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ABSTRACT

The papers presented at the meeting describe new directions in higher education and a variety of innovations in nursing education both nationally and in the southern region. Included also are annual reports of studies and surveys about nursing in the south. Among the topics covered are: an external degree program; modes of student progression; curriculum developments; clinical performance examination; the associate degree; the bachelor's degree; graduate study; new deans and directors; and women and nursing. (MSE)

NON-TRADITIONAL DEVELOPMENTS IN NURSING EDUCATION

Proceedings of the 24th and 25th meetings of the

Council on Collegiate Education for Nursing

Southern Regional Education Board

SOUTHERN REGIONAL EDUCATION BOARD

The Southern Regional Education Board (SREB), formed in 1948 at the direction of the Southern Governors' Conference, was the first interstate compact for higher education in the United States. The Board directs regional planning and action in higher education; its central concern is the optimum use of higher education resources of the Southern region.

SREB staff members work with state government officials and representatives of academic institutions and other agencies to: research and report the needs, issues, and developments in higher education; conduct cooperative and institutional programs to improve all levels and types of programs in higher education; provide consulting services to the region; and serve as fiscal and administrative agent in interstate arrangements for regional educational services and institutions.

The Board, which has no power of enforcement, depends entirely on the interest and commitment of cooperating states and institutions. Its basic operating costs are provided by member states, while program activity is financed for the most part by foundations and federal agencies. Member states are Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

COUNCIL ON COLLEGIATE EDUCATION FOR NURSING

Since its inception in 1948, the Southern Regional Education Board (SREB) has been involved in regional planning for nursing education. In that year, a Board Commission on Education in the health professions was organized; a key subcommittee on nursing made recommendations for regional planning in nursing education. This subcommittee was followed in 1951 by the Committee on Nursing Education, which identified the need for "adequately trained instructors, supervisors, and administrators" as the South's most significant priority in nursing. The Committee stipulated that the master's degree was essential preparation for such positions. At that time there were no graduate programs in nursing in the region; first attention then, was to the development of master's programs and six were established by the mid-Fifties. Regional attention was next directed toward strengthening and expanding nursing education programs at all levels. The Council on Collegiate Education for Nursing was formed in 1962 as the major mechanism for working toward these goals.

Over the next decade, supported by two successive five-year grants from the W. K. Kellogg Foundation to SREB, the Council provided a forum for testing new ideas and at the same time was the means for planning and implementing a wide range of activities, including statewide planning, curriculum theory and development, and inservice training for administrators and faculty.

A three year grant (1972-75) by the Division of Nursing, DHEW, enabled SREB and the Council to assess the need for continued regional planning, and to explore and develop plans for a more permanent arrangement. In 1975, as an outgrowth of three years study, the Council became a self-supporting membership organization in affiliation with SREB. Council membership includes deans and directors of associate degree, baccalaureate, graduate and continuing education programs for nurses in more than 200 colleges and universities in the South. The Council, in cooperation with SREB, provides a forum for sharing information and promoting communication among all types of collegiate nursing education programs, conducts studies and publishes reports, plans and conducts regional activities to stimulate research in nursing within colleges and universities, and engages in other action to strengthen nursing and nursing education in the South.

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Southern Regional Education Board
130 Sixth Street, N.W.
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Foreword

This publication about non-traditional developments in nursing education includes papers presented at the 25th meeting of the Council on Collegiate Education for Nursing, spring 1976. The papers describe new directions in higher education and a variety of innovations in nursing education nationally and in the Southern region.

Because this single publication serves as an account of the Council's activities for the year 1975-76, it also includes one paper presented at the 24th Council meeting, which focused on the impact of nursing on the changing status of women. Included also are annual reports of studies and surveys about nursing education in the South.

The Council's activities in the period covered in this publication were conducted by the Council's Executive Committee: Marie L. O'Koren, Chairman; Georgeen H. DeChows, Vice-Chairman; members Shirley Lee, Eloise R. Lewis, Gwendoline R. MacDonald, Glendola Nash, and Robert W. Vogler.

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NEW DIRECTIONS IN HIGHER EDUCATION

William R. O'Connell, Jr.
Project Director
Undergraduate Education Reform
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We have come to a significant crossroads in the history of higher education. We now are in the midst of a struggle to figure out exactly where we are and which way we go from here. The most recent past has been a period of enormous growth for higher education which has brought on the current era of concern for equality -- equality of opportunity, of education, of outcomes -- which has caused great confusion and the need for many to seek some definition of identity. What is happening now, however, may give some clues as to where things may be moving in the future.

Today I would like to talk with you about some of the things we have observed over the past 3 years now of work in the SREB, Carnegie-financed project in Undergraduate Education Reform. First, I'd like to mention a few of the factors influencing current directions, both from outside the institutions and from within, and then share with you some observations about the current themes of reform we have identified.

Some of the social and economic forces outside the institution influencing the consideration of new directions include population shifts, economic and accountability factors and the public lack of faith in social institutions.

Population

Available census data show that the birth rate in the United States is declining drastically, now reaching the zero polulation growth rate. The number of live births in 1960 totaled 4,258,000 while the number had dropped to 3,280,000 in 1972. This, of course, means that there will be fewer of the traditional college-aged students in the future. In addition there is evidence that fewer 18-to 21-year-olds have been choosing to go to college in the last few years. However, the current year's enrollments did increase in some places in certain types of institutions, but not necessarily in the 18-to-21-year-old group. Stephen Dresch of Yale University has developed a mathematical model through which he makes very specific estimates of future higher education enrollments. He predicts that between 1980 and 1990, undergraduate enrollment will shrink by 46 percent. He says:

If that view of the future is correct, the growth of enrollment in the 1970's, the big decline in the 1980's, and a further, though slower, decline in the 1990's add up to this: Colleges and universities will have only two-thirds as many students in the year 2000 as they had in 1970.[1]

Financial and Accountability Factors

There are several pressures on higher education today resulting from the current economic situation. The economy itself poses problems for institutional operation with the inflation of fixed costs, such as utilities, heating or cooling, supplies, insurance, and support wages, in addition to the need to improve salaries for all types of personnel. Taxpayers are becoming more concerned about increasing costs that imply the need for new taxes; and higher education now has more competition for public funds as social needs are being met more fully. Today higher education must be viewed by federal and state appropriations bodies in relation to the needs for aid to cities, mass transportation, crime prevention, health care and a number of others which you can name. At the same time there is expressed concern about the way institutions are managed and there are new pressures for higher education to show more effective use of its resources.

Lack of Faith in Social Institutions

In his president's report to the Carnegie Corporation a couple of months ago, Alan Pifer wrote about the crisis of confidence facing higher education. In his statement, "Higher Education in the Nation's Consciousness," he said,

> Higher education has become the object of widespread skepticism. After an era of unprecedented growth, affluence and exalted status in the 1960's, it stands very much on the defensive. No longer is it assured of the unquestioning public regard and financial support it once enjoyed. Increasingly, doubts are being voiced as to whether its benefits are not outweighed by its costs and burdens.[2]

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[1] "Will Enrollments Nosedive?", The Chronicle of Higher Education, February 10, 1975, p. 7.

[2] Alan Pifer, "Higher Education in the Nation's Consciousness," 1975 Annual Report, Carnegie Corporation of New York (New York), p.3.

If it is any comfort to you this phenomenon is not altogether new.

A classic example of incompatibility in content, as related to both the learning goals and learning styles of the students, is witnessed in the following quotation from a 1744 document. It was written by the Indians of the Six Nations at Lancaster, Pennsylvania, who were invited to send students to William and Mary College in Virginia. Their reply has been preserved for us by Benjamin Franklin:

> We know that you highly esteem the kind of learning taught in those Colleges, and that the Maintenance of our young Men, while with you, would be very expensive to you. We are convinced, that you mean to do us Good by your Proposal; and we thank you heartily. But you, who are wise must know that different Nations have different Conceptions of things and you will therefore not take it amiss, if our Ideas of this kind of Education happen not to be the same as yours. We have had some Experience of it. Several of our young People were formerly brought up at the Colleges of the Northern Provinces: They were instructed in all your Sciences, but, when they came back to us, they were bad Runners, ignorant of every means of living in the woods ... neither fit for Hunters, Warriors, nor Counselors, they were totally good for nothing.
>
> We are, however, not the less oblig'd by your kind Offer, tho' we decline accepting it; and, to show our grateful Sense of it, if the Gentlemen of Virginia will send us a Dozen of their Sons; we will take care of their Education, instruct them in all we know, and make Men of them.[3]

Contributing to the current lack of faith in social institutions are 1) relatively high unemployment, even for college graduates, 2) the declining economic return we have come to expect from a college education; 3) evidence that graduates may have to take jobs for which they are over-qualified or not trained. Manpower needs and cyclic changes affect this somewhat, but these factors still pose a problem.

Recent court cases and governmental policies forbidding discrimination against persons without degrees or special credentials have contributed also to changing attitudes toward collegiate education.

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[3]William H. Bergquist and Steven R. Phillips, A Handbook for Faculty Development (Washington, D.C.: The Council for the Advancement of Small Colleges, 1975), p. 16.

The Supreme Court case of Griggs vs. Duke Power Co.[4] is frequently cited to illustrate this situation. In that case the court ruled that the use of special tests or other mechanisms as controlling forces in selection for jobs is forbidden unless it can be shown that they relate directly to job skills required. This has implications for those positions that we normally consider requiring a college degree. Last year, in a case relating to the Arlington County, Virginia police force, the U.S. Equal Employment Opportunity Commission ruled that a college degree could not be used as the basis for higher pay since it discriminated against those unable to gain that credential. Perhaps if there were some evidence that a degree made a difference in the competence of the individual, the case might have been different.

College has been sold on its social value and the promise of higher incomes and social status. However, recently it has not delivered on those promises. To many, it is no longer the magic answer. This is cause for concern and the need for clearer definitions of goals and purposes.

The forces for change within the field of higher education itself include a new diversity of students, mobility -- greater student mobility and less professional mobility -- and national group pressures.

Student Diversity

Several observers of American higher education have identified three historical eras of development: first, the era of elitism; then, the meritocratic period; and now, the egalitarian era. After a long beginning period in which higher education served an elite clientele, the period over the past few recent decades has been termed the meritocratic era.

The meritocratic era was characterized by selective admissions and an emphasis on "academic excellence." The emphasis then was on selecting those who could fit in and be "successful." A careful look behind academic excellence of that period shows that its production may have been more the work of the admissions office than the teaching faculty. In other words, if you start with quality, you end with quality.

The building expansion of the 60's along with concepts of mass higher education and open admissions has moved us into an egalitarian era and left us with a dilemma. The task now is not merely selecting

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[4] Griggs vs. Duke Power Co., 401 U.S. 424 (1971)

those who will be successful and trying not to get in their way, but the task is to help all who can succeed -- a totally new challenge!

The new diversity includes students less well-prepared academically, students from other cultural groups and a dramatic increase in adults (encouraged by learning society concepts -- industry, clubs, unions, etc.). This diversity has stimulated many new approaches for reaching "new clienteles." These approaches are used sometimes to get them in and increase numbers, but hopefully more often to better serve those who come.

To some, the problem of the egalitarian approach to education is how to accomplish the same goals as during previous eras. In other words, equality of opportunity should lead to equality of outcome. Somehow all learners should end up with the same achievements and rewards, and academic accomplishments of all others. As one way of doing this, some institutions have created remediation programs with the idea that if these students can be made ready for college, then business can go on as usual after that. In other words, change those individuals into traditional college students.

Remediation programs work for some students, particularly those who are already pretty close to the traditional mold to start with. For many, these programs do not work and are not as successful as we would hope. Another approach to dealing with these individual differences is to accept the differences for what they are. This approach permits individual differences upon entry and then attempts to devise processes that will allow all to succeed in meeting standards of the college.

Two major individual differences among students are being accepted today and dealt with -- differences in individual learning styles and, especially, differences in the amount of time required for learning. Throughout this period of ferment, there is a growing belief that all can learn and there is emerging evidence from research to confirm it.

Devotees of Benjamin Bloom's mastery learning theory will remember his point that, given enough time, 70 to 80 percent of students can achieve at the mastery level roughly the traditional A or B level. This point assumes flexible teaching and learning techniques.

Gil Sherman, director of the Georgetown Center for Personalized Instruction stated in an SREB workshop that, "If there is one law of education, it probably is that we cannot hold time and quality constant. If we opt for quality, we must allow time to vary."

Mobility

The second force within higher education exerting pressure for new

directions is mobility. The mobility of the American population is one cause of the greater diversity of students, especially older adults, in higher education. More important, however, is the current reduction of the mobility of faculty. We are in a period of no-growth, which means coping with what you have. Improvements or changes must be made by remodeling rather than by adding. Individual professors must develop or regain loyalty to their institutions. Consequently, good teaching may in the future pay off somewhat the way national writing and research recognition did in the past.

National Group Pressures

At the more mundane, and for some, opportunistic level, we should not underestimate the influence of funding agencies and national commissions which have called attention to and pointed toward new directions by their recommendations and grants in specific areas. Here I refer to the recommendations from the Carnegie, Gould and Newman Commissions and grants made by the Fund for the Improvement of Postsecondary Education, the Carnegie Corporation and the Lilly Endowment, as examples.

Themes of Educational Reform

Three themes of educational reform seem to emerge as we have tried to review and categorize our interpretations of current developments. They include the development of a diversity of options, changing knowledge bases and relationships among disciplines, and a variety of what can be called non-traditional learning opportunities.

Diversity of options. Students today can choose to learn more different things, in more different ways, at different times, in different places -- all for college credit -- than ever before. They can choose from different institutions, different programs within institutions, different courses within programs, and different learning experiences and techniques within courses. Students can design tailor-made programs through learning contracts and external degree arrangements.

Changing knowledge bases. The bases of knowledge on which programs are built are frequently being revised and rearranged to allow for new relationships. This adjustment may come about to allow a curriculum to accomodate aspects of social policy through problem-focused or issue programs such as black studies, environmental studies, women's studies, urban studies or energy studies. The adjustments may be to respond to desires for career or vocational aspects, especially since upgrading or retraining due to a tightened labor market may require new groups of knowledge in order to develop special abilities or competencies. Also,

the interest in competency-based curricula is stimulating an interest in new relationships among disciplines to assist students to be able to demonstrate the competence an institution espouses.

Non-traditional learning opportunities. The current "movement," if it can be called that, is really a "freeing-up" of traditional teaching structures and practices, many of which have not been as seriously questioned as in the present. To paraphrase the title of the Gould Commission report, the key effort today is and must be designing for diversity. That is, providing more ways for persons to learn, at more times, and in places not considered traditional. The Gould Commission defined non-traditional as more an attitude than a system. As you recall, the Commission said,

> This attitude puts the student first and the institution second, concentrates more on the former's need than the latter's convenience, encourages diversity of individual opportunity rather than uniform prescription, and de-emphasizes time, space, and even course requirements in favor of competence and, where applicable, performance. It has concern for the learner of any age and circumstance, ror the degree aspirant as well as the person who finds sufficient reward in enriching life through constant, periodic, or occasional study. This attitude is not new; it is simply more prevalent than it used to be.[5]

The trends emerging as non-traditional, new and additional learning opportunities seem to be characterized by a shift from the emphasis on teaching to a concern for learning. What is happening calls into question traditional concerns about courses, credit hours, clock hours, semesters and years. This allows talk and planning toward meeting objectives, competencies and finding ways different individuals learn whatever is determined to be important to both the institution and to the student. Therefore, time becomes flexible; achievements and requirements are reviewed in optional ways; and techniques vary to suit the diversity of students' needs and abilities, as well as the diversity of talents on the faculty. A central theme running through all of this is a thoughtful analysis of what is important for one to learn, related to the particular subject or field, and then the development of various possibilities or options for how one can learn.

Several terms and approaches can be used to categorize today's new directions. The following are examples:

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[5]Commission on Non-Traditional Study, Diversity by Design (San Francisco: Jossey-Bass, Inc. 1973), p. XV.

Individualizing Instruction: PSI-Keller Plan, audio-tutorial, independent study, mentor system, contracts in programs and courses

Computer Assisted Instruction (CAI): PLATO, Ticcit

Gaming and Simulation

Experiential Learning: Off-campus learning, field experiences, cooperative education, internships, community-based (Vista, Peace Corps, U.Y.A., Teacher Corps)

Open University: Creative use of media to present traditional material in non-traditional ways

University Without Walls Concepts: external degree programs, credit for life experience

New Kinds of Institutions: Minnesota Metropolitan State College; Empire State College; Florida International University; New College, University of Alabama

Summary

These current developments seem to imply several new directions for higher education's future. There is no doubt in my mind that the current efforts aimed at instructional change will have a lasting impact on our enterprise. "Non-traditional" developments, (some of which this meeting is focused on) with all and whatever their meanings, have raised a level of consciousness about our activities which cannot be ignored. To me that is good!

In the face of outside pressures, waning public confidence, economic problems and probably no growth, the real task is to achieve renewal and reform from within our institutions. There will be no additional development to gloss over the questions of credibility and help us forget the new issues we now must face. One way of coping with the need for self-renewal is to see that non-traditional alternatives for learning are provided at all regular education program levels.

Too much of what is being developed and tried has been added on or considered tolerable for a small number of faculty and students. Too often we hear, "Well, that's all right for them." We now need to involve in these developments the dragging middle group of faculty who only have been watching these changes with some interest, but have not jumped in themselves. There is plenty of evidence that this next group

is willing to participate, but unsure of how to begin. They need to be encouraged, supported and helped.

The area of instruction/learning is unquestionably the next "frontier" of American higher education. K. Patricia Cross recently put it this way,

> Today's non-traditional movement (which includes clienteles and educational efforts) is the last frontier of the expansionist years. It promises to complete the task of making college-level study available to every citizen who wants it . . . .
>
> The non-traditional movement is taking the ultimate expantionist step with its promise to use all learning experiences as the curriculum, and the world as its campus.[6]

This development will require moving attention from education for "all" to education for "each" in a pluralistic setting much like society's moving acceptance of cultural pluralism. The ultimate goal then will focus on optimal education for individual learners. Cross said further, "Today's timid beginnings will accelerate . . . until by the year 2000 an instructional revolution will have changed higher education in fundamental ways."[7]

Your efforts in nursing education help to set the pace for what is to come and this Council meeting on non-traditional developments is further evidence that this regional body remains on the cutting edge of new directions in higher education.

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[6] K. Patricia Cross, The Instructional Revolution. Paper presented at Concurrent General Session I, 31st National Conference on Higher Education, sponsored by American Association for Higher Education, Chicago, March 8, 1976, p. 1.

[7] Ibid., p. 2. See also, Cross, Accent on Learning (San Francisco: Jossey-Bass, Inc., 1976).

CURRICULUM PROJECT: AN ASSESSMENT

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May I express my gratitude to you at the outset for being asked to return here today to tell you a little more about the past and the future of the Nursing Curriculum project. Many of you will recall that the findings and recommendations of the Nursing Curriculum project were presented to the Nursing Council in the fall of 1974 -- about 1½ years ago. At that time our presentation was focused on predictions and assumptions about health care delivery some ten years hence, what might be happening in higher education in the future, and, globally, our feelings concerning the direction of nursing and nursing education within the next decade. Since that time we have received some accolades, some criticisms, and some indifferent reactions, so that I am reminded of the Calvin Coolidge story about the letters he received as President from citizens who were critical of his administration. The country was much younger then and so he was able to answer each one personnally by writing at the bottom of the writer's own letter the words -- you never know, you may be right -- and returning it to the sender. And so it is with the findings and recommendations of the Nursing Curriculum project: you may take the attitude -- you never know, they may be right; or if you feel more negative than that, it may be phrased in a different way -- you never know, they may be wrong. I would certainly agree with those of our critics who said we hadn't a revolutionary spirit and yet we did in the ambiance of those early years of the seventies effect a middle-of-the-road philosophy that has gained us some supporters.

Parenthetically, I might say that I am using the editorial we to refer to those individuals who worked with the project --both staff and participants -- because the work was done by them through the discussion of issues and by reaching a consensus concerning what ought to be done about them.

The assumptions the project participants made about women, health care, and higher education, have been published and distributed to you so that today I'd like to focus on one or two assumptions we made about nursing and how all these assumptions were melded together with the others to become the final recommendations of the project.

It has taken some time to pull these ideas, these assumptions, from the context of the project's work. But let me begin by presenting one very real concern of the project members that was subsequently the

concern of nurses and other persons to whom the findings were presented. That is to say that I hope to trace one which I consider important and ask you to keep in mind that it is one of many.

Most would agree with Esther Lucille Brown who said in 1974 that bedside nursing is in a precarious state. That may sound to you like an "overkill" but, in fact, we heard it wherever we traveled -- whenever nurses began to talk about the nursing care patients received in hospitals. I don't need to tell you what that talk concerned but, just so we are communicating in concert with one another, I mean the CVA patient who was left to sit in a chair for eleven hours because the nurses had forgotten that he had been placed there or the woman with two fractured arms who was lifted by these same two arms into a sitting position. I'm certain that each of you could contribute your own stories to these tales of horror but I, just like you, find the whole notion unpleasant and even disturbing to think about.

I can't say that all 36 project members would agree to the reasons for this state of affairs and yet there was little denial that this general condition existed. Even though much of the discussion in the project was devoted to the status of the nurse working in the hospital, we found it impossible to lump all hospitals together. And so we began to talk about the differences between community hospitals (secondary care institutions), and medical centers or research hospitals (tertiary care institutions). What could be said of one could often be said of the other, but this wasn't always true because their purposes are very different and, therefore, the kind of behavior expected from nurses in these hospitals is also different.

One of the reasons for bedside nursing coming into question in the early seventies was defined by Marlene Kramer who wrote one of the early papers for the project. It is a familiar theme -- "adapting to" or "living in" bureaucratic settings -- but one that still teased the minds of our project participants and so we developed it a little further in our thinking. If one looks at the classical definitions of bureaucracy, one is appalled that it has changed so little since the late 1800's, and I mean: 1) attention to the formal organization and the hierarchy of positions within an agency; 2) the importance of the formal rules and regulations; 3) the adherence to the seniority system; and so on and so on. Perhaps even more astounding than that is the distance that the more knowledgeable and responsible people have from the actual day-by-day work of the bureaucracy. Indeed this explains the paradox that our critics have made us so aware of -- the absence of the most knowledgeable nurse from the bedside. And this was our fate before the creation of the role for the clinical specialists in hospitals some fourteen years ago. But have you noticed that within the last 5 to 6 years there has been a plethora of new roles for nurses in tertiary care -- ones that please some of us very little. Some are specialist

roles for technicians (CCU) and some are specialist roles for generalists. And I believe nurses are the only group among health care disciplines that would understand that statement.

The idea of bureaucracy also brought to our minds the values that we teach students which are sometimes mythical at best. As an example, 1) you are a professional and, therefore, your responsibility is greater to your patient than to the agency for which you work, or, 2) you are an autonomous worker set upon a destiny to improve health care practice in hospitals. I don't mean to belittle these values but merely to point to the fact that they seldom represent reality for other than masters' graduates -- and sometimes not for them. As Helen Weber is fond of saying, this causes the student to become a critic of either the system of nursing services for which she works or the school of nursing from which she graduated.

An even more powerful idea that we hardly dared to think about but which is one often mentioned by our critics, is why we haven't divorced ourselves from the hospital administrator who assigns our work load and determines our activities as staff nurses, head nurses, or whatever other nursing role comes into his purview, and have the nursing administrator report directly to the hospital board. This is a question that needs our most serious attention and our most united effort if we ever do get our act together.

Because realistically many of our problems can be traced to the lack of a role alter ego to the physician in the hospital -- some one in nursing who is on a par with, who is analogous to, the physician. Until we do have this individual -- and we are beginning to get them -- then nursing in hospitals is technical and will remain that until the authority base is changed. I think it was these notions that, more than any, were reflected in the participants' obsession with the use of power, with the desire to graduate students who are willing to be assertive and to take risks and, therefore, bring about change in hospitals.

The staff got to wondering -- after the fact -- if the problem wasn't also somewhat associated with the social status of the nurse in the hospital. This thought, in turn, brought to our minds tantalizing, but forbidden notions having to do with labels or names for nurses. Should we call the graduates of our multiple preparation programs nurses, or should we call some of them by a different name? This idea generated a lot of emotion, as you can imagine, but of course it wasn't a task properly belonging to a curriculum project. It was the tip of the iceberg. Some of us agreed with Sadler, Sadler, and Bliss that the word nurse is archaic and sex-linked but, of course, the issue, like the iceberg, goes much deeper and, as it does, it becomes a curricular concern.

In fact it is the most pervasive issue of the seventies -- one that has been building for some time -- and it is simply our inability as a group to differentiate nurse-providers. While we believed that time, the healer of most difficulties, would also have its effect on this problem, the project seemed a propitious opportunity to look this matter square in the eye and take a stand, at least as far as the body of nursing knowledge can define it.

In other words, we could, as a curriculum project, identify the body of nursing knowledge in global terms but could not attempt to define "who is the nurse" -- clearly a matter for organized nursing to deal with.

In the schema of nurse-workers developed by the project, we included all nurse workers from the nursing assistant to the nurse prepared at the doctoral level. Each level and type of nurse included in this group was providing nursing services -- whether or not we like to think about nursing in those terms.

This inclusion of all workers was done primarily on the advice of persons other than project members who felt that an avenue for upper mobility should be demonstrated in the project's publications. Upon reflection, it wasn't such a bad action because a part of our definition of nursing was that it is a range of services peopled by levels and types of practice.

If you recall, the first level of RN provider identified was the associate degree graduate whom we envisioned as necessary to the provision of secondary care in hospitals and other settings. This nurse will continue our traditional role in community hospitals and health care agencies where the need for care is

1. directed toward clients who are experiencing illnesses that are common and well-defined;
2. who have been identified as being ill; and
3. who's nursing problems require processes that are standardized, in common use, and directed toward alleviating problems where the outcomes are predictable.

Actually, this differs very little, if any, from the concepts of the associate degree program and differs from the Lysaught report in the fact that the project members saw ADN graduates prepared primarily for employment in episodic and NOT distributive nursing settings. But this is not the nurse who can lead us out of our bureaucratic dilemmas, unless she is unusually gifted, or who can solve our problems concerning relative parity with physicians in hospitals. What this nurse should be able to do is to give expert clinical care at the level described above and, if our ADN programs in the South will limit their expectations to just these guidelines, it is more than enough for the rest of us to expect.

Parenthetically after the completion of the initial theoretical work, the staff asked that a group of leaders in associate degree education envision how the project's recommendations could be demonstrated. They said precisely the same kinds of things: let's mount a project to investigate better methods of clinical teaching; let's continue to do workshops for faculty; and let's do it by establishing consortia and inter-institutional cooperative planning.

The seminar members phrased their recommendations in terms of body of knowledge and it was their next assumption that secondary care nursing was the base, the set of common competencies, upon which all of nursing practice and, therefore, nursing education programs could be predicated. This idea implies upward mobility within a system of education -- and we mean by that -- a statewide plan for advancing those nurses who desire further education up the career ladder as rapidly, but as soundly, as possible.

The baccalaureate program, according to the seminar members, was also to provide a core of secondary care -- one that would be given initially in generic programs but could be transferred in from ADN and diploma programs -- and, in addition, a core of primary care and an area of concentration was to be elected by the student in either tertiary or primary care. But now we are speaking of a different kind of nurse for the hospital, still a generalist, but with additional saleable skills in hospital practice. And because of her small group experience and her increased abilities to provide leadership we can expect, at the very least, to get some ideas generated on how to solve nursing's most pervasive problem -- improved bedside care.

Another of the project's pervasive notions concerned new roles for nurses in primary care (first and continuing contact). This was a role we assumed that baccalaureate graduates would be moving into on an ever-increasing basis. They are going to be doing histories, physicals, monitoring clients with chronic diseases, supervising healthy children, giving health care instruction, and so on -- another of the distinguishing differences between the baccalaureate graduate and the other graduates.

When we asked leaders in baccalaureate education how they envisioned the recommendations being demonstrated, they asked for a model curriculum to be developed that would match the one just described. They asked for satellite programs and help with developing sound methods for granting advanced placement. They asked for assistance in educating faculties to give primary care so they could, in turn, teach students to do the same. All of these ideas seem important and it is my hope that all are funded to begin as soon as possible.

It must be obvious to you now that we are building to a mighty crescendo -- the graduate program. The project members deemed this area of our educational responsibility to be our greatest need -- our highest priority for support to both quality of its offerings and to the numbers of its students. We identified for this level new roles and old roles, and new students and old students. Clinically we were thinking about clinical specialists and nurse practitioners. Functionally we were thinking about educational and clinical administrators, teachers, novice researchers and organizational leaders. We were not timid about recommending more doctoral programs when institutions feel they are ready to offer the same.

For it is from this level of practice and education that the nurses and the solutions to solve the dilemmas we began this presentation with will come.

NEW YORK REGENTS EXTERNAL DEGREE PROGRAM AND IMPLICATIONS FOR TRADITIONAL NURSING PROGRAMS

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The question has been raised as to what potential influences the External Degree in Nursing Program might have on regular, on-campus nursing programs and on nursing in general. Many of the educational practices that come to mind are not new; some already are being practiced. What is new is the extent to which openness and flexibility in the educational system are becoming available to more students. Some of these possibilities have resulted from the New York Regents External Degree Program.

The Regents External Degree concept exemplifies a truly unique approach to education. It is the most fully developed assessment degree program available in this hemisphere and the only one in nursing in the world, to our knowledge. I'm sure you will agree it deviates considerably from the traditional approach to obtaining an academic degree. The fundamental difference is it's emphasis on assessment rather than on instruction. The focus is on learning rather than on teaching, and on the candidate's demonstration of essential knowledge and competencies, irrespective of how and where that learning occurred. It's a very logical approach -- for some types of students. It's an alternative, not a substitute.

I believe the nursing community, especially nursing education, will benefit significantly from this unique, national program. Some educators have told me they think it will "revolutionize" nursing education. Others, however, believe it will have little effect. Both of these may be true to some extent, depending on the clients, the type of program and the aspect of nursing being discussed. I would like to suggest some of the more direct and significant influences; or spin-offs, that seem logical to me, both for nursing education and for nursing in general. These changes tend to fall into categories pertaining to the teaching-learning process, curriculum structure and implementation, student evaluation and, ultimately, to nursing practice.

Teaching-Learning Process

Certainly one of the most outstanding features of the External Degree Program, that is clearly documented by its graduates, is the ability of self-disciplined, highly motivated adults to achieve educational goals when given the opportunity. Emphasis is placed fully on the learner, to acquire knowledge and skills specified by the responsible faculty. Candidates are directed to sources of information and learning, but they must take full responsibility both for learning and for successfully demonstrating the expected level of cognitive and performance abilities. Whether they take college courses or proficiency examinations is up to them. They may study independently, or in college courses, in groups, or with a tutor on the

job, or off; they may proceed slowly or quickly; they may use any conceivable combination of strategies, methods or procedures. But ultimately, to acquire the degree, candidates must demonstrate, without equivocation, their knowledge of basic arts and sciences and nursing and their ability to apply these knowledges in the practice of nursing at the level predetermined by the faculty and enforced by trained expert evaluators. What candidates know and can do is deemed more relevant than how they learned it.

Both State Board results and follow-up employment studies we've conducted thus far have clearly documented the success of this approach for the candidates who were able to complete such a demanding program. On the average, 94 percent of all graduates to date who have taken State Boards have passed on the first attempt, and with scores significantly higher than the national average. Last July, 97 percent passed the licensure exams with a composite mean score of 556; only one of the 155 subtests taken was failed. Figure 1 illustrates the results for these two groups.

Furthermore, employers rate their performance and knowledge as better than or average in relation to other beginning RN's in their agencies. Almost unanimously (94 percent) they said they would employ other External Degree graduates if given the opportunity and would encourage their staff to pursue their education through this approach. They also found these RN's to be just as autonomous, and to hold the values and attitudes consistent with expectations of RN's in their agencies. This preliminary data is based on the first follow-up study which includes employers and supervisors in about 40 work settings in nine different states. A more detailed report is being published in Nursing Outlook, probably in the June issue.

The significant point being made here is that although these individuals learned in a variety of ways, under many different circumstances, over a variable period of time, and from many "teachers", when given the opportunity and guidance, they were able to learn and to demonstrate the knowledge and competencies expected of them. They disciplined themselves to study, even though they worked full time and had heavy family responsibilities. Their commitment to goal achievement obviously is high; they're also characterized as perseverant, idealistic and determined, based on a study conducted by a graduate student from Russell Sage College.

Perhaps the continued success of this total assessment model will persuade faculties of regular nursing programs to allow the learning process to become more flexible, while making the expected outputs more specific and more stringent. Our experience has led to the conviction that where competencies to be learned are clearly specified and students are held accountable for learning them, their learning is more goal-oriented and self-directed as well as more positive in outcome. And because these two points are emphasized, the process of how the students learn can vary according to their past experience and knowledge, availability and preference of methods and life circumstances. It's true, everyone does not have to learn in the same structured way.

Figure 1

Regents External Degrees in Nursing - State Board Results

February and July 1975

	February 1975		July 1975	
	No.	%	No.	%
Candidates Taking State Boards	38		31	
Total State Boards Passed	35	92%	30	97%
Total State Boards Failed	3	8%	1	3%
Subtests Taken	190		155	
Subtests Passed	187	98.5%	154	99%
Subtests Failed	3	1.5%	1	1%
Score Ranges				
300's or below	6	3%	12	7%
400-499	40	21%	32	21%
500-599	82	43%	63	41%
600-699	50	26%	39	25%
700-799	12	6%	9	6%
TOTALS	190	99%	155	100%

The external degree program provides a fresh example -- a reason for faculties to take a new look at the old concepts -- that students learn in different ways and in different time frames, and that they need not go through a uniform experience to acquire comparable knowledge and skills. This idea certainly is not new, but it is newly illustrated through this program, which is based entirely on assessment.

Flexibility in the teaching-learning process need not adversely affect high standards of academic or clinical performance. To the contrary, where learning is more specified, and objective evaluation tools are used, higher standards may be expected of students and graduates. In fact, when candidates pass the seven written exams and then meet the vigorous demands of the two-and-a-half-day clinical performance examination, they gain a new feeling of self-confidence -- because they have been measured against a high standard of excellence while under considerable stress, and have been successful.

Repeatedly our graduates tell us two things about the CPNE: it's the most difficult experience of their life which they never want to repeat, and having come through it successfully, they feel more confident in their ability to practice nursing. The same sentiments were expressed by students enrolled in a regular ADN program in our area that adoped our CPNE to evaluate clinical competence of their students. I will discuss details about performance evaluation in this afternoon's session.

Also in terms of influences the External Degree might have on the teaching-learning process in more traditional programs, it should be clear by now that the usual roles of teachers and students are significantly modified. In the assessment model the role of the faculty is to determine and specify what should be learned, suggest ways and means of learning it, and determine methods of evaluating the achievement of expected knowledges and skills. The candidate is responsible for learning -- in whatever way is most suitable in his circumstances. The candidate also is expected to demonstrate the level of competence expected for the particular area being examined -- written or clinical performance.

Faculty members of regular, on-campus programs also realize that their stereotyped role of the past may be changing. But this does not imply any diminution of their centrality and importance. Teachers in general higher education are being called mentors, facilitators and educational consultants because they envision and fulfill their role differently. Again, the emphasis is on the learner and on providing flexibility in the teaching-learning process.

I believe the success of the external degree program will encourage many nursing faculties to seek ways to make learning in their own program more flexible and individualized.

The degree to which these points are applicable, however, depends on many factors, but perhaps they are most relevant to programs that are implementing the open curriculum concept. I believe adult learners are more able to be self-disciplined, and pursue the achievement of a goal with more tenacity. But all that has been said could be applied in some degree to any program, for the emphasis is on the need to increase clarity and specificity of expected competencies, to increase flexibility and individualization in the learning process, to place more direct responsibility on the student for learning, and to make evaluation more objective and consistent.

Curriculum

These points also suggest some influences the external degree concept might have on the structure and implementation of the curriculum for regular on-campus programs. Although the content remains the same, changing methods of approach undoubtedly also affect the curriculum. For example, smaller units of learning and evaluation might be more suitable. Modules, which include statements of specific objectives, and competencies to be learned, suggested resources, and specified method and level of expected achievement, make independent study quite natural. Currently, many programs are using self-directed study in one way or another. The External Degree differs in that it facilitates maximum use of it. Once again, the content and expected competencies are comparable to other programs. However, candidates may use tutors, learning contracts, work experience, small groups, films, laboratory demonstrations, or various combinations of these and similar methods to learn.

The conflict between structure and flexibility is not new. Many believe that a curriculum is most valid when it is highly structured, when it establishes every sequence, and when it specifies the time and space within which learning takes place. When students rotate through this structure and the designated time and space alloted, and accumulate enough academic currency, they are awarded the degree. Many of us have experienced this in both basic and graduate programs, and know that time and space, and numbers of credits do not necessarily mean that learning has occurred.

The external degree illustrates that where outcome behaviors are structured, movement toward acquiring those competencies can be highly flexible and individualized. I have come to strongly believe that flexibility should emphasize rigidity of expected competencies, but flexibility in methods used to achieve them.

The extent to which these ideas are applicable, however, is fully contingent upon the beliefs of the faculty, institutional constraints and characteristics of the student body. And, once again, I think they

are more appropriate with the experienced adult learner than the novice just out of high school. But recently the shift toward an older and more heterogenous student body seems to characterize students in nursing programs, especially in associate degree programs. In all types of nursing programs, we are seeing many students with other degrees and considerable experience. Such backgrounds have consequences for both the teaching-learning process, the curriculum and the use of evaluation procedures.

Evaluation

I believe the single most significant contribution of the Regents External Degree Program is its unequivocal emphasis on objective evaluation. The program grew out of a decade of successful experience with the College Proficiency Examinations, which included nursing, and developed the concept of credit by examination to its logical conclusion. If it is possible, and reasonable to obtain credit for a course by taking a standardized exam, then it also is possible and reasonable to obtain a college degree by passing a series of such examinations. The concept of credit by examination is widely used throughout the country. Our office now administers some 80 different standardized examinations covering a wide range of subjects, including two different sets of exams in nursing.

A significant step forward was taken earlier this month when the New York Commissioner of Education, Ewald Nyquist, announced that arrangements had been completed with the American College Testing Program which will make available all CPE and RED written examinations throughout the country beginning in November of this year. ACT has more than 1800 testing centers in the United States and abroad, which means that candidates in the external degree program may write examinations in their own locale rather than coming to New York. It also means that the examinations are available for other legitimate purposes as well.

Regular on-campus programs throughout the country have persistently urged us to make our nursing examinations available to accommodate their own academic needs. Until now this has been possible, but students had to come to New York to take them. Beginning in November they may be administered at the discretion of faculties in associate and baccalaureate programs, for advanced placement, screening, or whatever purpose will assist faculty and students to meet their goals. Arrangements for testing outside New York State should be arranged with ACT's main office in Iowa City. Their availability reduces the need for faculties to devote time to develop similar exams. This could become a significant factor as colleges reduce the number of faculty and staff to balance the budget.

The most important influence of these exams and the broader application of the concept of credit by exam is seen for open curriculum programs. By having valid and reliable tests in nursing and supportive sciences, advanced placement can be more objectively determined. Students with prior education and experience will have a fair opportunity to compete for enrollment and credits. Experiential learning may be used, when it is based on objective evaluation procedures, whether in theory or practice. It no longer will be necessary to give "blanket credit" for diploma preparation because of the lack of available standardized examinations in nursing. As a matter of fact both CPE's and REDE's in nursing are useful in this regard. Students could be expected to document their knowledge through designated College Proficiency or External Degree nursing examinations for the award of credit. Basically, a particular configuration of examinations designated by the faculty, could be used to determine:

Admission of students;

Placement of students;

Number of credits to be awarded;

Graduation of students.

Since these exams have been developed jointly by content experts and psychometric experts and have been normed on thousands of students, the faculty have considerable confidence in their results.

The University of the State of New York has been described as a national examining university; it provides a function which has been lacking on instructional campuses, and with it new possibilities exist for the education of people of all age groups. We have a healthy relationship with regular on-campus institutions. We accept their courses for transfer in meeting requirements for the external degree, and a growing number accept and use our examinations for their own degree programs. In this way more members of the community can acquire the education they seek and need to fulfill their career.

But perhaps the single most important point regarding evaluation emanating from the external degree experience is that clinical performance also can be objectively and consistently measured. I believe this will have a <u>profound</u> influence on traditional nursing education. This subject has captured the thoughts of nurse educators all over the country as they look for a better method to deal with a central part of nursing. Clinical evaluation is an age old problem and one filled with anxiety, guilt, frustration and disappointment. I've been a clinical teacher and I recall all too well the struggles to fairly evaluate the student's clinical ability.

The External Degree faculty worked diligently for three years to develop an objective, workable clinical examination. More than 250 candidates now have taken this CPNE; and about 76 percent pass it. Candidates are eligible only after they successfully complete the 7 written exams, pay the fee of $250 plus travel and three days expenses, and when they feel ready to demonstrate the competencies required. They receive a detailed study guide listing all requirements and are responsible for learning all aspects of nursing care described in it. They also are responsible for making the appointment for the two-and-a-half day exam. How they learn, how long they take and the resources they use are entirely dependent upon the candidate. Regardless of the process, they must pass a minimum of 175 critical nursing behaviors with 100 percent accuracy to pass the exam, and no one is excused from taking it.

It is most important that this examination should not be confused with the "clinical experience" component in the traditional nursing program. It is not a teaching episode, nor does it stand in the place of clinical instruction. Remember, the external degree is an assessment not a teaching program. Rather it is an objective examination designed to evaluate the achievement of clinical competence at the level expected by the faculty. In this sense it is just like the written examinations. They are not for teaching purposes, but to test how well and to what extent the candidate has learned. The CPNE tests the candidate's ability to meet a standard of excellence in nursing practice established by the faculty and vigorously implemented by trained evaluators. It is this examination that tests the candidate's ability to integrate and apply knowledge, make decisions, plan, implement and evaluate nursing care under specified conditions, and to do so with a designated level of competence. It is this exam more than any other single factor that gives us confidence in the program and its graduates. It is this exam that screens out the incompetent, misguided, and unqualified candidates and attests to the ability of those who pass it.

It should be pointed out again that the External Degree Program operates on the premise that people learn in many ways but, to acquire the degree, that learning must be documented through valid assessment procedures. In terms of the clinical component, our follow-up studies indicate that candidates learned to practice nursing in both structured and instructional settings. They had worked in nursing from two to 25 years, with an average of nine years per candidate. More than half of them had attended RN preparatory programs and whether diploma, AD or BSN, they had completed more than 50 percent of the curriculum. Two-thirds were practicing LPNs, a few were diploma RNs who wanted the academic credential, one had an RN diploma from Poland and also had attended an ADN program in this country. Several had considerable experience as military corpsmen. They had worked in a wide variety of settings. Many made deliberate arrangements with their supervisors or inservice

directors to rotate to other units for more experience; they worked on days off and on vacations to learn that which was lacking to round out their competencies. They asked questions, read, observed and looked for opportunities to improve their practice.

I would again emphasize one of our basic tenets: how a person learns is less important than what they learn and how competent they are in applying it.

During our final pilot test of this performance exam, we had local RNs and nursing students take the exam as mock subjects, without disclosing their real identity to the evaluators. The RNs had one to three years of experience and were in responsible positions in local hospitals. After the grueling two-and-a-half day examination they declared they had never -- as student or graduate -- been so closely scrutinized, or been held to such a level of performance. They also were quick to admit that they would welcome on the staff anyone who completed the External Degree Program. They had learned from personal experience how rigorous were its demands and how difficult it was to satisfy the ever present objective evaluators. This was no "practical test" but a true assessment of a nurse's ability to apply knowledge and to meet the needs of actual hospitalized adults and children.

The fact that such an examination has been developed -- at a cost of close to $200,000 -- could have a major influence on nursing programs at all levels and on nursing practice. It provides a format and mechanism to greatly reduce the subjectivity and personality aspects of clinical evaluation. It makes performance evaluation more consistent, more comparable, more objective and more realistic. It also assures both graduates and their employers of the competence to practice nursing. Ability to perform in the clinical area is examined directly, rather than assumed.

I believe the External Degree and the W. K. Kellogg Foundation have provided a remarkable service to nursing and the consumer, especially in this regard. I hope more and more faculties will develop objective and stringent performance examinations which require students to demonstrate competence in nursing practice. We are glad to help toward this end.

Nursing Profession

Other ways in which the External Degree potentially could influence nursing include the following:

1. More nurses could become better prepared, even though they live in rural or small town areas where facilities or opportunities are limited.

2. As local people have the opportunity to learn and demonstrate their knowledge and competence, they'll do so; and will remain in their community to serve local needs.

3. Many nurses will be enticed to remain in nursing if they have the opportunity to acquire the credential and the pay for work they're capable of doing. They need the stimulus of achievement and reward.

4. REX provides the stimulus to study, to improve, to become more knowledgeable and competent -- while still serving family and community.

5. Nursing service will be able to encourage their nursing staff to study, to learn, to obtain a higher degree -- whether AD, BS, or MS -- because REX provides the program or a stepping stone.

6. This program also brings nursing education and nursing service much closer together because it emphasizes that learning can come through the self-study and work experiences as well as through classes. It also encourages the application of learning to the job, to improve practice and the patient's care. It improves competence in the real world of the candidate and his client. It gets the worker to think, to question, to seek answers, to read, to apply learning and to want to continue improving practice. It is a step in the direction of promoting lifelong learning.

In closing, I want to emphasize that the Regents External Degree is an alternative program not a replacement or substitute for generic programs. I suggest that we recognize that alternative methods can accomplish the goals of nursing education and nursing service -- that assessment has a valid place in the spectrum of higher education and nursing. Through this program we can learn to trust the value of learning acquired elsewhere -- so long as we validate it with objective tools. We even have to learn that students can and do teach themselves -- far more then we generally recognize. To be sure, the program is not the same as other nursing programs but it assuredly is equivalent to and, in many cases, surpasses them.

I do not think other external degrees in nursing will spring up across the country, as some fear. This is a national program and now with the facilities of the ACT network, another similar, costly project in nursing is not needed. When we complete the BSN external degree we will have spent about $2 million in developing nursing programs alone. We are glad to share what we have developed because we strongly believe it will improve the cause of nursing. Too many other projects await our attention to duplicate efforts.

I close with a quote from Florence Nightingale that seems most appropriate for this discussion: She said in the preface to Notes on Nursing:

> "I do not pretend to teach her how, I ask her to teach herself, and for this purpose, I venture to give her some hints."

THE SCENIC ROUTE: MODES OF STUDENT PROGRESSION

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If Florence Nightingale were to walk into a School of Nursing today, she would be astounded. The education of nurses and nursing students have changed that much! We have seen nursing education come from the handmaiden to the physician (I'm not sure extender is not an updated term for handmaiden) to 1050 hours to two years in a hospital setting, followed by three years of a rigidly prescribed curriculum, with the star-billing being given to the big "5" of the hospital organization, OB, Peds, Med, Surg and Psych, to five years of more rigidly prescribed college-centered education with the star still being the big '5', to the more modern model of back to two years this time in a collegiate setting and back to three and four years this time in a collegiate setting and with the star billing shifting from the big "5" to integration, then, finally in the last five years the star changing from things to people. The top billing with the big "S" now stands for star-student. It is now the student we are concerned with we now have the student progress through the curriculum rather than the curriculum control the student!

As Florence looks about after 200 years of resting -- her first encounter with the new star prompts the question, "But how can this be so?" And her answer from the 1970-1980 student, "Why M.S.N.-- the scenic route."

The conversation continues, "Tell me about the scenic route.

"Well, perhaps I should start by saying -- remember when your mother was pregnant with you, and your father and she were touring the continent and stopped off in Florence, Italy. The beauty of Florence was so breathtaking. Your father, having decided on the route, was so pleased that your mother was so enthralled that she wished to stay, to have her child born there. And from your beauty and the beauty of Florence, Italy came your name. Now you see, Ms. Nightingale, if not for the scenic route, we would not have a Florence Nightingale. It might have been Paris, Venice, London, etc."

"Yes, I see; now tell me about your scenic routes?"

"Well, Ms. Nightingale, I hardly know where to begin, so let me tell you some of the ideas my teachers and I have been discussing in Trends this week.

"Trends?"

"Oh, yes, that's a discussion of -- Where is Health Care going? What are the needs of the future? We discuss such things as, Educating the Whole Student, Caring for the Whole Client, Role of State Boards in Program Renewal, Learner-Centered Curricula, Week-end College, External Degree, Contract Learning, Alternatives to Degrees, Alternative Degrees, Teaching and Learning in the year 2000, Standardized Testing-Good or Bad?"

Ms. Nightingale raises her head, pauses, and says, "My things have certainly changed."

"Yes, I remember reading that you were not in agreement with standardized testing, Ms. Nightingale."

"True, but tell me, Ms. Student of 1980, what does all this have to do with the scenic route? Patient care? Tell me of your classes' progression."

"Ms. Nightingale, I know its difficult, but the scenic routes in our class are all quite different because, you see, we, the students are different. Let me tell you of those at the Medical College of Georgia. We have what is called PATHWAYS TO THE BACHELOR OF SCIENCE IN NURSING DEGREE. Some students call this 'foot paths' to the B.S.N."

As one of the 32 schools in the nation selected to participate in the open curriculum project of the National League for Nursing, the School of Nursing, Medical College of Georgia, offers a variety of flexible pathways by which any student meeting admission standards may earn the Bachelor of Science in Nursing degree. These pathways or "curriculum tracks," or routes are outlined as follows:

1. Basic Generic Studies -- Without Previous College Credit or Health Care Experience

   MCG SONAT PROGRAM -- SONAT, that's an acronym for our satellite at Athens -- School of Nursing at Athens. Students in the above category who have graduated from high school within one year of application may enroll in this experimental three-year program. Students are committed to 12 consecutive quarters of enrollment (including summers) on the Athens campus. Non-nursing course work (90 quarter hours) of core curriculum is taken in classes at the University of Georgia, taught by University of Georgia faculty, with regularly enrolled students of the University of Georgia. Nursing coursework (90 quarter hours) is taken on the University of Georgia campus in classes limited to nursing students and taught by Medical College of Georgia School of Nursing faculty. Students enrolled in this program have all the rights and privileges of University of Georgia students

and also those of MCG. Students enrolled in the program who, for any reason, cannot meet the 12 quarter consecutive attendance requirement or other requirements of the experimental design cannot continue in this program. They may, however, transfer without loss of credit (or any other penalty) to the Augusta campus and continue working toward their BSN degree.

Any student in the above category may enter the four-year program on the Augusta campus. Provision is made in this program for self-paced learning so that exceptionally able students may take more than the normal course load during regular quarters and also attend accelerated summer sessions, thereby completing degree requirements in three years. Students who wish to proceed at a slower pace or who have remedial learning problems may take normal or decreased course loads and complete degree requirements in four to five years.

2. Transfer Graduates -- No Health Care or Nursing Experience

Students in this category may transfer up to 90 quarter hours of non-nursing (core curriculum) college credit into the nursing program on the Augusta campus. This credit may have been obtained through coursework at other institutions of higher education, through the College Level Examination Program, through United States Armed Forces Institute courses or examinations, through correspondence courses, through other acceptable proficiency examinations, or through a combination of these methods. Such students will find it possible to complete BSN degree requirements in two calendar years. Exceptionally able students may, of course, utilize the opportunities provided for acceleration during regular quarters and summer sessions and complete degree requirements in less than two years.

Students in the above category may, beginning in the fall quarter of 1976, also transfer credit as noted above into the MCG SONAT program located on the Athens campus and complete BSN degree requirements in one calendar year of accelerated study. This program permits any student completing pre-nursing-core curriculum requirements at the University of Georgia or other institutions of higher education to obtain the BSN degree in a total of three calendar years of study.

3. Transfer Undergraduates -- With Health Care and/or Nursing Experience

Students in this category include medical corpsmen and clinical specialists of the Armed Forces as well as licensed practical nurses and students who have not completed diploma requirements from vocational, associate degree, or hospital schools of nursing

programs. Any of these may transfer into the nursing programs on the Augusta campus. No, they are not like the Knights of Templars, but we will talk of that later.

College course credit, CLEP and USAFI credit, other proficiency examination credit, or combination of these up to 90 quarter hours may meet requirements of the core curriculum of the University System of Georgia. In addition, such students may challenge, by examination, and receive credit for up to 45 quarter hours of nursing coursework. The length of time required for these students depends on amount of credit transferred and achievement on challenge examinations in nursing courses. All may continue to utilize CLEP examinations or other proficiency examinations to meet core curriculum requirements after entering the nursing program. Highly individualized programs of study are designed for each of these students based on diagnosed learning needs. By special arrangement with the United States Army 91-C (Clinical Specialist) program, challenge examinations in nursing courses are supplied to any Army Education Center in the world requesting them, and may be given at such education centers to any students who have been admitted to MCG.

4. Registered Nurse Students -- Graduates of Associate Degree Programs in Nursing Who have Passed State Board Examinations for Nurses

All college credit (all core curriculum courses and nursing coursework credit up to 60 quarter hours) is transferred into either the RN curriculum on the Augusta campus or into the off-campus RN program which is taught by MCG School of Nursing faculty based in Athens and providing classes in Athens and Milledgeville each quarter. The RN curriculum provides for 30 to 45 quarter hours of coursework in nursing and for as many non-nursing courses as are required to complete the quarter hour core curriculum requirements. Associate degree graduates normally are able to transfer 45 quarter hours of core curriculum credit and 45 quarter hours of nursing course credit. They are, therefore, usually able to complete degree requirements by obtaining 45 more quarter hours of core curriculum (through coursework or by CLEP examination) and 45 more quarter hours of coursework in the RN curriculum. Those who choose coursework to complete core curriculum requirements will take six quarters to meet degree requirements. Those who choose the credit by examination route can meet degree requirements in three quarters of study.

5. Graduates of Hospital Diploma Programs in Nursing Who Have Passed the State Board Examinations for Nurses

Any applicable college credit is transferred into either the RN curriculum on the Augusta campus or into the off-campus RN programs in Athens or Milledgeville. These students are given credit for what they know. We care not where they learned it; just that it has been learned! In addition, these students receive, depending on the curriculum of their hospital school and their achievement within it, 50 to 60 quarter hours of equivalency credit in nursing coursework.

In general, students from Georgia hospital diploma schools have acquired 45 quarter hours of college coursework and receive 60 quarter hours of equivalency credit. After enrolling at the Medical College of Georgia, they make take core curriculum courses or receive credit by examination to complete 45 more quarter hours of core curriculum requirements. This work may be taken concurrently with the 30 required quarter hours of nursing coursework in the RN curriculum, but preferably precedes entrance into the RN curriculum.

Out-of-state students and Georgia RNs who finished hospital diploma programs before 1960 are largely from programs which did not provide for college coursework while in the hospital diploma program. These students must meet all core requirements either by coursework or through credit by examination. They receive the same equivalency credit in nursing as noted above.

6. Students with Baccalaureate Degrees

Students with non-nursing baccalaureate degrees follow the same program as those who are transfer undergraduates, either with or without health care or nursing experience.

Students with non-nursing baccalaureate degrees who are registered nurses are immediately eligible for entrance into the Master of Science programs in nursing. These students take baccalaureate nursing equivalency examinations to demonstrate baccalaureate level proficiency in nursing before being admitted to MSN degree candidacy.

The conversation with Florence Nightingale might continue.

"Oh, yes, Ms. Nightingale, nursing has moved from an intuitive type care to a highly specialized service to the people of the nation, involving care, cure and maintenance of health. The graduates of the master's programs are our teachers, researchers, clinicians and scholars.

You see, Ms. Nightingale, the many routes we, my classmates, have taken to get our goal, but if not for your mother and father taking the scenic route to Florence, I would not be here today."

"Miss Nurse of 1980, this has been so interesting; I have so many questions to ask. My, look at the group that has gathered about us as you have told me of your school; let us ask them to help me with my questions."

Ms. Nightingale looks to the group and says, "In having tea with my old friend Benjamin -- Benjamin Disraeli the prime minister, we were talking of the future and the university in that future! He said, 'Florence, a university should be a place of light, of liberty and of learning.' Tell me has the university served nursing well?"

THE CURRICULUM OF ATTAINMENTS

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THE PROGRAM

In the fall of 1973, The Florida State University School of Nursing was selected as one of three programs on the campus to participate in the development and implementation of a competency-based, time-variable degree program. The Curriculum of Attainments was developed as a response to the State of Florida's legislative mandate to the State University System to seek methods by which the time required to obtain the baccalaureate degree could be shortened. The program was administered by the FSU Division of Instructional Research and Service and funded by the Fund for the Improvement of Postsecondary Education.

A member of the Nursing faculty was appointed mentor of the program. Her initial task was to coordinate faculty activities toward the identification of the expected competencies for a graduate of the baccalaureate degree program in nursing at FSU. Practicing professional nurses in the community served in an advisory capacity.

During the winter, summer and spring quarters of 1974, the mentor and faculty identified twenty terminal generic competencies, organized them into four divisions, and began the development of learning packages.

The terminal generic competencies were derived from a number of sources: the observed activities of competent professional nurses in varied settings; present course materials; current nursing and related literature; and the philosophy and objectives of the School of Nursing.

The divisions -- Role Identification and Development, Communication and Perception, Health Maintenance and Promotion, and Health Restoration and Rehabilitation -- were used to group the terminal competencies. Because the nursing major is organized into four levels of complexity, faculty then wrote more specific level competencies for each terminal competency which progressed from simple to complex around four core concepts:

Role: The Nurse and the Nursing Process

Focus: Life Cycle of Man from Conception to Death

Dimension: The Individual, Family, Group, Community

Continuum: Health Maintenance - Health Promotion - Health Restoration

The learning packages, each worth two hours of academic credit, were to be the basic instructional units to be utilized by the students. A total of 32 packages were developed by faculty with expertise in the various content areas. Some examples of learning package titles are as follows:

Level I - Foundations of Contemporary Nursing

Introduction to Patient Care
Introduction to the Nursing Process
Introduction to Health Assessment

Level II - Professional Role Development I

Communication and Perception I
Life Cycle Adaptation
Health Hazards
Procedural Development I
The Expanding Family
Biopathology of Episodic Illness I

Level III - Concepts of Oncology
Concepts of Rehabilitation
Biopathology of Extended Illness

Level IV - Continuing Education
Health Team Collaboration

An example of a terminal generic competency and specific level competencies is as follows:

Terminal Generic Competency

1. Knows the philosopical, historical, educational, and legal influences on contemporary nursing practice.

Level Competencies

1.101 Compare current definitions of nursing with personal philosophy and that of the School of Nursing.

1.102 Compare practical, associate, diploma, and baccalaureate programs in nursing in terms of education, licensing and practice.

1.103 Given a specific period of history, outline the key events and influences on the development of contemporary nursing practice.

1.104 Identify and discuss nursing's strengths and weaknesses in relation to criteria for a profession, including the ANA Code of Ethics.

1.105 Given nurse-client situations and events occurring in a health care setting, identify the legal and ethical implications of the health worker's behavior.

1.106 Given events involving patients, determine which are unsafe. Accurately and completely describe the unsafe accidents.

1.107 Evaluate examples of physicians' orders and nurse's notes related to patient care from admission to discharge in terms of legal considerations.

1.201 Given a list of legal situations occurring in certain areas of the hospital, i.e., emergency room, labor and delivery, pediatrics, operating room, psychiatry community, and identify ways of providing legal protection.

1.202 Identify the legal implications in the storage and administration of narcotics.

1.301 Differentiate the purpose of the ANA and the NLN and outline their evolvement. Describe other contemporary nursing and health-related organizations.

1.302 Given a list of milestones in development of present day systems of nursing education, justify the significance of each event.

1.401 Compare the Florida Medical Practice Act and the Nurse Practice Act with those of another state to identify differences in legally defined role dimensions. Discuss current efforts to change these laws.

A learning package contains one or more modules. Each module has the following components:

Statement of Terminal Competency

Preview of the Module

Statement of Level Competencies

Assessments (Diagnostic and/or Evaluative)

Learning Activities

References

Handouts and/or Study Guides

THE MENTOR

The mentor is the person responsible for the COA program within the School. She should be a generalist rather than a specialist, one of the more qualified faculty with a broad background in her field. She should have an established reputation as a teacher, and possess open communication with faculty and practicing professional colleagues. She should understand the total curriculum as well as her colleagues' abilities, so as to choose effective tutors and to utilize available resources. She should have expertise in curriculum and evaluation, be creative in instructional development, and be able to exercise flexibility in all aspects of the program.

The mentor should enjoy students as unique individuals, relate to them as colleagues in the learning process, guide them in an on-going assessment of their strengths and weaknesses, support and encourage their questions, be available for consultation when needed, serve as a positive role model to them, and cut the apron strings when the time is right.

In addition to her teaching responsibilities, the mentor also guides the faculty in the revision of the instructional materials, maintains records of student evaluation outcomes, consults with jury members as needed, and supervises the varied administrative activities, such as correspondence with prospective students, submission of progress reports and so on.

TUTORS

Faculty and practicing professional tutors have an invaluable role to perform. They provide much of the student instruction in individual and small group conferences, as well as in clinical settings. Their anecdotal notes are helpful to the mentor in her counseling of students as they progress through the program. Tutors also contribute to the revision of learning packages and assessment tools.

THE JURY

The jury, composed of faculty and practicing professional members, is responsible for the certification of the students' attainment of the terminal generic competencies and for the retroactive assignment of letter grades to the competencies and to the learning packages. Students receive S (satisfactory) grades as they successfully complete each learning package in the program. The jury's task is then to devise instruments which enable them to determine the students' competence as a graduate of the program. The current jury utilizes four basic evaluative measures: 1) a simulated patient care situation, 2) objective and essay examinations, 3) a grand rounds presentation based on a clinical practicum, and 4) a personal interview. The jury members, who are experts in each of the four divisions, also assess the student's portfolio of her work throughout the

program and consult with the mentor as they deem necessary.

Letter grades are then assigned to the terminal competencies and to the learning packages. The student has two transcripts, one reflecting each of the two sets of grade assignments. Needless to say, this is an anxiety-producing experience for the student but the thirteen who have completed the process unanimously praise the jury's supportive attitude, the objectivity of the assessments, and the valuable learning experiences gained.

THE PILOT STUDY

Fifteen incoming generic students volunteered for the pilot study, which began in the fall of 1974. Members of a control group were randomly selected and baseline academic and psychological testing was done. Both groups were heterogeneous and had comparable academic ability. The COA group consisted of twelve women and three men, thirteen Caucasian and two black students (one male and one female). One student was lost from the program, thirteen have graduated, and one will complete the jury process this quarter. One student completed the COA program six weeks before the traditional deadline for her class. Others finished from one to four weeks early.

On-going evaluation of the pilot group is being done by the DIRS staff, including an anticipated post-graduation survey of the group. Let me say, subjectively speaking, that I believe the graduates of this program to be more self-confident, more self-directed and more goal-oriented than our traditional graduates. These behaviors can be attributed, I believe, to the individualized attention which they received as well as their opportunity to participate actively in the learning process without the "fear of failure."

PRESENT AND FUTURE EFFORTS

The faculty have identified several areas in which ongoing effort is required. Some of these areas are the development and/or acquisition of more valid and reliable assessment tools; and the increased utilization of enabling competencies to further delineate the expectations of student performance on each level.

The number of terminal generic competencies has been refined to seventeen; the level competencies are reviewed periodically by the faculty; and learning packages are revised to keep them in line with current trends in nursing and in education.

IMPLICATIONS OF THE PROGRAM

The generic students who have especially benefited from the COA approach are those who feel bound by the restraints of a traditional

curricular schedule and rigid course requirements as well as those who for academic and/or personal reasons would be penalized by the traditional time structure.

The COA approach is currently being used by all our Registered Nurse students. Its advantages for this group are the recognition and utilization of past experiences, the individualization of learning activities, and the flexibility of scheduling.

Another group who would conceivably benefit from the COA structure are students with a college degree in another field.

SUMMARY

The Curriculum of Attainments is based on the concept of student competency certified by jury process without regard to the time spent in attaining competence. It is the belief of the FSU Nursing faculty that COA is a viable option for students who enter the program with past experiences and current needs for a time-variable, individualized learning environment. Many of the concepts utilized in the COA have been integrated into the School's revised curricular structure. The COA program and the School's experience with it have stimulated and challenged the faculty to seek more creative, individualized approaches to the educational preparation of the professional nurse.

CLINICAL PERFORMANCE EXAMINATION

Carrie B. Lenburg, Coordinator
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In discussing the general topic of developing objective clinical performance examination in nursing I will use the New York Regents External Degree Program as the prime example. Almost without exception, it is the only program to my knowledge that uses an intensive, lengthy, individual clinical examination to validate the student's nursing competence prior to graduation. But more and more regular on-campus faculties are searching for ways to systematically and reliably test students in this critical component of the program.

We have much more to learn, but we have made a positive start in the right direction. I'm sure you will find ways of modifying our techniques to better serve your own needs. I am glad to share what we have learned.

Before I enumerate some general criteria, I'd like to tell you briefly how the Regents External Degree Clinical Performance in nursing Examination (CPNE) was developed and who was involved.

The Regents External Degree Clinical Performance Examination

The ten-member performance subcommittee worked diligently for nearly three years to create an explicit, objective, measurable test of clinical nursing competence. More than 500 full faculty days and $100,000 -- exclusive of staff and the coordinator's time -- were spent on this one examination. In addition, more that $5,000 and three months were spent on the final pilot test. Because of the extensive detail, only a summary of the examination and the committee's activities will be presented here.

Seven of the performance subcommittee members were concurrently employed as full-time clinical educators in seven different ADN nursing programs, primarily from New York, both upstate and downstate; one member was from New Jersey. Three members also were on the Overall Faculty Committee. Although three members were not clinical nursing educators, each one had significant expertise in associate degree education; two were professors at Teachers College, Columbia University and the third had administered several ADN nursing programs since the early 1950's. Together they brought a wealth of current and historical knowledge and expertise regarding expectations of clinical competence for the associate degree nursing graduate. However, this did not make their task easier since they had no model to emulate, no example to follow.

The task assigned to this subcommittee by the Overall Faculty was to develop an examination of essential aspects of nursing which could not be measured on written examinations. Furthermore, it was to include all phases of the nursing process: planning, implementation and evaluation. It was not to be another test of the same material already examined but, rather, a different test to evaluate a candidate's competence to apply knowledge, make decisions, and actually administer direct nursing care to selected hospitalized patients. Unlike the norm-referenced written examinations, it would be a criterion-referenced examination based on a clearly delineated standard of excellence against which each candidate's performance would be measured.

After several months of discussion and effort, the first pilot test was conducted in a hospital setting. Much was learned from that experience, but it became very clear that the test was too cumbersome and totally unworkable in its existing form. The system of weighting some aspects of nursing care as more important than others proved to be a gigantic headache and impossible to apply in the real setting. A new approach was necessary and so the Committee started again.

Repeatedly, the notion of simulation was suggested, but the Committee decided that the CPN examination had to be conducted in an actual patient care setting if it was to be fully accepted as valid proof of the candidates' nursing ability. Many more months of debate and discussion were spent before the final format was developed.

The Committee realized very early that attempting to evaluate every task or function expected of the beginning RN was patently impossible. Instead they concentrated on identifying those areas most commonly encountered by and essential to the nurse at the technical level. Similar to the concept routinely used in test development, sampling of nursing activities and behaviors became a basic idea that was both logical and made the examination manageable. However, for the implementation phase, three categories were identified:

- required areas of nursing care (to be tested in every patient care situation);
- selected areas of nursing care (various combinations could be used);
- overriding areas of concern (physical jeopardy, emotional jeopardy and asepsis) would apply at all times.

Each of the 20 areas ultimately identified was explicitly defined (not always an easy job); then critical nursing behaviors essential to that area of care were meticulously outlined (an even more difficult job).

The Committe constantly worked to identify the critical elements of the area of care, isolating those behaviors essential to the patient's well-being, as opposed to steps in a procedure, traditional routines or personal preferences. Finally, consensus was achieved bit-by-bit as each critical element was worded as a single, observable behavior, expressed in objective, bias-free terms.

Ultimately the examination format became clear and very logical. Clinical competence could be tested using a patient care situation (PCS) as the gross unit of measurement, incorporating the three major aspects of nursing process: planning, implementation and evaluation. Because planning and evaluation are changeable and typically dependent upon many variables, guidelines rather than critical elements were written for these two phases. Critical elements were reserved for use during the implementation phase. The specified guidelines and critical elements became the finite units of measurement that had to be satisfied to demonstrate acceptable clinical competence. Therefore, during each PCS all guidelines and critical elements pertaining to required and selected areas of care and overriding areas of concern had to be performed with 100 percent accuracy to pass that portion of the examination.

Obviously one PCS was inadequate as a basis for determining clinical competence, especially since total accuracy was demanded. Also, the Overall Faculty Committee had instructed the subcommittee to evaluate the candidate's competence in administering care to both children and adults in the general patient care areas. (Nursing care related to the variety of patient care settings is tested in the other seven examinations.) After thoughtful deliberation; the committee decided that a minimum of three and a maximum of five patient care situations (PCS) would be required. Like all other aspects of the examination this decision was pilot-tested and reviewed by the Overall Faculty before final acceptance.

The candidate was required to satisfactorily administer care during two of a possible three adult PCSs and one of a possible two child PCSs. On the average, each PCS requires 50 critical elements, resulting in a minimum of 150 critical elements to be satisfied with 100 percent accuracy in order to pass the performance examination. Since each critical element is essential to patient care, if only one was omitted or failed that entire PCS was failed. Candidates were given one opportunity to repeat a child and/or adult PCS, requiring an additional 50 to 100 critical elements. Each PCS, including planning, implementation, and evaluation was expected to be completed in two-and-a-half hours. All PCSs were to be completed according to a specified schedule over a two-day period to allow maximum opportunity for success and to reduce the failure based on an "off-day" performance.

With this much of the exam completed, the Committee established the criteria for selecting the hospital setting and kinds of patient units to be used. They also determined the conditions under which the examination would be administered, and criteria for selection of patients and clinical evaluators.

Throughout the months of development, several mini-pilot tests were conducted by the seven committee members currently engaged in clinical instruction. This proved most advantageous since each had a different group of students and different clinical environment to test the particular facet then being developed. Based on this trial, revisions were

made to improve the criteria for selection of patients, number and wording of critical elements, and guidelines related to scheduling and communications with the hospital staff.

The last pilot test was initiated two months later, and served as the basis for final revisions. During this full dress rehearsal, two categories of subjects were paid to perform as if they were actual candidates. Clinical evaluators, trained to observe each candidate's performance objectively, using only the precisely worded standard of performance, were completely uninformed of the background of their subjects. The project was designed to include both "qualified" and "unqualified" subjects. Half of the unqualified group were first semester ADN students from three local programs; the other half were third semester ADN students. All of the qualified subjects were registered nurses with 1 to 3 years of nursing experience, half from diploma and half from ADN programs. The evaluator's task was to apply the Clinical Performance in Nursing Examination (CPNE), along with all attendant rules and regulations, as meticulously and objectively as possible to determine whether or not the instrument screened out unqualified subjects and screened in qualified subjects while their background and preparation were concealed.

After the several weeks required for the pilot test, the results were clear and impressive: none of the unqualified subjects passed, but all of the qualified subjects ultimately were successful, even though all PCSs were not passed. With the keen excitement that accompanies success, the Committee went to work on the finishing touches and one of them included a new dimension.

Two major factors observed earlier which were confirmed during the final pilot test led to the addition of a simulated laboratory phase to the performance examination. First, it was observed that the administration of IM and IV medications generally were ordered only every six hours, meaning that only the second and fourth PCSs would provide the opportunity for their inclusion. Second, the Committee was aware that candidates needed a period of orientation prior to beginning the examination; they also realized that some efforts would have to be taken to reduce their anxiety. Also most candidates live outside the Albany area, and would have to arrive in town the evening before the examination. Therefore, it was decided that the CPNE would be extended to cover a two-and-a-half day period, beginning with an orientation and nursing laboratory experience late in the afternoon of the first day. The five PCSs would be scheduled on the succeeding two days as previously planned.

Once this decision was made, the laboratory portion was enlarged to include oral as well as IM and IV medications, since the unit dose system is used in the testing hospital and simulation in the nursing laboratory would provide the opportunity to test the candidate's ability to pour

drugs from a stock supply. Furthermore, since violation of the principles of asepsis was found to be one of the most common reasons for failure in both the pilot tests, even among RNs, application of a sterile dressing also was added to the laboratory phase. The same critical elements would be used in both the laboratory and PCSs.

As finally developed, then, successful completion of the performance examination required that the candidate pass two of three adult PCSs, one of two child PCSs and one of two laboratory experiences -- all with 100 percent accuracy according to the guidelines and critical elements for all phases of the nursing process. This raised the minimum number of critical elements to approximately 175. By early December, 1974, the CPNE was ready for initial administration to the candidates who had anxiously awaited its completion.

It should be pointed out that while the committee was refining the CPNE, arrangements were being made to use St. Peter's Hospital (Albany, NY) for the two major pilot tests and subsequently as the initial testing center. Over a period of several months the coordinator met with members of the hospital staff, including the director of nursing, her assistants, supervisors, head nurses, staff nurses and the in-service instructors. To a very large extent, the success of the CPN examination was, and is, based on the positive attitude and cooperation of the hospital administrator, director of nursing and the staff. Conducting a clinical examination program is significantly different from a program of clinical instruction. Distinction between these and the role of the nursing staff in the performance examination had to be clarified until the ideal balance was reached between providing essential patient care and non-interference with critical aspects of the exam. Communication between staff and clinical evaluators is of utmost importance.

During the last two pilot tests a number of clinical evaluators were oriented for this unique function. Initially, recommendations for these positions were made by members of the CPNE committee; others were received later when the pool had to be enlarged. The coordinator worked with the evaluators in small groups and supervised them individually. Each was required to be a current and experienced clinical instructor, with a master's degree in nursing. In addition to review of the external degree program as a whole, the evaluator manual and candidate study guide were thoroughly reviewed. Evaluators were responsible for knowing the precise contents of the exam and all other required conditions and specifications. These evaluators were ready when the time came to administer the first actual CPN examination. Subsequently, many others have been oriented and added to the pool.

On December 10, 1974, the first three candidates arrived to face the rigorous demands of the performance examination. All three worked full-time as LPNs while going to school part-time and studying independently. All three passed. During the next five weeks, a total of 50 candidates took the examination and 42 were successful, becoming the first graduates of this unique program. One candidate typified the reaction of most at the

conclusion of the CPNE by saying: "I've lost four pounds this weekend -- by sitting! I've been through a lot of things, including the Korean War, but nothing as difficult as this."

We have continued to learn from the experience of these past months with the CPNE. From that context several criteria may be suggested for others contemplating the development of a similar examination. Time precludes an exhaustive list; rather, these are meant to serve as examples of the kinds of considerations that should be made.

1. The scope and complexity of nursing behaviors to be evaluated must be sorted out from the total that are possible. Some organizing theme must be identified as a way of integrating the exam and making it one cohesive whole. We decided to focus on an entire patient care situation and on it to superimpose the steps of the nursing process: planning, implementation and evaluation of patient care.

2. An array of particular areas of care to be evaluated must be selected and priorities assigned to meet the specified objectives and/or level being tested; some to apply to every situation and others to be selected within a range of possibilities.

3. The essential critical elements that will serve as the most finite units of measurement must be written explicitly and as free of bias and ambiguity as is humanly possible. This requires a period of time to initially develop, pilot test and refine before acceptable critical elements are derived.

4. The level and extent of expected competence must be clearly specified for students and evaluators. Because we used critical elements, we had no choice but to use 100 percent competence.

5. The conditions under which the exam will be administered and candidates evaluated must be itemized systematically in detail and must be free of ambiguity. Candidates as well as evaluators must be informed of these conditions well in advance of the exam.

6. Each point or critical element to be evaluated must relate to a directly observable behavior rather than to a belief or an assumption about that behavior. Only what is seen, heard, measured or otherwise observable is legitimate and admissible evidence.

7. Each critical element must contain only one behavior for evaluation. Each element must be considered a discrete behavior, to be enacted because it is essential to the patient's well-being.

8. Each element must be written in such a way as to apply to a variety of patient care situations rather than to only one particular situation. Each critical element, therefore, is both extremely specific and general, at the same time; it is explicit, expected, behavior that applies to a general classification of performance. For example, with medications, critical elements relate to all forms of medications.

9. Certain aspects of care are overriding and apply at all times. Explicit definitions and guidelines for use must be formulated. We use, for example, three overriding areas of concern: physical jeopardy, emotional jeopardy, and violation of asepsis.

10. Ultimately, exact areas of care to be evaluated must be validated not only by the panel of experts but also by subjecting the exam to objective pilot testing and validation studies. In the six months prior to administering the exam for the first time, we conducted two pilot tests of the instrument, process and forms. The findings substantiated our hunches and the exam was further refined based on these experiences. For those of you familiar with computer programming, this process is rather like getting caught in what I call a "development do-loop", -- develop test, administer, refine, retest, refine, administer, refine, administer, and on, ad infinitum.

In relation to the implementation of performance evaluation, still other factors must be considered and criteria applied. These relate to the evaluation setting, hospital and evaluation personnel, and conditions controlling the process of candidate evaluation.

The exam setting must be selected so as to maximize opportunities to administer the exam as designed. Clearly stated criteria for selecting hospitals and patient units help to insure appropriate clinical facilities necessary for the exam. Some points for consideration include: a sufficient number of adults and children in non-specialty areas to facilitate selection; adequate nursing staff, supplies and equipment, and physical space; attitude of support and cooperation toward the performance examination by agency and unit personnel.

After the hospital and particular patient units to be used are selected, all levels of personnel must be given a thorough and detailed orientation, especially emphasizing the importance of their part in the conduct of the examination. The distinctions between clinical instruction and clinical examination must be made explicit. Controls placed on exactly what nursing care will be administered, the time restrictions for each PCS, (two-and-a-half hours in our case), and the need for complete staff cooperation must be understood clearly. Without

such an understanding, the patient may be neglected if staff perform certain aspects of care that are crucial to the examination.

Consequently, detailed staff orientation and continuing communication is imperative if the performance exam is to be conducted successfully. I personally worked with the hospital personnel in our testing center over a period of six to seven months before we were free of undesirable incidents. This included many meetings with directors, in-service instructors, supervisors, head nurses and unit staffs. Part of the problem relates to the mobility of some workers from unit to unit, limited close supervision by team leaders, people away on vacation, days off or sick leave, or new members joining the staff without sufficient discussion on the exam process. Therefore, several months of continuous orientation are necessary until everyone realizes the difference between clinical examination and clinical instruction and is able therefore to cooperate fully and support these efforts.

WHO

All of the effort spent in identifying and defining precisely what is to be evaluated, and all of the effort spent in orienting a large segment of the hospital staff, however, are useless unless those who conduct the examination are prepared thoroughly and are capable of performing the exclusive role of objective evaluator. In the case of the external degree, all evaluators must be master-prepared teachers in nursing with at least three of the past five years in clinical instruction at the ADN level. While these criteria are essential they alone do not insure a satisfactory evaluator. In fact, part of the critical orientation for evaluators is a reprogramming of their usual and instinctive approaches to students.

Two of the biggest problems teachers have in becoming evaluators are that they constantly want to use their hands to help and they find it almost impossible to remain silent. Even then, some have great difficulty refraining from giving non-verbal clues. Facial expression and body movements can be quite effective in influencing the candidate whether on a conscious or subconscious level. However, in the clinical performance exam, especially as developed for the external degree program, the evaluator must be as objective an observer as possible -- an honest reporter of candidate's actions and inactions. She has two major functions, both terribly important: 1) to objectively observe and evaluate the candidate's performance in relation to the specified behaviors, and 2) to protect patients from harm or threat of harm.

Therefore, each evaluator undergoes a rather intensive orientation which involves becoming aware of the influence on the candidate of her own verbal and non-verbal behavior and the presence of biases, personal

preferences, and habits that actually are not critical to the patient's welfare but are nonetheless entrenched in her clinical frame of reference.

PROCESS CRITERIA

Criteria governing how the exam shall be administered also are most important. Time precludes going into a detailed discussion but some areas that must be considered may be itemized as follows:

1. Patients must be selected according to predetermined specifications and should present comparability of nursing needs for each PCS. Any one candidate should have as equal an opportunity of passing or failing as any other candidate. Criteria for patient selection should insure that patients are of comparable difficulty, have comparable language, are present at the time designated for the exam and require the essential areas of nursing care, to name just a few considerations.

2. To insure patient safety and thorough and objective evaluation of candidates each PCS must be evaluated one at a time, i.e., one candidate administering care to one patient with one evaluator carefully observing. The evaluator must observe every critical element or its omission in order to complete objectively the examination record -- called the nursing process assessment record. Hunch, inference, assumption, or any other "maybe" category is unacceptable.

3. Whether or not the candidate satisfactorily performed the critical elements and guidelines is the conclusive evidence of the candidate's clinical competence. We use a Nursing Process Assessment Record which lists each critical element for each area of care; each item must receive a positive evaluation as specified in order for the candidate to pass. Any omission or error results in failure and is described in detail for the permanent record.

4. Candidates are informed well in advance of the prespecified behaviors expected during the performance exam. These are explicitly identified in the candidate's study guide and are the same points of evaluation used by evaluators.

5. Candidates receive the study guide on request and apply for the exam when they believe they are ready and able to successfully demonstrate complete nursing care for both adults and children in a hospital setting.

6. Because we usually schedule six candidates to the CPN exam simultaneously, a clinical associate is employed to orient

candidates, coordinate the activities of six candidates and six evaluators during the two-and-a-half day exam and to serve as liaison between hospital staff and examination staff. She insures the completion of all necessary legal records and serves as a resource person for everyone involved with the exam.

7. Whenever the actual, real-life situation provides inadequate opportunities to evaluate particular areas of care deemed essential, a simulated laboratory situation should be used instead. The same critical elements are used for both lab and actual PCS.

8. Candidates require a period of orientation deliberately designed to reduce anxiety and to inform them of the reality of the examining situation. Every effort should be made to inform and minimize confusion and anxiety so that the exam measures the candidate's true competence and not merely his reaction to an extremely important and stressful situation.

In summary, the RED performance subcommittee devoted approximately 500 full faculty work-days of undivided attention to developing this performance exam. The details focus on what shall be evaluated, who shall do it, how it shall be done, where and all other related conditions. It is my hope that you will find this brief description and the criteria helpful as you work to make your performance examinations more objective, more consistent, more comparable, and more systematic. These are all critical variables that must be considered in implementing such an examination.

I am in the midst of preparing a monograph to be published soon by the New York State Education Department which describes the development of the ADN program, and includes the clinical performance and written examination study guides. It also includes a portion of the evaluator's manual. If you are interested in receiving a copy, write to:

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REPORT: ASSOCIATE DEGREE DISCUSSION GROUP

Georgeen H. DeChow, Chairman
Nursing Department
Manatee Junior College
Bradenton, Florida

The status of Assembly Bill #10932 on the "1985" Resolution which has been introduced into the New York State Assembly was discussed. The bill has been assigned to the Assembly Higher Education Committee. It has not been introduced into the Senate as yet. The work of N.U.R.S.E.S (Nurses for a Reasonable System of Education and Service) was reported. The names and addresses of the sponsors of the bill and the membership of the Assembly Committee on Higher Education were circulated. Those who have not written to oppose this bill were encouraged to do so.

Almeda Martin, Chairman of the Council of Associate Degree Programs of the National League for Nursing, discussed the motion passed by the Council of Baccalaureate and Higher Education Degree Programs at its meeting in Houston, March 17-19, 1976. The resolution requests the Board of Directors of NLN to actively support the "concept that by 1985 all candidates for licensure to practice nursing hold a baccalaureate degree with an upper division major in nursing." This motion would appear to be in opposition to a recent NLN Board statement which requested that action to change the educational and practice systems in nursing not be undertaken unilaterally and not be taken without study and planning.

Many members of the group expressed their concerns about the continuing efforts to change the system of nursing education without recognizing the role of the associate degree programs and graduates within this system. At a time when associate degree nursing programs are preparing the largest number of Registered Nurses, these actions seem to indicate a lack of understanding of the effect of such actions on the practice system.

The discussion led to the passage of the following motion, "The Associate Degree group of the Council on Collegiate Education for Nursing recommends that the Executive Committee of the Council of Associate Degree Programs of NLN call an ad hoc Council meeting this spring (1976) for the purpose of preparing a statement on the place of the Associate Degree Nursing Program in the educational system for nursing and the role of this graduate in practice." The Associate Degree group requests that this motion be forwarded to the Department of Associate Degree Programs at NLN.

Actions under consideration in Georgia and Florida which would extend both Associate Degree and Baccalaureate programs were discussed. In Georgia an additional amount of time would be added to each program. In Florida a six-month internship for all new R.N. graduates is being proposed. Efforts to counteract these moves were discussed.

REPORT: BACCALAUREATE DISCUSSION GROUP

Sylvia E. Hart
School of Nursing
University of Tennessee
Knoxville, Tennessee

The Baccalaureate Discussion Group of the SREB Council on Education in Nursing considered the following resolution and voted its adoption with 20 favoring, 3 opposed and 5 abstentions.

WHEREAS, the SREB Council on Collegiate Education for Nursing passed the following resolution in November 1975, namely:

> "WHEREAS, the Associate Degree Nursing Program was designed to help fill a gap in essential nursing services; and
>
> WHEREAS, for the past twenty-one years Associate Degree Graduates have made a substantial impact on the quality and quantity of essential nursing services; and
>
> WHEREAS, the SREB Curriculum Project has identified entry levels for nursing practice; and
>
> WHEREAS, the SREB Curriculum Project has described a system of education to prepare graduates eligible for licensure as registered nurses;
>
> THEREFORE BE IT RESOLVED, that the SREB Council on Collegiate Education for Nursing reaffirms its support for the concept that Associate Degree Education prepares the first level registered nurse for Secondary Care and is essential for today's society."

and

WHEREAS, the National League for Nursing Council of Baccalaureate and Higher Degree Programs passed a resolution at its Houston meeting in March 1976 which supports the concept of the "1985 New York State Resolution,"

BE IT RESOLVED THAT
the SREB Council on Collegiate Education for Nursing finds it necessary to reaffirm its November 1975 resolution and to convey that reaffirmation to the NLN Council of Baccalaureate and Higher Degree Programs.

The group also expressed interest in having the Council explore at one of its future meetings the issue of kind and amount of clinical supervision needed for RN's enrolled in baccalaureate nursing programs.

Other issues such as meeting NLN criteria while utilizing innovative teaching strategies, budgetary constraints and their implications, utilization of ACT and NLN pre-nursing tests as predictors of achievement for baccalaureate students and related matters were discussed but no action was taken.

REPORT: GRADUATES STUDIES DISCUSSION GROUP

Dixie Koldjeski
Director of Graduate Studies
East Carolina University
School of Nursing
Greenville, North Carolina

The Graduate Studies Forum's topic was to think about some of the non-traditional developments in graduate education.

Dr. Koldjeski initiated discussion by presenting a review of the literature as to non-traditional developments in graduate education in nursing. She attempted to seek out endeavors in curriculum, instruction, and design areas. Many innovative teaching strategies were presented but little evidence was found that graduate studies efforts included delving into the non-traditional.

She suggested two possibilities for this apparent lack of findings in the literature. One, there was little in the way of non-traditional efforts being attempted; and two, graduate faculties were so busy innovating and developing the non-traditional that they did not have time to report their findings in the literature. This seemed to be the reason that the group wished to accept.

Subjects discussed included the advantages and the disadvantages of part-time curricula for graduate education; the use of multidisciplinary course offerings including doctors, nurses, physicians' assistants, etc; the role of elective in graduate education; and the need for humanism and experiences essential to the development of the graduate student needed to be a significant part of the educational experience.

Considerable time was devoted to discussing the restrictions, either real or imagined, as to the employment of the nurse with an MPH on a baccalaureate faculty. The League implies that persons responsible for teaching must have a clinical speciality area, and the Master's of Public Health is not viewed as a clinical specialization in nursing per se. A dean present at the meeting felt it was the responsibility of the dean to give rationale to the League and to use graduates of MPH programs. There are only five of these schools in the nation, and there appears to be a very definite shortage of nurses prepared in either public health or community health nursing. There was a brief discussion as to the pros and cons of the criteria used by the League in reference to accreditation processes.

Quite a bit of time was devoted to discussing how affective experiences can be built into the program for the part-time student. Questions were raised as to the possibility of building-in some of these experiences with high intensity weekends, seminars, and providing grouping of students according to interest areas. An observation was made that students have a way of forming groups as they see the need for the interchange of ideas. The need for a change in the traditional methodologies of teaching was deemed essential.

The participants agreed that innovative endeavors were ongoing at the universities, and there was a need for these to be presented to colleagues through the literature. Somehow, faculty has to negotiate time for both research and publication if, in fact, they are to be integral parts of a university faculty. All expressed the need of time for research; concern was expressed that faculty fear criticism when placing their ideas before the public.

REPORT: CONTINUING EDUCATION DISCUSSION GROUP

Discussion Leader
Frances P. Koonz, Director
Continuing Education
School of Nursing
University of Maryland
Baltimore, Maryland

The continuing education discussion group focused on three topics:

A review of services available from the Education Research and Evaluation Branch at the National Audio Visual Center in Atlanta was outlined. Susan M. Sparks, R.N., Ph.D., Education Specialist would be available to conduct a tour of the Center, or would meet with the continuing education group during the fall 1976 Council meeting. Services available through the Center were discussed, including receiving announcements of new materials developed or acquired by the Audio Visual Center.

A discussion of the current status of the state-wide planning for continuing education in the region took place. Members present reviewed activities and plans, including some of the problems encountered.

A continuing education project in SREB was discussed. Both Pat Haase and Mary Howard Smith met with the group and suggested that consideration be given to a project to be mounted through the implementation of the Curriculum Project. Funding could be awarded to a single university for a workshop, etc., or for a multi-institutional project. It was suggested that the work of the previous committee be reviewed with emphasis on any recommendations for future action.

Individual members expressed their interest in participating in a planning meeting to discuss a regional demonstration project in continuing education in nursing.

REPORT: NEW DEANS AND PROGRAM DIRECTORS DISCUSSION GROUP

Eloise R. Lewis
Professor and Dean
School of Nursing
The University of North Carolina
at Greensboro
Greensboro, North Carolina

The forum for new deans and program directors was well attended and the response indicated keen interest. The designated time provided only a beginning.

One of the purposes of the forum was to provide the new deans and program directors in the region the opportunity to begin to know one another well enough to encourage colleague exchange and continuous dialogue that would be mutually beneficial.

The topics discussed were those which appeared to be of greatest immediate concern to new deans and program directors.

Major discussion focused on the need to develop skill in preparation of documentation -- for administration -- necessary to justify some of the special needs of a nursing program. From the discussions it would appear that the financial base of most of the programs rests on the number of FTE's generated. Therefore, it is of utmost importance that (1) faculty teaching loads, (2) contact hours, and (3) faculty student ratios be interpreted and presented in such a way that the information "fed to the computer" represents a realistic picture of need. Documentation is often difficult to develop and is frequently not well understood by persons in administration or in the computer center.

Although many persons perceived this problem as one of the major concerns there were those who had had some success in handling the problem and made helpful suggestions. The discussion posed several questions:

1. How can we best help one another in developing sound, realistic, and justifications of need -- in informal forum discussions or in a special program?

2. Would an SREB publication be sufficiently useful or helpful enough to justify the expenditure of time and money?

3. Are there sources already available that persons have found helpful? If so, how can they best be shared?

Some members of the group expressed the need to have discussions on the differences in the meaning of upper and lower division components of the nursing program. Members of the group cited the major sources in the literature which they knew to be helpful and made many constructive suggestions about available resources.

In summary, it would appear that there is need to develop a mechanism where the most common day-by-day problems that trouble new deans and program directors can be shared.

REGIONAL RESEARCH PROJECT #1

Continuing Education in Nursing Research: A Summary of Progress and Prospects

Joyce Semradek
School of Nursing
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina

Progress to Date

The first year-long workshop of the regional research project designed to demonstrate and evaluate a method of regional research training and development was completed in January. This first workshop has moved us toward achieving the project's specific aims, namely, increasing the clinical research competence of faculty in schools with graduate programs, generating research which has a potential for improving patient care, and identifying factors which help or hinder the conduct of such research within the realistic constraints of a faculty workload.

Twenty participants from 13 states were selected for the 1975 workshop. They represented a wide range of interests and experience. Six of the twenty participants had doctorates, three were clinical specialists, and one was a nursing service administrator.

During the course of the year only one of the original number (20) of participants dropped out of the project. Three faculty moved to other schools in the South. Though the move caused delays for two of them they plan to continue their proposed research. Two participants who remained in their original positions had to abandon their original plans because of unforeseen changes in the local setting. Others pursued their original aims with only minor alterations in design.*

The participants returned to Chapel Hill for the final week-long session with their research in various stages of completion. To accommodate the diversity, the first three days were focused on individual projects. Time was devoted to individual work with consultation on design,

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*A list of the participants and the titles of their studies appeared in an earlier report to the Council (Spring, 1975) and in Nursing Research, Vol. 24, September-October 1975, p. 334.

analysis and writing available as necessary. During this time, most participants drafted an article of some aspect of their research even if it was not completed. Some used the time and consultation to move ahead with analysis or revising or refining study plans.

The last two days of the week focused on future planning for both the participants and the regional project. Participants planned the promulgation or continuation of their current research activities and arranged for future collaboration with other participants who shared their interests. To keep participants abreast of the developing interests of their colleagues and to facilitate continued collaborative involvements in research, a newsletter will be circulated to participants during the remainder of the project period.

Participants were also asked to evaluate the workshop and to respond to ideas for the coming year. Specific recommendations have been incorporated in the plans for the next workshop, described below.

To take advantage of their experience, we formalized a system for continuing to obtain their opinions as planning proceeds. An advisory board was created to review and comment on workshop plans as they evolve. In addition, three of the participants were asked to join the project steering committee to assist in future planning.

Prospects Ahead

Based on our past experience and the recommendations of participants in the first workshop, the project steering committee has made some changes in focus and format. Since a majority of participants recommended concentrating on fewer, common projects, this workshop will focus on no more than four problem areas whose study has promise of improving patient care. Participants will be recruited because of their interest in one or more of the present problems and will be selected on the basis of their ideas for studying them. Efforts will be made to include a larger number with major nursing service responsibilities -- another strong recommendation from the first group.

Like the first year-long workshop, the second will include three group sessions at Chapel Hill with interim work at home institutions. The first session, lasting a week, will be held Tuesday through Saturday, September 7-11, 1976; the second, a three-day session, will be held Wednesday, Thursday and Friday, November 17, 18 and 19, 1976; and the third, lasting a week, will be held in September, 1977.

During the first session, participants will develop a proposal for a pilot study. Support needed during the interim to implement the proposed plans in the local setting will be arranged before participants return

home. At the second session, two months later, they will make alterations in their design and arrange assistance needed for continuing the study during the interim. During the final week-long sessions, participants will interpret their studies, prepare a written report and plan for future promulgation.

As in the last workshop, sessions will include some group instruction and discussion of methodologic issues. However, instead of working on individual research, participants will be working in subgroups on a common research problem. Within the problem subgroups there is room for variation -- some participants from different institutions may wish to work on a common design and thus replicate the study in different settings; others may wish to study different aspects of the problem, test different interventions or develop different measures. Consultants will be available to provide assistance with substantive and methodologic problems posed by each specialized area of research. Focus on a limited number of common projects will permit the inclusion of larger numbers of participants without requiring additional consultant time. Moreover, working on common projects, even if collaborators are replicating studies in different settings, helps reduce the isolation of researchers -- one of the purposes of the regional project.

Interim support, which was a problem during the last workshop, will also be improved. While preserving the needed individuality, we have planned a more realistic and efficient system of providing support from workshop preceptors and promoting support in home settings and among participants. Moreover, to further reduce the isolation of researchers, we are encouraging two collaborators from each locale to attend the workshop sessions together, although this may not always be feasible.

Another persistent problem reported by the former group is their work load at home. Though this is not under the control of the steering committee, we hope that by recruiting participants now for the fall semester, there will be sufficient time to allow for adjustment of schedules.

Application packets have been mailed to deans and directors of schools with baccalaureate and master's programs. If you do not receive the packets or would like further information about the coming workshop, contact Joyce Semradek, Project Director, School of Nursing, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina 27514.

Steering Committee

Evelyn Anderson, Associate Professor of Nursing, University of Texas at San Antonio
Dorothy Brundage, Assistant Professor of Nursing, Duke University
James W. Dickoff, Professor of Philosophy, Kent State University
Patricia James, Professor of Philosophy, Kent State University
Mary V. Neal, Professor of Nursing, University of Maryland at Baltimore
Audrey Spector, Nursing Programs Director, Southern Regional Education Board
Nancy Strand, Director of Nursing, University of Arkansas Medical Center
Carolyn Williams, Associate Professor of Nursing and Assistant Professor of Epidemiology, University of North Carolina at Chapel Hill
Phyllis Verhonick, Professor of Nursing, University of Virginia

HIGHLIGHTS OF GROUP DISCUSSION

Gwendoline R. MacDonald
Dean, College of Nursing
University of South Florida
Tampa, Florida

Following are the highlights of the discussions held by the four groups. These highlights are summarized from minutes submitted by the recorders for each group.

Associate Degree Group

There was discussion of and general support for exploring the possibility of the SREB Council sponsoring a national conference for AD nurse educators. Such a conference might focus on the competencies of AD graduates for practice using the SREB Curriculum Project recommendations as a framework for the conference. Other conference topics might include administrative problems, including budgeting, evaluation of clinical practice, use of clinical resources, and integration of audio-visual materials in courses of study. Other topics mentioned in the group discussions included: 1) development of leadership skills; 2) National Health Insurance plans and changes in health care delivery; 3) role of the Director of Allied Health versus Director of Nursing Education; 4) peer group -- faculty evaluations; 5) leadership theory basic to nursing via group process; 6) management skills and strategies; 7) accreditation methods, issues, and alternatives; and 8) Buckley Amendment as it affects student evaluations and records.

The associate degree group also spent considerable time listening to Dr. Jerry Griffin discuss the New York State Nurses' Association resolution regarding preparation for nursing practice. As a result, the group voted to ask the Council to support a resolution that associate degree programs prepare first level registered nurses for secondary nursing care and that their graduates are essential to meeting health needs in our society. (See p. 64 for resolution.)

Baccalaureate

Following are the questions posed during discussions in this group and some of the responses elicited from the group:

1. What kinds of activities are being carried out to prepare the student for changing roles of women and nurses?

    a. Introduce self-awareness in the psychiatric setting through small group seminars, etc.

    b. Make students aware of political power and influence through personal contact, letter writing, internships in political offices.

c. Establish an elective course in Rational Therapy Behavior including peer pressure and assertiveness training.

d. Encourage active rather than passive learning behavior in students.

e. Include the male student in the new socialization process.

f. Look at the role model that we ourselves are depicting to students.

g. Provide opportunities for students to serve on nursing and university or college-wide committees.

h. Project the total concept of family life.

i. Develop student health team projects and formal class participation.

j. Encourage the establishment of nursing clinics with nurses functioning in independent roles.

k. Direct attention to the commitment of nursing administrative personnel to a role of equality with other administrative personnel.

l. Need to take a look at what students want in role models.

m. Promote more involvement in nursing organizations by nurses.

2. What benefit can this Council be to baccalaureate programs?

a. Encourage programs for faculty development within higher education.

b. Develop faculty skills in physical assessment.

c. Determine faculty needs and then plan workshop to meet these needs.

Graduate

The group discussing graduate education focused on theory building and research. Discussion also included the need for change in traditional labels for practitioners -- the need for labels that would provide a new image. Also needed are more opportunities for students to have experience in other than traditional settings, i.e., in rural

settings, non-medical center settings and settings providing opportunities for development of collaborative relationships with other health professionals.

The group also discussed the need for more flexible approaches to providing graduate education: summer and satellite programs, more part-time offerings, moving away from the medical model, more flexibility in meeting requirements, etc.

This group recommended the following as possibilities for future Council programs: 1) systems approach; 2) criteria for evaluating education and practice in non-traditional settings; 3) study of labels for various kinds of practitioners and the images they convey; and 4) preparation of nurses for practice in public health. It was suggested that the Council sponsor a series of separate meetings for faculty, students, and administrators in graduate programs.

Continuing Education

This group began with a discussion of what's going on in continuing education for nursing with each participant contributing from activities in their setting. Attention was directed to continuing education programs in self-awareness, basic group concepts, effective management of conflict and agreement, human relations. Also discussed were workshops on rape and on assertiveness training versus assuming role responsibility. The discussion included resources available, e.g., National Audio-Visual Center, National Library of Medicine, and satellite continuing education.

Discussion indicated a need for coordination of production of audio-visual teaching materials regionally, evaluation of materials, and more interdisciplinary efforts that bring members of the health services professions together for continuing education.

This group recommended that there be longer group sessions for continuing education at future Council meetings. It was also recommended that the Council consider sponsoring programs that focus on self-awareness, development of self concept as a person versus as a nurse and value clarification.

R E S O L U T I O N

ASSOCIATE DEGREE EDUCATION

WHEREAS, the Associate Degree Nursing Program was designed to help fill a gap in essential nursing services; and

WHEREAS, for the past twenty-one years Associate Degree Graduates have made a substantial impact on the quality and quantity of essential nursing services; and

WHEREAS, the SREB Curriculum Project has identified entry levels for nursing practice; and

WHEREAS, the SREB Curriculum Project has described a system of education to prepare graduates eligible for licensure as registered nurses

THEREFORE BE IT RESOLVED that the SREB Council on Collegiate Education for Nursing reaffirm its support for the concept that Associate Degree Education prepares the first level registered nurse for Secondary Care and is essential for today's society.

Adopted November 7, 1975 by the SREB Council on Collegiate Education for Nursing.

WOMEN AND NURSING: REFLECTIONS AND PREDICTIONS

Sylvia E. Hart
Dean, School of Nursing
The University of Tennessee, Knoxville
Knoxville, Tennessee

In my view there have been many positive actions taken in recent years which indicate that some very important and concerned groups of people have taken the accusation of bias against women very seriously. Just as we all needed to be shocked into an awareness of the problems and oppression experienced by other minority groups a decade or two ago, so we ourselves as a professional group predominantly comprised of women needed to be shocked into an awareness of just how extensively the sexual bias so prevalent in our society was working against us. Our general lack of awareness of the depth of the problem is probably best reflected in previous editions of books for children. I speak now about the stereotyping of women's roles in general.

Until it was called to our collective attention and we began to react to it, the traditional roles of girls in stories about children, and of women in stories about families, were those which have always been associated with household tasks and with the bearing and rearing of children. All of us are old enough to remember absorbing this kind of literature as we moved through our preschool and elementary educational experiences and there was little done to remove these stereotypes from our mentality as we moved into secondary and higher education and assumed our roles in adult society. It is refreshing to note that now, at least to some extent, children's books depict children engaging in activities that cut across the traditional sexual role depictions and stories are now being read by children in which it is just as appropriate for a girl to be playing football as it is for a boy to be baking a cake.

However, I fear that the collective inferiority with which the previous literature has afflicted us is well imprinted on our minds and is being overcome only with great difficulty. And I have also noticed that despite the fact that children's books do now cross sexual lines and do depict a much better mix of what characterizes male and female roles these lines are not usually crossed when children's literature depicts health care workers. Much of the children's literature still being published depicts the white coated physician, always a male, with his stethoscope around his neck, who is accompanied on his visits to the sick by the nurse, always female, always sexually attractive and always listening to, rather than talking with, the doctor. These same stereotypes are reinforced in the toy department of most department stores. If the doll is male, wearing a lab coat and a stethoscope, it is a doctor doll. If the doll is female, wearing a white dress or possibly now a white pantsuit and carrying a little white bag with a Red Cross on it, it is a nurse doll.

In the medical television shows to which we and the public at large are all overexposed, the physician still is almost always male and, with a few refreshing exceptions, the female nurse depicts typical subservience to the male dominance so clearly portrayed by the physician. I am encouraged by those television shows which have broken with this kind of stereotyping. We are still, in my opinion, quite far from a colleagueal relationship with the medical profession and part of our problem, it seems to me, is that it has not occurred to most consumers that nurses and physicians are equal partners on the health team. The media is doing us a service when it presents nurses and doctors as human beings capable of asking and answering questions, capable of making small and sometimes large judgmental errors, and also capable of accomplishing great things.

I have been encouraged by some other societal developments which, in my view, can only help the profession of nursing. One is that junior high schools in many city and county school systems have discarded courses in cooking and sewing for girls, and manual or industrial training for boys, and have substituted courses entitled "Living Mechanics" or "Household Arts." These courses are required for both boys and girls and they include information and skill development related to simple household repairs, the use of carpenter and other mechanical tools as well as such basic and useful culinary arts as baking a pie, sewing on a button, or putting up a hem. When these students enter the nursing profession I think they will present a better mix of manual skill dexterity than we have seen in the past.

In the midst of these general social changes, some with a direct and some with an indirect impact upon our profession of nursing, some other events have occurred which are worth mentioning. There was a time, and I am sure it is a time that most, if not all of us can remember, when patients spoke lovingly and devotedly about "their doctor." During that same period of history there was hardly a patient who spoke with that same level of admiration and devotion about "their nurse" although there have always been a few exceptions to this generalization, particularly, I suppose, in the arena of public health and private duty nursing. The public, however, has become increasingly disenchanted with the kind of medical attention it has been receiving. And the concept of the family doctor, with all that the term once meant, has been replaced by a somewhat secure, somewhat skeptical feeling that somewhere there is a doctor ready, willing and able to serve you. You may never see the same one twice but you will be seen, and treated, and charged for services rendered.

Meanwhile, back in the nursing profession, some nurses began calling themselves independent nurse practitioners and established viable practices. Others began working in rural clinics or in areas where health care delivery had been nonexistent or woefully inadequate and clients being served by these nurses began to build up confidence in and rapport with "their nurse." I recently had the opportunity to work with several groups of senior students in our own program who have

part of their Community Health nursing experience in some of the small Applachian communities surrounding the Knoxville area. The nurse practitioners, usually one nurse to a clinic, that are operating these facilities are viewed by the clients who are served in these clinics as "their" nurse. They are perfectly satisfied to have their examinations conducted by the nurses, to receive their treatments from them and to pay them as they are able for services rendered. I have noted with interest that in our area, at least, about as many of these nurses are male as are female. Perhaps it is because these consumers have had relatively little exposure to the traditional medical and health care system that they have no difficulty at all in viewing the nurse as their primary provider and that the nurse's gender is irrelevant.

One area where many practicing nurses have continued to perpetuate sexual stereotyping to the great detriment of our professional status is in the provision of total care to hospitalized patients. In many areas of this country it is still common practice for some female nurses to delegate certain kinds of professional nursing tasks to male orderlies or aides if the needed care is for a male patient. The nursing tasks delegated to untrained or technically trained individuals by professional nurses often include complicated and potentially dangerous procedures, the administration of parenteral medications and maintaining cleanliness, nutrition and elimination. By the same token, it is still sometimes a problem to convince some nurses that male nursing students have a right to the same kind of maternity nursing experience as female students and that the maternity ward is an appropriate place to assign a male staff nurse. I believe that at least on this issue the medical profession is ahead of us in their ability to view their patients as people in need of nursing care. And I firmly believe that as long as these attitudes and behaviors prevail among even a minority of professional nurses, these nurses are saying loudly and clearly to the consumer that they have been unable to separate their professional responsibilities from some unintegrated component of their own sexuality.

I have been encouraged by the trend nationally and regionally toward a better gender mix within the nursing profession. More men are entering the profession though they are obviously still a minority group and will probably continue to be for the forseeable future. As long as they represent only one or two percent of the total nursing population, the stereotyping that nursing is a female profession will continue to be perpetuated. The male nurse will also continue to be viewed as a rather unique individual. Only recently a patient who had been cared for by one of our male students said to me, "I really got excellent care from that boy. When he came in to take care of me I was worried because I figure if the guy couldn't make it in medical school he probably wouldn't be a very good nurse either."

I don't think this patient's remark is atypical of the prevailing social attitude that men are in nursing because they couldn't make it in a more male oriented or prestigious field or, in some cases, that there is something wrong with "their maleness."

I have been pleased and encouraged by the trend which is finally moving nursing educational programs into the mainstream of academic life and that more and more nurses are being prepared in colleges and universities rather than in hospitals. This cannot help but improve the professional stature of nursing and I think it has played a large part in attracting males to the profession. I think too that we are beginning to arrive at first class citizen status on college and university campuses. It was a long time before the need for graduate preparation for nurses was recognized by the profession itself, and the lag that always exists between the time an idea is accepted and the time it is implemented at a significant level is frequently as long as a generation. Therefore, when nursing began to move into academic institutions faculty who assumed responsibility for conducting these programs were not, in general, as qualified for bonafide university and college positions as their colleagues in other departments and disciplines. Some concessions were made early and some are still being made, but I don't think there is much doubt that we have been second class citizens on college campuses for two reasons. First of all, we are still almost exclusively women. And secondly, we still, though to a decreasing degree, don't have credentials comparable to our professional counterparts. But now that we have significantly improved our collective academic credentials as well as our visibility on college and university campuses, I fear that we may be overextending ourselves or at least making some moves prematurely. Let me speak specifically to this point.

Many nurses who have become highly qualified academically by pursuing doctoral and post-doctoral education have left the profession and have become identified with the disciplines in which they were trained. Some have done this because of their own frustration with the profession and its apparent inability to accept and accommodate people with this kind of training. Some have done it because positions in other departments were more lucrative or more prestigious with more opportunities for upward mobility. Other highly qualified nurse educators and administrators are being recruited to fill high level administrative positions, sometimes because they are best qualified for the position. While it is satisfying to read about nurses who have been hired for these positions, and while it is a pleasure to read high quality research in Sociology, Psychology, Anthropology, and Physiology which is now being reported by nurses, this in my view does not necessarily represent an unmixed blessing for our profession. On the one hand it does give nursing and women some visibility and prestige that has not always been accorded us, but on the other hand it takes these very qualified people away from the profession in a very direct and practical sense. The statistics on the academic preparation of nursing faculty teaching in basic nursing programs still indicate that it will be a long-time before all nursing faculty hold a Master's degree in anything. And nurses prepared at the doctoral level are an even scarcer commodity. If those who are best trained and most highly qualified continue to move out of the profession, for

whatever reason, I believe it will take us much longer than it should to build up the backlog of people who will provide us as a nursing profession with the kind of academic and professional viability that we need. And I believe that this kind of housekeeping should precede any other kind of mobility that takes nursing talent anywhere but where we need it most.

There is another two-sided dilemma which I would like to present for your consideration, and that is the continuing proliferation of basic nursing programs and, to some extent graduate programs, which is still occurring at an alarming rate despite the hard statistics that we have at our fingertips indicating the kinds of resources upon which we draw in the development of such programs. There is no doubt that any community or region or vested interest group can always provide convincing data about the need for yet another nursing program. But central to the problem is the fact that university and college presidents or chancellors are interested in having these programs. They are interested in reporting at the end of each fiscal year that student enrollment has increased, that there are more faculty and staff employed by the college, and that there is, or soon will be, a new building, the nursing building, added to the physical plant. This last point is an important one. It is difficult for a university administrator to resist establishing a nursing program when he knows that it is possible to add another building to the campus with 67 to 75 percent of the cost of that building provided by the federal government. It is even more difficult when he learns that the expense of establishing a new program can be at least partially subsized by a special project grant and that, when students are enrolled there will be capitation money. In the face of all these pluses, such realities as the availability of qualified faculty, clinical resources and the true needs of society are overlooked, denied or rationalized away. And I think that, in some cases, nursing faculty and administrators have been are being drawn into the establishment of programs by being given all of the "good" reasons for this kind of program development, but not being privy to actual and potential problems until it is much too late. And to some extent, at least, this is related to what might be called a condescending relationship between male administrators and a female dominated profession.

One of the most encouraging accomplishments for which our profession can take credit was the passing of the new Nursing Training Act by both houses of Congress and, perhaps more important, the dramatic way by which the presidential veto was overridden by these same legislative bodies. In my entire experience as a professional nurse I have never seen our professional organizations work so effectively with such astonishing results, especially in the light of the present state of our country and of the economy. I believe that those nurses who have moved into the political arena are representing us extremely well. They have developed a level of political and legislative sophistication which compares favorable with the expertise portrayed by other professional lobbyist groups. I think that those nurses most directly involved in

the final passage of that legislation, and who are now immersed in the appropriation issue deserve the collective support, recognition, cooperation and gratitude of the entire profession. Not only are they helping all of us by obtaining necessary supplemental funds to continue to improve the quality of our programs but they have given the profession the kind of mature visibility that it has needed for a very long time. I believe a lot of politicans who never thought about the matter before realized during the process of the Nurse Training Act legislation that the nursing profession was indeed a vital force in the Health Care Delivery System and it is one profession which will be taken very seriously in the future.

A great deal has been said and written about the identity crisis which the nursing profession is still experiencing and about the fact that we are still battling for the kind of recognition that we deserve. I will not reiterate any of these comments, as they are readily available in the literature and many of the previous speakers have spoken eloquently to this issue. I have tried to identify what I believe to be encouraging signs emerging within the profession in such areas as practice, politics, education, administration and health care. And while I have identified some problem areas, I believe these can and will be solved. There is, in my view, only one thing that we need to fear. And that is, in our effort to move toward a higher level of professional autonomy with more significant recognition of our contributions, both actual and potential, we will dissipate our energies and further confuse the public if we continue to engage in internal controversy. We have some very important issues that still remain to be resolved within our profession. We need to continue to work on the improvement of nursing practice; we need to continue to improve program quality at every level; we need to continue our colleagual aspirations in relation to other members of the health team; and we need to continue our visibility and input into political, legislative and legal issues in which nursing has a stake. With all of those things to be done it is discouraging to me to see that the most serious debate which is presently raging within our profession, and especially among educators, is that related to accreditation and who should do it. If there is anything we do not need in our profession it is duplication of effort and a meaningless struggle to determine which subgroup is Number One. With all of the things within nursing that are not quite what we would like them to be, why can't we leave those things alone that are at least functional and for the most part highly efficient. If, for example, one of our organizations has developed a sound accreditation process which is c efully implemented, constantly reviewed, religiously monitored and ethically governed, how can we justify spending any of our time or energies on determining whether or not another organization should assume this responsibility. It has been decided that the whole issue needs to be studied. And, in fact, it is being studied. I must ask the question, what is it that needs to be studied? What other information do we need? We know how many programs there are in the United States, we know how many are accredited and how many are not, we know the exact process by which accreditation or nonaccreditation

is accomplished, we know what the criteria are, how they are developed and applied, and the process by which those criteria are changed. Well, some nurses accept that logic but proceed to say that then, at least, the other organization should be responsible for the review and accreditation of continuing education programs and of programs which prepare nurse practitioners. But is even this economically feasible? Can we afford the luxury of having two organizations involved in what is essentially the same process? Would it not be much more simple, much more economical and much more logical to view continuing education programs and nurse practitioner programs as parts of the offerings of an academic unit in nursing? And if an additional criterion or two are necessary to make this plan viable, then let's develop them.

The accreditation issue is obviously not the only one which divides us. But whatever the issue is, I believe that collectively we must come to an understanding about who should do what and then trust our colleagues to do it well. Perhaps if we could make that idea a reality, we could lay to rest that long believed myth about women -- that we are an insanely jealous and insecure group of people who trust no one, not even our professional associates.

Let me close by saying that we, as women and more importantly as nurses, have invested deeply in our profession. We have had and will continue to have our problems. But more and more, it seems to me, there is more that unites and less that separates us. We are better able to articulate our collective goals, and meaningful dialog with other professional groups is occurring with regularity. If we continue to believe that it is possible to improve the quality of health care and of life for all citizens, and if we continue to believe that nursing has a major, a central, a crucial role in that process, our differences will diminish, our professional viability will be strengthened and our identity problem as women and as nurses will disappear because then there will be no doubt at all about the reason for our existence.

COUNCIL BUSINESS

With Chairman Marie L. O'Koren presiding, the Council held business meetings at the fall 1975 and spring 1976 Council meetings. Between Council meetings, the Executive Committee conducted the Council's affairs. Minutes of the business meetings and reports given at the meetings, summarized here, are available to members on request.

SALARY STUDY

The Council voted to participate in an annual faculty salary study to be conducted each fall, in which Council membership will be requested to complete questionnaires, the results of which will be treated anonymously and confidentially. Subsequently, the first survey was conducted in fall 1975. A report of the results was distributed at the spring 1976 meeting (See Appendix B) and individuals commented they were glad to have the information and wished to continue the annual study.

BYLAWS

An ad hoc Bylaws Committee formulated the basic framework for bylaws which members reviewed by mail in the fall 1975 and adopted at the spring 1976 meeting.

FREQUENCY OF MEETINGS

After discussing the possibility of meeting once each year instead of twice, the Council voted that at least for 1976 and 1977, meetings will be twice per year.

COMMITTEES

The Executive Committee determined in 1975 that all committees would be ad hoc until bylaws were adopted. Action on appointment of a Research Committee was deferred until information is available about the future of the research proposal which was submitted to the DHEW Division of Nursing. A Continuing Education Committee will be appointed; members of the Continuing Education Committee for the Regional Planning for Nursing Project were asked to continue serving through fall 1975.

MEMBERSHIP

For the year 1975-76, 194 institutions participated in the Council. The institutions are represented by 271 individuals, which includes 194 nurse administrative heads and 77 program directors.

Members were requested to let the Council's Executive Director know about the types of problems, if any, encountered concerning billing procedures for membership dues. Pledges, at least, are to be in by January 31 of each year. Payments of membership dues should be made before June 30 each year.

BUDGET AND FINANCES

The Council's budget, income, and expenditures, reported at each business meeting, were as had been anticipated before the Council began its new arrangements as a dues paying organization July 1, 1975. The annual financial report will be available to members after June 30, 1976, which marks completion of the first fiscal year.

COST CUTTING

A roster of members will be prepared only once per year, in the fall, and distributed to the members.

Publications of each individual Council meeting will not be produced. The Council voted in favor of publishing the proceedings of the 24th and 25th meetings in one document which will include major addresses, reports and information about the Council's activities. The publication will be offered for sale at a cost to cover publication costs.

The annual statistical survey about enrollments and graduations will be included in the publication instead of being distributed separately (See Appendix A).

BICENTENNIAL OBSERVANCE

The Council's celebration of the nation's Bicentennial will extend from spring through fall, 1976. Members were asked to bring to the spring Council meeting news items about nursing in their schools, community or state. The news items (including little known events and facts about nursing education and practice in the past 200 years and plans and predictions about the future) will comprise the Bicentennial report which will be presented at the fall 1976 meeting.

RESOLUTIONS ABOUT ASSOCIATE DEGREE EDUCATION

At the fall 1975 Council meeting, a resolution was developed by directors of Associate Degree programs and adopted by the total Council. The resolution resolved "that the SREB Council on Collegiate Education for Nursing reaffirm its support for the concept

that Associate Degree Education prepares the first level registered nurse for secondary care and is essential for today's society." (See report of discussion groups for entire resolution.)

At the spring 1976 meeting, concern about Associate Degree Education was again expressed and the Council adopted a resolution, this time originating in the Baccalaureate Discussion Group, "that the SREB Council on Collegiate Education for Nursing finds it necessary to reaffirm its November 1975 resolution and to convey that reaffirmation to the NLN Council of Baccalaureate and Higher Degree Programs." (See Group Discussion reports for entire resolution.)

PROJECTS AND PROPOSALS

Project IODINE Follow-up. A proposal to follow-up the project on increasing opportunities for disadvantaged in nursing education was approved by the Division of Nursing, DHEW, subject to negotiations prior to activation of the grant. The proposal is entitled "Faculty Development in Nursing Education."

Research Development. A proposal, "Research Development in the South," was approved by the Division of Nursing, DHEW, and awaits funding.

Analysis and Planning Project. A one-year project, "Analysis and Planning for Improved Distribution of Nursing Personnel and Services," began September 15, 1975 by sub-contract with the Western Interstate Commission on Higher Education. Audrey Spector is project director and Katherine Le Guin is coordinator. Thirty-five nurse leaders from the South (most of them Council members or nominated by the Council) participated in a training program on planning for nurse manpower conducted by this regional project.

Nursing Curriculum Project. Originally scheduled to terminate September 30, 1975, the NCP project was extended by the Kellogg Foundation through October 31, 1976. The project's publications include three already distributed and two that are in process. Project staff Mary Howard Smith and Patricia T. Haase have continued work on plans to implement recommendations developed by the project. Proposals for several demonstration projects are completed or far advanced, and additional proposals are anticipated. The demonstration project proposals will be acted on individually by the Foundation. A proposal is also being developed for a coordinating staff at SREB to assist the demonstration projects and to facilitate further study of curricular change in non-demonstration institutions.

SOME STATISTICS ON NURSING EDUCATION IN SREB STATES*

The following tables present some data about nursing education in the 14 SREB states including information about schools of nursing and admissions and graduations. Some national data about schools of nursing are included for comparative information. These data have been taken from the reports of the American Nurses Association and the National League for Nursing, and are an updating of the information printed annually for fall Council meetings. It should be noted that regional data from previous years have been revised in the following tables to represent the 14 states presently members of the SREB compact. Therefore, chronological comparison of regional data should be made only within this report and not with previous reports which presented data about 15 states.

A few observations are noted here regarding nursing education programs and student enrollments:

Table I shows that the number of newly established programs preparing students for RN-licensure in 1973-74 decreased nationally and regionally over the previous year. Associate degree programs continue to represent the majority of the new programs, nationally and regionally.

The 15 new programs in the region which opened in 1973-74 more than offset the number of programs, 11, which closed that year. (See Table II.)

Table III presents the number of programs in the region preparing students for RN-licensure, according to type of program and accreditation status. In 1974, 55% of the 370 programs were accredited programs. By type of program, 74% of the baccalaureate programs were accredited, 36% of the associate degree programs were accredited, and 82% of the diploma programs were accredited.

Table IV reveals the continued increase in the number of admissions to practical nurse programs in the region and, at the same time, a decrease in the number of these programs. Approximately 9,400 more students were admitted to the three types of RN programs in 1973-74 than were admitted to practical nurse programs. Of the 30,024 students admitted to RN programs in 1973-74, approximately 34% were admitted to baccalaureate degree programs, 51% to associate degree programs, and 15% to diploma programs.

In 1973-74, the number of graduations from RN programs exceeded the number of graduations from practical nurse programs, which is a marked change from previous years. (See Table V.) Of the 16,600 students graduating from RN programs in 1973-74, approximately 27% graduated from baccalaureate programs, 53% from associate degree programs, and 18% from diploma programs.

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*This report was prepared by Audrey Spector and Helen Hanson.

Table I

Number of State-Approved Initial Programs of Nursing Education - R. N., Which Were Newly Established, 1966-67 Through 1973-74, in United States and 14 SREB States

Year	Number of New Programs Established			
	Total	Bacc. Degree	Assoc. Degree	Diploma
1966-67				
United States	79	12	66	1
SREB States	29	3	26	0
1967-68				
United States	65	14	51	0
SREB States	19	2	17	0
1968-69				
United States	85	21	62	2
SREB States	32	11	21	0
1969-70				
United States	75	17	56	2
SREB States	18	1	17	0
1970-71				
United States	64	17	47	0
SREB States	19	5	14	0
1971-72				
United States	64	11	52	1
SREB States	25	4	21	0
1972-73				
United States	51	13	37	1
SREB States	22	4	18	0
1973-74				
United States	42	9	32	1
SREB States	15	3	12	0

Sources: State-Approved Schools of Nursing - R.N., National League for Nursing, New York, New York 10019, 1967 ed., pp. 100-101; 1968 ed., pp. 102-103; 1969 ed., pp. 104-105; 1970 ed., pp. 108-109; 1971 ed., p. 103; 1972 ed., p. 91; 1973 ed., p. 93; 1974 ed., p. 103; and 1975 ed., p. 106.

Table II

Number of Initial Programs of Nursing Education - R.N., Which Closed According to NLN Accreditation Status, 1966-67 Through 1973-74 in United States and 14 SREB States

Year	Total	Number of Programs Closed: Bacc. Degree NLN Accred. Yes	Bacc. Degree NLN Accred. No	Assoc. Degree NLN Accred. Yes	Assoc. Degree NLN Accred. No	Diploma NLN Accred Yes	Diploma NLN Accred No
1966-67							
United States	33	0	1	0	3	15	14
SREB States	9	0	1	0	1	3	4
1967-68							
United States	41	0	0	0	2	28	11
SREB States	16	0	0	0	1	9	6
1968-69							
United States	39	1	1	0	2	23	12
SREB States	13	0	0	0	0	8	5
1969-70							
United States	58	0	0	1	1	39	17
SREB States	16	0	0	0	0	13	3
1970-71							
United States	56	0	2	0	0	38	16
SREB States	16	0	0	0	0	9	7
1971-72							
United States	49	0	3	1	0	35	10
SREB States	6	0	0	0	0	2	4
1972-73							
United States	55	1	1	1	2	35	15
SREB States	13	1	0	0	1	7	4
1973-74							
United States	43	1	2	1	5	29	5
SREB States	11	0	0	0	2	7	2

Sources: State-Approved Schools of Nursing - R.N., National League for Nursing, New York, New York 10019, 1967 ed., p. 99; 1968 ed., p. 101; 1969 ed., p. 103; 1970 ed., p. 107; 1971 ed., pp. 104-105; 1972 ed., pp. 92-93; 1973 ed., pp. 94-95; 1974 ed., pp. 104-105; and 1975 ed., pp. 104-105.

Table III

Number of Initial Programs of Nursing Education - R.N., 1961 and 1967 Through 1974 by Type of Program and NLN Accreditation Status, in 14 SREB States

Year*	Total Programs	Number of Programs								
		Baccalaureate Degree			Associate Degree			Diploma		
		Total	Accred.	Not Accred.	Total	Accred.	Not Accred.	Total	Accred.	Not Accred.
1961	264	47	25	22	18	1	17	199	95	104
1967	313	57	37	20	92	6	86	164	103	61
1968	316	59	38	21	108	11	97	149	102	47
1969	335	70	41	29	129	19	110	136	96	40
1970	336	70	44	26	146	36	110	120	84	36
1971	339	75	48	27	160	43	117	104	76	28
1972	357	79	53	26	180	53	127	98	77	21
1973	366	81	55	26	198	62	136	87	71	16
1974	370	87	64	23	205	74	131	78	64	14

*Number of programs in existence as of October 15 and accreditation status of programs as of January of the following year.

Sources: State-Approved Schools of Professional Nursing, National League for Nursing, New York, New York, 1962 ed.

State-Approved Schools of Nursing - R.N., National League for Nursing, New York, New York, 1967 ed., p. 102; 1968 ed., p. 104; 1969 ed., p. 106; 1970 ed., p. 110: 1971 ed., p. 106; 1972 ed., p. 94: 1973 ed., p. 96: 1974 ed., p. 109; and 1975 ed., pp. 108-109.

Table IV

Admissions to Initial Programs Which Prepare for Beginning Practice in Nursing, 1960-61 and 1966-67 through 1973-74 in 14 SREB States

Academic Year	Practical or Vocational		Total Admissions to RN Programs	Baccalaureate Degree		Associate Degree		Diploma	
	Programs	Admissions		Programs	Admissions	Programs	Admissions	Programs	Admissions
1960-61	289	8,321	9,813	46	2,229	15	546	209	7,038
1966-67	449	13,469	12,726	55	3,932	67	2,938	167	5,856
1967-68	472	14,412	13,412	57	3,871	92	4,188	164	5,353
1968-69	489	15,873	15,012	59	4,359	108	5,573	149	5,080
1969-70	522	18,522	18,741	70	5,582	129	8,040	136	5,119
1970-71	508	19,995	18,879	70	5,148	146	8,683	120	5,048
1971-72	514	20,245	23,842	75	7,451	160	11,223	104	5,168
1972-73	506	20,291	27,849	79	8,786	180	14,029	90	5,034
1973-74	502	20,637	30,024	81	10,258	198	15,364	87	4,402

Sources: Facts About Nursing, American Nurses' Association, New York, New York 10019, 1962-63 ed., pp. 94 and 185. State-Approved Schools of Nursing - R.N., National League for Nursing, New York, New York 10019, 1967 ed., pp. 102-103; 1968 ed., p. 105; 1969 ed., p. 107; 1970 ed., p. 111; 1971 ed., p. 107; 1972 ed., p. 107; 1973 ed., p. 97; 1974 ed., p. 110; and 1975 ed., pp. 110-111.
State-Approved Schools of Nursing - LPN/LVN, National League for Nursing, New York, New York 10019, 1967 ed., p. 69; 1968 ed., p. 71; 1969 ed., p. 72; 1970 ed., p. 76; 1971 ed., p. 72; 1972 ed., p. 65; 1973 ed., p. 66; 1974 ed., pp. 96-97; and 1975 ed., pp. 104-105.

Table V

Graduations From Initial Programs Which Prepare for Beginning Practice in Nursing; 1960-61 and 1966-67 through 1973-74 in 14 SREB States

Academic Year	Practical or Vocational		Total Graduations from RN Programs	Baccalaureate Degree		Associate Degree		Diploma	
	Programs	Graduations		Programs	Graduations	Programs	Graduations	Programs	Graduations
1960-61	289	5,291	5,639	46	914	15	157	209	4,568
1966-67	449	8,403	7,196	55	1,415	67	1,058	167	4,723
1967-68	472	9,802	7,894	57	1,742	92	1,344	164	4,808
1968-69	489	10,874	8,305	59	2,141	108	2,120	149	4,044
1969-70	522	11,785	8,825	70	2,325	129	2,922	136	3,578
1970-71	508	12,084	9,691	70	2,429	146	3,732	120	3,530
1971-72	514	14,202	11,102	75	2,605	160	5,076	104	3,421
1972-73	506	14,507	13,262	79	3,078	180	6,890	98	3,294
1973-74	502	14,675	16,600	81	4,481	198	8,796	87	2,990

Sources: Facts About Nursing, American Nurses' Association, New York, New York 10019, 1962-63 edition, pp. 95 and 185. State-Approved Schools of Nursing - R.N., National League for Nursing, New York, 10019, 1967 ed., pp. 102-103; 1968 ed., p. 105; 1969 ed., p. 107; 1970 ed., p. 111; 1971 ed., p. 107; 1972 ed., p. 95; 1973 ed., p. 97; 1974 ed., p. 110; and 1975 ed., pp. 110-111.
State-Approved Schools of Nursing - LPN/LVN, National League for Nursing, New York, New York; 10019, 1967 ed., p. 69; 1968 ed. p. 71; 1970 ed., p. 76; 1971 ed., p. 72; 1972 ed., p. 65; 1973 ed., p. 66; 1974 ed., pp. 96-97; 1969 ed., p. 72; and 1975 ed., pp. 104-105.

A-6

REPORT OF
A SURVEY OF NURSE FACULTY IN COLLEGE-SPONSORED
NURSING PROGRAMS IN 14 SREB STATES, SEPTEMBER, 1975

On August 4, 1975 a memorandum was sent to the heads of college-sponsored nursing programs in the 14 Southern Regional Education Board states. An enclosed postcard questionnaire requested the following information:

RETURN TO SREB NURSING EDUCATION PROJECT BY SEPTEMBER 8, 1975

I. Number of employed nurse faculty by highest earned credential:

	A) No. of Persons	B) Full-time Equivalent
Doc. deg.	____	____
Mas. deg.	____	____
Bac. deg.	____	____
Assoc. deg.	____	____
Diploma	____	____
TOTAL:		____

II. Number of vacant budgeted positions ____

III. Total no. of budgeted positions (Total of I & II) ____

Number of additional full-time positions expected to be budgeted for nurse faculty members between:
9/1/75 and 8/31/76 ____
9/1/76 and 8/31/77 ____

Type program for which additional positions are budgeted: AD__ B__ M__

Signed_____
Institution _____
State_____ Date_____

The following table shows the number of programs questioned; the number responding by September 30, and the percent of programs responding by type of program:

Type of Program	Number of Programs Questioned	Number of Programs Responding by 9/30/75	Percent Programs Responding
TOTAL	279	259	93%
Associate Degree	185	171	92%
Associate and Baccalaureate Degrees	4	3	75%
Baccalaureate Degree	62	59	95%
Baccalaureate and Master's Degrees	17	15	88%
Associate, Baccalaureate, and Master's Degrees	7	7	100%
Master of Public Health Degree*	4	4	100%

* Three institutions in the South offer Master of Public Health Degrees; one of the institutions offers two separate masters programs.

TABLE I

Number of Budgeted Positions for Nurse Faculty, Number of Vacant Budgeted Positions, and Percent of Budgeted Positions Vacant, by Type of Program in 14 SREB States, as of September, 1975

Type of Program	Number of Full-Time Budgeted Positions	Number of Positions Vacant	percent of Budgeted Positions Vacant
TOTAL N: 259	4,399	273	6.2%
Associate Degree N: 171	1,876	102	5.4%
Associate and Baccalaureate Degree N: 3	75	11	14.7%
Baccalaureate Degree N: 59	1,069	73	6.8%
Baccalaureate and Master's Degree N: 15	1,023	61	6.0%
Associate, Baccalaureate and Master's Degree N: 7	356	26	7.3%
Master of Ph N: 4	33	9	27.3%

The total number of full-time positions reported by all types of programs is an increase of 528 over 1974 data, when 3,871 positions were reported by 230 programs. The percent of budgeted vacancies decreased this year, from 6.8% in 1974. The following table shows a comparison of 1969 and 1975 data describing budgeted positions and vacancies according to type of program offered.

Type of Program Reporting	Number of Programs Reporting	Number of Full-Time Budgeted Positions	Number of Positions Vacant	Percentage of Budgeted Positions Vacant
All Programs				
1975	259	4,399	273.0	6.2%
1969	159	1,711	179.5	10.5%
Associate Degree Programs				
1975	171	1,876	102.0	5.4%
1969	101	639	80.5	12.6%
Baccalaureate Degree Programs				
1975	59	1,069	73.0	6.8%
1969	45	576	61.0	10.6%
Baccalaureate & Master's Degree Programs				
1975	15	1,023	61.0	6.0%
1969	10	464	35.0	7.5%

The 1975 returns, by type of program, also showed that:

- Associate degree programs in four states accounted for 48, or 47% of the 102 reported vacancies. In one of these three states, 22% of the budgeted positions in AD programs were vacant.
- Baccalaureate degree programs in two states accounted for 41, or 56% of the 82 vacancies reported by baccalaureate degree programs.
- Five baccalaureate & master's degree programs in four states accounted for 33, or 54% of the 61 vacancies reported by this type of program.

TABLE II

Expected Additional Full-Time Budgeted Positions for Nurse Faculty Members, by Type of Program in 14 SREB States

Type of Program	Number of additional full-time positions expected to be budgeted between:	
	9/1/75 and 8/31/76	9/1/76 and 8/31/77
TOTAL N: 259	178	318
Associate Degree N: 171	86	136
Associate and Baccalaureate Degree N: 3	6	9
Baccalaureate Degree N: 59	70	109
Baccalaureate and Master's Degree N: 15	9	42
Associate, Baccalaureate and Master's Degree N: 7	6	18
Master of PH Degree N: 4	1	4

The number of additional budgeted positions anticipated in the region in the next two years (1975-77) is 496. This is a decrease from the 569 expected in 1974, for the two-year period 1974-76.

TABLE III

Academic Preparation of Employed Nurse Faculty
in Collegiate Schools of Nursing as of September, 1975
in 14 SREB States

Type of Program In Which Faculty Employed	Number of Faculty Employed	Highest Earned Credential				
		Doctoral Degree	Master's Degree	Bachelor's Degree	Assoc. Degree	Diploma
TOTAL N: 259	4,262	255	2,665	1,260	36	46
Associate Degree N: 171	1,826	20	843	882	36	45
Associate and Baccalaureate Degree N: 3	64	4	40	20	0	0
Baccalaureate Degree N: 59	1,038	62	758	218	0	0
Baccalaureate and Master's Degree N: 15	1,001	141	799	60	0	1
Associate Baccalaureate & Master's Degree N: 7	333	20	225	80	0	0
Master of PH. N: 4	25	7	16	2	0	0

Faculty preparation in 1975 is compared to that in 1969 (as reported in the Agenda Book of the 13th Council Meeting) on the following page.

	Number of Programs Reporting	Number of Faculty	Percent of Faculty According to Highest Degree Held		
			Doctorate	Master's	Less than Master's
All Programs					
1975	259	4,262	6%	63%	31%
1969	159	1,532	4%	67%	29%
Associate Degree Programs					
1975	171	1,826	1%	46%	53%
1969	101	559	less than 1%	50%	49%
Baccalaureate Degree Programs					
1975	59	1,038	6%	73%	21%
1969	45	515	3%	73%	24%
Baccalaureate & Master's Degree Programs					
1975	15	1,001	14%	80%	6%
1969	10	429	10%	80%	10%

INFORMATION ABOUT
MASTER'S DEGREE PROGRAMS IN SREB STATES

The following report summarizes information received from 23 schools of nursing and 3 schools of public health in the 14 SREB states which offer master's degree programs for nurses. The data are collected and reported for the fall term of each year. Data of previous years may be found in the agenda or proceedings books for past fall meetings of the SREB Nursing Council.

The 1975 data reported in Tables I through V represent enrollments and graduations reported by the 23 schools of nursing and 3 schools of public health in the region, four more schools of nursing than the 19 returning the questionnaire in 1974. Three additional schools of nursing which reported they were in the process of planning a master's program are not listed in these tables.

A few observations are made regarding these data:

Master's degree program enrollments in 1975 increased by 789 students (56%) over 1974 enrollment, whereas 1974 enrollments had shown an increase of only 28 students (2%) over 1973 enrollments. Comparison of full-time and part-time enrollments in 1974 and 1975 reveals the following: full-time enrollments increased by 338, or 40% in 1975, while part-time enrollments increased by 451, or 81% in 1975. (Table I)

Graduations from master's degree programs in 1974-75 increased by 60 or 9% over 1973-74 graduations. In last year's report, 1973-74 graduations showed a 1% increase over 1972-73 graduations.

Table III presents the number of students enrolled in each master's degree program. A comparison of this information with 1974 data indicates that enrollments increased in 14 schools of nursing while 5 schools of nursing and 3 schools of public health reported decreases in 1975 enrollments.

A comparison of 1974 and 1975 data describing graduations according to nursing focus of the curriculum (Table IV) reveals increases in 1975 graduations with majors in medical/surgical nursing, maternal/child health, pediatrics, psychiatric/mental health, and public health nursing. Eleven schools of nursing and one school of public health reported an increase in the number of graduations in 1975; seven schools of nursing and two schools of public health reported a decrease. Three schools that had graduate students enrolled and are listed in Table III had no students graduating in 1975 and are therefore not listed in Table IV.

Table V presents data describing 1975 graduations according to clinical nursing focus and functional component of the curriculum. The number of graduations with no clinical focus decreased from 42 in 1974

to 21 in 1975. Supervision and administration remained steady from 1974 to 1975, while teaching and clinical specialization increased. The 1975 report shows for the first time, graduations with continuing education as the functional component.

Further information about present enrollments and future curricular offerings is presented in outline form following Table V.

Table I

Enrollments in Master's Degree Programs
in SREB States, 1965 and 1971-75

	Fall 1965	Fall 1971	Fall 1972	Fall 1973	Fall 1974	Fall 1975
Total all students	414	945	1145	1373	1401	2190
New admissions	264	576	683	773	782	1103
Full-time	229	453	554	461	552	660
Part-time	35	123	129	312	230	443
Continuing Students	150	369	462	600	619	1087
Full-time	111	242	272	312	289	519
Part-time	39	127	190	288	330	568

Table II

Graduations from Master's Degree Programs
in SREB States, 1965-66 and 1970-71 through 1974-75

	1965-66	1970 71	1971-72	1972-73	1973-74	1974-75
Total	162	415	479	635	643	703
Schools of Nursing	130	355	419	553	559	628
Schools of Public Health	32	60	60	82	84	75

Table III

Enrollments in Master's Degree Programs in SREB States, Fall, 1975

	Total All Students	New Admissions			Continuing Students		
		Total	Full-Time	Part-Time	Total	Full-Time	Part-Time
TOTAL	2190	1103	660	443	1087	519	568
Schools of Nursing	2088	1030	594	436	1058	495	563
University of Alabama	103	79	61	18	24	18	6
University of Central Ark.	14	2	0	2	12	2	10
University of Arkansas	27	17	12	5	10	7	3
University of Florida	41	17	15	2	24	20	4
Emory University	59*	51	46	5	8	4	4
Georgia State University	25	25	0	25	0	0	0
Medical College of Georgia	178**	102	53	49	76	45	31
University of Kentucky	42	28	22	6	14	11	3
Louisiana State University	43	9	2	7	34	26	8
Northwestern State University of Louisiana	52	7	4	3	45	2	43
University of Maryland	275	103	59	44	172	114	58
Mississippi University for Women	3	3	2	1	0	0	0
University of Mississippi	16+	6	4	2	10	10	0
University of Southern Miss.	43	6	2	4	37	12	25
University of North Carolina at Chapel Hill	56	30	29	1	26	25	1
Duke University	18	12	11	1	6	3	3
University of South Carolina	59	45	22	23	14	3	11
University of Tennessee	28	22	14	8	6	5	1
Vanderbilt University	47	45	43	0	2	0	2
Texas Woman's University	612	242	85	157	370	107	263
University of Texas	202	91	59	32	111	43	68
University of Virginia	58	41	18	23	17	10	7
Virginia Commonwealth Univ.	87	47	29	18	40	28	12
Schools of Public Health	102	73	66	7	29	24	5
Tulane University	21	16	14	2	5	4	1
Johns Hopkins University	44	31	26	5	13	12	1
University of North Carolina at Chapel Hill	37	26	26	0	11	8	3

* Plus 8 post-masters students.
** Plus 35 students enrolled in the "summers only" program.
Does not include 40 students enrolled in summer school program.

Table IV

Number of Graduations from Master's Degree Programs in SREB States, by Institution and Nursing Focus
September 1, 1974 - August 31, 1975

Institution	Clinical Nursing Focus of Curriculum							
	Total	M-S	MCH	Ped.	Psy/MH	PH	Other	None
TOTAL	703	242	86	49	142	100	63	21
Schools of Nursing	628	242	86	49	140	59	31	21
Univ. of Ala.	56	18	5	9	8	4	12	..
Univ. of Central Ark.	5	..	..	..	..	3	2	..
Univ. of Ark.	6	3	1	1	..	1	..	..
Univ. of Fla.	29	2	8	9	10	..	..	..
Emory Univ.	57	26	5	6	11	9	..	..
Medical Coll. of Ga.	88	39	7	..	26	..	3	13
Univ. of Ky.	20	7	1	4	5	..	3	..
La. State Univ.	2	2	..	..	..	..	..	..
Northwestern St. Univ. of La.	16	16	..	..	..	..	..	..
Univ. of Maryland	64	21	2	7	20	10	..	4
Univ. of Miss.	28	9	18	..	1	..	..	..
Univ. of South. Miss.	1	..	..	..	1	..	..	..
Univ. of N.C. at C.H.	26	11	6	4	5	..	..	..
Univ. of S.C.	24	11	..	..	2	7	..	4
Univ. of Tennessee	8	2	..	..	1	5	..	..
Vanderbilt Univ.	28	9	..	..	9	..	10	..
Texas Woman's Univ.	101	38	21	..	22	20	..	..
Univ. of Texas	37	20	10	3	3	..	1	..
Univ. of Virginia	12	..	..	5	7	..	..	..
Va. Comm. Univ.	20	8	2	1	9	..	..	..
Schools of P.H.	75	0	0	32	2	41	0	0
Tulane Univ.	3	..	..	..	..	3	..	..
Johns Hopkins Univ.	32	..	..	..	..	..	32	..
Univ. of N.C. at C.H.	40	..	..	..	2	38	..	..

Table V

Number of Graduations from Master's Degree Programs in SREB States, by Clinical Nursing Focus and Functional Purpose of the Curriculum September 1, 1974-August 31, 1975

Clinical Nursing Focus	Total	Functional Purpose of Curriculum				
		Admin.	Supv.	Teaching	Clin. Spec.	Other
TOTAL	703	49	16	258	344	36
Medical-Surgical	242	11	0	98	133	0
Maternal-Child	86	5	0	54	27	0
Pediatric	49	0	0	15	34	0
Psychiatric/Mental Health	142	2	0	52	88	0
Public or Community Health	100	13	16	34	37	0
None *	21	18	0	3	0	0
Other **	63	0	0	2	25	36

* Includes: Continuing education (3)

**Includes: Cardiovascular nursing (12), Family nurse clinician (13), General (1), Physical/Mental (2), General MPH Program (26), and Nurse Midwifery (9).

FURTHER INFORMATION ABOUT CURRICULA AND ENROLLMENTS

1. Curricula or majors to be offered for the first time in 1976-77:

   University of Florida - Child Psychiatric Nursing
   University of Mississippi - Pediatric Nursing and Community Health Nursing
   University of Virginia - Medical-Surgical Nursing
   Tulane University - Nursing Administration
   Johns Hopkins University - MPH - Community Nurse Specialist

   In addition, the Family Nurse Clinician program previously offered by the Medical College of Georgia but not offered in 1975-76, will again be offered in 1976-77.

2. Responses to the question: "Were qualified applicants to your program for 1974-75 denied admission? If yes, please state reason for denial."

   Sixteen schools of nursing and the three schools of public health responded that no qualified applicants were denied admission this year. The five schools that denied admission to qualified applicants reported that limited faculty and/or clinical resources were the reasons for such denial.

3. Responses to the question: "Could more students have been accepted and admitted to your program with existing faculty and facilities? Please explain reason for response."

   Twelve schools of nursing reported that more students could have been admitted. More students could have been admitted to the following clinical areas of study: community health nursing (three schools), psychiatric nursing (two schools), medical-surgical nursing, maternal-infant nursing, and nursing administration (one school each). Ten schools of nursing and the three schools of public health reported that no additional students could have been admitted this year.

APPENDIX B

Report of the Faculty Salary Study Council on Collegiate Education for Nursing Southern Regional Education Board 1975-76

The Council voted at its fall 1975 meeting to conduct a faculty study among its members. Subsequently, the Council's Executive Committee advised on a questionnaire and Marie O'Koren, Council Chairman, agreed to conduct the study.

In January 1976 the questionnaire was mailed to nurse administrative heads of collegiate nursing education programs in the South who are members of the Council. A total of 196 questionnaires were mailed; 162 responses were received.

Dr. O'Koren reported the findings of the survey at the spring 1976 Council meeting. The report is reproduced in the following pages, along with a copy of the memo to the schools and the questionnaire.

TYPE OF INSTITUTION IN WHICH DEAN FUNCTIONS

Type of Institution	Number	Percent
Private	29	17.9
State Supported	126	77.8
Unidentified	7	4.3
Total	162	100.0

Rate of Return = 82.6%

Deans Salary Study
Private Schools with Associate Program(s) Only
1975-76

Salary Ranges (12 mo.)	Number	Percent	
10,000 to 15,000	2	40.0	
15,001 to 20,000	2	40.0	Mean = 17,218
20,001 to 25,000	1	20.0	Median= 18,000
Total	5	100.0	

Deans Salary Study
Private Schools with Program(s) at All Degree Levels
1975-76

Salary Ranges (12 mo.)	Number	Percent	
10,000 to 15,000	2	50.0	
15,001 to 20,000	1	25.0	Mean = 16,417
20,001 to 25,000	1	25.0	Median= 15,933
Total	4	100.0	

Deans Salary Study
Private Schools with Bachelor's and Graduate Program(s) Only
1975-76

Salary Ranges (12 mo.)	Number	Percent	
10,000 to 15,000	1	5.0	
15,001 to 20,000	9	45.0	
20,001 to 25,000	6	30.0	Mean = 22,236
25,001 to 30,000	2	10.0	Median= 20,913
30,001 to 35,000	1	5.0	
35,001 to 40,000	1	5.0	
Total	20	100.0	

Deans Salary Study,
State Supported Schools with Associate Program(s) Only
1975-76

Salary Ranges (12 mo.)	Number	Percent	
10,000 to 15,000	6	07.7	
15,001 to 20,000	46	59.0	Mean = 19,184
20,001 to 25,000	22	28.2	Median= 18,947
25,001 to 30,000	4	05.1	
Total	78	100.0	

Deans Salary Study
State Supported Schools with Program(s) at All Degree Levels
1975-76

Salary Ranges (12 mo.)	Number	Percent	
10,000 to 15,000	---	---	
15,001 to 20,000	3	30.0	
20,001 to 25,000	2	20.0	Mean = 25,050
25,001 to 30,000	2	20.0	Median= 25,250
30,001 to 35,000	2	20.0	
25,001 to 40,000	1	10.0	
Total	10	100.0	

Deans Salary Study
State Supported Schools with Bachelor's + Graduate Program(s) Only
1975-76

Salary Ranges (12 mo.)	Number	Percent	
10,000 to 15,000	---	---	
15,001 to 20,000	5	12.8	
20,001 to 25,000	10	25.6	
25,001 to 30,000	11	28.2	Mean = 28,072
30,001 to 35,000	8	20.5	Median= 26,225
25,001 to 40,000	3	7.7	
40,001 to 45,000	1	2.6	
45,001 to 50,000	1	2.6	
Total	39	100.0	

Faculty Salary Ranges By Rank (9 months)
Private Schools with Associate Program(s) Only
1975-76

Faculty Rank	Minimum	Maximum
Instructor	7,000	12,222
Assistant Professor	8,595	12,500
Associate Professor	11,500	17,000
Professor	12,500	18,500

Number of Responses - 5

Faculty Salary Ranges By Rank (9 months)
Private Schools with Program(s) at All Degree Levels
1975-76

Faculty Rank	Minimum	Maximum
Instructor	9,315	13,910
Assistant Professor	10,440	15,943
Associate Professor	11,520	18,083
Professor	12,033	20,758

Number of Responses - 4

Faculty Salary Ranges By Rank (9 months)
Private Schools with Bachelor's and Graduate Program(s) Only
1975-76

Faculty Rank	Minimum	Maximum
Instructor	7,500	13,200
Assistant Professor	7,875	19,500
Associate Professor	9,375	24,000
Professor	9,750	27,000

Number of Responses - 20

Faculty Salary Ranges by Rank (9 months)
State Supported Schools with Associate Program(s) Only
1975-76

Faculty Rank	Minimum	Maximum
Instructor	6,900	15,888
Assistant Professor	8,350	25,000
Associate Professor	8,520	25,000
Professor	8,680	26,750

Number of Responses - 78

Faculty Salary Ranges by Rank (9 months)
State Supported Schools with Program(s) at All Degree Levels
1975-76

Faculty Rank	Minimum	Maximum
Instructor	8,900	14,000
Assistant Professor	11,900	18,000
Associate Professor	13,500	26,000
Professor	17,000	26,000

Number of Responses - 10

Faculty Salary Ranges by Rank (9 months)
State Supported Schools with Bachelor's + Graduate Program(s) Only
1975-76

Faculty Rank	Minimum	Maximum
Instructor	7,500	16,000
Assistant Professor	9,000	20,250
Associate Professor	10,500	22,500
Professor	12,000	32,625

Number of Responses - 39

APPENDIX B

		Schools with Associate Program(s) Only		Schools with Bachelor's + Graduate Program(s) Only		Schools with Program(s) at All Degree Levels		All Schools	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Highest Degree Held by the Dean	Bachelor's	2	2.6	--	----	--	----	2	1.3
	Master's	69	88.5	23	39.7	6	42.9	98	65.3
	Doctor's	7	9.0	35	60.3	8	57.1	50	33.3
	Totals*	78	100.0	58	100.0	14	100.0	150	100.0
	No Reply	9	10.3	2	3.3	1	6.7	12	7.4
Dean's Years of Service in Present Position	1 – 2 Years	22	26.8	12	22.2	3	23.1	37	24.9
	3 – 5 Years	19	21.2	18	33.3	3	23.1	40	26.8
	6 – 8 Years	20	24.4	10	18.5	5	38.5	35	23.5
	9+ Years	21	25.6	14	25.9	2	15.4	37	24.8
	Totals*	82	100.0	54	100.0	13	100.0	149	100.0
	No Reply	5	5.7	6	10.0	2	13.3	13	8.0
	Mean Years**	6.2		7.0		5.8		6.5	
	Maximum Years**	24		29		12		29	
	No. with 20+ Years	3	3.7	4	7.4	0	0	7	4.7
Dean's Salary, $-000	10.0 – 14.9	13	15.3	6	10.2	3	21.4	22	13.9
	15.0 – 19.9	49	57.6	10	16.9	3	21.4	62	39.2
	20.0 – 24.9	19	22.4	17	28.8	2	14.3	38	24.1
	25.0 – 29.9	4	4.7	8	13.6	3	21.4	15	9.5
	30.0 – 34.9	--	----	8	13.6	2	14.3	10	6.3
	35.0+	--	----	10	16.9	1	7.1	11	7.0
	Totals*	85	100.0	59	100.0	14	100.0	158	100.0
	No Reply	2	2.3	1	1.7	1	6.7	4	2.5
	Mean $-000**	18.0		25.2		22.2		21.1	
Dean's Salary Basis, Months	9, 9½	12	14.0	8	13.3	1	6.7	21	13.0
	10, 10½	7	8.1	3	5.0	--	----	10	6.2
	11	6	7.0	2	3.3	--	----	8	5.0
	12	61	70.9	47	78.3	14	93.3	122	75.8
	Totals*	86	100.0	60	100.0	15	100.0	161	100.0
	No Reply	1	1.1	--	----	--	----	1	0.6
Program(s) for Which the Dean is Responsible	Associate	87	100.0	--	----	15	39.5	102	49.3
	Bachelor's	--	----	58	70.7	15	39.5	73	35.3
	Master's	--	----	16	19.5	7	18.4	23	11.1
	Doctor's	--	----	2	2.4	--	----	2	1.0
	Sub-field Specialty	--	----	6	7.3	1	2.6	7	3.4
	Totals*	87	100.0	82	100.0	38	100.0	207	100.0
	Mean, per Dean***	1.0		1.4		2.5		1.3	
Full-time Faculty, School of Nursing, 1975-1976	Under 25	83	95.4	39	65.0	5	33.3	127	78.4
	25 – 49	3	3.4	15	25.0	7	46.7	25	15.4
	50 – 74	1	1.1	2	3.3	3	20.0	6	3.7
	75 – 99	--	----	2	3.3	--	----	2	1.2
	100 – 124	--	----	--	----	--	----	--	----
	125+	--	----	2	3.3	--	----	2	1.2
	Totals*	87	100.0	60	100.0	15	100.0	162	100.0
	25+	4	4.6	21	35.0	10	66.7	35	21.6
Control the College or University	Private Agency	5	6.2	20	33.9	4	26.7	29	18.7
	State Government	76	93.8	39	66.1	11	73.3	126	81.3
	Totals	81	100.0	59	100.0	15	100.0	155	100.0
	No Reply	6	6.9	1	1.7	--	----	7	4.3

*Percentage totals may not add to 100.0 due to rounding. **Based on those replying. ***Assumes 87, 60, and 15, in order, all replying.

M E M O R A N D U M

TO: SREB Council on Collegiate Education in Nursing Members

FROM: Executive Committee of the Council

SUBJECT: Faculty Salary Study

DATE: January 20, 1976

In keeping with the Council's decision at the Fall 1975 meeting to conduct a faculty salary study among its members, the attached questionnaire has been developed. We would appreciate your completing the questionnaire for return by February 20, 1976, in order that a report may be prepared for the Spring meeting. We wish to assure you that the information you submit will be held in strict confidence. Neither individuals nor institutions will be identified in the report of the study.

Please return the completed questionnaire to:

Dr. Marie O'Koren
University of Alabama School of Nursing
University of Alabama in Birmingham
University Station
Birmingham, Alabama 35294

We appreciate your participation in this study.

MLO'K:dw

SREB Council on Collegiate Education for Nursing
Faculty Salary Survey for 1975-76 School Year

Directions: Please respond to this short questionnaire, and give responses as accurately as possible using check (✓) marks or figures requested. Data should relate to the present 1975-76 academic year. The results of this questionnaire can be shared with you at the spring meeting, or sent to you at your school. To preserve anonymity, do not give your name or school (unless you so desire) and then return the questionnaire to Dr. Marie L. O'Koren.

Questionnaire Items

1. Are you dean of a private____, or state____ institution? (Check ✓)

2. Are you employed in a multidisciplinary Health (or Medical) Science Center (i.e., working with schools of medicine, dentistry, or other health disciplines)?

   Yes ____ No ____ (Check ✓)

3. What is the total student enrollment at your university or college? _____ (Rough estimate)

4. What is the total number of faculty at your university or college? _____ (Rough estimate)

5. How many students are enrolled in your school of nursing? (Check ✓)

   Less than 100 ____; 100 to 300 ____; 300 to 500 ____; 500 to 700 ____;

   700 to 1,000 ____; more than 1,000 ____

6. How many full time equivalent (FTE) nursing faculty do you have in your school of nursing? (Check ✓)

   Less than 25 ____; 25 to 50 ____; 50 to 75 ____; 75 to 100 ____;

   100 to 125 ____; more than 125 ____

7. Indicate programs under your responsibility.

   A. Associate Degree Program: Yes ____ No ____ Student enrollment size ____

   B. Baccalaureate Degree Program: Yes ____ No ____

      Student enrollment size _____

   C. Graduate Programs: Yes ____ No ____ Student enrollment size _____

      1) Master Program Yes____ No ____ Student enrollment _____

         Number of subfield specialized programs _____

2) Doctoral Program Yes ____ No ____ Student enrollment _____

Special contract programs: Family Nurse Practitioner, et cetera

Student enrollment _____

8. In round figures, what is your present salary for the academic year of 1975-76? $ _____; salary range if known $ _____

9. Is your appointment term 9 ____, 10 ____, 11 ____, or 12 months? (Check √)

10. How do you think your salary compares with non-nursing deans or directors in your university or college? Higher ____, about same ____, lower ____ (Check √)

11. Do you hold a doctoral degree? Yes ____ No ____ If not, what is your highest degree earned? _____

12. Approximately how many years have you served in the dean or director role? ____

13. In round figures, what is the present salary range for faculty, according to faculty rank, schedule, or other categorization?

14. Are faculty appointment terms 9 ____, 10 ____, 11 ____, or 12 ____ months? (please check /)

Thank you for your participation!

Please send completed questionnaire in enclosed envelope:

Dr. Marie L. O'Koren
University of Alabama School of Nursing
University of Alabama in Birmingham
University Station
Birmingham, Alabama 35294

APPENDIX C

ROSTER OF MEMBERS

SREB Council on Collegiate Education for Nursing

October 10, 1975

(Persons who have paid or pledged membership fees for the year July 1, 1975 to June 30, 1976).

Nurse Administrative Heads

Type of Program	Institution
	ALABAMA
A	Ms. Dolores Higgins, Director Department of Nursing Education Gadsden State Junior College George Wallace Drive Gadsden, Alabama 35903
A	Ms. Rhoda L. Kirkpatrick Chairman, Division of Nursing J. C. Calhoun State Community College P. O. Box 2216 Decatur, Alabama 35601
A	Ms. Mable E. Lamb Director of Nursing Division of Health Related Technology Jefferson State Junior College 2601 Carson Road Birmingham, Alabama 35215
A	Dr. Dagmar E. Brodt, Director School of Nursing College of General Studies Livingston University Livingston, Alabama 35470
B	Dr. Hilda F. Reynolds, Chairperson Division of Nursing Mobile College P. O. Box 2144 Mobile, Alabama 36601
A,B	Dr. Laurene Gilmore Dean, School of Nursing Samford University Birmingham, Alabama 35209

CODE

A - Associate
B - Baccalaureate
M - Master's (Ph designates a school of public health)
Ph.D - Doctorate
CE - Continuing Education

Type of Program	Institution
A,B	Ms. S. Betty Thomas Dean, School of Nursing Troy State University Troy, Alabama 36081
B	Dr. Lauranne Sams, Dean School of Nursing Tuskegee Institute Tuskegee, Alabama 36088
B,M	Dr. Marie L. O'Koren, Dean School of Nursing University of Alabama University Station Birmingham, Alabama 35294
B	Ms. Mary Lloyd Acting Dean, School of Nursing University of Alabama in Huntsville Box 1247 Huntsville, Alabama 35807
B	Dr. Elizabeth S. Martin Dean, School of Nursing University of North Alabama Florence, Alabama 35630
B	Ms. Earline B. McRae, Director Division of Nursing University of South Alabama Mobile, Alabama 36688
	ARKANSAS
B,M	Dr. Jeanette P. Grosicki Chairman, Department of Nursing University of Central Arkansas Conway, Arkansas 72032
A	Ms. Pat Williams, Head Nursing Department Southern State College Magnolia, Arkansas 71753

Type of Program	Institution
	ARKANSAS (continued)
A	Ms. Elaine Forrest, Director Associate Degree Nursing Phillips County Community College Helena, Arkansas 72342
A,B, M	Dr. Elois R. Field Dean, School of Nursing University of Arkansas Medical Center 4301 West Markham Little Rock, Arkansas 72201
	FLORIDA
B	Sr. Judith Ann Balcerski, Dean School of Nursing Barry College 11300 N.E. 2nd Avenue Miami, Florida 33161
A	Dr. Joseph Keller Chairman, Division of Allied Health and Nursing Brevard Community College 1519 Clearlake Road Cocoa, Florida 32922
A	Ms. Marjorie Brantferger Broward Community College South Campus 3601 Johnson Street Hollywood, Florida 33021
A	Ms. Barbara A. Warren, Chairman Department of Associate Nursing Daytona Beach Community College Daytona Beach, Florida 32015
B	Ms. Eunice J. Burgess Dean, School of Nursing Florida A & M University Tallahassee, Florida 32307
B	Ms. Esther L. Mooneyhan Acting Chairperson Nursing Program Florida International University Tamiami Trail Miami, Florida 33199
	FLORIDA (continued)
B	Ms. Marjorie Sparkman Acting Dean, School of Nursing Florida State University Tallahassee, Florida 32306
A	Ms. Olive V. Galloway Dept. Chairman - Nursing Dept. Hillsborough Community College 39 Columbia Drive Tampa, Florida 33603
A	Ms. Joan Joyce Coordinator of Nursing Program Hillsborough Community College 39 Columbia Drive Plant City Campus Tampa, Florida 33203
A	Ms. Frances Hammett, Director Health Education Division Indian River Community College 3209 Virginia Avenue Fort Pierce, Florida 33450
A	Ms. Chrystal A. Callups, Director School of Nursing Lake City Community College Lake City, Florida 32055
A	Ms. Georgeen H. DeChow, Chairman Nursing Department Manatee Junior College 5840 26th Street West Bradenton, Florida 33506
A	Ms. Denise Kahn, Dean Nursing Education Department Miami-Dade Community College Medical Center Campus 11380 N.W. 27th Avenue Miami, Florida 33167
A	Ms. Betty A. Morgan Chairman, Nursing Department Palm Beach Junior College 4200 Congress Avenue Lake Worth, Florida 33460

Type of Program	Institution
	FLORIDA (continued)
A	Ms. Irene Workman, Head Nursing Department Pensacola Junior College Pensacola, Florida 32504
A	Dr. Carol Bradshaw, Coordinator Nursing Programs Santa Fe Community College Gainesville, Florida 32601
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A	Ms. Almeda B. Martin Chairman, Nursing Department St. Petersburg Junior College P O. Box 13489 St. Petersburg, Florida 33733
B,M	Dr. Blanche Urey, Dean College of Nursing J. Hillis Miller Health Center University of Florida Gainesville Florida 32610
B,M	Ms. Barbara Buchanan, Dean School of Nursing University of Miami P. O. Box 375, Biscayne Annex Coral Gables, Florida 33124
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A	Mr. Luis E. Folgueras, Chairman Health Related Programs Valencia Community College P. O. Box 3028 Orlando, Florida 32811
	GEORGIA
A	Ms. Fannie Dewar, Acting Director Department of Nurse Education Abraham Baldwin Agricultural College ABAC Rural Station Tifton, Georgia 31794
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B	Ms. Mildred B. Pryse Acting Chairman Department of Nursing Albany State College Albany, Georgia 31705
A	Sr. M. Bonaventure Oetgen Head, Department of Nursing Armstrong State College Savannah Georgia 31406
A	Ms. Edith M. Larson Director of Nursing Program Dalton Junior College Dalton, Georgia 30720
A	Ms. Anne Tidmore, Head Nursing Department DeKalb Community College 555 North Indian Creek Drive Clarkston, Georgia 30021
B,M	Dr. Edna Grexton, Dean School of Nursing Emory University Atlanta, Georgia 30322
A	Ms. Eelen D. Nora Director of Nursing Education Floyd Junior College P. O. Box 1864 Rome, Georgia 30161
A	Ms. Catherine Summerlin Chairman, Department of Nursing Education Georgia College Milledgeville, Georgia 31061

Type of Program	Institution
	GEORGIA (continued)
A	Ms. Rosella Deriso, Chairman Department of Nursing Georgia Southwestern College Americus, Georgia 31709
A,B, M	Ms. Evangeline B. Lane, Chairman Department of Nursing Georgia State University 33 Gilmer Street Atlanta, Georgia 30303
A	Ms. Charlotte S. Sachs Director of Nursing Education Kennesaw Junior College Marietta, Georgia 30061
B,M	Dr. Dorothy T. White, Dean School of Nursing Medical College of Georgia Augusta, Georgia 30902
A	Ms. Sarah Lee Patram, Director Department of Nursing North Georgia College Dahlonega, Georgia 30533
A	Ms. Mary I. Hipp Chairman, Division of Nursing South Georgia College Douglas, Georgia 31533
B	Ms. S. Virginia Harmeyer Director, Division of Nursing Valdosta State College Valdosta, Georgia 31601
A	Dr. J. Yvonne Webb, Director Department of Nursing West Georgia College Carrollton, Georgia 30117
	KENTUCKY
A	Ms. Theresa Sharp, Director Nursing Education Cumberland College Box 659 Williamsburg, Kentucky 40769
A,B	Ms. Charlotte Denny Chairman Department of Nursing Eastern Kentucky University Richmond, Kentucky 40475
A	Ms. Martha A. T. Knudson Chairman, Associate Degree Nursing Program Elizabethtown Community College University of Kentucky Elizabethtown, Kentucky 42701
A	Ms. Patsy C. Turner Chairperson, Department of Nursing Education Kentucky State University Frankfort, Kentucky 40601
A	Ms. Effie Kemp, Chairman Associate Degree Nursing Program Lexington Technical Institute University of Kentucky Lexington, Kentucky 40506
A	Ms. Jane Ray, Head Department of Nursing and Allied Health Morehead State University P. O. Box 856 Morehead, Kentucky 40351
B	Dr. Ruth E. Cole, Chairman Nursing Department Murray State University Murray, Kentucky 42071
A	Ms. Dixiana Smith, Chairman Nursing Department Northern Kentucky State College Louis B. Nunn Drive Highland Heights, Kentucky 41076
B	Sr. Kathleen Mary Bohan Chairman, Nursing Department Spalding College 851 South 4th Street Louisville, Kentucky 40203

Type of Program	Institution
	KENTUCKY (continued)
B, M	Dr. Marion E. McKenna, Dean College of Nursing University of Kentucky Lexington, Kentucky 40506
A	Ms. Marie L. Piekarski Coordinator, Program Planning and Development University of Kentucky Community College System Lexington, Kentucky 40506
A	Ms. Virginia Lehmenkuler Head, Nursing Department Western Kentucky University Bowling Green, Kentucky 42101
	LOUISIANA
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A	Ms. Barbara W. Odom Director of Nursing Louisiana State University in Alexandria Alexandria, Louisiana 71301
A	Ms. Irma A. Andrus, Director Department of Nursing Louisiana State University in Eunice P. O. Box 1129 Eunice, Louisiana 70535
B	Ms. Lynda Jane Jones, Head Nursing Department McNeese State University Lake Charles, Louisiana 70601
	LOUISIANA (continued)
A	Ms. Mary Blackmon, Head Nursing Department Nicholls State University Thibodaux, Louisiana 70301
B	Ms. Betty E. Smith, Director School of Nursing Northeast Louisiana University Monroe, Louisiana 71201
A,B, M	Dr. Peggy Ledbetter, Dean College of Nursing Northwestern State University Confederate Memorial Medical Center CMMC - Suite 1100 - Box 293 1541 Kings Highway Shreveport, Louisiana 71130
B	Ms. Ellienne Tate, Director Nursing Division Southeastern Louisiana University College Station, Box 781 Hammond, Louisiana 70401
MPH	Dr. Edna Treuting, Coordinator Community Health Nursing Programs School of Public Health and Tropical Medicine Tulane University 1430 Tulane Avenue New Orleans, Louisiana 70112
B	Ms. Ruby Tillery, Dean College of Nursing University of Southwestern Louisiana Lafayette, Louisiana 70501
B	Ms. Flora A. Blackstock, Dean School of Nursing William Carey College (Mississippi) New Orleans Campus 2700 Napoleon Avenue New Orleans, Louisiana 70115

Type of Program	Institution
	MARYLAND
A	Ms. Margaret B. Keller Director of Nursing Education Allegany Community College Willow Brook Road Cumberland, Maryland 21502
A	Ms. Patricia Lavenstein Chairperson, Nursing and Mental Health Division Catonsville Community College Catonsville, Maryland 21228
B	Ms. Frances Eickess Acting Chairman Nursing Department Columbia Union College Takoma Park, Maryland 20012
B	Ms. Doris Reese, Acting Dean School of Nursing Coppin State College 2500 West North Avenue Baltimore, Maryland 21216
A	Ms. Agnes A. Kemerer Director of Nursing Education Frederick Community College Frederick, Maryland 21701
A	Ms. Thelma C. Harding, Director Nursing Program Hagerstown Junior College 751 Robinwood Drive Hagerstown, Maryland 21740
A	Gloria Farnum Nursing Director Harford Community College 401 Thomas Run Road Bel Air, Maryland 21014
MPH	Dr. Alice Gifford Associate Professor School of Hygiene and Public Health Johns Hopkins University Baltimore, Maryland 21205

Type of Program	Institution
	MARYLAND (continued)
B	Dr. Kay Partridge, Director Nursing Education Johns Hopkins University Baltimore, Maryland 21205
A	Ms. Helen A. Statts, Chairman Associate Degree Nursing Department Montgomery Community College Takoma Park, Maryland 20012
A	Ms. Viola Levitt, Director Nursing Department Prince George's Community College 301 Largo Road Largo, Maryland 20870
B	Ms. Ruth C. Schwalm, Chairperson Nursing Department Administration Building Rm 136 Towson State College Baltimore, Maryland 21204
B,H	Dr. Marion I. Murphy, Dean School of Nursing University of Maryland 65 West Lombard Street Baltimore, Maryland 21201
	MISSISSIPPI
A	Ms. Bobbie Anderson, Chairman Department of Nursing Hinds Junior College Raymond, Mississippi 39154
A	Ms. Jimmie Wright Director of Nursing Itawamba Junior College Drawer 1503 Tupelo, Mississippi 38801
A	Ms. Shirley T. Griffin Director, Associate Degree Nursing Program Jones County Junior College Ellisville, Mississippi 39437

Type of Program	Institution
	MISSISSIPPI (continued)
A	Ms. Margaret Armstrong, Head Associate Degree Nursing Program Meridian Junior College Meridian, Mississippi 39301
B	Ms. Marion Bassett Dean, School of Nursing Mississippi College Clinton, Mississippi 39058
A	Ms. Ann Eidson, Director Nursing Department Mississippi Delta Junior College Moorhead, Mississippi 38761
A	Ms. Eileen Callahan, Chairman Nursing Department Jefferson Davis Campus Mississippi Gulf Coast Junior College Handsboro Station Gulfport, Mississippi 39501
A,B M	Dr. Bettye Jane Smith Asst. Dean of Nursing School of Nursing Mississippi University for Women Columbus, Mississippi 39701
A	Ms. Marjorie Duncan, Chairman Department of Nursing Education Mississippi Valley State University Itta Bena, Mississippi 38941
A	Ms. Mary Emma Piper Director of Nursing Northwest Mississippi Junior College Senatobia, Mississippi 38668
A	Ms. Charlotte Odom, Director Department of Nursing Education Pearl River Junior College Poplarville, Mississippi 39470
	MISSISSIPPI (continued)
B,M	Dr. Edrie J. George Dean, School of Nursing University of Mississippi Medical Center Jackson, Mississippi 39213
A,B, M	Dr. Elizabeth C. Harkins, Dean School of Nursing University of Southern Mississippi Southern Station, Box 95 Hattiesburg, Mississippi 39401
A	Ms. Flora Posey, Director Department of Nursing University of Southern Mississippi at Natchez Duncan Park Natchez, Mississippi 39120
	NORTH CAROLINA
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B,M	Dr. Ruby Wilson Dean School of Nursing Duke University Durham, North Carolina 27706
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A	Ms. Grace Lee, Director Nursing Department Gardner-Webb College Boiling Springs, N. Carolina 28017

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	NORTH CAROLINA (continued)
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B	Dr. Frances Farthing Chairman, Nursing Department Lenoir Rhyne College Hickory, North Carolina 28601
B	Ms. Naomi Lynn, Dean School of Nursing North Carolina Agricultural and Technical State University 312 North Dudley Greensboro, North Carolina 27411
B	Ms. Helen S. Miller, Chairperson Department of Nursing Education North Carolina Central University Durham, North Carolina 27707
A	Ms. Jean Irving, Chairperson Nursing Department Rockingham Community College Wentworth, North Carolina 27375
B,M	Dr. Laurel Copp, Dean School of Nursing University of North Carolina Chapel Hill, North Carolina 27514
MPH	Dr. Dorothy M. Talbot, Head Department of Public Health Nursing School of Public Health University of North Carolina Chapel Hill, North Carolina 27514
B	Dr. Marinell Jernigan, Dean College of Nursing University of North Carolina Charlotte, North Carolina 28223
B,M	Dr. Eloise R. Lewis, Dean School of Nursing University of North Carolina Greensboro, North Carolina 27412
	NORTH CAROLINA (continued)
A	Ms. Dorothy Dixon, Director James Walker Memorial Associate Degree Program in Nursing University of North Carolina Wilmington, North Carolina 28401
B	Dr. Marjorie Baker, Head Nursing Department School of Arts and Sciences Western Carolina University Cullowhee, North Carolina 28723
A	Ms. Marlene M. Rosenkoetter Chairwoman, Nursing Department Western Piedmont Community College Morganton, North Carolina 28655
B	Ms. Mary Isom, Dean School of Nursing Winston-Salem State University Winston-Salem, North Carolina 27102
	SOUTH CAROLINA
A	Ms. Harriet Robinson, Director Nursing Education Program Baptist College at Charleston P. O. Box 10087 Charleston, South Carolina 29411
A,B	Dr. Geraldine Labecki, Dean College of Nursing Clemson University Clemson, South Carolina 29631
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A	Ms. Ella P. Garrison, Dean Allied Health Sciences Greenville Technical College Greenville, South Carolina 29606

Type of Program	Institution
	SOUTH CAROLINA (continued)
A	Ms. Emily Capers, Chairman Department of Nursing Lander College Greenwood, South Carolina 29646
B	Dr. Marcia Curtis, Dean College of Nursing Medical University of South Carolina 80 Barre Street Charleston, South Carolina 29401
A	Ms. Eleanor Stringer, Coordinator Associate Degree Program in Technical Nursing Aiken Regional Campus University of South Carolina Aiken, South Carolina 29801
A,B, M	Ms. Betty M. Johnson Dean, College of Nursing University of South Carolina Columbia, South Carolina 29208
	TENNESSEE
A	Ms. Mary G. Windham, Director Department of Nurse Education Austin Peay State University Clarksville, Tennessee 37040
A	Ms. Dorothy Scott, Chairman Nursing Department Belmont College Nashville, Tennessee 37203
A	Mr. Robert W. Vogler, Director Nursing Department Cleveland State Community College P. O. Box 1205 Cleveland, Tennessee 37311
A	Ms. Deanna Naddy, Director Nursing Education Columbia State Community College Columbia, Tennessee 38401

Type of Program	Institution
	TENNESSEE (continued)
B	Ms. Maria B. Hawkins, Chairman Department of Baccalaureate Degree Nursing East Tennessee State University Johnson City, Tennessee 37601
A	Ms. Eleanor H. Lowry, Chairman Department of Associate Degree Nursing East Tennessee State University Bristol Memorial Hospital Bristol, Tennessee 37620
A	Ms. Lois Holloman, Director Nursing Department Memphis State University Memphis, Tennessee 38111
A,B	Ms. Christine Perkins, Chairman Department of B.S. Nursing Southern Missionary College Collegedale, Tennessee 37315
A	Ms. Christine Sharpe Acting Director Nursing Education Tennessee State University 3500 Central Boulevard Nashville, Tennessee 37203
A	Ms. Isabel H. Neely, Chairman Department of Nursing Union University Jackson, Tennessee 38301
B	Mrs. Marjorie Szekan, Director Department of Nursing University of Tennessee Chattanooga, Tennessee 37401
B	Dr. Sylvia E. Hart, Dean School of Nursing University of Tennessee Knoxville, Tennessee 37916

Type of Program	Institution
	TENNESSEE (continued)
A	Ms. Judith Wakim, Director Department of Nursing University of Tennessee Martin, Tennessee 38237
A,B, M	Ms. Ruth Neil Murry, Dean College of Nursing University of Tennessee Memphis, Tennessee 38013
A	Ms. Dorothy Laux, Chairman Associate Degree Program in Nursing University of Tennessee 323 McLemore Street Nashville, Tennessee 37203
B,M	Dr. Sara K. Archer, Dean School of Nursing Vanderbilt University Nashville, Tennessee 37203
A	Ms. Emogene Jasper Director of Health Programs Walters State Community College Morristown, Tennessee 37814
	TEXAS
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B	Dr. Geddes McLaughlin Dean, School of Nursing Baylor University 3616 Worth Street Dallas, Texas 75246
B	Ms. Sandra Blassingame Chairman, Nursing Division Dallas Baptist College P. O. Box 21206 Dallas, Texas 75211
A	Ms. Mary Hardy, Chairman Associate Degree Nursing El Centro College Dallas, Texas 75202

Type of Program	Institution
	TEXAS (continued)
A	Ms. Mary Moses, Director Health Occupations Division Grayson County College 6101 Highway 691 Denison, Texas 75090
B	Dr. Glendola Nash Dean College of Science and Health Professions Houston Baptist University Houston, Texas 77036
B	Mr. John M. Lantz, Director Nursing Division Incarnate Word College 4301 Broadway San Antonio, Texas 78209
B	Dr. Betty Jo Hadley, Dean College of Health Sciences Lamar University P. O. Box 10062 Beaumont, Texas 77710
A	Ms. Elaine M. Geissler Director, Department of Nursing Laredo Junior College Laredo, Texas 78040
B	Ms. Nancy Schoenrock, Chairman Department of Nursing Mary Hardin-Baylor College Belton, Texas 76513
A	Ms. JoAnn Schoen, Director Nursing Education McLennan Community College Waco, Texas 76703
A	Ms. Lucile McCoy, Chairman Allied Health Department Odessa College Odessa, Texas 79760
A	Ms. Mary Frances Patterson Head, Dept. of Nursing Education Pan American University Edinburg, Texas 78539

Type of Program	Institution
	TEXAS (continued)
B	Dr. Jewellean Mangaroo Dean, School of Nursing Prairie View A & M University Houston Clinical Center 2600 Southwest Freeway Houston, Texas 77006
A	Ms. Shirley Pinterich Chairman, Department of Nursing Southwestern Union College Keene, Texas 76059
A	Ms. Jean Pryor, Chairman Nursing Department Tarrant County Junior College South Campus Fort Worth, Texas 76119
B	Dr. Virginia Jarratt, Dean Harris College of Nursing Texas Christian University Fort Worth, Texas 76129
B	Dr. Shirley Dooling Dean, School of Nursing University of St. Thomas 3812 Montrose Boulevard Houston, Texas 77006
B,M	Ms. Billye J. Brown, Dean University of Texas School of Nursing at Austin 1700 Red River Austin, Texas 78701
B,M Ph.D	Dr. Marilyn D. Willman, President University of Texas System School of Nursing Austin, Texas 78712
B,M	Ms. Christine Bonds, Dean University of Texas School of Nursing at El Paso El Paso, Texas 79902
B,M	Ms. Myrna Pickard, Dean University of Texas School of Nursing at Fort Worth 1500 South Main Street Fort Worth, Texas 76104
B,M	Ms. Dorothy M. Damewood, Dean University of Texas School of Nursing at Galveston Galveston, Texas 77550
B,M	Ms. Dorothy Otto, Acting Dean University of Texas School of Nursing at Houston Houston, Texas 77025
B,M	Dr. Patty Hawken, Dean University of Texas School of Nursing at San Antonio San Antonio, Texas 78284
B	Dr. Hazel Aslakson, Head Department of Nursing West Texas State University Canyon, Texas 79015
	VIRGINIA
B	Dr. Vida Jane Huber Chairman, Nursing Department Eastern Mennonite College Harrisonburg, Virginia 22801
B	Dr. Evelyn Cohelan, Chairman Department of Nursing George Mason University 4400 University Drive Fairfax, Virginia 22030
B	Ms. Fostine Riddick, Chairman Department of Nursing Hampton Institute Hampton, Virginia 23669
A	Ms. Evelyn C. Bacon, Director Nursing Program J. Sargeant Reynolds Community College P. O. Box 6935 Richmond, Virginia 23230

Type of Program	Institution
	VIRGINIA (continued)
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A	Ms. Goldie O. Bradley Chairman, Nursing Division Norfolk State College Norfolk, Virginia 23504
A	Ms. Marietta Cohen, Head Nursing Program Northern Virginia Community College 8333 Little River Turnpike Route 236 Annandale, Virginia 22003
B	Dr. Virginia W. Smith Chairperson, Nursing Department Old Dominion University Norfolk, Virginia 23508
B	Dr. Carol W. Batra Department of Nursing Radford College Radford, Virginia 24142
A	Ms. Daris Small, Chairman Allied Health Division Nursing Department Shenandoah College Winchester, Virginia 22601
A	Ms. Elizabeth Evans, Head Department of Nursing Thomas Nelson Community College Drawer K, Riverdale Station Hampton, Virginia 23366
A	Ms. Shirley Lee, Director Nursing Division Frederick Campus Tidewater Community College Portsmouth, Virginia 23703

Type of Program	Institution
	VIRGINIA (continued)
B,M	Dr. Rose Marie Chioni, Dean School of Nursing University of Virginia Charlottesville, Virginia 22903
B,M	Dr. Doris Yingling Dean, School of Nursing Medical College of Virginia Virginia Commonwealth University 1200 East Broad Richmond, Virginia 23173
	WEST VIRGINIA
B	Ms. Jean Roy Chairman, Nursing Department Alderson-Broaddus College Philippi, West Virginia 26416
B	Ms. Bonnie Douglas, Director Baccalaureate Degree Nursing Program Marshall University Huntington, West Virginia 25701
A	Ms. Giovanna Morton, Director Associate in Science in Nursing Degree Program Marshall University Huntington, West Virginia 25701
A	Ms. Dorothy Brooks, Head Nursing Department Morris Harvey College Charleston, West Virginia 25304
A	Ms. Minnie Keller, Director Department of Nursing Parkersburg Community College Parkersburg, West Virginia 26101
A	Ms. Dolores L. Floria Chairperson, Department of Nursing Salem College Salem, West Virginia 26426
A	Ms. Dorothy Johnson Director of Health Professions Southern W. Va. Community College Williamson, West Virginia 25601

PROGRAM DIRECTORS

Type of Program	Institution
	ALABAMA
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B	Dr. Norma Mobley, Asst. Dean and Chairman Baccalaureate Program School of Nursing University of Alabama University Station Birmingham, Alabama 35294
M	Dr. Jean A. Kelley, Asst. Dean and Chairman Graduate Program School of Nursing University of Alabama University Station Birmingham, Alabama 35294
CE	Ms. Phyllis Loucks, Director Continuing Education School of Nursing University of Alabama Birmingham, Alabama 35294
	ARKANSAS
M	Dr. Frances C. Dalmé Associate Dean Graduate Programs School of Nursing University of Arkansas Medical Center 4301 West Markham Little Rock, Arkansas 72201
CE	Ms. Marilyn Glasgow Assistant Dean Continuing Education School of Nursing University of Arkansas Medical Center 4301 West Markham Little Rock, Arkansas 72201

Type of Program	Institution
	ARKANSAS (continued)
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A	Ms. Yvonne Robinson, Director Associate Degree Nursing Program University of Arkansas 33rd and University Avenues Little Rock, Arkansas 77204
A	Ms. Ernestine Brooks, Chairman Associate Degree Nursing Program University of Arkansas at Monticello Monticello, Arkansas 71655
B	Director Baccalaureate Program Department of Nursing University of Central Arkansas Conway, Arkansas 72032
M	Director, Graduate Program Department of Nursing University of Central Arkansas Conway, Arkansas 72032
	FLORIDA
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M	Dr. Dorris B. Payne, Assistant Dean Graduate Program College of Nursing University of Florida Gainesville, Florida 32610

Type of Program	Institution
	FLORIDA (continued)
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CE	Director of Continuing Education Department of Nursing Georgia State University 33 Gilmer Street Atlanta, Georgia 30303
B	Mr. Preston Lee Davidson Associate Dean Undergraduate Program School of Nursing Medical College of Georgia Augusta, Georgia 30902

Type of Program	Institution
	GEORGIA (continued)
M	Dr. Patricia A. Moxley Associate Dean Graduate Programs School of Nursing Medical College of Georgia Augusta, Georgia 30902
CE	Ms. Susan M. Bruno Associate Dean Continuing Education School of Nursing Medical College of Georgia Augusta, Georgia 30902
B	Dr. Philip E. Delorey Associate Dean Undergraduate Programs School of Nursing (Athens) Medical College of Georgia Augusta, Georgia 30902
	KENTUCKY
A	Ms. Paulina Sloan, Coordinator Associate Degree Nursing Program Eastern Kentucky University Richmond, Kentucky 40475
B	Ms. Betty R. Rudnick Assistant Dean Undergraduate Education College of Nursing University of Kentucky Lexington, Kentucky 40506
CE	Ms. Irma Bolte, Assistant Dean Continuing Education College of Nursing University of Kentucky Lexington, Kentucky 40506
	LOUISIANA
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Type of Program	Institution
	LOUISIANA (continued)
B	Mrs. Martha Morris, Acting Director Baccalaureate Program School of Nursing Louisiana State University 420 South Prieur Street New Orleans, Louisiana 70112
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B	Ms. Barbara Dickerson, Head Baccalaureate Degree Program College of Nursing Northwestern State University Confederate Memorial Medical Center 1800 Warrington Place Shreveport, Louisiana 71101
M	Dr. Marie DeVincenti, Head Master's Degree Program College of Nursing Northwestern State University Confederate Memorial Medical Center 1800 Warrington Place Shreveport, Louisiana 71101
CE	Director, Continuing Education College of Nursing Northwestern State University Confederate Memorial Medical Center 1800 Warrington Place Shreveport, Louisiana 71101

Type of Program	Institution
	MARYLAND
B	Dr. Elizabeth Hughes Associate Dean Baccalaureate Degree Program School of Nursing University of Maryland 655 West Lombard Street Baltimore, Maryland 21201
M	Dr. Frieda M. Holt Associate Dean Graduate Degree Program School of Nursing University of Maryland 655 West Lombard Street Baltimore, Maryland 21201
CE	Ms. Frances P. Koonz, Director Continuing Education School of Nursing University of Maryland 655 West Lombard Street Baltimore, Maryland 21201
	MISSISSIPPI
M	Ms. Nancy Herban Director, Graduate Program Mississippi University for Women Columbus, Mississippi 39701
B	Associate Dean Undergraduate Program School of Nursing University of Mississippi Medical Center Jackson, Mississippi 39216
M	Dr. Faustena Blaisdell Associate Dean, Graduate School School of Nursing University of Mississippi Medical Center Jackson, Mississippi 39216
CE	Director, Continuing Education School of Nursing University of Mississippi Medical Center Jackson, Mississippi 39216

Type of Program	Institution
	MISSISSIPPI (continued)
B	Ms. Louise M. Carlton, Chairman Baccalaureate Program School of Nursing University of Southern Mississippi Southern Station, Box 95 Hattiesburg, Mississippi 39401
M	Dr. Mary Collete Smith Chairman, Graduate Program School of Nursing University of Southern Mississippi Southern Station Hattiesburg, Mississippi 39401
CE	Ms. Elizabeth C. Benjamin Chairman, Continuing Education School of Nursing University of Southern Mississippi Southern Station, Box 95 Hattiesburg, Mississippi 39401
	NORTH CAROLINA
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CE	Dr. Mallie Penry, Director Continuing Education School of Nursing East Carolina University P.O. Box 2753 Greenville, North Carolina 27834

Type of Program	Institution
	NORTH CAROLINA (continued)
B	Dr. Virginia R. Gover, Director Undergraduate Program School of Nursing University of North Carolina Chapel Hill, North Carolina 27514
M	Dr. Betty Sue Johnson, Director Graduate Program School of Nursing University of North Carolina Chapel Hill, North Carolina 27514
B	Ms. Catherine M. Turner Director, Baccalaureate Degree Program School of Nursing University of North Carolina Greensboro, North Carolina 27412
M	Ms. Margaret G. Klemer, Director Master's Degree Program School of Nursing University of North Carolina Greensboro, North Carolina 27412
CE	Ms. Marjorie G. Anderson Director, Continuing Education School of Nursing University of North Carolina Greensboro, North Carolina 27412
	SOUTH CAROLINA
A	Mr. Leon Roswal, Director Associate Degree Program College of Nursing Clemson University Clemson, South Carolina 29631
B	Dr. Arline M. Duvall, Director Baccalaureate Program College of Nursing Clemson University Clemson, South Carolina 29631

Type of Program	Institution
	SOUTH CAROLINA (continued)
CE	Ms. Dorothy Tayrien, Director Continuing Education Program College of Nursing Medical University of South Carolina 80 Barre Street Charleston, South Carolina 29401
M	Dr. Imogene Cahill, Director Graduate Program College of Nursing Clemson University Clemson, South Carolina 29631
A	Ms. Donna Moss, Director Associate Degree Program College of Nursing University of South Carolina Columbia, South Carolina 29208
B	Dr. Eugenia Lee, Director Undergraduate Program College of Nursing University of South Carolina Columbia, South Carolina 29208
M	Dr. Irene Brown, Director Graduate Studies College of Nursing University of South Carolina Columbia, South Carolina 29208
CE	Dr. Elizabeth Stobo, Director Continuing Education College of Nursing University of South Carolina Columbia, South Carolina 29208
	TENNESSEE
CE	Ms. Evelyn K. Tomes, Chairman Department of Nursing Education Meharry Medical College 1317 Albion Street Nashville, Tennessee 37208

Type of Program	Institution
	TENNESSEE (continued)
CE	Director, Continuing Education College of Nursing University of Tennessee Memphis, Tennessee 38163
A	Ms. Christine Shultz, Chairman Associate Degree Program Department of Nursing Southern Missionary College Collegedale, Tennessee 37315
B	Ms. Helen F. Bigler Associate Dean Undergraduate Affairs School of Nursing Vanderbilt University Nashville, Tennessee 37203
B	Dr. Norma Lang, Director Undergraduate Program The University of Tennessee College of Nursing Memphis, Tennessee 38163
M	Dr. Shirley Burd, Director Graduate Program The University of Tennessee College of Nursing Memphis, Tennessee 38163
	TEXAS
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Type of Program	Institution
	TEXAS (continued)
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	VIRGINIA
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M	Dr. Eleanor Repp, Asst. Dean Graduate Program School of Nursing Medical College of Virginia Virginia Commonwealth University 1200 East Broad Richmond, Virginia 23173
CE	Ms. Betty Gwaltney, Director Continuing Education Program School of Nursing Medical College of Virginia Virginia Commonwealth University 1200 East Broad Richmond, Virginia 23173
CE	Ms. Ruth Glick, Coordinator Continuing Education Nursing Program Northern Virginia Community College Annandale, Virginia 22003
B	Dr. Judy A. Bancroft Undergraduate Programs School of Nursing University of Virginia Charlottesville, Virginia 22903
	VIRGINIA (continued)
M	Dr. Barbara Brodie Assistant Dean Graduate Programs School of Nursing University of Virginia Charlottesville, Virginia 22903