

Nursing Education: Past, Present, Future

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LEARNING OUTCOMES

After reading this chapter you will be able to:

- Develop an understanding of the historical evolutions, contributions, and differences of various nursing education programs.
- Critique contemporary options for nursing education in the context of social, political, and economic trends and issues.
- Explain the process of accreditation in nursing education.
- Analyze curriculum and instruction in relation to learning nursing practice.
- Develop a personal philosophy of nursing education that reflects trends and issues in nursing education and practice.

Introduction

This chapter provides a descriptive account of nursing education including how its past has shaped its present and how current times are influencing and delineating its future. Understanding the continuum of development in nursing education promotes an awareness of the diversity that exists within nursing education and the common purposes that bind it together, encourages shared understandings of the various pathways that exist within nursing education, and promotes community among nursing students,

nurse educators, and nurses regarding the complexities surrounding educational preparation for nursing practice.

This chapter begins with a discussion of the levels of nursing education prevalent since the turn of the 20th century and the issues associated with each program (see Table 2-1). The discussion begins with practical nursing, the most basic level of nursing education, and progresses to describing more advanced nursing education programs. The second half of the chapter focuses on curriculum and instruction in nursing education, beginning with a description of curriculum and instruction and including exemplars that describe what students learn and how they learn it in today's nursing schools. One might wonder why it is important for nursing students to understand curriculum and instruction. In the past, what and how students learned was the specialty of faculty. However, recent evidence suggests that student-centered curriculum and instruction can improve learning outcomes (Candela, Dalley, & Benzel-Lindley, 2006). As faculty respond to this trend, they seek approaches that overcome learning environments where teaching and learning as well as the teacher and the learner are separate, discrete, polarizing entities, each with his or her own predetermined roles, functions, and expected responsibilities. This means that students play an increasingly active role in their own learning. Therefore, a goal of the latter part of this chapter is to promote dialogue between teachers and students to encourage mutual trust, respect, and understanding for the content and processes involved in the preparation of nursing students for contemporary nursing practice.

TABLE 2.1 THE HISTORICAL EVOLUTION OF NURSING EDUCATION PROGRAMS

Early 1900s	1920s–1930s	1940s–1950s	1960s–present
Practical nursing	Practical nursing	Practical nursing	Practical nursing
Nightingale Schools	Diploma schools	Diploma schools	Diploma schools
Diploma schools	BSN	BSN	BSN
		ADN	ADN
Postgraduate education	Postgraduate education	Master's degree	Master's degree and CNL
	EdD for nurses	Doctorates for nurses	PhD, DNSc, ND, DNP

Abbreviations key for Table 2-1: ADN – associate degree in nursing; BSN – bachelor's of science in nursing; CNL – clinical nurse leader; DNP – doctorate of nursing practice; DNSc – doctorate of nursing science; EdD – doctorate of education; ND – nursing doctorate; PhD – doctorate of philosophy

As with any chapter in a nursing textbook, it is important to remember that this chapter provides an extensive synopsis of nursing education, particularly important aspects of the topics at hand. Students and teachers are encouraged to use this chapter as a platform for discussion, which can be further enriched by exploring the reference list provided at the end of the chapter. In this way, this chapter provides an excellent gateway to engage readers in the study of nursing education and to pursue ways of integrating its content with other sources of knowledge.

Understanding Nursing Education Programs

To gain an understanding of the various nursing education programs and the context within which they were developed, the discussion for each program includes a historical account of the program's development, the unique and significant issues and challenges associated with the program, and information on contemporary trends related to the program. This approach provides a comprehensive overview that captures the essence of available avenues to achieving a nursing degree. A description of mobility programs and a discussion of the educational accreditation process and its important role in ensuring high quality nursing education programs are also included.

Practical Nursing Education

“Unlike the historically untrained or poorly trained practical nurse, who had unlimited and unsupervised freedom to practice, the present practical nurse is often a hybrid. Today’s practical/vocational nursing student is being taught basic skills during the educational program. After licensing, the LPN/LVN [practical nurse] is permitted to perform complex nursing, as delegated by the registered nurse and allowed by the nurse practice act” (Hill & Howlett, 2005, p. 80).

Responding to a Need: A Historical Overview of Practical Nursing Education

Practical nursing, the most basic level of nursing practice, began with the industrial revolution of the late 1800s. To meet labor workforce demands during this time, many people moved from rural areas to urban areas. Women needing employment often provided domestic services, including those associated with caring for the sick (Kurzen, 2005). To support the skills of this new healthcare provider, in 1892 the Young Women's Christian Association (YWCA) located in Brooklyn, New York, offered the first formal practical nursing course. Over time, landmark reports about the state of nursing education contributed to the development of practical nursing programs. For example, in 1923 Josephine Goldmark compiled a report (see Table 2-2) titled *Nursing and Nursing Education in the United States*. In it she recommended higher education standards for practical nurses, laws

TABLE 2.2 DOCUMENTS INFLUENCING TRENDS AND ISSUES IN NURSING EDUCATION

Name of Document	Year Published	Contribution to Nursing Education
Goldmark Report	1923	Studied the field of nursing education and recommended minimal education standards
Burgess Report	1928	Studied nursing practice and education and addressed the need for major changes in the profession and for the development of a more comprehensive educational philosophy
Brown Report	1948	Recommended vocational education for practical nurses and recommended that education for registered nurses be in an institution of higher learning
Ginzberg Report	1949	Suggested it would be more economical for hospitals to eliminate diploma nursing programs and begin a 2-year course of study for student nurses in colleges
<i>Nursing Schools at Mid-Century</i> (West & Hawkins)	1950	Identified that many schools of nursing were not meeting standards, which provided evidence for reforming diploma nursing education

regulating their practice, and improved environments for their training. In 1948 Lucille Brown compiled another report, *Nursing for the Future*, which hastened the growth of practical nursing programs by emphasizing vocational schools as good environments for practical nursing programs. Today most practical nursing programs are in vocational schools.

Working as a Practical Nurse: Scope and Function

Since the first half of the 20th century, the scope and function of practical nurses have become increasingly sophisticated. They are licensed to practice either as licensed practical nurses (LPNs) or as licensed vocational nurses (LVNs), and they work under the supervision of registered nurses. Nurse practice acts for the practical nurse vary from state to state, but generally, the practical nurse is responsible for stable patients and patients with common health conditions. They also are responsible for collecting and reporting abnormal data, offering suggestions for developing and changing nursing care, providing bedside care, teaching health

TABLE 2.2 DOCUMENTS INFLUENCING TRENDS AND ISSUES IN NURSING EDUCATION *(continued)*

Name of Document	Year Published	Contribution to Nursing Education
<i>Community College Education for Nursing</i> (Montag)	1959	Established the validity of the ADN (2-year nursing) program as adequate preparation for nursing practice
<i>American Nurses' Association Position Statement</i> (ANA)	1965	Stated that those licensed to practice nursing should be educationally prepared in institutions of higher education
<i>Toward Quality in Nursing</i> (U.S. Public Health Service)	1963	Cautioned against preparing all nurses at the baccalaureate level
National Commission for the Study of Nursing and Nursing Education	1970	Cautioned against preparing all nurses at the baccalaureate level
Pew Health Professions Report	1998	Identified competencies nurses would need to prepare for nursing practice in the 21st century

maintenance, and participating with the healthcare team in evaluating nursing care (Kurzen, 2005).

Understanding Practical Nursing Education Today

The scope and function of practical nurses reflect the need for appropriate knowledge and capabilities to fulfill this supportive healthcare role (Mahan, 2005). Practical nursing education programs are often offered in community colleges. Most programs are 12 to 18 months in length, and graduates of these programs complete a state practical nursing exam (National Council Licensure Examination for

A nurse checks the heart rate of a patient.



Practical Nurses [NCLEX-PN]; see Chapter 4) prior to being employed. For some individuals, this short course of study is a stepping stone to pursuing advanced nursing education. It also allows them to work as a practical nurse while obtaining further education. For others, practical nursing becomes a long-term career option. In either case, employment possibilities for practical nurses vary and are more plentiful in some states than in others. Long-term care facilities, clinics, hospitals, and home health care are the largest employers of practical nurses, with home health care leading the way in employment options. According to the Bureau of Labor Statistics (2006a), rising elderly populations, in-home medical technologies, and patient preference for home health care will increase the number of practical nurses needed in this area. As a result, one can expect that practical nursing will continue to be an integral part of the fabric of nursing education and nursing practice.

Diploma Nursing Education

“Your own first steps toward a nurse’s skill—and toward the coveted nurse’s cap,” Miss Reamer said, “Will be classes. But not for long.” They [student nurses] would learn the hospital routine gradually on the wards, then more and more, until each student would be responsible for her own patients” (Wells, 1943, p. 29).

Training vs. Educating: The History of Diploma Nursing Education

The quote above is from *Cherry Ames*, a fictional series of books about nurses that enamored many, encouraged the pursuit of nursing careers, and indeed

reflected diploma nursing programs of that time in nursing education's history. Diploma nursing (originally known as "hospital nursing") began during the latter part of the 19th century with a growth in hospitals. Knowledge of asepsis partially spurred hospitals' growth and precipitated a demand for more nurses. Training of hospital nurses at this time was based on an **apprenticeship model** where nursing students provided service (direct patient care) in exchange for a few educational lectures, room and board, and a monthly allowance (King, 1987). The apprenticeship model flourished because it offered women an opportunity for a vocation, it improved care of the sick, and decreased the cost of nursing service in hospitals while student nurses provided patient care services for a minimal allowance (Bullough & Bullough, 1978).

Despite the benefits of the apprenticeship model, it underwent criticism from nursing education leaders. Goldmark (1923) in particular emphasized that the training needs of students and the service needs of hospitals were incongruent. She wrote that when "the needs of the sick must predominate; the needs of education must yield" (Goldmark, p. 195). In other words, Goldmark argued that the hospital training of nurses was unbalanced. Training in the care of children, for example, was relinquished if students were needed to care for patients on the surgical ward. Similarly, May Ayres Burgess published a report in 1928 titled *Nurses, Patients, and Pocketbooks* (later known as the Burgess Report) that argued that within the apprenticeship model, students' patient assignments were based on the hospital's needs rather than on the educational needs of the students.

To balance the academic needs of nursing students with their need for clinical experiences, Dr. Richard Olding Beard advocated for university education for nursing students. He contended that university education would eliminate the incongruence between the hospital's service needs and the educational needs of students. In 1909 Beard began a nursing program at the University of Minnesota. This program is often heralded as the first baccalaureate nursing program. However, it closely resembled diploma education because, even though nursing students met university standards for admission and coursework, they were required to work 56 hours a week on the hospital ward (Bullough & Bullough, 1984).

Shifting to a New Era in Diploma Nursing Education

Following Dr. Beard's efforts, the **National League for Nursing Education (NLNE)** made numerous attempts to redesign diploma nursing education programs. In 1917, 1919, 1927, and 1937 the NLNE published *Standard Curriculum for*

KEY TERM

Apprenticeship model: A model of nursing education that was prevalent during the first half of the 20th century, where student nurses learned nursing practice by providing service to hospitals.

KEY TERM

National League for Nursing Education (NLNE):

A professional organization in nursing that fostered excellence in nursing education by supporting nursing education research, engaging in policy making and advocacy efforts related to nursing education, and promoting faculty development. It was the precursor to the National League for Nursing.

Schools of Nursing. This report encouraged diploma programs to decrease students' time working on the ward and to increase their education by offering 3 years of course work in the sciences and clinical experiences caring for diverse populations (e.g., medical surgical, pediatric, and obstetric patients). The work of Beard, the NLNE, and other reports on the state of nursing education did contribute to restructuring diploma nursing education. Stewart (1943), in fact, related that these efforts better informed the public about the state of nursing education, promoted experiments with new models of nursing education, and encouraged reform in schools of nursing (pp. 182–183).

During the middle of the 20th century, diploma nursing programs continued to thrive, and other reports such as *Nursing Schools at the Mid-Century*, compiled by West and Hawkins and published in 1950, promoted high standards in diploma nursing programs. Nonetheless, changes in health care such as rapid advances in medical technology and the expansion of knowledge in treatments for diseases required nurses to have sound theoretical preparation (Melosh, 1982). These changes signified a decline in hospital-based diploma programs and the beginning of a new era in nursing education where education would occur predominantly in colleges and universities.

Understanding Diploma Nursing Education Today

As of 2006 there were only about 60 diploma programs in the United States, with most of them located in the northeast (National League for Nursing [NLN], 2006). Hospitals that continue to support diploma programs maintain this educational option because these programs supply the nurses needed in their hospitals, they provide a geographically accessible program for some students, they offer a nursing degree in a short length of time, and they often offer tuition remission. To meet the educational needs of diploma students, many of these programs collaborate with colleges and universities to offer students options to obtain associate and baccalaureate degrees. Additionally, it is important to note that despite the reasons for the decline of diploma programs mentioned earlier, some studies suggest that diploma nurses are as competent in research, leadership, and critical thinking as graduates from other undergraduate nursing programs (Clinton, Murrells, & Robinson, 2005). Thus, for now it seems that diploma programs, though having experienced a turbulent history, are persisting and will continue to be a valuable asset to the nursing profession.

Associate Degree Nursing Education

“Every story in the mosaic of history has a beginning, a cast of characters, a set of social circumstances, and its own momentum. The development of a new, two year program for educating professional nurses during the years just after World War II is no exception” (Haase, 1990, p. 1).

Creating New Models of Nursing Education: The History of Associate Degree Nursing Education

As noted previously, in 1943 Isabel Stewart remarked that efforts to redesign diploma nursing education included experimenting with new nursing education models. One model was associate degree nursing education. It began in response to the post–World War II nursing shortage and it gained momentum following the Ginzberg Report (1949), which suggested that in comparison to a 4-year nursing program it would be more efficient and economical for colleges to offer a 2-year course of study in nursing. Ginzberg believed that not all nurses needed baccalaureate education to provide patient care. Nurses could be prepared to provide safe and competent patient care in less time than baccalaureate education, which would provide a feasible solution to the nursing shortage.

It was at this time that Mildred Montag (1951) described how 2-year associate degree nursing programs, housed in community colleges, could prepare registered nurses (RNs) as semi-professionals. This group of RNs would meet the demand for nurses by acquiring enough nursing skill and judgment to provide nursing care, but not the expert skill and judgment of baccalaureate-prepared nurses. Further study by Montag (1959) suggested that nurses prepared with an associate degree were performing similarly to staff nurses prepared with baccalaureate degrees. Moreover, those within the nursing profession believed that, with the exception of preparation in leadership and public health, nurses with an associate degree provided outstanding bedside nursing care (Smith, 1960). Others contended the associate degree program's focus on learning rather than on service to hospitals provided educationally sound preparation for nursing practice (Lewis, 1964). Still others believed that its accessibility and affordability through community colleges made this degree inclusive. For the first time in the history of nursing education, the associate degree in nursing offered those with little access to baccalaureate nursing programs the opportunity to become registered nurses (Hassenplug, 1965).

Emerging Controversies in Associate Degree Nursing Education

Indeed there were many advantages to associate degree nursing education, and these advantages remain present in today's associate degree nursing programs. Nevertheless, at the height of this program's success, in 1965, the **American Nurses Association (ANA)** published a position paper stating that those licensed to practice nursing should be prepared in institutions of higher education (universities). It also stated that the minimum preparation for the professional nurse should be a baccalaureate degree. In other words, the position paper equated

KEY TERM

American Nurses Association (ANA): A professional organization for nurses that develops various standards of nursing practice and promotes change through policy development.

professional nursing with baccalaureate education. This potentially meant that associate degree–prepared nurses could not practice as registered nurses unless they had licensure requirements that were different from baccalaureate–prepared nurses.

Despite these challenging circumstances, studies conducted since the ANA’s position paper through the 1990s showed that, especially in hospital settings, there were unclear differentiations between nurses prepared in associate degree nursing programs and those prepared in baccalaureate degree programs (Bullough, Bullough, & Soukup, 1983; Bullough & Sparks, 1975; Haase, 1990). In fact, many studies showed registered nurses performed essentially the same in practice regardless of academic preparation. Studies occurring in the 2000s, however, are beginning to present a different picture. Current research suggests that baccalaureate–prepared nurses are associated with improved patient outcomes, that hospitals prefer to hire baccalaureate–prepared nurses, and that “magnet” hospitals have a higher percentage of baccalaureate–prepared nurses (Graf, 2006). This is not to say that associate degree nursing programs (like many diploma programs) will disappear. However, these studies do indicate mobility programs (discussed later in this chapter), through which associate degree–prepared nurses obtain baccalaureate and higher degrees in nursing, will take on even greater significance than they have in the past.

Understanding Associate Degree Nursing Education Today

According to the U.S. Department of Health and Human Services Health Resources and Services Administration, National Center for Health Workforce Analysis (2006), 52.8 percent of those wishing to become nurses enter associate degree nursing (ADN) or associate degree in science (ASN) programs. As a result, these programs remain one of the most feasible options of becoming an RN, and they address the nursing shortage by preparing nurses who are safe practitioners. Moreover, faculty members of ADN/ASN programs take responsibility for ensuring graduates are prepared for registered nurse roles in advocacy, leadership, professional involvement, lifelong learning, and evidence-based practice (National Organization for Associate Degree Nursing [N-OADN], 2006). Clearly, the nursing profession must support such nurses in practice and the educational programs that prepare them. However, it is important to note that only 20.7 percent of associate degree nurses return to school for baccalaureate and higher degrees (U.S. Department of Health and Human Services, 2006). Because the associate degree in nursing is considered an initial entry degree into practice as a registered nurse, it is important to investigate why so few associate degree–prepared nurses return to school. Advocates of nursing education need to provide opportunities and incentives for associate degree–prepared nurses to pursue further education.

Baccalaureate Nursing Education

“Very many private schools [hospital schools] of nursing still exist, but like the private schools of medicine that remain, there is a handwriting upon the walls of their future. . . . It says that their days are numbered, that “the old order changeth, giving place to the new,” that the day of the university education of the nurse has come” (Beard, 1920, p. 955).

Advocating for University Education: The History of Baccalaureate Nursing Education

Dr. Richard Olding Beard (quoted above), a great supporter of baccalaureate nursing education, followed the thinking of Florence Nightingale and the **Nightingale Schools**. Nightingale believed that nursing education should occur outside of hospitals and the medical model (Stewart, 1943). This model of nursing education would avoid apprenticeships where nursing students received less education in the principles of nursing care because they were providing long hours of service to hospitals. Nightingale advocated for nursing students to learn sound theory in anatomy and physiology, surgery, chemistry, nutrition, sanitation, and professionalism; to train under the guidance of ward sisters who were nurses with experience and dedication to the profession; and to be part of a system that was financially independent from hospitals (Stewart).

The Nightingale philosophy initially succeeded in the United States when Bellevue School of Nursing in New York adopted it in 1873. However, opposition to it, which included arguments that nurses do not need to be overeducated, that hospitals needed nurses for service, and that independent funding for nursing schools was unrealistic, maintained diploma nursing education. Despite the overwhelming support for diploma schools, several nursing education leaders during the early 1900s continued to believe in university education for nurses and subsequently persisted in advocating for baccalaureate nursing education.

For example, in 1901, Ethel Gordon Bedford Fenwick, founder of the International Council of Nurses, asserted it was time for nurses to be educated in universities where they could become skilled practitioners able to address local, national, and international health issues (Fenwick, 1901). Additionally, Dr. Beard supported leaders in nursing education who wanted higher educational standards for nurses. He convinced the University of Minnesota to begin moving nursing education into higher education. In 1909 this university began its first nursing program. Though, as referred to previously, it resembled diploma programs, it did represent the beginning of a slow movement in nursing education toward baccalaureate education for nurses.

KEY TERM

Nightingale Schools: Schools of nursing developed by Florence Nightingale that promoted student nurses learning the theory and practice of nursing outside of hospital control.

Struggling to Develop Baccalaureate Nursing Education

Many schools followed the University of Minnesota's lead to offer students courses that supplemented diploma education. The most progressive of these programs was started at Teachers College, Columbia University, in 1917. Here students received 2 years of science at the university, 2 years of nursing at Presbyterian Hospital in New York, and 1 year of specialization in either public health or education (Bullough & Bullough, 1978). By the 1930s the number of students completing this "collegiate curricula" doubled, but these emerging baccalaureate programs remained chaotic and often resembled today's graduate education with an emphasis on specialization in public health, teaching, administration, and clinical specialties (Stewart, 1943, p. 276).

In the 1940s the development of baccalaureate nursing education continued, but the struggle to define it, develop curricula for it, and understand nursing roles from within it remained problematic. The Brown Report was especially helpful in making bold statements about baccalaureate nursing education. Brown (1948) wrote that nursing education belonged in institutions of higher education and that curricula in higher education for nursing education be integrated (including liberal and technical training for professional practice). She also wrote that the degree granted from integrated curriculum should be the Bachelor of Science in Nursing and that these nurses be prepared for complex clinical situations requiring high levels of education and skill.

By the 1960s baccalaureate education was taking shape. In particular, preparation in liberal education, intellectual skills, and content in leadership, management, community health, and teaching differentiated it from diploma or associate degree education (Kelly & Joel, 2002). The struggle for baccalaureate education seemed to be resolving, and the American Nurses Association position paper (1965) calling for the baccalaureate to be the entry-level degree for nursing certainly strengthened the argument for baccalaureate education. Nonetheless, other groups, including the Surgeon General's Consultant Group's document *Toward Quality in Nursing* (U.S. Public Health Service, 1963) and the National Commission for the Study of Nursing and Nursing Education (1970) were cautious in firmly stating that all licensed nurses needed baccalaureate preparation. These groups advocated for additional research to understand the skills and responsibilities required for high quality patient care. But this specific research (described in the next section) would not occur until nearly 40 years later.

Understanding Baccalaureate Nursing Education Today

Since the 1960s, baccalaureate nursing education programs have doubled. Today there are approximately 674 baccalaureate programs (Amos, 2005). Although there was a decline in enrollments in these programs during the 1990s, since 2001

enrollments have increased, with an 18 percent increase in baccalaureate-prepared nursing graduates (AACN, 2006b). Until recently, little research existed that responded to calls put forth in the 1960s to understand the relationship between educational preparation and quality patient care. As described previously, studies showed registered nurses, regardless of academic preparation, perform similarly in practice. A series of recent studies is changing this understanding because each of these studies has shown that hospitals with more baccalaureate-prepared nurses have lower patient mortality rates (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005; Tourangeau, 2007).

As evidence mounts showing the relationship between higher education for nurses and improved patient outcomes, one could expect the momentum for the baccalaureate degree as the degree needed for entry-level practice as a registered nurse to increase. See Contemporary Practice Highlight 2-1 for an example of one state's proposal to address baccalaureate registered nurse preparation. What matters here is that support for baccalaureate nursing education does not mean opposing practical, associate, or diploma nursing education. Rather, it means striving to encourage nursing peers without baccalaureate degrees to pursue this degree, becoming active in making baccalaureate education accessible and affordable, and working as a team regardless of the academic preparation of a nurse.

CONTEMPORARY PRACTICE HIGHLIGHT 2-1

BACCALAUREATE EDUCATION IN THE STATE OF NEW YORK

In 2007 the New York State Nurses Association introduced a bill (A2480/S294) that would require registered professional nurses to attain a baccalaureate degree in nursing within 10 years of their initial licensure. The bill is modeled after an existing requirement in the state of New York that requires public school teachers to obtain a master's degree within 5 years of their initial teaching certification. If this bill to advance nursing education within the state of New York succeeds and becomes a law, it may mean that other states follow suit, thus increasing the number of

baccalaureate-prepared nurses nationwide. A coalition entitled Coalition for Advancement of Nursing Education (CANE) has been formed to generate support within the state of New York for this bill (<http://www.rneducationadvancenyc.org>). As of February 2008, bill A2480/S294 had been referred to the higher education committees of the New York State Assembly and State Senate. The status of this bill can be tracked on the New York State Nurses Association website (Retrieved 4/10/08 from <http://www.nysna.org/advocacy/acti>).

Graduate Education

“When one turns to the other . . . he [sic] finds a distinct possibility that a fresh and conspicuously enlarged contribution may soon come from many more nurses who find places of great social and professional usefulness in consultation, planning, research, writing, and the promotion of health services. . .” (Brown, 1948, p. 98).

Advancing Nursing Education: The History of Master's Preparation in Nursing Education

The quote above by Esther Lucille Brown was a prelude to the formation of nursing education programs that granted nurses master's degrees. At the time of her statement few nurses had master's degrees (known at that time as “specialties”), and many who had preparation beyond basic nursing education had postgraduate education. Postgraduate education was training nurses received through internships in areas such as pediatrics and infection control, practicum experiences in midwifery and anesthesia, or theoretical preparation in public health and nursing education (Bullough, Bullough, & Soukup, 1983). It also included additional training for nursing supervision and administration (Brown, 1948). Prior to the 1950s, if nurses wanted to obtain a master's degree rather than postgraduate education, they had to seek an advanced degree in another field such as sociology or psychology (Bullough & Bullough, 1984).

During the 1950s nurses first had the opportunity to obtain a master's degree in nursing when Rutgers University in New Jersey offered a master's degree in psychiatric nursing. This first master's degree prompted additional programs, which interestingly reflected specializations of the early postgraduate education in nursing (e.g., teaching, pediatrics, administration). As masters in nursing programs grew, support for them also increased. In 1969 and 1978 the ANA advocated for nurses' advanced preparation in theory to improve practice and in specialty nursing roles to offer high levels of competence in particular areas of nursing practice. By the 1970s societal trends encouraged an even greater demand for masters in nursing programs (Murphy, 1981). For instance, healthcare environments needed nurses with advanced preparation in areas such as research, teaching, administration, and clinical areas of nursing practice. The Council of Baccalaureate and Higher Degree Programs (1985) provided further support for master's preparation by stating that the nation needed nurses prepared with master's degrees in nursing to meet society's nursing needs.

Reforming Master's Preparation in Nursing Education

Despite support for master's education for nurses, Starck (1987) argued that by the 1980s there were far too many master's preparation programs, which served only to confuse the public. She pointed out that by the later 1980s there were 257 titles of masters in nursing programs. She provided recommendations for

reforming master's degree programs whereby all master's-prepared nurses would receive core preparation in leadership, management, teaching, intellectual curiosity, creative inquiry, collaborative and consultative skills, and professionalism (p. 20). This preparation would provide the public with a clear understanding of a master's-prepared nurse. It would also prepare nurses to work in settings where autonomy and fiscal management were needed. For instance, she projected trends in healthcare costs would lead to the need for master's-prepared nurses to manage community-based nursing centers and to oversee companies providing services to hospitals.

Understanding Master's Preparation in Nursing Education Today

Starck (1987) was correct in projecting the need for master's-prepared nurses to function within a greater scope (e.g., there are now community-based clinics managed by nurse practitioners). Today there are a variety of master's degree programs, and according to the Bureau of Labor Statistics (2006b) there will continue to be a great demand for clinical nurse specialists, nurse practitioners, midwives, and anesthetists, especially in medically underserved areas. For a nurse wishing to seek graduate preparation, the continued variety of specializations from which to choose is appealing and personally satisfying. Nonetheless, in today's healthcare environment, it has become important to "think outside the box." Will the master's-prepared nurse of today be able to meet the needs of society in the future?

Recent trends include a movement toward a new model of graduate education called the Clinical Nurse Leader (CNL). The CNL focuses on generalist preparation, rather than specialist preparation (AACN, 2007b). The reason for developing such a role comes from evidence suggesting a need for nurses with master's education to develop methods for improving patient outcomes, coordinate evidence-based practice, and promote client self-care and client decision making. The AACN does not suggest that the CNL replace other master's-



An emergency room nurse.

prepared nurses; however, it contends this role will provide the public with nurses who have a comprehensive understanding of the broader healthcare system.

Despite the movement to develop the CNL, it is controversial. There are those who contend that the CNL only adds confusion to the multiple existing graduate education pathways, that its development undermines the roles of other nursing specialists (e.g., nurse practitioners and clinical nurse specialists), and that it minimizes the leadership role of every professional nurse (Erickson & Ditomassi, 2005). The AACN has attempted to address such concerns by describing the differences between these roles and the importance of the CNL (AACN, 2005). These conflicts highlight the need for continued dialogue about the CNL, the need for research on its efficacy, and the overall impact of this role in nursing practice specifically, and in healthcare systems generally.

It is clear, however, that there is an ever-increasing need in the United States for nurses prepared at the master's-degree level. The complexity of the healthcare system, the critical shortage of nurse educators, and the need for advanced practice nurses to deliver cost-effective, evidence-based patient care are just three of the driving forces that require nurses be prepared beyond the baccalaureate level to provide leadership in nursing administration, education, and practice.

Developing the Discipline of Nursing: The History of Doctoral Education

Doctoral education for nurses has existed since the 1920s. Doctoral programs originally prepared nurses for administrative and teaching roles. The first program was offered in 1924 at Teachers College, Columbia University, where nurses received an educational doctorate (EdD). Nurses received EdDs because the nursing profession had not developed its own doctoral programs, these doctorates were accessible through programs that offered part-time study, and the programs discriminated less against women as compared to programs in other fields (Bullough & Bullough, 1984). It was not until the latter part of the 20th century that doctoral programs in nursing developed. They developed out of recognition that the nursing profession needed its own research and theoretical base. As a result, doctoral programs in nursing dramatically increased, and offered nurses the opportunity to conduct research and develop theory within their own discipline.

Evolving Doctoral Programs in Nursing Education

The PhD (doctorate of philosophy) in nursing is often referred to as the “gold standard” for adequate doctoral preparation because it ensures nurses are competent to conduct research, which develops nursing knowledge and theory (Kirkman, Thompson, Watson, & Stewart, 2007). Despite the merit of the PhD, in the 1960s Boston University challenged it by beginning the DNSc, or the clinical doctorate. Many thought this doctorate would prepare nurses for doctoral

level work in clinical practice, rather than research and theory (Loomis, Willard, & Cohen, 2007). Regardless of its original intent, over time, studies indicated that the DNSc (also known as the DNS or DSN), in many respects, is equivalent to the PhD (Loomis et al., 2007). Another challenge to the PhD occurred in the 1970s when Margaret Newman of New York University advocated for the ND (Nursing Doctorate) program. Similar to the DNSc, with the noted exception that the ND also prepares individuals for basic licensure as a registered nurse, she believed an ND would prepare nurses just as medical schools prepare physicians—for application of advanced knowledge in clinical practice. The first ND program began in 1979 at Case Western Reserve University in Cleveland, Ohio. This evolution of doctoral programs has essentially created two pathways for doctoral education in nursing, one that is research oriented and another that is practice oriented.

Understanding Doctoral Preparation in Nursing Education Today

Doctoral programs are entering a new and progressive era. The DNP (doctorate of nursing practice), proposed by the **American Association of Colleges of Nursing (AACN)** (AACN, 2007a) to become the terminal degree for advanced practice nursing by 2015, is the newest doctorate focusing on advanced preparation in clinical practice. It is comparable to practice doctorates in fields such as pharmacy and physical therapy. The DNP provides advanced preparation in scientific foundations of nursing practice, leadership, evidence-based practice, healthcare technologies, healthcare policy, interprofessional collaboration, clinical prevention and population-based health care, and advanced nursing practice in specialty areas (AACN, 2006c).

A great deal of controversy has surrounded the development of the DNP. Those supporting it suggest it offers improved formal preparation for advanced practice nursing roles not obtained by a master's degree in nursing (Hathaway, Jacob, Stegbauer, Thompson, & Graff, 2006). Nurses who have completed the DNP degree report that it provides them with improvement in their clinical expertise and the ability to shape healthcare policy (Loomis et al., 2007). Opponents of the DNP believe that it only serves to confuse the public about various nursing roles and functions. Additionally, its development precludes preparation for the role of nurse educator, creates possible shortages of advanced practice nurses who cannot afford to take the additional coursework needed to complete the DNP, and excludes schools of nursing that may not have the resources to develop a DNP program (Chase & Pruitt, 2006).

Despite these debates, today there are 46 DNP programs, with 140 more nursing schools considering starting this program (AACN, 2007c). As the DNP

KEY TERM

American Association of Colleges of Nursing (AACN): A professional organization in nursing that serves baccalaureate nursing and higher degree nursing education programs by influencing the quality of nursing education and practice through research, advocacy efforts, policy making, development of quality educational standards and indicators, and faculty development.

gains momentum and nurses prepared with the DNP begin to enter the workforce, it will be important for all in the nursing profession to understand how the DNP-prepared advanced practice nurse can potentially contribute to the nursing profession. For example, outcome studies that demonstrate how nurses with a DNP influence the health of individuals, groups, and populations will be necessary to document their contributions to health care. Although not necessarily receiving academic preparation as educators, in response to the nurse faculty shortage many DNP-prepared nurses will likely find roles as nurse educators in schools of nursing—will they be adequately prepared to assume these roles? (See Contemporary Practice Highlight 2-2.) Another important consideration will be what resources are needed to assist in the development of DNP programs in significant enough numbers in schools of nursing with diverse educational missions to produce the number of advanced practice nurses needed in the United States.

It will also be essential to help the public and other healthcare providers understand the DNP role. Nurses who are considering the pursuit of doctoral education will need to carefully consider which doctoral degree is the best fit for their professional career goals—the PhD, DNS, or DNSc degree with a research focus or a practice doctorate such as the DNP.

Mobility Programs in Nursing Education

“There is more depth to my practice now. I see nursing theory behind everything I do.” (Delaney & Piscopo, 2007, p. 170)

CONTEMPORARY PRACTICE HIGHLIGHT 2-2

PREPARATION FOR TEACHING NURSING

The AACN has supported the development of the Doctorate in Nursing Practice (DNP) role. Yet, until recently, the NLN had not taken a position on the creation of the DNP role. In April 2007 the NLN released a statement that emphasized its support of all nursing programs. In this statement, the NLN stressed the need to ensure that nurses with advanced degrees be prepared in nursing education as much as they are prepared for

advanced clinical practice, research, and theory development. It recommended a minimum of a certificate in teaching and learning principles to ensure a qualified pool of nursing faculty prepared to teach nursing students.

Source: National League for Nursing. (2007). *Doctorate of nursing practice—reflection and dialogue*. Retrieved February 19, 2008, from http://www.nln.org/aboutnln/reflection_dialogue/refl_dial_1.htm

Creating Options: Advancing Nursing Careers

Deepening one's knowledge base and understanding of nursing as well as advancing one's nursing career often occur through mobility programs. **Mobility programs** (also known as educational mobility or career ladder programs) enable individuals to enter the nursing profession from different educational points or pursue professional career development through additional academic preparation without losing credits from previous degree work. This additional academic preparation often involves articulating or making a transition from one nursing degree to another, more advanced nursing degree.

For example, there are LPN to RN, RN to BSN, RN to MSN, and even BSN to PhD mobility programs to name a few of the educational mobility options that are available in nursing. The RN to BSN or RN to MSN degree programs enable RNs who hold a diploma in nursing or an ADN (ASN) degree to return to school to pursue either a BSN or an MSN degree and receive credit for their previous coursework and possibly their work experience. There are also programs for those individuals who hold previous non-nursing baccalaureate degrees that enable them to complete a BSN in an accelerated time frame, usually within 12–18 months. These are commonly referred to as second-degree, fast track, or accelerated nursing programs. Accelerated programs for those individuals with previous non-nursing baccalaureate degrees who wish to receive a generic master's degree in nursing also exist. The commonality in all of these mobility options is that they enable the learner to achieve the advanced degree in a timely manner by recognizing and giving credit for previous academic accomplishments and frequently allowing the learner to prepare a portfolio documenting work experiences that can also be evaluated for potential academic credit.

Advancing one's nursing practice can also occur through continuing education programs that result in specialized credentials, certifications, or continuing education credits. For example, nurses can obtain additional education to become certified in diabetes education, critical care, or wound and ostomy care. They can also obtain continuing education by attending conferences or completing online courses or independent studies on particular topics relevant to their area of practice. Given this chapter's focus on academic nursing education programs, what follows is a description of issues and trends related to formal academic mobility options.

Supporting Mobility Programs

Mobility programs have a long history in nursing education and, in recent years, many of these programs have grown due to progress in distance education technologies, making the acquisition of advanced education more accessible. These

KEY TERM

Mobility programs: Nursing programs that facilitate the seamless articulation or transition from one degree in nursing to another degree (e.g., LPN to RN, ASN to BSN, ASN to MSN, BSN to PhD).

programs have also flourished under pressure from various nursing organizations to promote baccalaureate and higher degrees in nursing. For example, in 1991 the National League for Nursing issued a position statement urging schools of nursing to coordinate articulation from one degree to another. They promoted the idea that schools should develop fair and equitable policies that allow students who have received credits for prior learning to transfer credits from one school of nursing to another. The American Association of Colleges of Nursing issued a similar position statement in 1998. The feasibility of these statements has increased in part because of governmental support, specifically Title II of the Nurse Reinvestment Act of 2002. This legislation funded mobility programs in a variety of ways to retain qualified nurses and to combat the nursing shortage.

Efforts to support mobility programs have resulted in many different degree articulation models. Some of these models are state mandated whereas others are voluntary. For example, some states have legislation in place mandating academic credit transfer from associate degree nursing programs to baccalaureate degree programs (AACN, 2006a). This model prevents graduates of associate degree nursing programs from encountering barriers to degree advancement, which can occur if baccalaureate programs do not accept academic credits from associate degree nursing programs. Voluntary programs, on the other hand, also exist to streamline the process of advancing from one degree to another. Some of these articulation programs are statewide initiatives (AACN), whereas others are agreements that exist between schools or within healthcare institutions (Eckhardt & Froehlich, 2004).

Reflecting on the Options: Advantages and Disadvantages of Mobility Programs

Regardless of the mobility options available, those considering a nursing career must weigh the advantages and disadvantages of mobility programs. On one hand they offer students flexible and dynamic options for advancing nursing careers. They are also often affordable and accessible and can expedite particular nursing degrees. For instance, students who wish to start their nursing career as an associate degree–prepared registered nurse can attend a community college. Once they decide to pursue a baccalaureate degree, they can continue working as an RN and complete an online baccalaureate completion program or a program at a nearby college or university. Or they may decide to pursue a master’s degree in nursing and opt to enroll in an RN-MSN program.

Possible disadvantages of mobility options can include, but are not limited to, increased time commitments to complete coursework, problems with transferring credits from school to school and gaining credit for prior learning, and risks associated with returning to school when one is faced with competing demands. For example, students who complete an associate degree program in 2 years and then return to school for a baccalaureate degree may return to school and struggle

through completing this degree on a part-time basis. Career and family commitments and demands may mean it takes longer to complete a baccalaureate degree than if pursuing the baccalaureate degree to begin with. These students may also encounter barriers in transferring credits and may need to show evidence of prior learning that can count toward their baccalaureate degree.

Regardless of the mobility program a student chooses, the likelihood of his or her success within it depends on the school's willingness to develop flexible and creative curricula (Boland & Finke, 2005). In response to the need for nurses prepared with baccalaureate and higher degrees, many schools of nursing are indeed designing flexible curricula and delivery methods that can accommodate learners returning to school to pursue nursing degrees.

Accreditation in Nursing Education

Accreditation is a process by which an institution's (e.g., school of nursing's) programs, policies, and practices are reviewed by an external accrediting body to determine whether professional standards are being met. Accreditation can also be considered to be a means of fostering continuous quality improvement in programs as the faculty also participate in the process to review and reflect upon all aspects of their program, with the goal of maintaining and improving quality.

Schools of nursing are accredited by the **National League for Nursing Accrediting Commission (NLNAC)** and/or the **American Association of Colleges of Nursing Commission on Collegiate Nursing Education (CCNE)**. Both NLNAC and CCNE are approved by the U.S. Department of Education. The NLNAC accredits all programs of nursing, whereas the CCNE limits its accreditation to BSN and MSN programs, and will eventually accredit DNP programs. Participation in the accreditation process of either NLNAC or CCNE is essentially a voluntary activity that schools undertake for the professional and public acknowledgment of the quality of their programs. Although accreditation by NLNAC or CCNE is a voluntary activity, it is an extremely meaningful one to the school and its students, because in some cases students can be denied access to scholarships/grants or admission to graduate programs if they are not enrolled in or graduates of a professionally accredited school. In addition to nursing's professional accrediting bodies, all schools of nursing are required to be accredited by the appropriate state board of nursing. Rules and regulations governing the operation and curricula of schools of nursing can be found in state board of nursing practice acts.

KEY TERM

Accreditation: A process by which an institution's (e.g., school of nursing's) programs, policies, and practices are reviewed by an external accrediting body to determine whether professional standards are being met.

KEY TERM

National League for Nursing Accrediting Commission: Affiliated with the National League for Nursing, this commission is an accrediting body for all types of nursing education programs.

KEY TERM

Commission on Collegiate Nursing Education: Affiliated with the American Association of Colleges of Nursing, this commission is an accrediting body for baccalaureate and higher degree nursing education programs.

The quality of nursing programs is measured through nationally established standards or criteria. Standards can include such things as how the school is fulfilling its mission and philosophy, how its curriculum is preparing students for nursing practice, and to what extent the qualifications of nursing faculty facilitate preparing future nurses.

The NLNAC and CCNE accredit schools for a period of time, usually 8–10 years, depending upon the agency and the review findings. Throughout the accreditation period, schools continue to use professional standards as benchmarks to evaluate their program, making necessary changes to ensure they maintain quality. Contemporary Practice Highlight 2-3 addresses the essential qualities and competencies that one of nursing's professional organizations, AACN, has deemed necessary for contemporary nursing practice; this document is used as a framework by many baccalaureate schools to ensure quality curricula.

KEY TERM

Curriculum: The overall structure of learning experiences within nursing education programs that reflects a school of nursing's mission and philosophy, program outcomes, course of study, and program evaluation methods.

Curriculum and Instruction in Nursing Education

Central to nursing education is curriculum and instruction. **Curriculum** is the overall structure of nursing education programs that reflects schools' mission and philosophy, course of

CONTEMPORARY PRACTICE HIGHLIGHT 2-3

THE AACN BSN ESSENTIALS OF BACCALAUREATE EDUCATION

In 1986 the AACN developed a document titled *The Essentials of Baccalaureate Education for Professional Nursing Practice*. The purpose of the document was to provide faculty in schools of nursing with an understanding of the competencies nursing students needed to function in contemporary health-care systems. Many schools of nursing use the "essentials" to structure the curriculum of their nursing education programs. Due to social, political, and economic trends and issues this document was updated in 1998. In 2007, the AACN determined it was necessary to update the document once again. Changes in the

document will likely mean revisions are on the horizon for many nursing curricula in order to remain current and up-to-date with contemporary practice. For instance, it is anticipated that the revised document will address the need to prepare students for evidence-based practice, information management, and expertise in evaluating patient outcomes (Martin, 2007).

Similar AACN documents for master's degree and DNP programs also exist, entitled the *Essentials of Master's Education for Advanced Practice Nursing* and the *Essentials of Doctoral Education for Advanced Nursing Practice*.

study, outcomes of learning, and methods of program evaluation. **Instruction** is the teaching and learning strategies and experiences faculty and students engage in to achieve the elements of the curriculum. Throughout the history of nursing education various trends and issues have influenced curriculum and instruction. For example, advances in germ theory added to what students learned about aseptic technique, progress in pharmacology changed what students learned about drug therapies, and research in educational theory changed how teachers taught as well as understandings of how students learn.

What follows are examples of some of the most prevalent trends and issues influencing curriculum and instruction today. The areas listed are not all inclusive nor do they signify a certain level of importance. The purpose of the overview is to provide you with an understanding of why you are learning what you are learning in your curriculum (i.e., important topics) as well as why teachers use particular methods of teaching and learning (i.e., important methods).

Learning Nursing: Important Topics in Nursing Education

Patient Safety

Patient safety has always been a priority in nursing education. In recent years, due to widely publicized medical errors, patient safety has taken on even greater importance. The book *To Err Is Human: Building a Safer Health System* (Kohn, Corrigan, & Donaldson, 1999) brought national attention to the issue of patient safety by discussing the number of people who die each year from medical errors. This, in turn, sharpened the focus of patient safety in nursing education. Gregory, Guse, Dick, and Russell (2007) urged nursing educators to begin the process of improving patient safety by examining how curriculum and instruction are contributing to students making errors and taking action to change teaching systems to reduce errors. Thus, nursing students today and in the future may experience a system of nursing education that prepares them differently than in the past to understand the practices and principles of reducing medical errors. Chapter 8 provides a further discussion of patient safety and creating a culture of safety in healthcare systems.

Cultural Competence

Cultural competence is the extent to which a nurse understands and has the skills required to effectively address the healthcare needs of individuals who hold cultural beliefs and values that are different from his or her own. As society continues to become increasingly diverse and global in nature, there is an increased emphasis on teaching concepts related to cultural competence in nursing curricula. For example, the U.S. Census Bureau (2004) reported that Hispanic and Asian populations are growing faster than the population as a whole. Therefore, all nurses are likely to work with healthcare providers and provide care to patients who have

KEY TERM

Instruction: Teaching and learning strategies and experiences faculty and students engage in to achieve the elements of a curriculum.

A nurse giving medication to an elderly patient.



cultural backgrounds with which they are not familiar. Nursing programs are integrating coursework and clinical experiences related to cultural diversity and global health care into the curriculum. These experiences can include, but are not limited to, clinical experiences in other countries and learning with nursing students who live in other countries (Fitzpatrick, 2007). Chapter 14 provides a comprehensive discussion of cultural issues that impact nursing practice.

Gerontology

According to the Centers for Disease Control and Prevention (2007), by 2030 the number of people over the age of 65 will have doubled to 71 million, which will comprise 20 percent of the American population. In a response to this trend, Thornow, Latimer, Kingsborough, and Arietti (2006) have developed a guide for nursing faculty to assist them in preparing nursing students to care for the elderly population. The importance of having a critical mass of nurses prepared to care for the growing population of elderly in the United States cannot be overstated. It is important for gerontology concepts and experiences to be integrated throughout nursing curricula to provide students with the skills required to care for both the well and ill elderly. The elderly as a vulnerable population is addressed in Chapter 13.

Evidence-Based Practice

Evidence-based practice is an approach to nursing care where nurses draw on the best available evidence to make clinical decisions. In nursing, evidence-based practice includes nurses' use of research studies and theory from within nursing and outside of nursing (e.g., medicine, psychology, sociology) to make clinical

decisions. For example, a nurse caring for a child with asthma draws on many sources of evidence to develop a therapeutic care plan for this child. Today's nursing students can expect to learn evidence-based practice through various activities where teachers provide instruction in best practices for gathering, analyzing, and synthesizing evidence. See Chapter 11 for a further discussion of evidence-based practice.

Technology and Informatics

Regardless of the practice setting in which students learn nursing care, it will include using various technologies and knowledge of informatics to assist with patient care. These technologies can include, but are not limited to, medical devices patients will use to provide self-care, as well as information retrieval, clinical information management, and documentation technologies. For example, students may have clinical experiences where they need to understand the use of various insulin pumps or pain management technologies that patients use at home, and that have patient teaching implications. Many schools of nursing are incorporating the use of personal digital assistants (PDAs) into the curriculum to help students immediately access information on medical terminology, laboratory values, and evidence-based information. Students' use of this device has important implications for improving their clinical judgment (Newman & Howse, 2007). Students are also being exposed to the use of a variety of clinical management systems. For instance, there are computerized physician order entry systems, telemedicine systems, and patient surveillance systems (Maffei, 2006), many of which have implications for ensuring patient quality and safety. Chapter 20 further addresses informatics and healthcare technology and their implications for nursing practice.

Interprofessional Education

A major movement in healthcare education is that of interprofessional education. It is defined as occasions when professionals learn with, from, and about each other to improve collaboration and quality of care (Barr, Freeth, Hammick, Koppel, & Reeves, 2006). The need for such education originates from concerns about patient care quality and safety and the overall importance of innovative ways to ensure good patient care outcomes. Preliminary research on interprofessional education indicated that it assists students in overcoming stereotypes about disciplines other than their own, promotes understandings across disciplinary boundaries, and improves students' ability to engage in teamwork (Freeth et al., 2001). Research on interprofessional education continues. For instance, current studies are investigating it as an approach to improving psychosocial care of oncology patients (see, for example, the Interprofessional Psychosocial Oncology Distance Education (IPODE) project at <http://www.ipode.ca>). Nursing students today will benefit from being open to and actively participating in emerging

models of interprofessional education. Chapter 6 further explores the topic of interprofessional research and practice.

Learning Nursing: Important Methods in Nursing Education

New Pedagogies

Pedagogy is a term used in nursing education that means the processes of teaching and learning. In the 1980s, nursing education experienced what was known as the curriculum revolution. It began when the National League for Nursing called for nursing schools to examine what students learn and how they learn (Tanner, 2007). In other words, teachers were urged to critically assess the pedagogies they were using and to use new pedagogies to better prepare students for nursing practice. This movement, along with educational research providing evidence for best teaching practices, has led teachers to avoid passive learning strategies (e.g., lectures). For instance, problem-based learning, cooperative learning, and service learning promote student-centered, active learning. Nursing students today can expect to be much more engaged and involved in the teaching and learning process as compared to nursing students of the past.

Critical Thinking

A significant movement that accompanied the curriculum revolution involved using pedagogies to ensure students could think critically in clinical practice. Critical thinking is variously defined, but put simply, it is the ability of nursing students to make sound clinical judgments and to provide safe patient care. Traditionally, students who learned the nursing process were thought to be learning critical thinking. During the past few decades the nursing process has been challenged as the best approach to developing students' critical thinking. It is still the case that the nursing process does assist students in thinking through assessment of patients' health status, devising nursing diagnoses, planning care, deciding on nursing interventions to support that care, and evaluating patients' responses to care. However, current research in nursing education suggests that students also need to engage in thinking processes that promote reflective thinking, where they build practical knowledge (knowledge from experience); embodied thinking, where they learn the importance of intuition; and pluralistic thinking, where they consider a clinical situation using many perspectives (Scheckel & Ironside, 2006). Today's nursing student can expect learning experiences where teachers use the nursing process, but also use other strategies to develop students' critical thinking practices.

Distance Education

With the advent of new learning technologies there has been tremendous growth in distance education. Distance education is instruction students receive in a location other than that of the faculty providing the instruction (Clark & Ramsey,

2005). Nursing students today can expect that many of the degree options covered previously in this chapter will be offered in distance education formats. For example, some students may choose a distance education format to obtain a master's or doctoral degree. There are even distance education programs for undergraduate education. What is important to understand is how a distance education program will serve the learning needs of the nursing student and whether enrollment in a distance education program is the best choice for the individual student.

Simulation

Simulation is a clinical situation that allows student nurses to function in an environment that is as close as possible to a real-life situation (Scheckel, 2008). It traditionally includes the use of live actors, written scenarios, games, virtual reality, and simple mannequins (Bearnson & Wiker, 2005). Teachers use these forms of simulation to foster critical thinking, an understanding of patients' values and needs, decision making, and hands-on skills. In recent years simulation has become more sophisticated, through the use of high-fidelity human patient simulators (HPSs). HPSs are computerized mannequins that include preprogrammed but modifiable patient scenarios, allowing a teacher to direct the simulator's actions so the simulator reacts in real time in response to actions taken by the student nurse (McCartney, 2005). For example, a teacher can program a simulator so that the student uses both critical thinking and psychomotor skills to provide care in an emerging complex patient situation such as an acute myocardial infarction. One significant advantage to the use of HPSs is that it allows students to experience clinical scenarios that they may not get exposed to in real clinical settings. There is emerging research supporting the effectiveness of HPSs in nursing education.

The Future of Nursing Education

In 1998 the Pew Health Professions Commission, a group of healthcare leaders charged with assisting health policy makers and educators teaching health professionals to meet the changing needs of healthcare systems, completed a report listing competencies healthcare providers of the future would need. The competencies listed in this *Fourth Report of the Pew Health Professions Commission* (O'Neal & Pew Health Professions Commission, 1998) included many of the issues discussed in this chapter. For example, the list included the need for healthcare professionals to be competent in evidence-based practice and critical thinking and to take responsibility for patient outcomes. Now 10 years later it is important to reflect on how the commission's projections were so accurate. How will nursing education need to prepare nurses in these competencies and future competencies as changes in the healthcare needs of society occur? Reflecting current initiatives in

professional education, Contemporary Practice Highlight 2-4 addresses the Carnegie Foundation for the Advancement of Teaching's Preparation for the Professions Program, a multiyear, multidisciplinary study that is investigating learning and effective teaching for nursing and other professions. The results of this study will undoubtedly influence future trends in nursing education.

Summary

This chapter provided insight into how nursing education will match the health-care needs of society with the educational preparation of nurses. In particular, practical nursing will continue to have a place in nursing practice, especially in home health care. Diploma and associate degree nursing programs will remain, but evidence linking baccalaureate education with improved patient outcomes suggests there will be a continued movement to prepare a workforce of registered nurses who will need a baccalaureate degree in nursing to be licensed as a registered nurse. Master's education in nursing will continue, but it may be accompanied by Clinical Nurse Leaders (CNL) who will provide oversight and coordination of many of the competencies the Pew Health Professions Commission projected. For example, one important role of the CNL may be to coordinate evidence-based practice in a hospital. Doctoral education can be expected to grow, especially with the development and implementation of the DNP. This newly formed role will prepare nurses for a high level of competency in direct service roles for a variety of clients with complex healthcare needs. Accompanying

CONTEMPORARY PRACTICE HIGHLIGHT 2-4

PREPARATION FOR THE PROFESSIONS PROGRAM

In 2004 and 2005 the Carnegie Foundation for the Advancement of Teaching, an organization committed to the improvement of teaching and learning, began a study to examine teaching and learning in schools of nursing. The Preparation for the Professions Program is a study where investigators are comparing nursing with other professions such as clergy, engineering, legal education, and medicine to determine what is common and different among these professions (Benner & Sutphen, 2007). The hope is

that such a study will show how these disciplines can inform one another about ways of changing and improving higher education for professional preparation. For example, are there caring practices of clergy that nurses can learn? This study has implications for shaping curriculum and instruction in nursing programs. Additional information can be found at the Carnegie Foundation for the Advancement of Teaching website: <http://www.carnegiefoundation.org/general/index.asp?key=30>.



the progression in nursing education will be changes in accreditation standards. As nurse educators keep pace with changes in health care, so too will the standards by which schools are accredited need to change. Changes in standards will subsequently mean ongoing but important changes in curriculum and instruction.

Nursing education is dynamic. This chapter explored the landscape of nursing education, including moments of celebration and times of turbulence and instability. Throughout the history of nursing education the nursing programs offered have been a direct reflection of social, political, and economic trends and issues. Nursing leaders and nurses have responded to changing needs by offering a variety of nursing programs. For example, during the 20th century, diploma programs were thought necessary to meet the needs of hospitals, which, with advances in medicine and technology, were multiplying rapidly.

A consistent theme throughout all of the changes in nursing education has been the presence of nursing leaders who diligently investigated the state of nursing education and advocated for reforms to improve the delivery of health care through quality nursing education. Amid the reforms, nursing education leaders and nurses educated within its systems have not wavered in keeping the patient at the center of care. The accreditation standards that arose from leadership in nursing education and the flexibility of nursing educators and nursing students in changing curriculum and instruction are evidence of the patient-centered care the nursing profession strives to provide. Nursing students of today are beneficiaries of a long history in nursing education that has been characterized by a sustained emphasis on advocacy for ensuring they are prepared for nursing practice.

Key Terms

- **Accreditation:** A process by which an institution's (e.g., school of nursing's) programs, policies, and practices are reviewed by an external accrediting body to determine whether professional standards are being met.
- **American Association of Colleges of Nursing (AACN):** A professional organization in nursing that serves baccalaureate nursing and higher degree nursing education programs by influencing the quality of nursing education and practice through research, advocacy efforts, policy making, development of quality educational standards and indicators, and faculty development.
- **American Nurses Association (ANA):** A professional organization for nurses that develops various standards of nursing practice and promotes change through policy development.
- **Apprenticeship model:** A model of nursing education that was prevalent during the first half of the 20th century where student nurses learned nursing practice by providing service to hospitals.
- **Commission on Collegiate Nursing Education:** Affiliated with the American Association of Colleges of Nursing, this commission is an accrediting body for baccalaureate and higher degree nursing education programs.
- **Curriculum:** The overall structure of learning experiences within nursing education programs that reflects a school of nursing's mission and philosophy, program outcomes, course of study, and program evaluation methods.
- **Instruction:** Teaching and learning strategies and experiences faculty and students engage in to achieve the elements of a curriculum.
- **Mobility programs:** Nursing programs that facilitate the seamless articulation or transition from one degree in nursing to another degree (e.g., LPN to RN, ASN to BSN, ASN to MSN, BSN to PhD).
- **National League for Nursing Accrediting Commission:** Affiliated with the National League for Nursing, this commission is an accrediting body for all types of nursing education programs.
- **National League for Nursing Education (NLNE):** A professional organization in nursing that fostered excellence in nursing education by supporting nursing education research, engaging in policy making and advocacy efforts related to nursing education, and promoting faculty development. It was the precursor to the National League for Nursing.
- **Nightingale schools:** Schools of nursing developed by Florence Nightingale that promoted student nurses learning the theory and practice of nursing outside of hospital control.

Reflective Practice Questions

1. As you reflect on this chapter, what are the advantages and disadvantages of the various degree options in nursing education today?

2. Nursing educators have often made changes in nursing education based on society's needs. How important is it to examine who decides what these needs are and who decides what changes are made in nursing education in response to these needs?
3. Nursing education has had many leaders who have ushered in important changes in the education of nursing students. What kind of leadership are you demonstrating that develops your ability to participate in leading nursing education in the future?
4. As knowledge in health care continues to proliferate, reflect on how you are learning nursing practice. Is it possible to know “all there is to know” about nursing practice? Is learning to think like a nurse more important than memorizing information?
5. A critique of nursing education is that its methods of curriculum and instruction have not changed—that is, teachers are still teaching using models of nursing education from the past. After reflecting on this chapter do you agree or disagree with this statement, and why?
6. After reading this chapter, in a few sentences can you describe what it means to be a nursing student today? How does the meaning you describe highlight areas of nursing education that will be important in preparing you for nursing practice?

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