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Nursing education in today's world: Recommendations for a program in Iowa

Abstract

The shift from an industrial to a high technology information society is occurring "so rapidly there is no time to react; instead we must anticipate the future" (Naisbitt, 1983, p. 18). John Naisbitt, the social forecaster and author of Megatrends, visualizes that our economy will be based largely on the creation, processing, and distribution of information. Because professional workers are almost all information workers, Naisbitt's prediction means that the demand for professional workers will continue to gain substantially.

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NURSING EDUCATION IN TODAY'S WORLD:
RECOMMENDATIONS FOR A PROGRAM IN IOWA

A RESEARCH PAPER

PRESENTED TO THE

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY AND FOUNDATIONS

UNIVERSITY OF NORTHERN IOWA

In Partial Fulfillment

of the Requirements for the Degree of

Master of Arts in Education:

Educational Psychology Teaching Major

by

Betty Lou Huston

June 1986

This Research Paper by: Betty Huston

Entitled: Nursing Education in Today's World: Recommendation For A Program In Iowa

has been approved as meeting the research paper requirement for the

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for the Master of Arts in Education degree with a major

in Educational Psychology: Teaching

at the University of Northern Iowa at Cedar Falls

on June 27, 1986 .

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CHAPTER I

Trends Which Influence Health Care Today

The shift from an industrial to a high technology information society is occurring "so rapidly there is no time to react; instead we must anticipate the future" (Naisbitt, 1983, p. 18). John Naisbitt, the social forecaster and author of Megatrends, visualizes that our economy will be based largely on the creation, processing, and distribution of information. Because professional workers are almost all information workers, Naisbitt's prediction means that the demand for professional workers will continue to gain substantially.

The arrival of the information society means that for the first time we have an economy based on a resource that is not only renewable, but self-generating. In this context, education for citizens of all ages and all walks of life is taking on increasing importance. Knowledge is generated through research. Universities provide the major setting for research and for dissemination and application of research findings. Therefore, investments made in universities are investments in one of the main components of our future economy.

Medicine and nursing are a part of that professional/information sector so vital to the future. A study of nursing education today requires a look at the way in which nursing education fits into medicine and nursing, the way it fits into the shift from an industrial society to an information society, and its relationship to the other larger influences affecting health care. Some of the latter influences, including the shift to an information society, provide

opportunities for nursing and nursing education, while other influences, such as burgeoning bureaucracies and the current economics of health care present major problems.

The opportunities for nursing and nursing education to create new knowledge, through the exchange of thoughts and through research, are fostered by an information society. The patient education component of the nurse's role is enhanced and refined in an information society because of an increased recognition of its importance in the prevention and management of conditions such as diabetes, cardiovascular disorders, maternal-child disorders, family crises situations, and numerous other medical and related conditions.

Major problems for nurses and nursing education are created by bureaucratic and economic trends. Health care is enmeshed in huge bureaucratic structures. Bureaucracies are characterized by fixed jurisdictional areas with firmly ordered systems of subordination (Page, 1973, p. 280).

The formal organizational structures in health care delivery systems are bureaucratic in nature. There are series of offices and positions within a hierarchical status structure related to the distribution of power (pecking order) within the organization. Merton (1940) describes the confusion of ends and means which may frequently occur in bureaucratic structures. The governing rules which are designed as means often become, for the membership, or parts of it, ends in themselves. Instrumental values tend to become terminal values in all established bureaucracies.

An example of this confusion of ends and means can be seen in nursing education when a student nurse begins the process of

professional education as a creative, thinking person and leaves as an inhibited conformist. Conformity is a highly valued characteristic of bureaucracies and success in a bureaucracy tends to require conformity. In actuality, the very opposite is a stated goal of the educational experience (Welch, 1980, p. 727).

Such conflicts over power and control in bureaucracies combine with the economics of today's health care delivery systems and technological advances to create an abundance of ethical dilemmas. For example, the American Nurses' Association regards patient advocacy as a part of the nurse's role. However, a nurse may jeopardize her job if she functions as a patient advocate. The nature of human beings involves the potential for error and limitations in certain situations; when things start to go bad for a patient, they may tend to snowball and situations may be difficult to reverse. The nurse may be aware of errors made but because of the threat of malpractice suits there may tend to be a "conspiracy of silence." Awareness of her obligations to the patient as well as her loyalty to the organization creates a dilemma for the nurse.

Economic Aspects

Hospitals today depend on "third parties" as their major source of revenue. On the average, 30% of these funds come from Blue Cross, 30% from government (Medicare and Medicaid), 30% from commercial and independent insurance, and 10% from self-pay by the patient (Iowa Hospital Association, 1985, p. 20). Medicare (Title XVIII) and Medicaid (Title XIX), both passed in 1965, direct hospitals to charge

patients uniformly for services provided. Low income patients cannot be charged less than well-to-do patients. Third party payers, however, are charged less than individual payers because of their "reliability" (IHA, 1985, p. 20).

There is considerable concern about the financial stability of the Medicare program, as seen in the following quote from the Journal of the National Medical Association:

> Medicare, hailed as a great safety net for the elderly when it was enacted almost 20 years ago, is expected to go bankrupt in the early 1990's. (Mazique, 1985, p. 367)

Efforts on the part of the medical profession to increase the awareness of its members of conditions which worsen problems rather than solve them are seen in the following writings of Mazique (1985, p. 367) in an article entitled, "Trends and Transformations in Health Care" and published in the Journal of the National Medical Association.

> Dr. Arnold S. Relman, editor of the New England Journal of Medicine wrote in Financier "Physicians have direct financial interests in proprietary hospitals and nursing homes, diagnostic laboratories, dialysis units, and many small companies that provide health-care services of various kinds. I believe that the risk to the reputation and self-esteem of the profession will be great if organized medicine fails to act decisively in separating physicians from the commercial exploitation of health care. Individually, physicians might be forgiven for following what appeared to be accepted practice; huge numbers of them, though, have compromised their integrity by milking the system to the utmost."

Delivery of health care is now a business run for economic gain. "A study by the Robert Wood Johnson Foundation indicated that in 1982, one million U.S. families were refused care for financial reasons" (Mazique, 1985, p. 366). While the hospital industry as a whole is

shrinking--the number of beds is decreasing--proprietaries (agencies providing health care delivery for profit and protected from free competition through monopolization, patent, trademark, or copyright) are expanding rapidly. A trend toward monopolization is evident, as is a great increase in the political power over policy formation that is held by these firms (Salmon, 1985, p. 410).

> Hospital Corporation of America (HCA) based in Nashville, Tennessee was a $4.2 billion concern (1984) owning over 355 hospitals in the United States, United Kingdom, and several other countries (this transnational health provider manages another 35,303 beds in 294 hospitals under contract, an increase of 11.4% over 1981). . . . HCA's recently announced merger with American Hospital Supply Corporation, the nation's largest medical supplier, will make their combined revenues in 1985 over $8 billion.

Salmon (1985, p. 412) expresses concern about encroachments of proprietaries into the teaching of medicine in educational institutions:

> Harvard Medical School's Massachusetts General Hospital considered selling the prestigious McLean Psychiatric Hospital to HCA . . . Relman remarks about the Harvard-HCA association: "Here is the bastion of academic medicine, with the most distinguished teaching hospital in the country, if not the world, face to face with the biggest, richest hospital company in the world. They want Harvard's imprimatur."

Furthermore, Humana (a rapidly growing proprietary specializing in heart surgery) recently contracted to build and operate Chicago Medical School's teaching hospital (Salmon, 1986, p. 412).

Historically, financial reimbursements to hospitals were based on room charges for the number of days a patient was hospitalized and the services provided. In the 1980s, efforts to reduce costs brought about a new cost system called prospective payment systems.

Health care financing by prospective payment systems (PPS) is based on a method of averaging historical costs, historical medical practices, and historical health care values. There are fully 468 categories in which such averaging is performed. Collectively, these categorized units comprise the diagnostic related groups (DRG's). The incentives provided by this system are, according to Young (1986), incentives to: (a) decrease hospital admissions, (b) provide fewer services, (c) decrease length of hospital stay, (d) shift services out of hospitals, and (e) specialize in select DRG's. Quality of care is now assessed at the end of the hospital stay rather than at the end of an episode of illness. What this results in are cases in which patients, especially elderly ones who live alone, experience serious difficulties after having been released prematurely. In addition, effective monitoring of care outside of hospitals has not been keeping pace (Young, 1986). That such inappropriate early discharge from hospital care of patients whose condition is far from stabilized is a serious concern accompanying the PPS and DRG's is a claim supported by Kuhn (1985). When reimbursement is fixed at the same amount for each given condition, no matter how long a patient is hospitalized, there are inevitable economic pressures to discharge people "on time" regardless of their actual levels of recovery.

Studies of patient outcomes at the end of an illness and of the rates of occurrence of preventable complications are likely to yield alarming data. If this is indeed the case, hopefully incentives for all involved in health care delivery to stop and take a look at what our purpose really is will be the result. Legislation (S 2331 and HR

4638), currently before both houses will, if passed, require hospitals to have a professional, such as a registered nurse or social worker, who is to have a discharge plan for every patient (Washington News Brief/May 1986). These two bills follow a year-long congressional probe of quality of care under Medicare's PPS (Washington News Brief/ May, 1986). Quality of care both in and out of the hospital and access to care are issues needing immediate attention (Young, 1986). In the long run, this could save money, as it is only logical that it costs less to keep a patient an extra day or two and prevent a complication than it does to readmit the same patient for treatment of a complication that could have been prevented in the first place. It seems unfortunate that "economic" arguments would prevail when patient safety, recovery, and the prevention of complications are at stake.

Ethical Aspects

As medical technology has continued to expand, the number of treatment options has increased and the number of "gray areas" in regard to ethically acceptable practice continues to climb.

For example, the possibility of organ replacement, both human and artificial, creates questions such as how do you decide who has the best prognosis--the donor or the recipient? Life and death decisions fall increasingly into the hands of health professionals. Will the health industry be manned by bureaucratic technologists who lack the wisdom and integrity to know when to use it? Or will courage, humility, and honesty lead us into the paths ahead? Crofts (1983) claims that both physicians and nurses share the "affliction of the

ability to cope," which he defines as the trained ability to do nothing when action is called for. He believes this is the case in an increasing number of "therapeutic decisions" with moral dimensions and large financial costs.

McCormick (1984) states that the main problem encountered by the emerging interdisciplinary ethics committees is the unwillingness of physicians to participate. Non-clinical people on these committees are regarded by physicians as incapable of sufficiently understanding the medical data on which medical judgments must be made. Since physicians are the "feeders," in that they send patients to hospitals, and hospitals don't want to alienate their feeders, physicians are in a position to thwart the work of these committees.

However, the physician is no longer the unchallenged authority in ethical decision making. With public awareness of the subjective element of many physicians' decisions on the rise, third party payers increasingly question diagnoses and require second opinions (Murphy, 1984).

Demographic Aspects

Major demographic changes are revolutionizing health care delivery. Two of the most significant changes are (a) the growth in the population of the elderly, and (b) changes in financing of health care. By the year 2050, it is projected that persons in the United States aged 65 and over will comprise 22% of the population (Arnold, 1986, p. 20). In 1984, this group was at about 12% (Arnold, 1986, p. 20). The speed with which this change is occurring translates

into many opportunities for health professionals. However, unless there is a reallocation of priorities to meet the special needs of this age group today, the potential for a crisis exists (Arnold, 1986, p. 21).

For example, the health care system has neglected chronic diseases and the prevention of diseases in favor of acute care, miraculous cures, and surgical interventions (Kuhn, 1985, p. 234). By the year 2020, the leading cause of death in the United States will be Alzheimer's Disease, according to predictions published by the U.S. Department of Health Task Force on Alzheimer's Disease in September of 1984 (Cox, 1985, pp. 145-150). Those making growth projections estimate the creation of more than 6,000 additional positions for nurses per year in long-term care. The need for nursing research in the primary, secondary, and tertiary care for Alzheimer's Disease is great (Cox, 1985, pp. 149-150).

Minority groups experience their own unique problems in regard to the medicare system. An example of this is identified by Mazique (1985, p. 367) who identified the following concerns and trends:

> A black male has a life expectancy of 64.8 years. Although he pays Medicare taxes throughout his working life, he is expected to die two months before he becomes eligible for benefits.

According to a 1985 Physicians' Task Force study, "Hunger in America: A Growing Epidemic," up to 20 million people may be hungry during some part of every month (Harvard University, 1985). The statistics on poverty trends in the United States are particularly alarming when analyzed, especially since 40% of these people are

children. In 1982, there were 34,398 persons below the poverty level; in 1983 35,398; in 1984 and 1985 and the projections are that these numbers and percentages will continue to rise (U.S. Bureau of the Census, 1984). Malnourishment causes major health problems, bringing medicine and nursing into today's efforts to meet the needs of this group.

In summary, American society is experiencing significant changes as a result of major technological, demographic, and economic shifts. Medical and ethical dilemmas emerge before old ones are solved and nursing is caught in the middle.

CHAPTER II

Nursing in Today's Context

Much of the writing about nursing today focuses on entry into the nursing profession (Briggs, 1985; Kalisch & Kalisch, 1986; MacLean & Kenney, 1985; ANA, 1978; NLN, 1985). Considerable doubt exists, however, as to whether or not nursing actually is a profession at this point in time. Miller and Keane (1983) define a profession as:

> . . . a calling or vocation requiring specialized knowledge, methods, and skills, as well as preparation in an institution of higher learning, in the scholarly, scientific, and historical principles underlying such methods and skills. A profession continuously enlarges its body of knowledge, functions autonomously in formation of policy, and maintains by force of organization or concerted opinion high standards of achievement and conduct. (p. 918)

In general, American society looks on nursing as a vocation rather than a profession. The presence of large numbers of vocational programs for training nurses in community colleges is evidence of this view of nursing. Few people feel the need for a nurse unless they are ill and then their original contacts are with their physicians, in whom they have the utmost trust. The nurses are considered secondary.

Graduates of vocational programs (two year), diploma (three year), and baccalaureate programs (four year) all write the same examination for a license to practice nursing. This would appear to be evidence that nurses do not differentiate between the vocational and so called "professional" nurse (nurses write the exams and control testing). Attempts to establish clear roles and functions for each of the three

levels is in conflict with the fact that two-, three-, and four-year graduates take the same exam. A double message is being conveyed.

On the other side of the coin, the fact that nurses do actually control licensure exams indicates that nursing meets the criteria for a profession regarding control of its own standards of achievement. In relation to "preparation in an institution of higher learning," again there is inconsistency because of the multiple programs in existence in a variety of settings (community colleges, hospitals, universities). In regard to "functions autonomously in formation of policy," the issues of power and control have been present since nursing began. In the early schools of nursing in America, nurses were encouraged to "attend" but not "enroll in" courses in medical school. Even today, nurses operate with little visibility in the political arena. The self-esteem normally accompanying membership in a "profession" appears to be largely absent. Nurses recognize their caring functions, but tend to rate them as less important than medical functions (Welch, 1980).

Parkinson (1986) identifies three historical images which still influence nursing. These are:

1. The folk image of the nurse as a "mother" who is kind, gentle, always available, nurturing, but not learned.

2. The religious image, based on the church's view of caring for the sick as important for the salvation of the soul of the care giver. From this outlook, medical care should be extended for love, requires celibacy, unworldliness, strict self-discipline--no formal learning.

3. The servant image, drawn from the 16th to 19th Century, when illness was viewed as a punishment for sin and care of the sick was far from charitable.

A major influence on nursing's development in the last century has been advancement in medical knowledge. Although a great deal of effort has been made to define the unique, autonomous role of the nurse, a satisfactory distinction between medicine and nursing has not been made.

Florence Nightingale's view of nursing held that the nurse has to ". . . put the patient in the best condition for nature to act upon him" (Parkinson, 1986, p. 146). The beauty of this definition lies in the humility it expresses. Even today, can either physicians or nurses do more? This definition implies that only God's grace heals. It can be used wisely as a guide. However, like other definitions, it does not differentiate between medicine and nursing.

Virginia Henderson (Parkinson, 1986, p. 146) defines nursing as:

> The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge.

The value of this definition is that it preserves the dignity and rights of the patient. However, the word "unique," which is an attempt to impute autonomy to the nurse, is misplaced, in the opinion of this author, for is it not the combined efforts of physicians and nurses that assist the individual in activities contributing to recovery or a peaceful death?

The American Nurses' Association (Parkinson, 1986, p. 147) defines nursing as "the diagnosis and treatment of human responses to actual or potential health problems." The key word here is "responses." Its purpose is to indicate a difference between medicine and nursing. Physicians are said to diagnose and treat diseases, as opposed to patient "responses" to them.

Human response to a health problem is mainly in the patient's realm. Both nurses and doctors can often influence the patient's level of acceptance and adjustment to a medical diagnosis. However, this is an inadequate definition of nursing and again does not differentiate between medicine and nursing.

The real difference between medicine and nursing is now and always has been, that medicine has consistently high educational requirements for which they receive recognition. It is very simple and it is time for nurses to quit playing "word games" choosing an illusion. The time and energy could better be spent working for consistently high educational standards in nursing recognizable to the public. If nursing is to be a profession alongside (not inferior to) other professions, a commitment to high educational standards, endorsed by society, is needed by nursing leaders as well as in the political-economic arena.

CHAPTER III

Nursing Education in Today's Context

The nursing profession is currently experiencing major changes and shifts. Two of the most notable changes are (a) the transition in hospital staffing towards all registered nurse (R.N.) staffing (Hartley, 1986), and (b) the emergence of more stringent educational requirements for its practitioners (ANA, 1978, p. 3).

Susan S. Hartley, Ph.D., Director of Statistics and Data Analysis for the American Nurses Association (ANA), conducted a survey of 75 nursing administrators concerning the effects of PPS's on nursing. Her most significant finding was a shift to all R.N. staff noted by 50 of 75 nursing administrators. This had been achieved through attrition of licensed practical nurses and nurse aides. Though hospital populations are down, the patients who are hospitalized are requiring the care of the most highly skilled professionals who put increasing emphasis on discharge planning and patient and family teaching (Hartley, 1986).

Nursing education, historically, has sought to respond to the needs of society. In the United States, legislative recognition of the need for trained nurses was first recorded by the Massachusetts Legislature in 1850 (Kalich & Kalich, 1986, p. 93). A state sanitary commission had been appointed to prepare plans for promoting public health. The commission recommended "that institutions be formed to educate and qualify females to be nurses" (Kalich & Kalich, 1986, p. 93). Nurses were encouraged to attend medical college lectures at the New England Female Medical College.

In 1868 the American Medical Association (AMA), led by Samuel D. Gross, M.D., suggested that schools of nursing be attached to hospitals (Kalich & Kalich, 1986, p. 97). In July of 1872, the New England Hospital nursing course was expanded into the "first general training school for nurses in America" (Kalich & Kalich, 1986, p. 97). It employed physician-instructors in all medical branches then in existence. A proliferation of nursing schools throughout the country was seen during the next twenty years as the training school had proven to be the most economical means of providing nursing care.

In January of 1904, a Nurses' Convention was held in Des Moines, Iowa for the purpose of organizing a State Association. This was brought about by the sentiment that "had developed in every section to the effect that the practice of nursing should be protected by an act of the legislature which would require all graduate nurses to register" (Wilson, 1931, p. 9).

Currently, four basic educational levels exist: Licensed Practical Nurse (LPN), Associate Degree Registered Nurse (ADRN), Diploma Registered Nurse (RN), and Bachelor of Science in Nursing (BSN).

The Diploma RN is a three-year hospital-based program with an affiliation with a university for the support courses. It is the opinion of this author that the diploma programs have maintained high entry and performance standards. However, the graduate of a diploma program does not receive university credit for the nursing courses successfully completed except by taking further examinations (in addition to the licensure exam). The diploma RN is integrated into the bureaucracy during the course of the program. Also, the diploma

graduate is a skilled bedside nurse, but lacks in knowledge of the humanities, research, and management.

The LPN educational programs were designed during a time when there was a shortage of registered nurses in order to relieve them of duties which the nursing leaders felt could safely be performed by a nurse with one year of training in the 1950s and 60s. The LPN was only to function under the direct supervision of an RN. Attempts were made to clearly limit the duties of the LPN and to provide close supervision of their functioning.

The associate degree programs are two year programs which were developed at community colleges with the move toward vocational education in the 1960s and 1970s. In general, they have much more liberal entry requirements and spend considerable time helping students with remedial skills in reading, writing, and math. The graduates of these programs today can, however, attain the same status as a three-year diploma graduate by writing the same board exam. They are considered A.D. R.N. or Associate Degree Registered Nurses and they do receive university credit for the nursing courses they complete, although their actual training may have been somewhat deficient. Programs began at a time when everyone had to be admitted to the hospital.

The Baccalaureate Degree programs are based in universities. Graduates of these programs tend to have had less "hands on" clinical experience than diploma graduates, but have had some clinical observation experiences. High standards are maintained for entry and throughout the programs. After 27 years of hospital experience, it is the opinion of this author that graduates of those programs tend to

have a broader understanding of cultures and humanities, more self-confidence, greater skill in management, and are less enmeshed in the bureaucracy, and more interested in research.

Clinical nurse specialists are trained in universities at the master's level and are certified through processes regulated by the ANA. In today's world, it is fast becoming necessary for a nurse to be educated at this level in order to be promoted to a head nurse. This is because of technological advances and increased medical knowledge, as described earlier.

As far back as 1965, acknowledging the importance of such trends, the American Nurses' Association recognized the need for reforms in educational programs for nurses and in its 1965 position statement asserted that education for all those who are licensed to practice nursing should take place in institutions of higher education (ANA, 1978). What became known as the "85 Proposal" presented a goal that by the year 1985 there would be only two basic levels of entry into practice, these being the two-year associate degree "technical" level and the 4-5 year baccalaureate "professional" level.

Between 1960 and 1980 a gradual increase in the number of baccalaureate, graduate, and specialized programs has occurred. Table 1 shows the shift towards higher education which has occurred.

Table 1

Graduations From Nursing Programs in the United States*

	Doctoral	Master's	Baccalaureate	Associate Degree	Diploma
1960-61	11	1,009	4,031	917	25,071
1970-71	41	2,083	9,856	14,534	22,065
1980-81	121	5,026	24,370	36,712	12,903

Note: *Excluding Guam, Puerto Rico, and the Virgin Islands.

Source: NLN Nursing Data Book 1981, pp. 39, 79, 90. New York: National League for Nursing, 1982. From American Nurses' Association, 1983, Education for Nursing Practice in the Context of the 1980s.

In 1985, the National League for Nursing (NLN), which is responsible for accreditation of basic educational programs in nursing, joined the ANA in promoting the change from four levels of preparation to two. It is interesting and significant to note, as shown in Table 1 there was a 600% increase in number of baccalaureate graduates from 1961 to 1981 and that there was a 50% decrease in diploma graduates during that same time period.

Future trends indicate that the call for higher education for nurses will continue. Kalich and Kalich (1986, p. 749) predict the following in regard to nursing's future:

> Looking ahead to the year 2000 and beyond, it is inconceivable that nurses will be doing what nurses do today. By the year 2000 nurses will be assuming more and more health-care responsibilities. A continuing political and economic controversy will surround the restructuring of legal, professional, ethical, and insurance responsibilities between physicians and nurses.

> Technology will continue to evolve in health care and will require of professional nurses more advanced and specialized skills and knowledge. For example, spare-parts surgery or transplants of human organs--including hearts, kidneys, livers, and lungs--which today are uncommon and high-risk procedures, will become commonplace. Success rates for these procedures will be higher because of advances in immunology and immunosuppressive drugs used to reduce the rate of rejection. Where transplants of human organs are not feasible, the use of artificial organs and limbs will be possible and successful.

These predictions mean that well educated and technically competent nurses who understand the patient and the physiological process, and the desired versus adverse reaction to medication and treatments, will be needed.

Other factors in support of making bachelor's degree preparation a requirement for entry into professional nursing have been defined by Riffle et al. (1985, p. 208):

1. The American system of education is structured so that the knowledge, skills, and attitudes expected of professionals are acquired at the bachelor's degree of higher level of education.

2. Nurses are licensed by society to make independent decisions that profoundly effect other people's health and lives.

3. Nurses are given responsibility in everyday practice situations that profoundly affect other people's health and lives both through direct care and through direction of a myriad of other workers who are providing care.

4. American society is now characterized as an information society; ability to assess the quality of information available is paramount.

5. High technology is well established and burgeoning; the balancing need for high quality humanistic services is deepening.

6. Colleges and universities are not overcrowded; there is valuable space available for nursing education in programs within the ongoing system of post-secondary education.

7. The supply of nurses prepared to teach in colleges and universities has grown dramatically and continues to grow.

8. Nursing research is establishing nursing as a bona fide intellectual endeavor.

The trend toward baccalaureate and master's degree preparation for nurses is gaining momentum. Today, the majority of state universities in America have baccalaureate in nursing programs and many also have masters degree nursing programs (NLN, 1985, Pub. No. 19-1986). In one year, between October 16, 1983 and October 15, 1984, nine new baccalaureate programs opened in America and eight diploma schools closed (NLN, 1985, Pub. No. 19-1986).

CHAPTER IV

A Specific Recommendation for a Nursing Education Program in Iowa

The social context in which nursing education functions today has been described. The arrival of the information society provides fertile ground for the growth of higher education for nurses and implementation of higher standards for nursing.

Economic problems are of major concern. Shifts in the methods of financial reimbursement by third party payers and trends toward monopolization are making access to care a problem for many. When health care delivery becomes a business operated for economic gain, quality of care both in and out of the hospital become major concerns. Citizens deserve access to high quality health care and sufficient periods of hospitalization, regardless of age, race or economic status. Evidence was presented earlier which would support the claim that baccalaureate preparation for nurses is the minimum level needed. The very nature of a liberal arts education broadens the student of nursing in understanding of human beings, and in the thinking and problem solving skills, so vital to solving the ethical dilemmas which they will face in their careers.

The body of medical/nursing knowledge has increased with technology and nurses are called upon to make assessments and judgments based on understanding of the patient's condition. Nurses must also operate and monitor complicated new equipment. All this takes training beyond what most nurses have received in shorter term programs.

Nursing Education in Iowa and the Waterloo-Cedar Falls Area

This author's locale for nursing education is Black Hawk County in Iowa, and the focus of this chapter is on Iowa in general and the Waterloo-Cedar Falls area (Black Hawk County) more specifically. In 1980 Iowa had a population of 2,913,808 citizens, of whom 387,382 were age 65 or over (U.S. Department of Commerce Bureau of the Census, 1980). As noted earlier, by the year 2050, persons over 65 are projected to be 22% of the population (Arnold, 1986, p. 20). Twenty-two percent of 2,913,808 is 582,761, which supports Arnold's prediction that the population of elderly will almost double.

Iowa is a conservative midwestern state of roughly three million people with a traditional agricultural economic base. As our country as a whole has moved from an agricultural to an industrial society and now to an informational society, Iowa has undergone some difficult times. A cursory review of the newspapers in Iowa over the past two years reveals farm foreclosures and layoffs in agriculturally related businesses such as the manufacture of tractors at the John Deere Corporation, the fortunes of whose manufacturing operations have an extremely important impact on the economic life of the Waterloo-Cedar Falls area.

Planning is needed in order for Iowans to control their future and act rather than react to changing times. An example of acting rather than reacting is to plan for higher education for nurses.

In Iowa, baccalaureate and masters programs for nurses are now confined to the University of Iowa at Iowa City, except for some

private programs whose costs are prohibitive to most. The metropolitan area of Waterloo and Cedar Falls contains two major medical centers: Allen Health Care Systems, Inc. and Covenant Medical Center. There is also Sartori Memorial Hospital. The area includes Americana Nursing Home, Friendship Village, and over thirty other care facilities for people over age 65. In spite of all this, the area has no means for nurses and prospective nurses to attain their baccalaureate or masters degrees. A look at the population of the Waterloo-Cedar Falls metropolitan area and the surrounding counties reveals the following population statistics:

Table 2

Population of Immediate Area in 1980

County	Population	County	Population
Buchanan	22,900	Black Hawk	137,961
Marshall	41,652	Tama	19,533
Benton	23,649	Delaware	18,933
Fayete	25,488	Hardin	21,776
Franklin	13,036	Floyd	19,597
Mitchell	12,329	Howard	11,114
Winneshiek	21,876	Allamakee	15,108
Butler	17,668	Bremer	24,820
Chickasaw	15,437	Clayton	21,098
Worth	9,075	Cerro Gordo	48,458
Grundy	14,366		

Source. U.S. Department of Commerce Bureau of the Census, 1980.

The total population for the counties listed in Table 2 is 555,956. Nursing is composed primarily of females. Because women often have responsibilities as wives and/or mothers in addition to their careers, and are not able to travel long distances to complete their education, geographic accessability to a nursing school is of prime importance to them. The situation is no different in the Waterloo-Cedar Falls community.

Another way to act in a rational, planned fashion, rather than to react in haste to unforeseen circumstances, is to evaluate current public expenditures for nursing education. Table 3 shows the number of two-year associate degree programs in community colleges in four states in relation to the number of baccalaureate degree programs.

Table 3

Number of Associate Degree and Baccalaureate Degree Nursing Programs in Four States

	Iowa	Missouri	Minnesota	Wisconsin
Associate Degree	20	16	10	14
Baccalaureate Degree	1*	5	3	3
Ratio of Baccalaureate Degree to Associate Degree	1:20	1:3	1:3	1:5

Note. *According to this resource Luther College in Decorah also receives some public support.

Source. National League for Nursing. (1985). State-approved schools of nursing, RN, 19, 24, 25, 36, 37, 39-41, 76-78.

Private BSN degree programs are available in Dubuque (Clarke College), Cedar Rapids (Coe College and Mount Mercy College), Lamoni (Graceland College), Des Moines (Grand View College), Mount Pleasant, (Iowa Wesleyan College), Decorah (Luther College), Davenport (Marycrest College), and Sioux City (Morningside College).

The 20 two-year associate degree programs in Iowa may have been needed at one time. However, as advances in technology and medical/nursing knowledge continues, the need for nurses prepared at this level continues to decrease and the need for higher education continues to increase. Preparation for this continuing trend will require adjustments in the designation of public and private funds. It is interesting to note that Iowa, with its population of only approximately 3 million, has significantly more publically supported associate degree programs than three nearby states with populations of over 4 million each. Table 3 shows that Iowa has twenty (20) associate degree programs and only one baccalaureate program--a ratio of 1:20, while Minnesota, with 4,075,970 population (U.S. Department of Commerce Bureau of the Census, 1980) has only half that number and Wisconsin, with 4,705,642 population (U.S. Department of Commerce Bureau of the Census, 1980), has only 14 such programs. Missouri, with a population of 4,916,766 (U.S. Department of Commerce Bureau of the Census, 1980), has a ratio of 1:3 in that it has five (5) baccalaureate programs and sixteen (16) associate degree programs. All of the programs referred to receive public financial support.

If Medicare funds finance medical education an equal amount should be designated to nursing education. Medicare funds have been easily

allocated for the payment of the education of medical doctors. This had not been the case for nursing education. For example, the Dole/Durenberger proposal designated one billion dollars of Medicare funds for medical education and none for nursing education. It is difficult to understand how Senator Durenberger could speak to a nursing economics group and say the proposal designated one billion dollars for "health education" and fail to state that the actual bill (S.1158) only calls for a study of the costs of nursing education (Durenberger, 1986, p. 9).

Recommendations

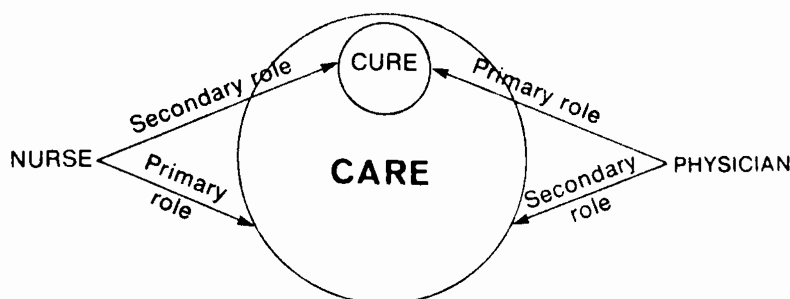
The University of Northern Iowa (UNI) at Cedar Falls, Iowa was established in 1876 as Iowa State Normal School and, on July 1, 1967, on recommendation of the State Board of Regents, it became a university. It has a student population of about 11,000 students. The current mission statement of UNI was approved by the Board of Regents in 1978 and states that the university endeavors to meet the educational needs and demands of society (UNI 1984-96 Catalog, p. 5). The mission statement further states that "future programs will be determined by the continuing study of existing programs and of developing needs." If the substance of this paper is to be taken seriously and if the mission statement of the university is to be taken seriously, then it would appear that the University of Northern Iowa has the rare opportunity to meet the needs and solve the problems discussed in line with its very purpose. The UNI mission statement further states, "If the University is to remain vital, it must consider

at the appropriate time the development of some new programs that fall within its general mission and meet the new needs of students and of society" (UNI 1984-86 Catalog, p. 5). A provision for the establishment of a College of Nursing at the University of Northern Iowa would provide opportunities for the university to address the array of modern health problems which have been identified and elaborated upon above. The construction of a suitable building to serve as a College of Nursing would be needed. A computerized health science library would be necessary because of the proliferation of journals and this would also be in preparation for an economy based on information processing.

The needs of the people call for collaboration of physicians and nurses in forming innovative specialized programs. The following diagram (Parkinson, 1986, p. 148) illustrates the coordination of care

Diagram 1

Care-Cure Concept



Source. M. Parkinson, 1986. Historical Influences and Expanding Roles of Nurses. In K. Sorensen and J. Luckman (Eds.), Basic Nursing: A Psychophysiologic Approach, p. 148.

and cure functions and the associated responsibilities of the nurse and the physician.

Diagram 1 shows the Care-Cure Concept in relation to the primary and secondary functions of physicians and nurses. The physician's primary function is to "cure" and secondary function to care, "which is best carried out in cooperation with the nurse. The nurse has a primary function to care and a secondary function to cure, which is carried out in cooperation with the physician" (Parkinson, 1986, p. 147). The care functions of the nurse include the provision of 24-hour care for inpatients which involves working weekends, 3-11 shifts and 11-7 shifts. Because many conditions call for immediate action and because the nurse is on the scene and available, the nurse must be prepared to diagnose certain medical conditions.

I recommend a program based on the Care-Cure Concept in cooperation with physicians. The greater portion of the curriculum for nursing would focus on care and caring because that is the nurse's primary role. A lesser proportion of the curriculum would focus on cure and be facilitated through involvement of physicians in the classroom and clinical areas, because this is primarily the physician's role. Each can benefit from listening to the other. Nurses need to respect the physician's expertise and authority in matters of cure and physicians need to respect nurses in matters of care and caring.

Caring would be the main guiding principle of the program. For example, pre-admission interviews would facilitate acceptance of caring individuals who meet the entrance requirements. Another guiding principle would be the right of the patient to be treated with dignity.

Ethical problems would be examined as to whether or not there is infringment on the right to be treated with dignity. This would help solve the problem of ethical dilemmas as identified earlier in the paper.

I further recommend that the program be facilitated by the establishment of four departments within the College of Nursing:

1. Department of Physiological Nursing
2. Department of Mental Health Nursing
3. Department of Maternal Child Nursing
4. Department of Gerontological Nursing

The first three are well estabished areas. The Department of Physiological Nursing would involve medical-surgical nursing.

A Department of Gerontological nursing would address the special problems encountered by the elderly and train professional nurses to care for their increased numbers elaborated upon in the discussion of demographic shifts. Clinical specialists in gerontology would provide leadership, role modeling and be involved in research. The fact that health care is utilized primarily by people over age 65 (National Center for Health Statistics, 1980) provides additional support for a Department of Gerontology.

On the undergraduate level, distribution of the nursing course content would be as follows:

1. Physiological Nursing--50%
2. Mental Health Nursing--25%
3. Maternal Child Nursing--12%
4. Gerontological Nursing--13%

On the graduate level, there would be opportunities for nurses to specialize in any one of the four areas. If insurance companies, Medicare and Medicaid, planned for direct reimbursement to nurses prepared at the graduate level, the problem of access to care described earlier would be addressed.

Expanding roles for professional nurses at both the undergraduate and graduate level call for specialized programs. The U.S. Department of Health, Education, and Welfare studied the extended (expanded roles for nurses) and published a report in 1971. The expanding role of the nurse was seen as leading to the improvement of physician-nurse collaboration to meet the increasing health care needs of the public. Areas of expanded function identified by the committee included the following:

> Increased skills in assessment leading to medical and nursing diagnosis
>
> More formalized methods of history taking for both medical and nursing purposes
>
> Increased peer collaboration with physicians in the planning and implementation of medical intervention
>
> Increased responsibility for nurses in areas of health surveillance and health maintenance for individuals and families not classified as acutely ill. (Parkinson, 1986, p. 151)

In further support of a graduate program for nurses, it is a well established fact that the existence of a graduate program enriches an undergraduate program because of the presence of faculty and research activities. Furthermore, advances in technology and trends in nursing graduations as shown in Table 1 indicate a need for nurses prepared at this level. Planning now for both programs would prevent duplication.

At the baccalaureat level, both a generic program for new students and a completion program for Registered Nurses is needed. The liberal arts component of the programs would be consistent with the present University of Northern Iowa requirements. A strong clinical component is recommended through contractual agreement with hospitals who are accredited by the Joint Commission on Accreditation of Hospitals (JCAH) and the many other community agencies. This would involve planning for preceptorships in the latter part of the undergraduate program and throughout the graduate program in addition to the clinical instruction for the more basic skills.

As argued earlier, nurses of the future will have to be prepared to meet and deal with complex economic, ethical, social, cultural, and technological problems. Professional nurses are needed for the wise application of technology. We will need increasingly educated professionals at all levels of health care delivery.

In summary, the financial, ethical, and demographic changes occurring in the United States present advantages as well as dilemmas and challenges for health care. Trends within both the health care industry and the nursing profession itself call for increased investment in higher education for professional nurses. Although this is a study of one community in Iowa and pertains to recommendations for one program, it is hoped that the questions generated by the study and proposals made will be useful in other areas of the country.

References

American Nurses' Association. (1978, October). Entry into nursing practice. Proceedings of the National Conference: February 1978. NE-4 5M.

American Nurses' Association. (1980). Nursing: A social policy statement. In K. Sorensen and J. Luckmann (Eds.), Basic nursing: A psychophysiologic approach (p. 147) Philadelphia: W. B. Saunders.

American Nurses' Association. (1983, April). Education for Nursing Practice in the Context of the 1980s. NE-11 5N, p. 10

Andreoli, K. (1985, January). Trends that may affect nursing's future. Nursing & Health Care, 6(1), 46-51.

Arnold, C. (Ed.). (1986, January-March). Implications of the growing number of senior citizens. Statistical Bulletin, pp. 20-21.

Arnold, C. (Ed.). (1985, January-March). Population profile: Persons aged 25-64. Statistical Bulletin, pp. 20-21.

Bowen, E. (October 29, 1984). Bringing colleges under fire. Time. In Perspectives in Nursing, 1985-1987, National League for Nursing, (41) 41-1985.

Briggs, N. (1985). Education and practice issues. In S. Van Ort & A. Putt, (Eds.). Teaching in collegiate schools of nursing, (pp. 199-211). Boston: Little, Brown and Co.

Carpenito, L. (1984). Handbook of nursing diagnosis. Philadelphia: Lippincott.

Cox, M. (1985). The changing health care delivery system: The long-term care perspective, withing National League for nursing. Perspectives in Nursing, 41, pp. 148-153.

Crofts, N. (1983). Learning ethics the hard way. New Doctor, 24, pp. 19-21.

Durenberger, D. (1986, January-February). Legislative perspective on health care in 1986. Nursing Economics $, 4(1).

Hartley, S. (1986, January-February). Effects of prospective pricing on nursing. Nursing Economics, 4(1).

Harvard University, School of Public Health, Physicians Task Force. (1985). Hunger in America, the growing epidemic, Boston: Harvard.

Henderson, V. (1964). The nature of nursing. New York: Macmillan.

Hipps, O. (1981, May). The integrated curriculum: The emperor is naked. American Journal of Nursing, pp. 977-980.

Iowa Hospital Association (1985). Iowa hospitals: A profile of service to the people. Des Moines, IA: Iowa Hospital Association, pp. 19-20.

Kalich, P.A., & Kalich, B.J. (1986). The advance of American nursing. Second Edition. Boston: Little, Brown, and Co.

Kuhn, M. (1985). Nurses and patients together: Healing the health care system. Perspectives in Nursing, 41, 233-237.

Lesparre, M. (1985). Focus on saving medicare. Hospitals 1985, 59(1), 68-73.

MacLean, T., Knoll, G., & Kenney, C. (1985). The evolution of a baccalaureate program for registered nurses. Journal of Nursing Education, 24(2), 53-57.

Mazique, E. (1985). Trends and transformations in health care. Journal of the National Medical Association, 77(5), 365-368.

McCormick, R. (1984, September). Ethics committees: Promise or peril? Law, Medicine & Health Care, 12(4), 150-155.

Merton, R. (1940). Bureaucratic structure and personality. Social Forces, 18, 561-568.

Moccia, P., & Mason, D. (1986, January-February). Poverty trends: Implications for nursing. Nursing Outlook, 34(1), 20-24.

Miller, B., & Keane, C. (1983). Encyclopedia and dictionary of medicine, nursing, and allied health. Philadelphia: W.B. Saunders Company.

Murphy, C. (1984, September). The changing role of nurses in making ethical decisions. Medicine, and Health Care, 12(24), 173-175.

Naisbitt, J. (1982). Megatrends. New York: Warner Books, Inc.

National Center for Health Statistics. (1980). National Health Interview Survey. In Iowa Hospital: A Profile of Service to The People (1985), Iowa Hospital Association.

National League for Nursing. (1985). State-approved schools of nursing, RN, 19, 24, 25, 36, 37, 39-41, 76-78. Pub. No. 19-1986.

Page, C. (1973). Bureaucracy's other face. In P. Rose (Ed.), The study of society (pp. 280, and 291-292). New York: Random House.

Parkinson, M. (1986). Historical influences and expanding roles of nurses. In K. Sorensen & J. Luckmann (Eds.), Basic nursing: A psychophysiologic approach (pp. 139-156). Philadelphia: W.B. Saunders Company.

Pinch, W. (1985, November). Ethical dilemmas in nursing: The role of the nurse and perceptions of autonomy. Journal of Nursing Education, 24(9), 372-376.

Riffle, K., Lamberth, F., Moine, G., & Fielding, J. (1985). Entry into practice: The continuing debate. In J. McCloskey & H. Grace (Eds.), Current issues in nursing. Boston: Blackwell Scientific Publications.

Rogers, M. (1985). High touch in a high-tech future. Perspectives in Nursing, 1985-1987, (41), 41-1985.

Salmon, J. (1985). Profit and health care: Trends in corporization and proprietization. International Journal of Health Services, 15(3), 395-418.

Styles, M. (1985). Accountable to whom? International Nursing Review. 32(3), 73-75.

Toppen, R., & Brower, H. (1985). Integrating gerontology into the nursing curriculum: Process and content. Journal of Nursing Education, 24(2), 80-82.

Torres, G. (1974). Educational trends and the integrated curriculum approach in nursing. National League for Nursing, 15-1522, 2.

Tripp-Reimer, T. (1984, Winter). Research in cultural diversity. Western Journal of Nursing Research, 6(1), 130-2.

University of Northern Iowa Catalog Issue. (1984-1986). Cedar Falls, IA.

Urquhart, A., Wooding, G., Budinger, K., & Henry, B. (1986, January). Perspectives on nursing issues and health care trends. Journal of Nursing Administration, 16(1), 17-24.

U.S. Department of Commerce Bureau of the Census, (1980). Number of inhabitants (PC80-1-A17). Washington, DC.

Wakefield-Fisher, M., Wright, M., & Kroft, L. (1986, March). A first for the nation: North Dakota and entry into nursing practice. Nursing & Health Care, 7(3), 135-141.

Washington News Brief. (1986, May). Discharge provision draws criticism from AHA. Modern Healthcare.

Welch, M. (1980). Dysfunctional parenting of a profession. Nursing Outlook, 28(12), 724-727.

Wilson, E. (1931). Historical outline of the Iowa state association of registered nurses and related organizations. Des Moines, IA.

Woodruff, A. (1985). Becoming a nurse: The ethical perspective. International Journal of Nursing Studies. 22(4), 295-301.

Young, D. (1986, January-February). PROPAC: Future directions. Nursing Economics, 4(1).