is mandatory in nature. These are problems for which there needs to be resolution, if any plan addressed to universal continuing education for nursing practice is to succeed.

I have identified eight (8) areas which seem to be the most persistent ones around which questions are asked when nurses gather to discuss mandatory continuing education.

1. The Definition - What is it?
2. The Cost - Who Will Pay?
3. The Resources - Who, What, Where, When?
4. Flexibility - Rigidity vs Openness
5. Credit - What Kind? From Whom?
6. Evaluation - Who decides? How is it done?
7. Coordination - How to ensure quality?
8. Control - Who implements and how?

It may seem strange to cite the definition of continuing education as a major issue in relation to this topic. Yet "What do you mean by Continuing Education?" is one of the questions most frequently asked by nurses with reference to this issue. It is interpreted as "having to go back to school," "having to get a degree" and thus engenders a great deal of fear. The fear is related to possible demotion or even loss of job if some formal approach to further education is not undertaken. And so it is important to reiterate the concept of continuing education as encompassing all learning activities in which a person engages beyond pre-service preparation.

I have a hunch it is the fear of not being able to measure up and not wanting to "go back to school" to compete with others that has led to the several suggestions about point systems and a kind of irrational insistence that almost any activity be classified as continuing education, e.g., belonging to the professional association or subscribing to a professional journal.

The definition needs to be broad and inclusive rather than exclusive–but it must be rooted in the premise that the whole thrust of continuing education in nursing is the improvement of practice and thus more effective health care delivery.

It would be blissfully simple to say–"Oh, this is adult education, so of course, the learner pays." Those of us in continuing education who try to survive on so hazardous a base know that a belief this simple is totally unreal. I believe that cost is undoubtedly the most critical

issue of all. It affects the recognized programs in continuing education (university or college-based), in-service education and the learner. Were the financial base for continuing education secure, most of the other issues would be easier to solve.

There are the usual sources of income to which many of us have become accustomed: (a) Fees from participants; (b) Governmental grants, state and federal; (c) Voluntary associations; (d) Combinations of the foregoing. These sources will undoubtedly continue to supply a large segment of support for the educational activity.

I view two other areas of support emerging—if indeed continuing education is to become a universal requirement for continued practice. One of these is increased employer funding of educational activities for improved practice. This involves the whole area of in-service or staff development for professional growth. It will necessitate earmarking an increased portion of the health care dollar for the continuing education of health workers, in this instance, specifically nurses. I would like to emphasize that I refer to all people in nursing, not only to hospital-based nurses. The nurse population, as a generalization, is part of the employee society, not the self-employed. Therefore, most of us deal with an employer of some description. The idea of increased employer funding is not so startling as it might seem at first blush. Part of it exists already, e.g., sabbaticals for many nurses in education; short-term educational leave for nurses in service with the employer willing to continue the salary and in many instances defray the cost of the program. Educational leave and opportunity for professional development have become negotiable items, fringe benefits, in contract discussion between employees and management. These activities are sporadic. They do however point a direction for us to pursue in stabilizing the financial base for continuing education. If Dr. Russell's statement in the 1970 Book of Proceedings comes to pass, and I quote: "the number of persons required for in-service education will probably exceed the present number required to staff diploma schools," and "institutions that decide to discontinue diploma schools ought to retain the facilities and staff for inservice education programs."[1] It would imply that funds would need to be allocated in generous amounts for implementation. Such a future directed plan will be essential to universal continuing education for nurses.

A second large area of funding that needs to be developed is that for programs existing or in the process of becoming within the educational system. It is imperative that continuing education in the

[1]Russell, Charles H. "Issues in Continuing Education for Nursing" in ENDS AND MEANS: The National Conference on Continuing Education in Nursing. (Notes and Essays on Education for Adults, No. 69.) Syracuse University Press, Box 8 University Station, Syracuse, New York, 13210. p. 14.

college or university be recognized as an essential component of the organization and be placed on a funding base equal to the formalized programs. It will be difficult to achieve, I doubt that anyone is going to be ecstatic over the notion of dividing an institutional budget three ways rather than two. The push for continuing education; the need to guarantee consumers of the service that it will be available and accessible makes it inevitable, I believe, that funding for higher education will include continuing education. We have a large selling job to do, beginning with our own colleagues, many of whom still do not view us as truly respectable. I am reminded of the comment by Dr. Theodore Shannon in his paper on Philosophies of Continuing Education yesterday and I paraphrase: "if we believe the millenium has arrived, that the whole world believes in continuing education as we do, it's because we are talking to ourselves." It is obvious, I think, that financial support and awareness of the magnitude of the cost are significant to implementation of universal continuing education.

A frequent response to the idea of continuing education to improve practice is "I am in favor of it but how available and accessible is it?" This issue really speaks to a variety of factors all having to do with resources, e.g. Human–the teachers; material–money, other media, physical facilities; institutional–the commitment which the institution is willing to make to continuing education.

What about the supply of teachers for continuing education, whatever its form? The evidence of lack in numbers of people prepared or available to teach in our organized programs is readily available. This relates to both those whom we would wish to employ full-time (if we were so fortunate as to have money) and those whom we wish to do programs for us in response to demand. When we ask the Community College and State College Programs in nursing to expand their activities into Continuing Education, they are willing, they, however, have the same major problem, lack of personnel and therefore, time. The Continuing Education Seminar in WCHEN (Western Council for Higher Education in Nursing) views the need for faculty prepared in the field as extremely critical. They have developed a grant proposal (hopefully it will be funded) that will attempt to develop some expertise in continuing education in 100 participants over a two year period. Its purposes naturally are, that by increasing the number of people prepared to increase the availability and accessibility of opportunity and thus the number of agencies committed to the concept. I would refer again to Dr. Russell's paper and his statement relative to personnel resources for in-service education. I have observed that a number of hospitals have retained one member of the faculty of the discontinued school for in-service but dedicate the use of their facilities to the collegiate programs in nursing for pre-service or graduate education.

Thus the formal programs have priority in use of facilities. Continuing education students may be denied access or displaced entirely. It seems to me that the increasing numbers of organized groups of in-service educators might give priority to Dr. Russell's suggestion about the need for a significant increase in their ranks.

Use of various media is certainly being explored and increasingly implemented in many agencies. I hope that some of you who are expert in the field will speak to this point later on.

None of the factors I have cited will have much opportunity for growth, expansion or even survival unless rooted in a firm commitment of the institution (whatever kind) to the concept of continuing education and its earnest desire that a program of continued education should be successful.

I have used the term flexibility to cover this area which seems to have a significant number of questions and concerns relative to the dimensions the requirements for evidence of continuing education might take. In many ways it harks back to the initial concern about definition. How open will the requirements be? Will they be so stringent that it will be impossible for nurses to achieve them? Stringency or exclusiveness might be instituted by insistence that only programs taken in an organized program of continuing education will be considered. Extreme openness, on the other hand, would consider membership in the professional association and/or subscription to a professional journal adequate evidence of continued growth for practice. It is imperative to keep constantly in mind that the whole thrust of the movement for universal continuing education is the improvement of practice by insisting that it be based upon current knowledge. This premise, it seems to me, dictates the direction in which criteria for requirements would move.

All of us are licensed to practice nursing, (though I find myself asking why with increasing frequency) yet many of us function in career areas not involved in nursing practice per se. Therefore, the question of what is appropriate evidence of continuing education becomes increasingly complex. Will the patient care practitioner and the educational administration practitioner be required to submit the same kind of evidence? Criteria about career tracks and their impingement upon practice need to be established. Variation in practice areas need to be identified and content relevant to their knowledge base would need to be known. Further delineation will need to be made relative to that which is current for those who maintain their present function area, and to consider that which is needed in expansion for those interested in change.

Another area of concern, perhaps a little less overt than the others, but very real is that of mobility. What is the effect on nurses moving

from other states or other countries in attempting to secure licensure in the new state?

The whole area of self-study, or independent study programs, needs to be developed and strengthened as part of the answer to accessibility as well as flexibility. It rather boggles the mind to think of the experimentation that could precede or arise out of the mandatory program.

This issue of flexibility is the one most frequently discussed among nurses. It places an enormous burden on the groups that will be involved in developing the programs in universal continuing education. It certainly means that a multiplicity of methods for continuing one's learning will need to be considered, and perhaps some to be invented.

The issue of credit may have less content for discussion than some of the other issues but it receives a great deal of air time whenever continuing education is discussed. It seems to follow a pattern among the nurse groups I have encountered on the issue of mandatory Continuing Education. The first questions are usually around the quantity, the point system, i.e., how much or how many points, as a kind of undifferentiated accumulation. This is seen as one kind of credit. There is also the credit awarded by the educational institution. Questions here relate to whether it will be academic (degree bearing) or extension (professional credit). How much is a credit worth? How does one become eligible for credit? In our situation (my home program) we are empowered to offer courses for credit (extension, professional credit) for all our courses. We may also offer courses for academic credit in selected instances. We use the general university system of 1 unit of credit for 10 hours of class (or 1 -30 if laboratory is involved). Many nurses, however, are interested in degree bearing credit whenever they take a course under the aegis of extension. This is a critical area and one in which we are going to need to do a great deal of negotiating if we are to use Continuing Education to the maximum extent in making upward mobility a reality to people in remote regions.

The other part of credit for continued professional growth rests in the employment setting. At present, nurses are attempting to have extension credit recognized as part of their employment dossier and therefore supporting evidence for promotion, increment, outstanding recognition. It is possible to conceive that if the National Task Force proposal[2] for a universal unit system for continuing education becomes a reality, in-service programs would become standardized, significant in content and provide the major share of evidence of continuing education for nurse practitioners.

[2]An Interim Statement of *The National Task Force* to Study the Feasibility and Implementation of a Uniform Unit for the Measurement of Non-Credit Continuing Education Programs.

Evaluation is multi-dimensioned and raises a whole series of questions to which it is difficult to find answers. The issue obviously is, how will we measure the outcomes? Will it be credit vs competency; attendance vs performance? There is some comfort in Dr. Kreitlow's reminder yesterday of how slowly change comes about, in the individual. It resolves in small measure the paradox of our saying change is rapid yet people change slowly.

I believe we will need to accept that in the beginning the evidence for continuing education will be that of credit and attendance. I believe equally strongly, that we will gradually begin to see a change in practice. If such change in practice is not self-motivated, it will be imposed. One of the strong forces behind changes and improvement in practice will be employer demands. This demand is already heard. On the premise that improved employment conditions and salary would improve practice, employers are asking for evidence of that promise fulfillment. If employers increase their share of the cost of continuing education their demand will be louder. I am optimist enough, however, to believe that most people exposed to learning opportunities will learn, and that if they learn they will indeed improve their practice.

You will note that I did not talk of evaluation tools and techniques which might be used to assess the worth of programs per se. I was viewing the issue as that related to mandatory continuing education and its eventual impact on practice.

That interest in continuing education is intense among some segments of the nurse population can be easily documented. Increased enrollment, frequency of requests and willingness to spend time are significant measures. There is another criterion of interest. This is the increased attention of people in the commercial area to the potentiality of developing various media and packaging programs as business ventures capable of success because of a ready made public. All of these developments can be viewed positively and can certainly feed into the need for availability and accessibility. They also point up the need for coordination at some level if the most effective and efficient use of human and material resources is to be achieved. Local, state and regional planning take on increasing significance to assure quality; adequate distribution; non-duplication and to prevent mushroom growth which may so overpower the system it will be immobilized.

The implications for coordination and collaboration are powerful. They move us away from competition and empire building, the "Stay out of my territory" attitude to one of sharing programs, resources, perhaps even funds. It will require the establishment of some kind of quality control board which will serve the function of screening programs and assessing their worth as contributory to the currency of

practice. I envision this kind of collaboration leading us to be able to decide among ourselves, the various components of continuing education, how each of us can best fulfill our purposes and thus in which areas of continuing education we should concentrate. For example, I dream of the millenium when we will all be soundly funded and the Community and State Colleges will be able to carry a large segment of continuing education in nursing. It would allow us in the university to concentrate our attention on post baccalaureate, post master's and post-doctoral study and on the preparation of personnel for continuing education programs. We can do a great deal more, faster and better when we achieve an adequate system of coordination. A factor not to be forgotten is that coordination and quality control also guarantee the consumer that she is receiving value for her dollar spent.

The legislative process is clear that the ultimate control rests with the state government. The question of which group will be charged with the responsibility for implementation is not so certain. The implementation or policing power may be delegated to the professional association; to the licensing body for nursing or to some other group created specifically to implement the program, e.g. as in California, a Council on Continuing Education for the Health Professions. The matter of control thus becomes an issue, something which can be debatable, because there are alternatives in it which may not have been considered before.

There are two other factors I want to talk of briefly because they are related to the concept of required continuing education. One of these is the question of alternatives to legislation. The most frequently mentioned is that related to Association membership, either mandatory or voluntary. As you know two States have launched programs of recognition in this regard. They are interesting developments to watch. The advantages I see in the legislative route however are: (1) it reaches to all practitioners in nursing, (2) highlights the need for finance, (3) has power to bring about coordination.

As a crystal ball gazer into the far future I see faculties in the undergraduate and graduate programs in nursing so immersed in the concept of continuing education, that they would not consider curriculum planning or development without considering the continuing education segment. I mean this as a total plan, so content, learning experiences, sequence and progress are influenced by what could be accomplished in continuing education. I am proposing that students in formal programs be counselled into courses in Continuing Education, if the content will enrich their program. Thus their belief in the significance of continuing education as a factor in continued professional growth is not left to chance. When and if that occurs, we will no longer need mandates for continuing education.

I have really come full circle, by looking at issues involved in legislation for continuing education in nursing. I now pose the central issue: should continuing education for nurse practitioners be mandatory? It is a philosophical issue, and one which remains debatable in spite of the imminence of its occurrence.

We are left with the task of: settling the issues (those presented here and others); stressing the need for and defining currency in practice; accepting the need for continued learning for all practitioners; and, moving toward curriculum planning in nursing to be 3 pronged rather than 2 pronged.

INTRODUCING THE CONTINUING EDUCATION UNIT

Paul Grogan
Professor of Engineering
University of Wisconsin-Extension

Introduction

It is my considerable pleasure to have this opportunity to address you. Having heard so much about "Women's Lib" in the past several months, my feeling in addressing a group of women—after virtually an entire adult life spent first in studying and later lecturing almost exclusively among my fellow engineers—is that of a "liberated man". Oh, I do recall talking ten or more years ago to a group of Wisconsin Nurses on *Weight and Measures*, or "You Tell Me Your Dreams and I'll Tell You Mine." But clearly the title of my remarks at that time only served to point out the separate points of view we carried within our respective psyches. There many be less entrancement in our subject for today, but I dare say we should be able to reach a meeting of the minds more easily and more quickly than we were capable of doing ten years ago.

Permit me to announce that I understand my job is to lead this discussion for the next 60 minutes. Your job is to participate. If any of you finish participating before I finish leading, please signal your desire to stop and we will quit then and there. The other thing I should say at the outset is that I'm not an educational psychologist, despite the hint of technical jargonese encompassed in the title of my remarks. I'm simply a mechanical engineer who apparently doesn't know the difference between a "B-t-u" and a "b-u-t". It may also be apparent in this context that I don't even know how to spell one of the four-letter words. Be that as it may, we thus are able to account for my straying afield from "power" and "energy" into the realm of "measurement" and "recognition" as applied to continuing education. In defense of my transgression, permit me to say what I view the educational psychologist as a man who says one, means two, thinks three and writes four on the blackboard. Being a mechanical engineer, I may say one, think two, mean three, and write four on the blackboard, but do you know what? Nine times out of ten, five is the right answer.

Background

Perhaps in my own self-defense now, I should explain to you something of my background in continuing education. This may help devolve my reason in being before you now in the role of espousing some form of uniform national standards concerning its measurement and recognition.

I was very actively engaged in the organization and conduct of continuing education programs for engineers for the 15-year period, 1951-1966. During that time, I was either immediately or administratively responsible for serving the continuing education needs of several thousands of engineers, year after year, whether new people in continuing programs or continuing people in new programs. It was a busy and productive time, but a time during which no one thought of the long-term consequences of our work or took stock of where we were going.

My conscience was finally awakened when I heard a dean of education in residence chastise one of his professional colleagues during a luncheon by saying:

> You and all of that public service activity in which you are engaged are just like so much writing in sand. The wind and wave wash over what you have done and there is nothing left of it.

He went on, extolling the virtues of engaging in "substantial research that could be put between hard covers of a book on a shelf somewhere." I could not help but think later that the dean of education was talking about not one but everyone of us in extension who was at that luncheon. It made me wonder at first about the supposed shallowness of our work. But it made me angry later than I fully comprehended that what we did commanded such little respect among our academic colleagues. How could this be when the same work received such generous response on a substantial self-support basis from the very clientele it served? The same could not be said about any other form of educational enterprise then extant in the country.

I brooded for a while about the wastage of 15 years on my part. But my real sense of loss was on behalf of the people who had supported programs under my immediate sponsorship and administration for 15 years. They had no emoluments to show for their faithfulness other than a joke book of dubious quality and merit and a collection of certificates that had been issued in a helter-skelter pattern and variety of formats. The latter would not even lend themselves to suitable use as wall covering for an office or den.

I resolved my dilemma and the attendant depression that went with it, at least temporarily, by taking a two-year leave of absence for

service with a national agency in Washington. But preparing in 1968 to return to extension-type activities, I realized that I should not waste the rest of my life in the offering of an educational smorgasbord with no stated purposes other than achieving a degree of self support by concentrating on refresher activities and current advances in the state of the art through non-credit courses and certificate programs without appropriate records, rewards or recognition. It was in this stage of my thinking that I decided to elicit the support of others on the national scene so that "measurement" and "recognition" of effort in noncredit continuing education could spring forth full-born, so to speak, and not dawdle away additional valuable decades in the unstructured or haphazard mode that characterized the field to date.

The National Planning Conference

It was thus that a National Planning Conference was convened in Washington, D.C., July 1 and 2, 1968, to determine the feasibility of establishing a uniform unit of measure nationally for individual participation in noncredit continuing education. More than 30 national educational and professional organizations were represented at the exploratory session. The principal outcome of the meeting was the formation of a National Task Force to continue the purposes and deliberations of the Planning Conference and to report its recommendations to the founding organizations at a later date. The following synopsis derives from the activities of the task force over a period of three years.

Problem Statement

Available knowledge is thought by many to double in 10 to 12 years for most areas of science, technology and related fields of practice. This typical "technological time to double" is not as spectacular as it may sound at first mention inasmuch as the infusion of new knowledge at the rate of seven percent per year results in a doubling of any given knowledge base in just over ten years. Nevertheless, this phenomenon requires constant improvement of the availability and use of continuing education programs directed to medical services personnel, among others, to maintain skills and awareness in the ever-changing frame of reference in which they must work and live.

We see increasing signs today of institutions, organizations and individuals seeking to "formalize" informal education as a device for making the pursuit of new knowledge ever more attractive to specific audiences or professional groups. More than 40 institutional and

organizational programs have been identified from Boston to Oregon and from California to Florida in which one aspect or another of recognition is given to individual effort in continuing education. The concern on the task force was that these programs are not transferable inasmuch as they were built around particular institutions, highly individualized systems of points, units and "credits," and often were the result of the driving force and dedication of a single individual. What would be the fate of the program when that individual was gone from the scene?

Specifics

On the other hand, the several objectives of the task force proposal for a continuing education unit may be stated in terms of a sequence of simple but progressive steps. These actions have been designed to take a sponsor of continuing education from minimal to more nearly full commitment to the concept of measuring and recognizing noncredit continuing education. These several steps represent the simple and orderly adaptations that institutions and society at large need to make, to the extent they are willing to do so at this time, in facilitating the establishment of a uniform national system for the measurement and recognition of individual participation in noncredit continuing education. The steps are so graduated that any prospective sponsor may exercise his own judgment with respect to just how far he is prepared to go at this time in accepting the recommendations of the task force as spelled out in its interim report.

Step One. *(Continuing Education Defined)* The first requirement in achieving this aim is to identify and refer consistently to all significant post-secondary level learning experiences, for which degree credit is not earned, as *continuing education.* This definition is intended to encompass the great wealth and diversity of educational opportunities referred to variously at the present time as *noncredit courses, extension activities, short courses, refresher, professional updating, state-of-the-art courses, evening division offering, off-campus instruction, certificate program, etc.* Continuing education, then, becomes a part of the totality of education as represented by the sometimes overlapping sequence of *elementary secondary, technical-vocational, undergraduate, graduate* and *continuing education.* We recognize but are not concerned that each of these principal categories of education lends itself to further classification as in the examples of sub-professional, professional and general adult education representing subsets of continuing education. The intent here is to deal with continuing education in the broad context that it has been defined in the first sentence, above, of this paragraph.

Step Two: *(Continuing Education Unit Terminology)* Given the definition of continuing education, it then becomes feasible and desirable to refer to all learning activities under that definition in terms of continuing education units. These units of continuing education are to be known variously as "c.e. units," "c.e.u." or, simply, "q". This simple convention, the adoption of which requires nothing more substantial than a change in state of mind, permits dropping the use of the innocuous terminology of "noncredit" from the lexicon of education. The same convention also avoids giving offense to those who rightfully feel that the terminology of "credit" must be reserved and applied exclusively to formal learning activities that traditionally culminate in a diploma or a degree. The continuing education unit envisaged here is not intended to apply under any forseeable circumstance, for diplomas or degrees since that need is served so ably and so well by the institutions that have been established specifically for such purposes.

Step Three: *(Continuing Education Unit Defined)* The next step in the evolution of a uniform measure has been to define the continuing education unit as 10 individual or contact hours of participation in an organized learning experience in which the *sponsor, content, format* and *direction* or name of the person in responsible charge of the activity are clearly identified. These are the minimum criteria essential to establishing the validity of the continuing education unit regardless of purpose to which it later may be applied. This unit of measure compares favorably in terms of its contact-hour requirements with the quarter hour of credit already established as a significant and acceptable threshold level of formal learning effort by an individual. Concepts of curricula, student and teacher workloads, use of facilities, identification of meaningful achievement, etc., can be built from this basic unit of measurement. The continuing education unit has the further advantage of being computed directly and simply for all formats and durations in the programming of continuing education wherever student contact hours can be determined. Any other common measure of student effort, whether formal or informal in nature, also may be readily converted into equivalent c.e.u. (or, simply, q) by virtue of the decimal nature of the latter unit.

Step Four: *(Wide Adoption Encouraged)* The concept of a c.e.u. as defined by the task force can take on meaning outside of academe only if it is possible to encourage its acceptance and use among professional societies, certificating agencies, placement activities, employers, personnel managers, counselors, licensing boards, etc. Each such potential user group should establish standards and incentives for

personal and professional development in terms of c.e.u. Each user group has a unique set of requirements concerning content, format, sources of sponsorship and number of c.e.u. to be acquired by individuals over a given period of time in the interest of their own development, career advancement and sense of well-being in a dynamic world of change. These standards, in effect, serve the purposes of accreditation. Moreover, the suggestion that recognition be external to educational institutions should help ward off the specter of "diploma mills" coming into existence as a result of these developments concerning the c.e.u. Recognition should be by and for the "user" and not the "sponsor". Thus it is possible to avoid adverse criticism of continuing education programs which offer either credits or degrees that are neither in the eyes of academe. The proposed system also permits, indeed encourages, the typical individual to marshal and utilize a host of continuing education resources in the form of in-service courses, association programs, use of educational consultants, subscribing to the offerings of proprietary schools and organizations, and the blending of a great number and variety of educational institutional programs to serve particular needs in meeting a well-formulated career objective.

Step Five: *(Standardized Descriptions Encouraged)* Given the markets for continuing education and its standardized units as outlined in Step Four, it then becomes feasible and desirable to describe virtually all continuing education activities in this mode. The critical parameters are to decide upon audience, purpose, format, content, prerequisites, qualifying requirements, duration, etc. There is nothing in this list that denies good educational philosophy and program management. These data, in turn, make it possible for others at removed locations and at later times to make intelligent judgments with respect to what the educational experience meant in terms of new learning acquired by the individual participant. Sponsors are therefore beholden to maintain abstracts of essential information indefinitely in their permanent records concerning every bona fide continuing education learning experience they conduct. These records serve the purpose of satisfying the inquiries that will be received from time to time about particular individuals who claim to have taken part in their previous course offerings. Indeed, this requirement of maintaining a reasonably permanent and highly transferable record (See Step Six, immediately below) are the principal responsibilities imposed upon the sponsor of continuing education activities. Organizations that do not offer as much by way of permanence of records and the ability to certify student records upon request automatically default as bona fide sponsors of continuing education experiences. There are no specific penalties, but

they simply do not participate in the building of individual records in terms of c.e.u. by virtue of this default. It is interesting to note that the matter of course evaluation is to be made by each user group in terms of the purpose to be served in recognizing the c.e.u. content of a particular course offering. This obviates the need for having as much done by the sponsors, themselves, or their immediate counterparts in the form of an accrediting organization that is broadly representative of the sponsors.

Step Six: *(Transfer of Records Facilitated)* Sponsors are therefore encouraged to establish a machine readable and easily transferable individual record concerning all continuing education students served. These records are to be maintained more or less indefinitely in terms of the Social Security numbers of individual students for the purpose of ready identification. The record also indicates basic details concerning the learning experience (See Step Five) in which each individual learner has participated. This machine record should be readily transferable to any inquirer (See Step Four) who wishes to recognize or otherwise reward the individual for consistency and excellence in the pursuit of continuing education.

Step Seven: *(Performance Evaluation Maintained Optional)* Sponsors may exercise considerable option concerning the establishment and maintenance of performance records by persons in continuing education. This may be done freely and interchangeably at their option according to any of three readily convenient and traditional grading systems: e.g., a) *auditor* or *observer,* designated X, for virtually passive participation as in the examples of participating in a lecture or demonstration; b) *satisfactory* or *unsatisfactory,* designated S or U, after the fashion of the pass-fail system currently in vogue in undergraduate instruction; such a system applies naturally and readily for the grading of the majority of continuing education programs where good attendance at sessions, participation in discussion, and the filing of a simple course appraisal form upon conclusion of the learning experience are sufficient to qualify the student for the satisfactory mark; and c) *conventional letter* or *numerical grades,* A through F or their numerical equivalents, and applicable whenever typical academic credit instruction standards are maintained in terms of attendance, recitation, outside reading and problem assignments in addition to the periodic and final evaluation of individual performance by examination.

Summary

Thus, the proposed system of a uniform unit of measurement of participation in noncredit continuing education set forth in the name of the national effort detracts in no way from the present system of continuing education in either its simplicity or its appeal. It is expected, however, that the more meaningful forms of professional recognition, each built upon its own requirements for participation in continuing education, will also carry its own stipulation as to how individual performance is to be evaluated. For example, proficiency or equivalency examinations may come into being, sector by sector, to remove any reasonable resemblance of doubt about the status the individual has obtained through continuing education once his knowledge and skill have been demonstrated by examination. But this development, as with all other rationale for forms of recognition, depends upon the existence of a basic module of continuing education. The task force feels that the continuing education unit, based on ten hours of participation in an organized learning experience, is the much-needed module to form the basis for recognition programs serving all sectors of society, including the medical and nursing professions and the several categories of support personnel nominally under the aegis of one or the other.

NATIONAL UNIVERSITY EXTENSION ASSOCIATION

The Continuing Education Unit
Pilot Project Report

TEN CONTACT HOURS OF PARTICIPATION IN AN ORGANIZED CONTINUING EDUCATION EXPERIENCE UNDER RESPONSIBLE SPONSORSHIP, CAPABLE DIRECTION AND QUALIFIED INSTRUCTION

After two years discussion, the National Task Force agreed on the above definition of a continuing education unit. The members spent many sessions analyzing the problems which might be encountered in the application of the c.e. unit, but it soon became obvious that field testing of the proposed unit would be needed to provide many of the answers.

In May, 1970, the members of the Executive Committee of the Conferences and Institutes Division of the National University Extension Association were asked if they would be interested in participating in a pilot project on the application of the c.e. unit. The response was enthusiastic and most of the members of the committee indicated that their institutions would be willing to participate. With this nucleus and a few others who heard about the pilot project, an orientation meeting involving twenty-one institutions was called in July, 1970, in Washington. Of those institutions represented, fourteen were ultimately able to cooperate in applying the c.e. unit during the 1970-71 school year and submitting reports on those activities to which the units were applied. A summary of the information contained in these reports and reported at the NUEA Annual Conference in Portland in May is attached.

This sampling of over 600 activities involving more than 28,000 individuals provides a fair sample of the major types of continuing education programs offered by universities: classes, intensive courses, workshops and conferences. In addition, a few less universal types were also sampled: correspondence courses, lecture series, and living room seminars.

Applications of the c.e. unit were consistent and uniform for evening classes and for intensive courses. Some inconsistency and minor difficulty were apparent when applying the criteria to conference programs and to the few correspondence courses reported. Much of this inconsistency must be laid to inadequate orientation of the individuals involved, often not the same person coordinating the pilot project. There was some sentiment to question the assignment of units to "every little event".

The major problem noted in the pilot projects was that of determining individual attendance and thus determining which individuals should be awarded c.e. units. No helpful or practical solutions were forthcoming to solve the problem, but it was generally agreed that there were inherent dangers, especially of diluting the value of the c.e. unit, in awarding units without adequate information about the participation by the individual participants. More emphasis should be placed on "satisfactory completion" of an activity, even though this may entail only attendance at the various sessions.

No single pattern was evident for the development of permanent records at the participating institutions. In some institutions it was difficult to obtain full cooperation of the registrar; in others the problems were resolved. A special effort was made by the university of Missouri-Rolla to develop a computer program. It was placed in operation during the spring of 1971 and offers a model for others wishing to develop computer based records. It is capable of printing out the record of an individual including a brief description of each of the courses on his record. Dean Ed Lorey can supply details on the program and the system.

Except for the permanent records, no serious administrative problems were reported. The Social Security number caused some difficulty, either in obtaining it from the student or in including it in the permanent records where the present system does not provide for it.

The reactions of students were sampled on an informal basis in most pilot projects, but at the University of New Hampshire Carmita Murphy asked the students to complete a questionnaire reacting to the c.e. unit. Eighty-five percent agreed that "I am interested in having my participation in a noncredit course or program recorded by the c.e. unit system." Excerpts from the comments made by the students are included at the end of the report.

Most participants felt that the c.e. unit had great potential which could only be realized when it was accepted much more widely, especially by industry and by professional and technical societies. We are now selling an idea for which we have not yet created a demand. While a few participants were cautious and wanted to wait for further results, no one expressed a desire to scrap the idea. The c.e. unit met with general acceptance which can be considered a significant accomplishment since it was applied by people and to people who had a limited opportunity to understand and evaluate the concept.

From the information provided in the pilot projects reports and from the discussions at the NUEA Annual Meeting in Portland, the following recommendations are being presented to the National Task Force for consideration.

RECOMMENDATIONS TO THE NATIONAL TASK FORCE

A. The summary of operating procedures distributed by the National Task Force to institutions and organizations initiating the application of the c.e. unit should include statements which:
    1. Emphasize the necessity for having some basis for determining "satisfactory completion" of the continuing education activity. The determination of satisfactory individual attendance in many programs has posed a significant administrative problem.
    2. Indicate the general concern evidenced by the pilot project coordinators for the indiscriminate awarding of c.e. units to short term (less than one c.e. unit) programs, particularly those of a conference type (i.e., those with a series of speakers not coordinated by a single director or moderator).
    3. Provide additional details, examples of applications and suggested operating procedures for those interested in initiating the application of c.e. units in their institutions.

B. The National Task Force is urged to contact professional associations and industry groups and, if possible, to obtain statements of acceptance or endorsement for the c.e. unit to the end that the user groups (students, societies and companies) will request the awarding of units to the educational programs in which they are involved at colleges and universities.

C. The National Task Force is urged to schedule regional orientation sessions on the c.e. unit during the summer and fall of 1971 for institutions, societies, companies, and governmental agencies involved in non-degree continuing education activities and interested in assessing the potential of the unit for their own operations.

RECOMMENDATION TO N.U.E.A.

An additional recommendation is made to NUEA to encourage its Divisions of Independent Study and Conferences and Institutes to develop a statement of policies on criteria and record-keeping for the c.e. unit.

RESOLUTION BY N.U.E.A.

The conferences and Institutes Division of NUEA sponsored the resolution below which was later passed at the Annual Association Business Meeting as an official resolution of NUEA. This action, along with the enthusiasm of the C & I Division, should encourage several

additional institutions to test the application of the c.e. unit during the coming year. The resolution reads:

BE IT RESOLVED, that the results of the pilot project to study the Continuing Education Unit be used as a basis for further study and recommendations for implementation by NUEA member institutions.

RELATED ACTIVITIES

1. As reported at Portland; the Oregon Academy of General Practice is now requiring continuing education as a condition for continued membership. Dr. Pennington reacted to the c.e. unit: "I think it offers a great deal when it actually comes time to put down on paper what has occurred in terms of continuing education."
2. As reported by William F. McCuiloch, University of Missouri-Columbia, The Missouri Veterinarian Association will meet shortly to plug the c.e. unit into its continuing education program. It will also be presented to the National association for possible use at that level.
3. A motion was passed by the Eastern Division of the U.S. Chamber of Commerce, Board of Regents to have that group explore the potential of relating c.e. units to their nation-wide institutes.
4. The University of Colorado is researching the possibility of using the c.e. unit for in-service training programs for teachers which are offered by the University but do not carry academic credit. Changed requirements for recertification of teachers can now be satisfied by in-service training.
5. A registered nurse in California is required to demonstrate that she has participated in a learning experience every two years to maintain her licensure. The c.e. unit is being investigated as a possible recording device.
6. Several articles have appeared during the past year to help disseminate the information about the c.e. unit. Note the bibliography below. The two most recent articles resulted in several requests to the NUEA Washington office for more information.

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Keith E. Glancy
The Johns Hopkins University
June, 1971

EXPLORING THE FEDERAL SCENE

Mary Hill
Acting Chief, Nursing Education Branch,
Division of Nursing, Bureau of Health Manpower Education,
National Institutes of Health

I am honored and pleased to be with you today to explore "the Federal Scene." This broad 'umbrella' topic is like a kaleidoscope where there are a given number of shapes and forms enclosed within a cylinder. These forms make a series of changing patterns by simply rotating the tube. I will share with you a selected few of the patterns which appear to have special relevance to us who are particularly interested in continuing education, but as with the kaleidoscope there is no end to the number and possible arrangement of variables we might look at if our time and energy were unlimited.

Perhaps the first thing we need to recognize is that health is a "hot" political topic in the 70's. The 92nd Congress has been dubbed "the Health Congress." Newspapers report we are moving rapidly from a military to a medical technology and that we are in a health care crisis. The other day I read that when the Chinese write the word "crisis" they use 2 characters; one meaning danger, the other opportunity. I like that approach. The President has declared "Good health care should readily be available to all of our citizens." In his health message last February he called for a new national health strategy based on four principles. Since these all have special meaning for health educators and nurse manpower I would like to recall them for you.

1. Assuring equal access.
2. Balancing supply and demand
3. Organizing for efficiency with emphasis on health maintenance and preserving cost consciousness.
4. Building on strength - capitalizing on the diversity of the health care system and exploiting strengths as well as correcting weaknesses.

Let's look briefly at the implications for nursing and continuing education as we examine these more closely.

1. Assuring equal access is aimed at removing racial, economic, social or geographical barriers which prevent obtaining adequate health protection. We have long been aware that those who live in sparsely populated areas or in urban ghettos tend to have less medical care available. One of the multiple problems which contribute to this has been the short supply of physicians. Steps to remedy this include increasing the number of physicians and adding to the health care system "physician extenders." These "extenders" include a new group identified as physician assistants, nurses, commonly known as nurse practitioners who are changing their traditional role and extending their area of practice, as well as an array of other technically prepared assistant groups. All of these, theoretically at least, will make health care more accessible to more people.

   One step geared to provide more equal access is included in the pending legislation. A provision for identifying geographical shortage areas, where if health professionals including nurses, choose to practice following graduation, a portion of their educational cost funded via a loan, can be forgiven in a shorter period of time than usual.

   Another approach to the problem of "access" has direct relevance for continuing education. It involves the establishment of area health education centers.

   The area health education centers are a concept drawn from the Carnegie Commission Report, and I would like to quote from the Commission's *Report on Higher Education and the Nation's Health* to describe the purpose of these new centers which I believe is of vital interest to nurses.

"These area health education centers, in essence, would be satellites of the university health science centers and would be visited on a regular basis by the faculty of the health science centers with which they were affiliated. Their educational programs would be developed and supervised by the health science faculty, and their patient care functions would rely on the expertise of the health science center personnel. The area centers in turn would provide assistance and counsel to the community and neighborhood health care facilities, including the private practitioners."

   So what you get is a sort of heirarchy, so to speak, of medical care. At the apex is the university health science center, with its research and teaching facilities. These would be large, comprehensive centers with all types of teaching and treatment. Radiating out from these centers would be the health education centers. They would have smaller, less

comprehensive facilities, but would still be able to treat almost every condition.

As envisioned by the Carnegie Commission the area health education centers would be developed in strategic spots around the country in such a way that every person in the United States would live within 100 miles of one of them.

Finally, surrounding the area health education centers would be neighborhood health care facilities. Each of these centers would be closely allied with at least one other center for exchange of teaching expertise and medical facilities.

Keep in mind that all of these centers will have to be staffed by nurses. These nurses will continually need to have their knowledge and skills updated if the mission of AHEC is to be accomplished.

2. Balancing supply and demand—We are aware that creating a demand without being able to supply the need ends rapidly in anger and frustation. When Medicaid and Medicare were created the expectations of many beneficiaries were not met and as a result medical costs inflated dramatically.

   In an effort to prevent this occurring again, the National Health Service Corps, established under the authority of the Emergency Health Personnel Act will permit the assignment of federally employed young health professionals to areas with critical manpower and health service deficits. Certification of need is required of medical and dental societies and by local government jurisdiction. To date ten nurses have been given assignments to such areas. This certainly is not a total solution but a positive move in the direction of an answer

3. The third principle the President suggested involved organizing for efficiency with emphasis on health maintenance while pursuing cost consciousness. In essence, build a system which is geared to 'health' rather than to sickness.

One of the approaches suggested to assist in meeting this principle is the creation of Health Maintenance Organization or HMO's. The HMO is an organized system of health care providing comprehensive services (ambulatory and hospital care at a minimum) to a voluntarily enrolled population for a fixed pre-paid fee. Consumers have access to a system and do not have to find each piece separately. The aim is to keep people healthy, rather than to treat costly, episodic periods of illness. It is hoped that emphasizing preventive medicine will help keep down rising medical costs.

The bill is also intended to deal with the problem of poor distribution of medical care personnel in many inner cities and rural areas. Special provisions in the bill allow medically under-served areas

to receive priority for HMO assistance in all forms - contracts, grants, loans, and loan guarantees.

Implications are clear for an increased emphasis on patient teaching - particularly in areas of health care and prevention - done by nurses.

The second implication is that much of this will be done in extra-hospital settings, for example, community centers or in patient homes.

4. The fourth point the President spoke to was building on strengths. One strength he addressed was the diversity of the system with the range of choices available to both professionals and clients. He stressed the need for cooperation and coordination between private and public efforts.

The Nurse Training Act of 1971 has been passed by the Senate but is waiting action in the House. Although we cannot look at firm legislation we do have some notion as to what portions of it have special relevance for continuing education.

Special project grants have always allowed for continuing education programming. In the new legislation not only will grants be available but the authority has been broadened to include contracts.

There are several specific kinds of projects outlined in the legislation for which application may be made. Only the projects of concern to those in continuing education will be listed and they are not in the order of listing in the legislation document.

1. Provide continuing education for nurses.
2. Develop training programs and train for new roles, types or levels of nursing personnel, including programs for the training of pediatric nurse practitioners or other types of nurse practitioners.
3. Develop programs for cooperative interdisciplinary training among schools of nursing and schools of allied health, medicine, dentistry, osteopathy, optometry, podiatry, pharmacy, public health or veterinary medicine, including training for the use of the team approach to the delivery of health services.
4. Research, develop or demonstrate advances in the various fields related to education in nursing.
5. Provide appropriate retraining opportunities for nurses who (after periods of professional inactivity) desire again actively to engage in the nursing profession.

In an age when we have had rapid growth in scientific knowledge, technology as well as health legislation, we are aware that professional practice trends to be strained. We have a tremendous need to keep nurses in every area of specialty abreast of new developments in the

field. This new legislation should go a long way in helping–if we use it to our advantage.

Continuing education has often been referred to as a "sleeping giant" or "an attempt to educate a parade" or a "star is ascending." The first two analogies have rather ominous sounds but the third carries a different connotation.

I would like to share two not so random thoughts about continuing education in 1971. It's tempting to make a "laundry list of problems and issues in continuing education" but you have had years of experience making those and are undoubtedly better at such compositions than I am.

The first thought has to do with that overworked but under utilized word, "plan." It would be interesting to know why we all support the need to plan but so seldom actively work at the process. Regardless of our feelings about it the Division of Nursing strongly favors this concept. Currently two contracts are being supported which will assist identified regions assess their needs and resources in an effort to plan for more effective continuing education. One contract is with MCPEN, Midwest Continuing Professional Education in Nursing, centered at St. Louis University, involves 8 midwestern states, and the other is with University of Wisconsin for 5 north central states.

At a time when professional relicensure and continuing education are being linked in several states the need for planning is even more critical. While it is premature to make a value judgment regarding the wisdom of such a relationship, it is safe to say that in nursing we are not tooled to undertake any broad system of mandatory continuing education now. We might pause to question if we can afford the luxury of magical thinking which suggests, "wishing will make it so."

Many of our past efforts have tended to be costly in both time and money. Part of this is the result of our reluctance to work cooperatively with agencies other than our own. If the goal of our programing is the improvement of patient care – rather than maintaining the identity of the sponsoring organization – such joint planning arrangements should result in better programing at lower cost, than are produced when we work alone. We talk about our need to plan as a health team – continuing education provides a splendid opportunity for initiating cooperative team efforts.

It is very tempting here to pause and talk about our new technologies or methodology or the tremendous need for evaluation but I'll save those for another day.

The second need I want to speak to is the need for systematic research in continuing education in nursing. We need to look critically at the variety of systems of organization and delivery. We are aware that the several levels of professional nursing make design of effective

systems difficult but we also know that this kind of study would be helpful not only to existing programs but in particular to new ones. Some research has been done in the evaluation of continuing education. Measuring knowledges and skills seems relatively easy but our research in behavioral modification – and this is the real test of effective education – is scant not only in nursing but in all continuing education.

The positive posture of the Division of Nursing in supporting continuing education has a strong historical base. In 1956 the Professional Nurse Traineeship Program was authorized and funds were made available for graduate level education of nurse leaders. The thrust was increased in 1960 when funding for short term study was provided for nurse teachers, administrators and supervisors in hospitals and related insititutions, public health agencies and schools of nursing. In 1963 nurse clinical specialists were added to the list of those eligible for short-term funds. You will be interested to learn that beginning in January 1972 all short-term traineeship funds are being decentralized to the 10 DHEW Regions. Short-term projects will be reviewed and processed from the regional rather than the central office at the Division. Forms and instructions as to the new format will shortly be available from either the central or the regional office.

Special project grants and contracts have been additional avenues which the Division has used to support continuing education. The new legislation offers additional opportunity. We are aware the problem remains enormous in scope. As the Division of Nursing continues to develop in response to legislation, we hope to increase our ability, through you, to meet the education and training needs of the nation's nurses.

CONTINUING EDUCATION—A WCHEN SEMINAR

G. Marjorie Squaires
Western Interstate Council on Higher Education
for Nursing Coordinator, Nursing Grant Programs,
University of California, Los Angeles

"IV Seminars

Section 1. Seminars. There shall be established four subgroups of the Council to be known as seminars. These seminars shall provide small work groups through which Western regional needs for higher education in nursing can more effectively be met. These seminars shall meet twice a year during the regular Council meeting and at such other times as the seminars may determine. The following seminars shall be organized:

(a) Seminar on Associate Degree Education
(b) Seminar on Baccalaureate Education
(c) Seminar on Continuation Education
(d) Seminar on Graduate Education"[1]

The above quote from the original WCHEN Charter of May 15, 1957 establishes Continuing Education as an integral and equal representative of nursing education under the WICHE umbrella. We have equal representation on the Executive Committee and specific responsibilities to one area of nursing education in the West. The council meetings held twice yearly not only give the individual Seminars an opportunity to conduct sessions dealing with projects and programs relating to their own level of nursing education but allow all Council members to meet jointly for an interchange in cooperative planning and problem solving. The "About WCHEN"[2], states the functions as follows:

"Recommend to the Commission policies relating to education and research in nursing.

Provide a medium for exchange of ideas and sharing of experiences by western institutions of higher education which offer nursing programs leading to the associate, the baccalaureate, or a higher degree.

Undertake cooperative planning for nursing education programs in the West.

1 From the "Charter of the Western Council on Higher Education for Nursing of the Western Interstate Commission for Higher Education," May 15, 1957
2 "About WCHEN," The Western Council on Higher Education for Nursing, Boulder, Colorado, 1969

Identify problems with respect to nursing education which need cooperative study and action.

Stimulate research in nursing in the Western region."

Within this framework it is not only possible but essential that all Council members representing all levels of leadership in nursing education in the West, plan together in a cooperative effort toward the achievement of a common goal.

Membership in the Continuing Education Seminar has recently grown from the original eight (8) universities conducting the leadership programs to a new membership of twelve (12). This is due to the recent appointments of faculty members with full-time responsibilities for Continuing Education in WCHEN member schools. With the national, regional and statewide trend directed toward continuing education for licensure renewal, we forseee many possible changes within our seminar structure. However we see little change in our functions, as increased membership represents commitments being made by the administration of the member schools to support such programs as a principal priority with emphasis comparable to that given the traditional teaching and research functions of the institutions of higher education. This movement could even be a matter of survival for some schools as we all have to look closely at the new approaches in professional educational such as the Carnegie Report, the London Open University, the Physician's Assistant and Associate, the Health Maintenance Organizations, etc.

Our involvement within the Council structure allows us the opportunity for direct contact with the other Seminars, which gives us some direction in joining them for a unified approach to nursing education.

The Council sees the need to look at our nursing service-nursing education laboratory approach which has put continuing education in a liaison position with the nursing community. It is indeed a two-way process. This is how Continuing Education fits into the total WCHEN structure.

Let us look back and review the development of this foreward looking approach to regionalization in nursing education and the involvement and accomplishment of the continuing education programs and projects during the last fourteen years.

The Western Regional Education Compact which created the Western Interstate Commission for Higher Education (WICHE), became operative in 1951 following ratification by five western states and subsequently by the remaining eight. At the same time nursing was well aware of the need to be included in a broader educational structure in order to not only identify itself as a profession but to survive. Nursing has had a great deal of "training school-traditional baggage" even in the

university setting which had to be dealt with in order to move toward the development of programs designed to nurture scholars in nursing as well as leaders.

The St. Louis Conference in 1955, 10 long years before the ANA Position Paper* was the beginning exploratory meeting with the planned program geared toward the identification of nursing education with higher education. Prior to this meeting the WICHE executive committee had authorized the director to call together an appropriate group to study nursing and advise the commission in the studies it might undertake in the professional field of nursing. Well known nursing leaders on this committee submitted their report to the commission in August of 1955 and in October 1955 Dr. Helen Nahm, on leave from the National League for Nursing commenced her survey which laid the groundwork for the Western Conference on Nursing Education – with the theme "Toward Shared Planning in Western Nursing Education" – held in Berkeley, California in January 1956.

The famous "Committee of Seven," Lulu Hassenplug, Chairman; Pearl Parvin Coulter, James Enoch, Katherine Hoffman, Amelia Leino, Annette Lefkowitz, and Kathryn Smith, met in Denver the following March. There were many rumors about that meeting during a blizzard but "Winds of Change" describes it in a way similar to the dialogue presented by Lulu Hassenplug and Helen Nahm at their WCHEN retirement meeting in Montana when they said that————————"Dr. Enarson locked the group in a small hotel room in Denver, put the key in his pocket and shouted through the keyhole, 'You may come out when you have produced an imaginative, creative program, 'and, so, they did develop a design for action".

One of the main concerns of this committee was the need to upgrade preparation of nursing service personnel in leadership positions in hospitals, public health services and other health service agencies. As a result of their deliberations, a proposal was prepared for a continuation education program which had as its goal the improvement of patient care through strengthening the leadership skills of those nurses in positions to guide the efforts of other nurses. The W.K. Kellogg Foundation in the summer of 1956 supported the continuation education grant to the extent of the consultant's position for five years and the first three-year series of the Continuation Education Project. And so WCHEN was born with the Executive Committee naming one of our former seminars members, Dr. Alice Ingmire as its first Chairman.

Dr. Fay G. Abdellah was the first WICHE Nursing staff member and was responsible for launching the Continuation Education Project. In July 1957, Jo Eleanor Elliott became the permanent staff member

* A Position Paper: American Nurses' Association, New York, N.Y. 1965

and has been our staunch leader and supporter through these fourteen years.

And so the first WCHEN continuation project was on its way in three subgroups of the West. Each of the (3) sub-regions would be responsible for the recruitment of participants and the conduct of 5-day conferences, 3 times a year for 3 years; a total of 9 conferences covering 45 days. The same participants would be involved for the duration of the series with 2 coming from each representative agency. The plan would utilize the booster principle including intensive learning which would be reinforced with new learning experience in strategic intervals. Participants would be able to return to their work settings and apply the new ideas between conferences. Agencies were to agree to accept the consultation furnished and to also accept some financial responsibility on the premise that everyone benefits and everyone contributes. The original grant was expanded to enable WICHE to have Dr. Frederick Todd evaluate the total project. At the conclusion of this project it was agreed that the program was workable and should be expanded to the entire western region. A grant was secured under the Professional Nurse Traineeship Program of the Public Health Service (Title VII, Public Law 105) through WICHE and was administered to the eight sub-regions beginning with a Central Training Course for leadership in planning and conducting continuing education courses in nursing and, on into our present WICHE series. The programs in the sub-regions differ in some aspects but are essentially the same.

Funds were obtained from the Public Health Service to do an intensive systematic evaluation of the 1962-64 series by the eight continuing education directors who had worked closely with Dr. Calvin W. Taylor and Dr. Faye G. Abdellah in devising nurse performance evaluation instruments during a Central Training Course. This group further refined the on-the-job rating forms and selected and refined one situational exercise which was used in the research study published in 1967, part I, Part II and Part III [1, 2, 3], as well as a 1962-1964 continuation study by 3 of the 8 regions.[4]

1 Ingmire, Alice, et al. The Effectiveness of a Leadership Program in Nursing. Boulder, Colorado: WICHE, 1967.

2. Ingmire, Alice, et al. The Effectiveness of a Leadership Program in Nursing: A Report of Pre-and Post- Performance Testing of Nurses in a Leadership Development Program, 1964-1966. Boulder, Colorado: Western Interstate Commission for Higher Education, 1967.

3. Ingmire, Alice, et al. The Effectiveness of a Leadership Program in Nursing: Follow-Up Performances of the Experimental Group. Boulder, Colorado: WICHE, 1967

4. Ingmire, Alice. A Leadership Program in Nursing, 1965-66. San Francisco: University of California Medical Center, 1967.

This research project involved the cooperation, interest and support of 4,500 individuals, 30 schools, 57 hospitals, 9 public health agencies, 2 State Boards of Nursing and a community health Council. A good deal of the required work of these directors on this project was accomplished on their own time and during the Annual Council meetings held twice yearly.

"Continuing Education in Nursing,"[1] a book written by eight of our seminar members and published by WICHE in 1969 was another ambitious project that consumed a great amount of time during seminar pre and post meetings as well as group cohesiveness.

Other programs have been offered by the Seminar group such as "Creativity-Accent on Creative Nursing" which was conducted in 1969 at Park City, Utah as an open conference.

All of us were involved in some way in the writing of the "WCHEN Guidelines for developing continuing education programs in nursing in the West," as well as working as a seminar or in small groups on grants such as the "Faculty Development" grant and a joint proposal with the Western Regional Assembly of Constitutent Leagues on "The Dynamics of Nursing Administration in Health Care Systems." All programs are based on the regional approach.

On May 15, 1972, WCHEN Charter will be 15 years of age, but some of us sometimes wonder if we are adults or if we in nursing are behaving like the 15 year old adolescent. I would like to quote a paragraph from "Winds of Change" in which Mrs. Coulter is telling about the 1957 organizational meeting and says, "If a means of facilitating cooperative planning were to be developed and to be successful, many ambitions for self and for individual schools of nursing would need to be discarded; all must work diligently and together; all must expect to make progress. A sound premise had brought these nursing leaders this far; now, the question was – could they learn to be less competitive, to broaden their perspective, and to submerge self-interest for the welfare of the group in order to accomplish their ultimate goal.[2]"

Can we answer to that now? Can we answer to the public for todays health care? Or are we playing the one-upmanship game there-by minimizing our commitment to our profession. Never have we been more in need of strong leadership than right now or more concerned with the utilization of the knowledge and strength of our experienced continuing education leaders.

1. Continuing Education in Nursing: Western Interstate Commission for Higher Education, Boulder, Colorado 1969

2. Pearl Parvin Coulter, *Winds of Change*, pg 21, Western Interstate Commission for Higher Education, Boulder, Colorado, July 1963

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CONTINUING EDUCATION ACTIVITIES OF THE SREB PROJECT IN NURSING EDUCATION

Helen C. Belcher
Director, Nursing Education Project
Southern Regional Education Board, Atlanta, Georgia

The present activities of the Southern Regional Educational Board Project in nursing education had their beginnings in 1962 when a five-year grant from the W.K. Kellogg Foundation was activated. A second grant was awarded in 1967 to continue a broad program of activities through 1971. During this ten-year period, interest in continuing education has been focused largely on college-sponsored schools of nursing both in terms of the continuing professional development of faculty members and in terms of university-sponsored continuing education programs for other nurses.

Before describing specific activities in continuing education, I would like to explain a little more about the project itself. SREB is an interstate agency formed by a compact signed by the governors of 14 Southern states (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia.)

Before telling you more about the particular project with which I have been associated, I want to mention that during this same period SREB also held grants for two other projects in continuing education. From 1967-70, Miss Annie Laurie Crawford directed an NIMH–supported project in teaching psychiatric nursing for about 35 faculty members from diploma schools of nursing in the South. During 1969 and 1970, Dr. Mary Howard Smith, SREB special programs associate, offered a workshop in two sessions on teaching with television for faculty members from baccalaureate and associate degree programs in the South.

Now to return to the Kellogg Supported project–upon recommendation of a conference of representatives from college-sponsored schools of nursing which was called in 1962 to advise on program activities, in 1963 SREB formed the Council on Collegiate Education for Nursing. The Council was created as a vehicle to facilitate cooperative planning between SREB and college-sponsored schools of nursing in the South. The Council had official representation from 63 colleges and universities in 1963. In 1971 it has official representation from 193 colleges and universities which offer a total of 234 nursing programs leading to associate, baccalaureate, or master's degrees in nursing.

The ways in which SREB has worked with the schools in the field of continuing education have been determined to a large extent by the needs and wants as expressed by the Council, the resources of the schools, and patterns of other successful SREB projects and activities. For the most part, under this project we have not sought the role of directly administering continuing education programs for nurses, but rather we have used our resources when possible to assist colleges and universities to do more in this area. This has usually been done during the planning period. Implementation of most programs has depended upon identifying a host institution which was willing and had the resources to work with SREB and a regional planning committee to develop a grant proposal. The application was then submitted by the institution and the grant awarded to the university or college with SREB acting as co-sponsor.

Between 1962 and 1966, under the first five-year project, the main activities in continuing education for faculty members were twelve workshops in curriculum planning, teaching, and clinical nursing; a three year project in teaching psychiatric nursing in baccalaureate programs and a small program of study-visits for faculty members to visit other schools to study their programs. The last two of these activities were administered directly by SREB. SREB was co-sponsor of the other activities which were hosted by several universities and colleges.

The present grant from the Kellogg Foundation began in 1967, and by the end of 1971 we will have completed a series of three seminars in administration and management for deans of baccalaureate and higher degree programs; five annual summer workshops for faculty members new to teaching in associate degree programs; and two summer workshops for faculty members with at least a year of teaching experience in an ADN program.

A three-year project in cancer nursing begun in 1966 was completed in 1969 at the University of Texas M.D. Anderson Hospital. In 1970 we also completed a three-year series of activities, administered by SREB, to improve teaching of medical-surgical nursing in master's degree programs. A three-year project to help train faculty members in ADN programs in psychiatric nursing was begun in 1970 (sponsored by the University of North Carolina at Chapel Hill). All of these projects have involved several meetings or seminars of relatively small groups of persons over a period of two or three years, and they involved some kind of interim assignment or work. This pattern has been particularly successful with continuing education activities for faculty members.

The contribution of SREB to these regional activities has been greater during the planning phase than during the operation of these activities. Most of the initiative for developing ideas into projects

depended on the resources of the regional project. When possible we responded to needs or requests from various sources by appointing a planning committee to grapple with an idea and come up with the basic plans for a workshop or a project. These meetings were usually held at SREB, at SREB expense, and detailed reports were prepared by staff. The staff usually explored prospects for funding, sought out a potential host institution which could carry these ideas forward, and generally tried to bring together the plan, a sponsor, and a funding agency to develop and to carry out a needed activity. The staff worked with persons from the prospective sponsoring college or university in whatever ways were needed to prepare the application. After submission of the application, the main responsibility shifted almost entirely to the university or college. SREB staff continued to help as requested, and as needed and especially in facilitating communication with schools throughout the region about the activity and relating the activity to other developments in the region.

The SREB Council on Collegiate Education for Nursing was involved in each of these activities in some way or other. For others, the idea emanated from discussions of the Council. For others, the idea was developed by a smaller committee or group and was later endorsed or recommended by the Council. The Council was kept informed about the progress of each of these activities throughout the period of its development and operation. Before each Council meeting, an agenda book is prepared which includes reports of all on-going activities. These booklets often include 50-70 pages of material. Following each meeting, a proceedings book is prepared which includes copies of principal papers and a summary of discussions and recommendations. These reports of CE activities for faculty members have heightened interest and concern about what is (or is not) available in the region by way of CE opportunities specifically planned for faculty members.

I might add here, that the semi-annual meetings of the Council itself provide a sort of continuing education program for heads of college-sponsored programs in the South. For instance, since 1962 the programs of the Council have been developed around such topics as statewide planning for nursing education (2 meetings), uses of multi-media in schools of nursing, the development, implementation and evaluation of a conceptual framework for nursing curricula, (3 meetings) and the implications of *An Abstract for Nursing* for the South.

This very brief summary of some activities will, I hope, illustrate some of the ways in which the SREB Project has attempted to increase the professional development of faculty members through continuing education. Each of these activities, could, of course, be described and discussed in greater detail.

Another facet of our efforts in continuing education has been focused on a regional group of faculty members who are employed full time (or nearly full time) in colleges and universities to operate continuing education programs for nurses. In contrast to the specific activities mentioned before, the work of this group is broadly oriented to planning and directing programs of continuing education for nurses.

This group came into existence in 1969 when, for the first time, several Southern university schools of nursing created positions for faculty members to work primarily in the field of continuing education. In 1969 there were eleven universities with nurses working at least half-time in CE. Prior to then only three or four universities had nurses in such positions and sometimes even these few positions were not filled.

This group has met four times, (approximately every six months) since 1969, and will hold its fifth meeting in November. At present there are eleven members of the group from ten Southern states.

The group is now called the SREB Conference Group on Continuing Education in Nursing. It has evolved into a sort of regional forum for discussion of timely issues in continuing education. The indications are that these discussions are useful to the members even though each person knows she nas to work out her own answers to questions in her own setting. Members of the group say that it is helpful to know what others are doing, and discussions seem to increase their awareness of possible choices or options for how to deal with perplexing problems.

Some of the issues or problems which have commanded a great deal of attention by this group in the past two years have been:

- statewide planning and coordination of continuing education
- the role of university schools of nursing in continuing education,
- the relationship of CE staff in nursing to other units of the school of nursing and other departments of the university,
- the relationship of the CE program in nursing of the university to other professional, health, and educational organizations and agencies throughout the state (and sometimes across state lines).
- financing and budgeting of CE programs.
- determining needs and priorities of nurses for CE.
- developing long range programs of CE.
- evaluating the effectiveness of CE programs.
- the role of university CE departments in continuing education for faculty members of college-sponsored schools of nursing, and
- obtaining and training the staff for continuing education.

Many other topics were considered along the way, such as, the selection and uses of advisory groups, recruiting and training staff for continuing education programs, the pros and cons of offering university credit for continuing education courses, how to differentiate between "needs" and "wants" of nurses for continuing education, continuing education for interdisciplinary groups, uses of mass and multimedia in continuing education, how continuing education could become more effective in changing nursing practice to improve care, and national developments of import to the region (such as the report of the National Commission for the Study of Nursing and Nursing Education, and the National Conferences on Continuing Education for Nurses.)

For each meeting, certain topics have been identified by the group in advance for discussion. Usually each member brings a written report on developments in her school, and statements and materials on the assigned subjects. This results in a great deal of exchange of written and oral material during the meetings. Between meetings, the exchange continues as the program directors are now on the mailing lists to receive announcements from each of the others.

This brief account will, I hope, give you some idea of ways in which the SREB Project in Nursing Education is involved in continuing education for nurses. There is much more that I could add, but I believe I have used up my allotted time. By way of conclusion I might say that we have tried to contribute to this important field of nursing education largely by helping to identify needs, to promote planning for specific activities which contribute to the continuing professional development of faculty members and to strengthen the quality of continuing education programs under college-sponsored schools of nursing.

REGIONAL APPROACH TO CONTINUING EDUCATION FOR NURSES IN NEW ENGLAND

Eileen Ryan
New England Council of Higher Education for Nursing
Wellesley, Massachusetts

It is a distinct pleasure for me to be here today to share with you the continuing education activities for nurses in New England. I would like to publicly thank Mrs. Signe Cooper for her invitation particularly in view of the fact that we in New England are at quite a different stage of development in the area of continuing education than represented by the other members of this panel.

First, I would like to note that the regional nursing program in New England, called the New England Council on Higher Education for Nursing has from its inception been primarily involved in the direct administration of continuing education offerings for nurses. These activities from 1962-68, supported largely by U.S.P.H.S. funding filled a very definite need for our region.

During that period of time there were no faculty positions for nurses in continuing education in our universities. However, within the last three years, six nurses have accepted newly created positions for the development of programs in continuing education at the University of Connecticut, Maine and Vermont, Boston University, Yale University and Boston College. This accounts in part for the transition from programming to broader regional planning with which the Continuing Education Interest Group of NECHEN is currently concerned.

I believe that in order to understand how the various regional programs operate, it is necessary to take a look at the history and development of each nursing program in relation to its parent body, its funding source and its unique goals and purposes. I do not intend to attempt to contrast and compare the three interstate compacts at this time, but will confine my remarks to NEBH/NECHEN. However, a serious study of the three groups is necessary in order to fully understand both the similarities and differences of functions and programatic activity. In February, 1970, Miss Virgina Henderson presented to the NECHEN membership a report of her study of the three compact agencies. To my knowledge, this was the first time such a comparative study was attempted.

It is well to bear in mind that the nursing program which is affiliated with a regional board such as WICHE, SREB, or NEBHE, functions within the defined goals and objectives of that compact body.

The advantages of such an arrangement are that the nursing program can work through the regular channels established by the compact agency with relevant legislature, professional and educational groups, thus making use of already existing mechanisms for regional planning. These agencies also provide an established framework for obtaining funds from outside agencies and foundations.

The New England Council in Higher Education for Nursing was the outgrowth of an earlier regional body, i.e., The New England Conference on Public Health Nursing which was organized in the late 50's. This body soon recognized the need for regional planning and the necessity to enlarge its scope to all areas of nursing education at the college/university level.

In 1962, the Conference petitioned the New England Board of Higher Education to be taken under its aegis. Several traineeship programs were run subsequent to this by the Regional Nursing Program under NEBHE as it was then called. The New England Council on Higher Education for Nursing was organized as a formal body within NEBHE in 1964, and a full-time Nurse Consultant for NECHEN was appointed. Mrs. Winifred Griffin held the title of Associate Director for Nursing Programs. NECHEN was organized with its own Executive Committee and By-laws. Membership is by institution with faculty representatives serving a specified term of office. There are presently fifty nursing programs in the six-state region of Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

During the four years that Mrs. Griffin was with the Board, a series of short-term traineeships were sponsored by NECHEN. In nine centers directed by seven universities nearly 1200 nurses from 450 health care institutions received updating of their teaching and administrative skills. These workshops were given over a three-year period in two five-day sessions. Another series of five inter-university faculty work conferences were conducted for over 100 faculty members focusing on the development of professional curricula. Published reports of these sessions are available at the NEBHE offices.

1. Proceedings of the First Inter-University Faculty Work Conference, 1964. (Papers presented a range of topics including philosophy, content development, learning theory, methodology and evaluation.)
2. "Theoretical Concepts Underlying Professional Nurse Education" 1966.
3. Psychosocial Bases for Nursing Care: Implications for Newer Dimensions in Generic Nursing Education, 1966.
4. Physical-Biological Bases for Nursing Care: Implications for Newer Dimensions in Generic Nursing Education, 1967.
5. Humanities and the Arts as Bases for Nursing: Implications for Newer Dimensions in Generic Nursing Education, 1968.

There were also two intensive training sessions for qualified nurses interested in teaching in associate degree programs. A grant from W. K. Kellogg Foundation and one from U.S.P.H.S. supported these sessions.

Two human relations sessions for nursing service administrators were also conducted during this period, and a study of the educational needs of the registered nurse employed in nursing homes was conducted in four of the six New England States.

NECHEN has sponsored an Annual Meeting and an Annual Forum for each of five years which brought together nurse educators and nurse practitioners to discuss mutual issues related to the education of nurses.

With the resignation of the full-time Associate Director for Regional Nursing Program in 1968, NECHEN activities were maintained by the part-time service of nurse consultants.

Subsequently (December, 1968), the Board made the decision to undertake a thorough review of NECHEN and its relationship to NEBHE in order to determine the potential for regional activities in nursing education. There was some question by the NEBHE staff and the NECHEN membership as to the appropriateness of a program which was confined mainly to continuing education. A task force was appointed and a report written which included the "purpose", structures, and functions of NECHEN with recommendations for future activity. These recommendations included suggestions for broader programs such as 1) the development of an open-ended system of education, 2) sharing of faculty and clinical resources, and 3) upgrading the education of all nurses.

In January, 1970, when I assumed the position as Program Director for Nursing Education with the New England Board of Higher Education, attempts were made to initiate programatic activities as suggested by the Task Force Report and the NECHEN membership. The five interest groups of NECHEN (Associate Degree, Baccalaureate Degree, Graduate Degree, Research & Continuing Education) were reactivated and a series of Interest Group meetings were held to determine priorities.

During this period the Continuing Education Interest Group has had several preliminary planning meetings to begin discussions toward the development of a rational, organized plan to meet the continuing education needs of nursing in our six-state region. This group will devote itself to long-range planning and will not become involved in programming as in the past. Some of the issues currently under discussion include:

- the establishment of a definition of continuing education for nurses in New England,
- the identification of common learning needs and priorities within the region;

- the establishment of policies and/or guidelines with relation to academic credit or continuing education units, evaluation of program offerings, sequential learning, and continuing education for relicensure;
- the identification of faculty and financial resources;
- the inclusion of health agencies offering educational experiences for nurses;
- interdisciplinary *planning* for all health professionals.

This is an interested, highly motivated, and creative group which is eager and anxious to work cooperatively in developing a plan for our region. Their interest may be attested to the fact that many of the group are in attendance at this Conference.

The next meeting is scheduled for the weekend of November 7-8, at the University of New Hampshire, where I am sure plans will be accelerated in response to this excellent conference.

In summary, I would like to say that many benefits can be accrued through regional planning, both economic benefits and the sharing of faculty and resources.

The steps in the development of a regional plan are at times slow and arduous. In those areas of the country where there is an established mechanism such as the inter-state compacts, this appears to be the most logical mechanism to utilize. However, as demonstrated here today, cooperative planning between states can be accomplished without such an agency. MCPEN and the North Central State Regional Planning group are excellent examples of what may be done without the constraints of a formalized structure and I am sure will serve to stimulate the formation of other such groups.

Each section or region of the country has its unique characteristics and problems. Some programs are not duplicable but only through shared thoughts and ideas as we have here today at this conference can the various programs be tested out and evaluated for our various purposes.

REGIONAL PLANNING IN THE MIDWEST

Emily Tait
Project Director, Midwest Continuing Professional Education for Nurses
St. Louis, Missouri

The MCPEN group, representing twenty-six schools of nursing and eight state nurses' associations in an eight-state, midwest region, including Illinois, Iowa, Kansas, Kentucky, Missouri, Nebraska, Oklahoma, and South Dakota, was awarded a planning grant for continuing nursing education by the Bureau of Health Professions Education and Manpower, HEW, PHS, National Institutes of Health, from September of 1970 through August, 1971. Actually, regional planning was initiated from the date of the first meeting, October, 1967, and is continuing at present under a six-month contract from the Bureau of Health Manpower Education.

To date planning has been directed to short-term learning. However, it now seems obvious that the future will demand a broader and more inclusive definition which includes self-directed learning and recognition for continuing education. The MCPEN members have defined continuing nursing education as consisting of programs of courses not necessarily directed toward a degree.

Five *specific problems* confront those who are concerned with continuing professional education in the Midwest area, as in many others.

1. Nurses – like other health practitioners and patients - are scattered over the area in a multitude of settings including small cities, larger population centers, and extensive rural areas.
2. Nurses are a highly mobile group with frequent changes of position.
3. Relatively few institutions, schools of nursing, hospitals or agencies offer continuing education opportunities. In addition shortages of facilities and faculty inhibit attention to new areas of nursing to the extent desired.
4. Little cooperation exists among schools, states, institutions and agencies to promote quality continuing education to help meet the health needs of the region.
5. Only limited studies are available relative to continuing education needs which would assist in resolving some of the problems encountered in the region.

The *overall* goal of the planning was to improve the quality of

professional nursing service, education and leadership in the region by pointing the way toward improved continuing education opportunities. Long-term expectations of the planning process were to:

1. Increase interest and communication in continuing education on the part of schools, associations, departments of health, hospitals, health related agencies, and interested others.
2. Reduce duplication of efforts by providing a mechanism for the sharing of strengths.
3. Provide stimulation to seek higher education through successful experiences in continuing education and add to the quantity of nurse leadership to serve the region.
4. Serve as a model to other regions and health related groups.
5. Produce important feedback which would assist in the improvement of undergraduate nursing education.

During the funded year, MCPEN *planned* to:

1. Catalogue existing continuing nursing education activities in the region, identifying gaps in existing programs.
2. Devise a set of overall guidelines for regionwide continuing education activities.
3. Identify sources of funding for continuing education programs.
4. Prepare organization plans for MCPEN appropriate to (2) and (3), including the involvement of all appropriate bodies concerned with improving the professional competence of nurses.
5. Develop plans and guidelines for the continuation of the regional planning process.

At the completion of the planning year most of the expectations and planned activities were realized in entirety or in part; others were not expected to lend themselves to evaluation at this time and will show overtly only in the future. At this point in time the planning year shows these *outcomes:*

1. Existing activities were catalogued and gaps in existing programs were identified.
2. Guidelines for regionwide activities were devised.
3. Sources of funding for programs were identified.
4. Organizational guidelines were prepared and approved with revisions by members at the October 1, 1971 meeting.
5. Plans for the continuation of the regional planning process based on the data and experience of the planning year were developed by the Steering Committee.
6. Increasing interest was shown by schools of nursing, state associations, departments of health, hospitals and health related agencies by an increase in membership, response to

requests for assistance, requests for data, and mutual consultation concerning continuing education.

7. Regional communication was advanced mostly through a bi-monthly newsletter, site visits and interviews, and circulation of the instruments developed during the planning and previous years.
8. Increased attention was directed to the continuing education needs of those working in isolated situations and in rural areas.
9. Interest in research and innovative activities was increased.

The activities and instruments employed during planning can be seen on the following chart.

Further planning needs are recognized in many areas. It seemed that the single area important enough to be included as the major goal of the present contract period involved the carrying out of surveys to elicit information on local geographic areas. This information is necessary for planning in selected regions of the states as well as to allnw for as much implementation as possible in this period of time.

Another area for planning which must be mentioned as it springs up at every move, is the furtherance of a system for the measurement and recognition of individual participation in non-credit continuing education.

The data collected during the planning year substantiated the formation of specific *aims for the years ahead.*

The aims are to:

1. Support and encourage programs for nurses in the new technologies of nursing.
2. Promote the development of programs for the leadership groups which will strengthen and up-date the knowledge and skills relative to their roles.
3. Seek out and encourage research in continuing education activities which will aid in resolving the problems encountered in the MCPEN region.
4. Act as a clearing house for the identification of needs and new developments in knowledge and practice, communications, and the coordination of continuing education efforts in the MCPEN region.

Finally, an extremely important factor in planning in the MCPEN experience involved the *decision making process.* Our decisions were democratic and represented the thinking of the members. Information was continuously submitted to members, allowing opportunity for immediate response through the newsletter, special reports, and other circulations such as those listed in the REGIONAL PLANNING chart.

The similarity of the problems and needs throughout the eight states as disseminated to the MCPEN members helped them to listen, communicate, share and work together.

Midwest Continuing Professional Education
For Nurses
REGIONAL PLANNING
1970-71

Instruments and Activities	Purpose	Who Involved	Results
1. MCPEN Questionnaire	Aid in survey of needs and resources in continuing education.	State Nurse Assns. Universities and Colleges.	Identified priority in program and content needs. Identified regional needs and gaps. Assessed sources of funding. Identified expected role of MCPEN in regional activity in continuing education in nursing.
2. Semi-structured interviews of university programs in continuing education.	Acquire general information to aid in coordinating, planning, and evaluating programs. Improve communication.	Heads of university programs. MCPEN Planning Project Director.	Information circulated in summary form on Origin of programs. Definitions of continuing education. Program purposes and objectives. Administration of programs. Funding of programs. Recognized needs and priorities for programs. Gaps between current and desired program activities. Publicity and motivation for programs. Enrollment procedures. Enrollees. Credit or recognition for continuing education. Evaluation procedures. Plans for future. Faculty resources available regionally. Expectations for MCPEN activity in continuing education.

Instruments and Activities	Purpose	Who Involved	Results
3. State Surveys	Information for planning continuing education in the states and MCPEN region.	State Nurse Assn. MCPEN Staff.	Information circulated on Geography of State (Travel, etc.) Cultural trends. Economic resources. State and nurse population characteristics. State health problems. Location of higher education in state. Programs in nursing. Recommendations for continuing education in state.
4. MCPEN Regional Survey	Aid in extending information about the region. Serve as a guide for regional planning and implementation.	MCPEN Staff MCPEN members (State Nurse Assns., Universities and Colleges)	Information circulated on: Geography of region (Travel, etc.) Cultural trends in region. Economic resources of region. Regional population and nurse population characteristics. Regional health problems. Regional higher education resources for continuing education. Recommendations for region (Abstracted from State recommendations) Significant factors in regional planning and projected action.
5. Model for Program Organization	Guids for organization of an on-going, yearly, continuing education program in a defined area of a state or states.	MCPEN Staff Consultants.	Identified steps in procedure: Localization of area. Consultation with MCPEN staff and state planning group (if established). Planning and implementing team utilizing regional, state, and local resources. Implementation strategies. Hypothetical model utilizing this procedure, the MCPEN state and regional surveys, and many local resources.

Instruments and Activities	Purpose	Who Involved	Results
6. MCPEN REGIONAL NEWS	Communication	MCPEN members. National, regional and community health agencies, educators, and interested persons.	Circulated bi-monthly, five times a year. Interagency and interdisciplinary sharing of data and information
7. MCPEN Organization Guidelines	Provide MCPEN members with organization to promote the goals of MCPEN.	MCPEN members	Established and defined: purpose, goals, membership, officers, committees, and meeting protocol to facilitate the implementation of MCPEN goals.
8. Interviews with significant health related and/or educational organization heads.	Establish relationships for planning and implementation of continuing education programs for nurses	MCPEN staff. Individuals and groups in health related and/or educational organizations.	Establish communication with organization, individuals, and groups. Planned working relationships. Shared data and research findings. Provided for mutual consultation concerning continuing education activities.

NORTH CENTRAL STATES PLANNING PROJECT

Signe S. Cooper
Project Director
North Central States Planning Project
for Continuing Education in Nursing

The North Central States area is the region most recently organized, and since the project is fairly new, my comments will be brief. This is an 18-month planning project, which began July 1, 1971.

The North Central States region includes a five-state area: Michigan, Wisconsin, Minnesota, North Dakota, and Montana. Except for the latter state, the states in this area are not included in interstate compacts for higher education. In this regard, the North Central region is more like MCPEN than other regions. The purpose of the project is to promote regional planning and interstate cooperation in continuing education in nursing. It will include an extensive study of existing resources, determine educational gaps and areas of need, and identify problem areas in nursing practice and nursing service. After the study has been completed, recommendations will be made and a regional plan formulated.

To date, I have identified that these states have two things in common:

1. Lots of winter!
2. Large rural areas with scattered nurse population.

Both these factors influence continuing education. The comments made earlier today about the move toward specialization in nursing was of interest, for it is obvious that the small rural hospital requires nurse generalists, and probably will for a long time to come. The project is concerned about the nurse who has no easy access to continuing education opportunities; the learning needs for the nurse in the small hospital or the county nurse who works alone are in sharp contrast to nurses employed in large metropolitan hospitals with on-going inservice education programs. Much different approaches may be required to meet the learning needs of the former; some innovative approaches are being tried, and we will be identifying these in our study, on the assumption that they may have broad application to other areas.

Activities to date:

We have established an advisory board, and this board held its first meeting in August. The board includes two representatives from each state, and has representatives from one board of nursing, state nurses association, regional medical program, and non-nurse educator (Dr. Kreitlow).

We are now in the process of selecting representatives to serve on state task forces. In most instances we will plan to work with existing education or continuing education committees of state nurses' associations.

In the project we plan to survey nurses about their learning needs. This will probably be a questionnaire to a random sample of nurses, with interviews with selected nurses. We will also meet informally with certain groups of nurses.

We have been locating and reviewing surveys and studies that have been done. For example, in Montana a state-wide survey with interviews was done through the regional medical program; this survey attempted to identify continuing education needs as perceived by nurses.

One area of concern is correlation with related projects. Obviously we do not wish to duplicate the ANA survey on continuing education. In addition, the Michigan Nurses' Association has an on-going continuing education study. Mrs. Harriet Sattig, the director of that project, is on our advisory board.

As the regional planning project progresses, there are a number of questions that arise. Among these are, How do we use available resources for continuing education more effectively? How do we get information about resources out to nurses? How do we motivate nurses to use available resources?

The questions are appropriate to all regions, of course, but the answers will be different for each region, since the resources are different.

The concept of regionalization is an interesting one. It helps us work together more closely, assists in learning about developments in other places, encourages sharing of ideas and resources, forces us to think and plan more broadly. By this time next year we will be able to report progress along these lines in the North Central States.

REFERENCES ON CONTINUING EDUCATION IN NURSING

Conference Proceedings:

THE PROCEEDINGS BOOK OF THE NATIONAL CONFERENCE ON CONTINUING EDUCATION FOR NURSES. (1969). Order from the Health Sciences Division, Virginia Commonwealth University School of Nursing, Continuing Education Program, 1220 East Broad Street, Richmond, Virginia 23219. Price $2.50 per copy. Make check or money order payable to the Medical College of Virginia.

ENDS AND MEANS: The National Conference on Continuing Education in Nursing. (Notes and Essays on Education for Adults, No. 69). Syracuse University Press, Box 8, University Station, Syracuse, New York 13210. Price $2.50 per copy.

Monographs:

American Nurses' Association, AVENUES FOR CONTINUED LEARNING, The Association, 10 Columbus Circle, New York, New York 10019 (Price 50 cents).

The National Commission for the Study of Nursing and Nursing Education, CONTINUING EDUCATION IN NURSING: NECESSITY AND OPPORTUNITY, The Commission, 208 Westfall Road, Rochester, New York 14620 (Price 25 cents).

Periodical:

THE JOURNAL OF CONTINUING EDUCATION IN NURSING, (bi-monthly), Charles B. Slack, Inc., 6900 Grove Road, Thorofare, New Jersey 08086.

Book:

CONTINUING EDUCATION IN NURSING. Western Interstate Commission for Higher Education. P.O. Drawer P, Boulder, Colorado 80302. Price $2.00.

As a backdrop for the conference, and basis for discussion, issue papers were published in the *Journal of Continuing Education in*

Nursing. They are to be found in *JCEN* Vol. 2, No. 4, and *JCEN* Vol. 3, No. 5. pp. 7-12.

Authors were invited to serve as resource persons to the discussion group.

Group I. Continuing Education: Whose Responsibility?

Author and Resource Person

May Hornback, Associate Professor and Chairman, Department of Nursing, University of Wisconsin-Extension, Madison.

Discussion Leader: Lorane Kruse

Recorder: Annie Laurie Crawford

Group II. Determining Needs and Priorities

Author and Resource Person

Jean E. Schweer, Professor and Director of Continuing Education, Indiana University School of Nursing, Indianapolis, Indiana.

Discussion Leader: Janet Nusinoff

Recorder: Geraldine Skinner

Group III. The Expanded Role of the Nurse

Author and Resource Person

Kathrine Nuckolls, Associate Professor and Chairman, Pediatric Nursing Program, Yale University School of Nursing, New Haven, Connecticut.

Author and Resource Person

Patricia McNelly, Graduate student, University of Wisconsin-Madison

Discussion Leader: Elda Popiel

Recorder: Ruth McHenry

Group IV. Interprofessional Approaches to Continuing Education

Author and Resource Person

Margaret S. Neylan, Associate Professor and Director of Continuing Education, Health Sciences Centre, School of Nursing, University of British Columbia, Vancouver, B.C., Canada.

Discussion Leader: Nan Farrell

Recorders: Jody Wall

Barbara Gessner

Group V. Financial Support for Continuing Education

Author and Resource Person

Barbara Lee, Program Director, W. K. Kellogg Foundation, Battle Creek, Michigan.

Discussion Leader: Enid Goldberg

Recorder: Dorothy Blume

PLANNING COMMITTEE

Faculty of the Department of Nursing, the University of Wisconsin Extension:

Shirley Adams, R.N., Specialist
Signe S. Cooper, R.N., Professor of Nursing
Barbara Gessner, R. N., Specialist
May Hornback, R.N., Ph.D., Chairman and Associate Professor of Nursing
Dorothy Hutchison, R.N., Associate Professor of Nursing
Ruth Lutze, R.N., Specialist
Florence E. May, R.N., Associate Chairman and Assistant Professor of Nursing
Julianne Murphy, R.N., Specialist
Anne Niles, R.N., Specialist
Norma Lang, R.N., Nursing Coordinator, Wisconsin Regional Medical Program

NATIONAL CONFERENCE ON CONTINUING EDUCATION IN NURSING
October 18-22, 1971

ROSTER OF PARTICIPANTS

ADAMS, RUTH C.
Associate Professor and Director
Continuing Education in Nursing
School of Nursing
University of Missouri Medical Center
Columbia, Mo. 65201

**ADAMS, MRS. SHIRLEY
Nursing Specialist
Department of Nursing
University of Wisconsin - Extension
610 Langdon St.
Madison, Wis. 53706

ALLEN, MRS. NANCY JEAN
Acting Nurse Coordinator
Central New York RMP
B-16, Apt. 16
New Slocum Heights
Syracuse, N.Y. 13210

ANDERSON, MRS. DIANN
Assistant Professor, School of Nursing
State University of New York at Buffalo
267 Niagara Falls Blvd.
Buffalo, N.Y. 14226

ARGONDIZZO, NINA T.
Assistant to Dean for Continuing Education
Cornell University – New York Hospital
School of Nursing
445 East 68th Street
New York, N.Y. 10021

ASHTON, BEVERLY
College of Nurses
Toronto
Ontario, Canada
49 St. Claire Ave. West
Apt. 506
Toronto 7, Ontario, Canada

BARNES, RUBY GILBERT
Professor, Director of Continuing
Education in Nursing
School of Nursing
East Carolina University
Apt. 46, University Townhouse
Greenville, N.C. 27834

BEHNKE, HELEN
Consultant for Nursing Publications
Springer Publishing Company
New York, New York
1 West 67th St.
New York, N.Y. 10023

* BELCHER, HELEN C.
Director, Nursing Education Project
Southern Regional Education Board
130 Sixth St., N.W.
Atlanta, Georgia 30313

*BLOCKSTEIN, WILLIAM L.
Professor and Chairman
Health Sciences Unit
University of Wisconsin-Extension
610 Langdon Street
Madison, Wisconsin 53706

* Faculty Program Participant
** Faculty Program Participant, and Member, Conference Planning Committee

BOLTE, IRMA M.
Director of Continuing Education
University of Kentucky
College of Nursing
Apt. 3B
2000 Cambridge Drive
Lexington, Ky. 40504

BOOTH, AUDREY
Director, Division of Professional Services
North Carolina RMP and Assistant Professor,
University of North Carolina School of Nursing
Rt. 7, Box 254
Durham, N.C. 27707

BRITTINGHAM, THELMA
Assistant Professor-Nursing
University of Evansville
2058 East Gum
Evansville, Ind. 47714

BROWN, DR. BARBARA J.
Chairman, Department of Nursing
Alverno College
3401 South 39th Street
Milwaukee, Wis. 53215

BRUNDAGE, MRS. DOROTHY
Assistant Professor
Duke University School of Nursing
Rt. 2, Box 258
Mebane, N.C. 27302

* BLUME, DOROTHY
Director of Continuing Education
The University of Texas
Nursing School (System-Wide)
School of Nursing
University of Texas
Austin, Texas 78712

BUFFINGTON, MRS. DOROTHY D.
Associate Professor and
Associate Project Director
Medical College of Georgia
School of Nursing
126 West Trinity Place
Decatur, Ga. 30030

BUNNELL, MARGARET
Director, Continuing Education
Program for Nurses
Rutgers University
The State University of New Jersey
416 Maple Place
Cranford, N.J. 07016

* CARROLL, MAURA C.
Assistant Clinical Professor and
Chairman, Continuing Education
University of California School of
Nursing, San Francisco
1343 3rd Ave.
San Francisco, Cal. 94122

CHASE, MRS. BEATRICE
Chairman, Department of Nursing
Memorial Hospital for Cancer
and Allied Diseases
315 West 57th St., Apt. 4G
New York, N.Y. 10019

CHASE, DR. SUE
Professor and Director
Continuing Education Program
School of Nursing
University of North Carolina
712 William Circle
Chapel Hill, N.C. 27514

CHUSID, MRS. ANITA
Instructor
Continuing Education in Nursing
New York University
Four, Washington Square Village
New York, N.Y. 10012

** COOPER, MRS. SIGNE S.
Professor of Nursing, University of Wisconsin-Extension and University of Wisconsin-Madison
Project Director, North Central States Planning Project
610 Langdon St.
Madison, Wis. 53706

CRAREY, FRANCES
Director, Division of Continuing Education
Health and Hospital Commission
Cook County
Chicago, Illinois
1900 W. Polk St.
Chicago, Ill. 60612

* CRAWFORD, ANNIE LAURIE
Head, Nursing Section,
Mid-South Regional Medical Program
and Assistant Professor
Psychiatric Nursing
Vanderbilt University School of Nursing
1100 Baker Building
110 21st. Ave. S.
Nashville, Tenn. 37203

DAURIA, ANNE M.
Associate Professor, Continuing Education Department
School of Nursing
Medical College of Virginia
Virginia Commonwealth University
Richmond, Va. 23200

DECOLONGON, CARMEN O.
Assistant Director
Division of Inservice
Cook County School of Nursing
1900 West Polk Street
Chicago, Ill. 60612

DINEEN, MARY A.
Director, Department of Baccalaureate and Higher Degree Programs
National League for Nursing
10 Columbus Circle
New York, N.Y. 10019

DITCHFIELD, ALTA
Director, Continuing Education Program in Nursing
Medical College of Georgia
School of Nursing
3280 Georgian Woods Circle
Decatur, Ga. 30034

DUBRULE, MRS. MARION D.
Associate Professor and Chairman
Continuing Education
Department of Nursing
St. Anselon's College
Ipswich Road
West Boxford, Mass. 01885

DULEY, MRS. ANNA LEILA
Director, Continuing Education
School of Nursing
Capital University
2876 Atwood Terrace, Apt. B
Columbus, Ohio 43224

FABER, HILKE
Assistant Director
Continuing Education Planning
Washington/Alaska RMP
1589 Alki S.W.
Seattle, Wash. 98116

FANCHER, JOANNA E.
Assistant Professor, Continuing Education Project Staff
University of Washington
No. 302
3731 University Way, N.E.
Seattle, Wash. 98195

* FARRELL, HONORA K.
Assistant Professor and Director,
Continuing Education
Adelphi University
Garden City
Long Island, N.Y. 11530

FENNESSY, CECELIA
Assistant Dean for Continuing Education
University of Illinois at the
Medical Center
College of Nursing
8012 South Albany
Chicago, Ill. 60652

FRESHMAN, DONNA
Coordinator, Continuing Education
for Nurses
Idaho State University
Box 239
Idaho State University
Pocatello, Idaho 83201

FORNI, PATRICIA BROWN
Project Director, MCPEN
St. Louis University
1401 South Grand
St. Louis, Mo. 63104

** GESSNER, BARBARA
Nursing Specialist
Department of Nursing
University of Wisconsin-Extension
1019 S. Knowles Ave.
New Richmond, Wis. 54017

* GOLDBERG, DR. ENID
Assistant Director, Nursing and
Allied Health, Western Pennsylvania
Regional Medical Program and
Director, Continuing Education
University of Pittsburgh School of
Nursing
3530 Forbes Ave.
Pittsburgh, Pa. 15213

GRIFFITHS, ESTHER M.
Assistant, Inservice Education
University of Michigan
Medical Center
1619 Pontiac
Ann Arbor, Mich. 48105

* GROGAN, PAUL
Professor, Engineering
University of Wisconsin-Extension
432 North Lake Street
Madison, Wisconsin 53706

* GWALTNEY, BETTY H.
Associate Professor of Nursing and
Director of Continuing Education
School of Nursing
Health Services Division
Virginia Commonwealth University
Medical College of Virginia
Richmond, Va. 23219

HARTLEY, NANCY
Specialist, Health Related Program
St. Petersburg Junior College
6875 Pinellas Point Drive
St. Petersburg, Florida 33712

HENSLEY, BONNIE K.
Assistant Professor, Continuing
Education
School of Nursing
University of North Carolina-Chapel Hill
3237 Pickett Road
Durham, N.C. 27514

** HESTAD, MRS. HELENE
Nursing Specialist, University of
Wisconsin-Extension, and
Assistant Project Director, North
Central States Planning Project
610 Langdon St.
Madison, Wis. 53706

HIGBIE, MRS. VIRGINIA
Assistant Professor of Nursing
University of New Hampshire
63 Edgewood Road
Durham, N.H. 03824

* HILL, DR. MARY SNYDER
Associate Director, Nursing Education
Branch, Division of Nursing
Bureau of Manpower Education
Dept. of Health, Education, and Welfare
National Institutes of Health
Bethesda, Md. 20014

HOFF, MRS. PATRICIA SHINE
Director of Nursing Affairs
Regional Medical Program of
Western New York
176 South Union Road
Williamsville, N.Y. 14221

** HORNBACK, DR. MAY S.
Chairman, Department of Nursing
University of Wisconsin-Extension
610 Langdon St.
Madison, Wis. 53706

HORVITZ, MRS. IDA
Assistant Professor, Director of
Continuing Education
Procter Hall
College of Nursing and Health
University of Cincinnati
Cincinnati, Ohio 45219

HORSWILL, KAY
Assistant Nursing Coordinator
Wisconsin Regional Medical Program and
University of Wisconsin-Madison
School of Nursing
3803 Monona Drive
Madison, Wis. 53714

HULL, PEGGY K.
Director, Education and Training
Ohio State University Hospitals
410 West 10th Avenue
Columbus, Ohio 43210

** HUTCHISON, MRS. DOROTHY J.
Associate Professor
Department of Nursing
University of Wisconsin-Extension
705 Viebahn St.
Manitowoc, Wis. 54220

JONES, ELIZABETH
Assistant Professor-Continuing Education
University of Texas
Nursing School (System Wide)
214 Archway
Austin, Texas 78712

JONESON, CAROLYN E.
Associate Chief, Nursing Service
for Education
Veterans' Administration Hospital
3804 Simms S.E.
Albuquerque, N.M. 81108

KEEFE, HELEN P.
Project Coordinator
Florida Regional Medical Program
3995 62nd Street North
St. Petersburg, Fla. 33709

KELLER, MARGARET
Nurse Education Coordinator
North Carolina Comprehensive
Stroke Program
C–5 Twin Castle
Beach Street and Grove Park Avenue
Winston-Salem, N.C. 27292

KELLY, DOROTHY
Editor
Supervisor Nurse
S–N Publications, Inc.
18 South Michigan Avenue
Chicago, Ill. 60603

KEUP, SISTER MICHALITA
Mental Health Coordinator
Alverno College
3401 South 39th Street
Milwaukee, Wis. 53215

KNOTT, SANDRA P.
Nurse Coordinator
Northeast Ohio Regional Medical Program
10525 Carnegie Avenue
Cleveland, Ohio 44106

* KREITLOW, BURTON W.
Professor
Educational Policy Studies
Agricultural and Extension Education
University of Wisconsin-Extension
1815 University Avenue
Madison, Wisconsin 53706

KRUSE, LORANE
Associate Professor and
Assistant Director, Continuing Education
Ohio State University
1585 Neil Ave.
Columbus, Ohio 43210

LAMBERT, MRS. LINDA
Director, Continuing Education
University of Arkansas
School of Nursing
11417 Birchwood Drive
Little Rock, Ark. 72205

** LANG, MRS. NORMA
Nursing Coordinator, Wisconsin
Regional Medical Program, and
Assistant Professor
University of Wisconsin-Milwaukee
School of Nursing
110 East Wisconsin Ave.
Milwaukee, Wis. 53202

* LARSON, CAROL M.
Acting Head, Allied Health Section,
Continuing Education and Training
Branch
Regional Medical Programs Service
Regional Medical Program Service
Rockville, Md. 20852

* LEE, BARBARA
Program Director W.K.
Kellogg Foundation
400 North Ave.
Battle Creek, Mich. 49016

LENDLE, JANET M.
Assistant Professor
College of Nursing
Arizona State University
317-C
6721 East McDowell
Scottsdale, Ariz. 85251

LOUCKS, PHYLLIS M.
Director, Continuing Education
and University Hospital
Nursing Projects Coordinator
University of Alabama in Birmingham
1919 Seventh Ave., South
Birmingham, Ala. 35233

** LUTZE, MRS. RUTH
Nursing Specialist
Department of Nursing
University of Wisconsin-Extension
610 Langdon St.
Madison, Wis. 53706

LYNCH, LILLIAN
Associate Professor
College of Nursing
University of Arizona
Tucson, Arizona 85724

** MAY, FLORENCE E.
Assistant Professor and
Associate Chairman
Department of Nursing
University of Wisconsin-Extension
600 W. Kilbourn Ave.
Milwaukee, Wis. 53203

McCARTY, GEORGIA
Northwest Texas Hospital
P.O. Box 1110
Amarillo, Texas 79105

McCLELLAN, MARILYN G.
Assistant Director, Nursing Service
for Staff Development
University of Rochester Medical Center
9 Cottonwood Lane
Pittsford, N.Y. 14534

McGILL, CLO
Assistant Professor
University of Texas Nursing School
at San Antonio
7703 Floyd Curl Drive
San Antonio, Texas 78229

* McHENRY, MRS. RUTH
Chairman, Department of Nursing
Wilkes College
Wilkes-Barre, Pa. 18700

* McNALLY, SISTER JEANNE
Director, Special Project in
Continuing Education
American Nurses' Association
10 Columbus Circle
New York, N.Y. 10019

*McNELLY, MRS. PATRICIA
Graduate Student
University of Wisconsin-Madison
2306 Calypso Rd., Madison, Wis. 53704

MEADE, MARY ELLEN
Assistant Professor, Nursing
Indiana University Northwest
607 Driftwood Drive
Lowell, Indiana 46356

MORRIS, ENA M.
Associate Editor
American Journal of Nursing
10 Columbus Circle
New York, N.Y. 10019

MOSLEY, MRS. LAURA C.
Assistant Professor of Nursing
Berea College
Box 380
Berea, Ky. 40403

** MURPHY, MRS. JULIANNE
Nursing Specialist
Department of Nursing
University of Wisconsin-Extension
Fox Valley Campus
Midway Road
Menasha, Wis. 54952

MURTAUGH, CAROL A.
Chairman, Nursing
Somerset County College
72 Center Street
Clinton, N.J. 08809

NEHREN, JEANETTE G.
Chief, Nursing Section
Continuing Education Branch
National Institute of Mental Health
No. 1514 South
4515 Willard Avenue
Chevy Chase, Md. 20015

NELSON, JOY B.
Head, Department of Continuing
Education
College of Nursing
South Dakota State University
Brookings, S.D. 57006

* NEYLAN, MRS. MARGARET S.
Associate Professor and Director
of Continuing Education in Nursing
University of British Columbia
School of Nursing
Health Sciences Centre
University of British Columbia
Vancouver 8, B.C., Canada

** NILES, MRS. ANNE G.
Nursing Specialist
Department of Nursing
University of Wisconsin-Extension
610 Langdon St.
Madison, Wis. 53706

* NUCKOLLS, DR. KATHERINE
Associate Professor and Chairman
Pediatric Nursing Program
Yale University School of Nursing
38 South St.
New Haven, Conn. 46510

** NUSINOFF, MRS. JANET
Assistant Professor Emeritus
Department of Nursing
University of Wisconsin-Extension
Route 2, Box 326
Winneconne, Wis. 54986

* OLSON, EDITH V.
Associate Professor of Nursing
University of Rochester, and
Nursing Coordinator
Rochester Regional Medical Program
260 Crittenden Blvd.
Rochester, N.Y. 14620

PAFUNDI, MARIE
Research Assistant
Health Manpower Project
Syracuse University
107 Roney Lane
Syracuse, N.Y. 13210

PERRY, PATRICIA C.
Acting Educational Director
Nursing Service
State University Hospital
Upstate Medical Center
37 Candlewood Gardens
Baldwinsville, N.Y. 13027

PIKE, CORA E.
Nurse Director
Maine's Regional Medical Program
295 Water Street
Augusta, Maine 04330

* POPIEL, MRS. ELDA
Professor and Assistant Dean
University of Colorado
School of Nursing
Continuing Education Services
4200 East 9th Ave
Denver, Colo. 80220

PORTER, PHYLLIS E.
Assistant Professor
University of Bridgeport
219 Adley Road
Fairfield, Conn. 06430

PRICE, ALICE
ROCOM
Montclair, New Jersey
Five Gardiner Place
Montclair, New Jersey

RACINE, BARBARA
Assistant Professor
University of Alberta
702-8708 106th Street
Edmonton, Alberta, Canada

REGAN, MARY H.
Assistant Director of Nursing
(Staff Education)
Massachusetts General Hospital
Boston, Mass.
24 Sterling Street
West Somerville, Mass. 02144

REYNOLDS, ALICE
Chairman, Committee on Continuing Education
School of Nursing
Syracuse University
103 Waverly Avenue
Syracuse, N.Y. 13210

ROBINSON, MRS. STELLA P.
Nurse Coordinator
Continuing Education
Charles Drew Postgraduate Medical School
1635 East 103 Street
Los Angeles, Cal. 90002

ROEHM, DR. MARYANNE E.
Director, Continuing Nursing Education
Indiana State University
R.R. 22, Box 390A
Terre Haute, Ind. 47802

* RYAN, EILEEN
Program Director for Continuing Education
New England Board of Higher Education
20 Walnut Street
Wellesley, Mass. 02181

RYKKEN, MARJORIE
Associate Professor
University of North Dakota
College of Nursing
3719 University Avenue
Grand Forks, N.D. 58201

SATTIG, MRS. HARRIETT H.
Project Director, Continuing Education
Michigan Nurses' Association
120 Spartan Avenue
East Lansing, Mich. 48823

SEPLAVY, LYNDA
Nurse Clinician
Long Island Jewish Medical Center
New Hyde Park, New York

* SCHWEER, JEAN E.
Professor and Director of Continuing Education
Indiana University School of Nursing
110 W. Michigan Ave.
Indianapolis, Minn. 46200

* SHANNON, THEODORE J.
Professor of Education
University of Wisconsin-Extension
610 Langdon Street
Madison, Wisconsin 53706

SIEGEL, MRS. FANNY F.
Director, Continuing Education Program
for Psychiatric Nurses
Teachers College
Columbia University
Institute for Nursing Research
New York, N.Y. 10027

SIMMONS, SANDRA
Director, Continuing Education
Michigan State University
School of Nursing
2294 Main Street, Apt. 4
Holt, Mich. 48842

* SKINNER, GERALDINE
Director, Continuing Education in
Nursing
University of Michigan
School of Nursing
Room G1107, Towsley Bldg.
Ann Arbor, Mich. 48104

SLACK, GEARLEAN M.
Director Continuing Education
West Virginia University
630 Vista Place
Morgantown, W. Va. 26502

SLOAN, MARGARET R.
Assistant Professor, Public Health
Nursing
School of Public Health
University of Minnesota
1325 Mayo
Minneapolis, Minn. 55455

* SPECTOR, MRS. AUDREY F.
Coordinator of Continuing Education
American Nurses' Association
10 Columbus Circle
New York, N.Y. 10019

STAFFORD, MARGARET
Project Director, Continuing Education
Video Nursing, Inc.
2834 Central Street
Evanston, Ill. 60201

SCHWAB, THERESE
Field Representative and Nurse
Consultant
South Dakota Regional Medical Program
602-17th Ave., S.W.
Aberdeen, S.D. 57401

* SQUAIRES, MRS. G. MARJORIE
Coordinator-Administrator,
Continuing Education in Nursing
University of California-Extension
10995 Le Conte Ave.
Los Angeles, Calif. 90024

STOBO, ELIZABETH C.
Visiting Professor
University of South Carolina
1520 Senate Street
Columbia, S.C. 29201

* TAIT, MRS. EMILY
Director, Continuing Nursing Education
St. Louis University
1401 South Grand Blvd.
St. Louis, Mo. 63104

TAPPER, MILDRED
Coordinator, Continuing Education
Boston University
School of Nursing
635 Commonwealth Avenue
Boston, Mass. 02215

TAYLOR, BEVERLY A.
Director of Staff Development
Medical College of Virginia Hospitals
No. 103
7107 Coachman Lane
Richmond, Va. 23228

TAYRIEN, DOROTHY P.
Assistant Professor of Nursing
in Continuing Education
University of South Carolina
80 Barre
Charleston, S.C. 29401

THELEN, ETHELDA S.
Coordinator, WICHE MS/RMP Project
Continuing Education for Nursing
Orvis School of Nursing
University of Nevada
1375 Carlin Street
Reno, Nev. 89503

TISON, MRS. DIANA J.
Inservice Chairman
Incarnate Word College
Rt. 10, Box 105 T
San Antonio, Texas 78216

TOBIN, HELEN M.
Director, Centralized Staff Development
University Hospitals of Cleveland
Cleveland, Ohio
3055 Yorkshire Road
Cleveland Heights, Ohio 44118

VAHLDIECK, ROSEMARY
Education Consultant, Public Health
Nursing
Wisconsin Division of Health
1 West Wilson Street
Madison, Wis. 53701

VERNA, MRS. ALICE E.
Assistant Professor and Director
Continuing Education
University of Connecticut
School of Nursing
96 Cemetery Road-Union
Stafford Springs, Conn. 06076

* WALL, MRS. JOANNE
Nursing Specialist,
Department of Nursing
University of Wisconsin-Extension, and
Nursing Inservice Coordinator
St. Mary's Hospital Medical Center
Madison, Wis. 53705

WARD, ETHEL R.
Coordinating Instructor
Intensive Care Services
Johns Hopkins Hospital
1512 Forest Park Avenue
Baltimore, Md. 21207

WATKINS, JOHN M.
President
Contemporary Publishing Associates
44 Richardson Street
Billerica, Mass. 01821

WEAVER, MRS. MABEL E.
Associate Professor
Sacramento State College
4648 Oxbow Drive
Sacramento, Calif. 95825

WHITAKER, MRS. JUDITH
Associate Professor, Continuing
Education
School of Nursing
University of Vermont
425 Dorest Street
South Burlington, Vt. 05401

WILLIAMS, SISTER ALOYSIUS
Continuing Education
University of Texas
Nursing School (System-Wide)
1101 North Campbell Street
El Paso, Texas 79902

ZEMLICKA, PEARL
Assistant Professor, College of Nursing
University of Iowa
College of Nursing
Iowa City, Iowa 52240