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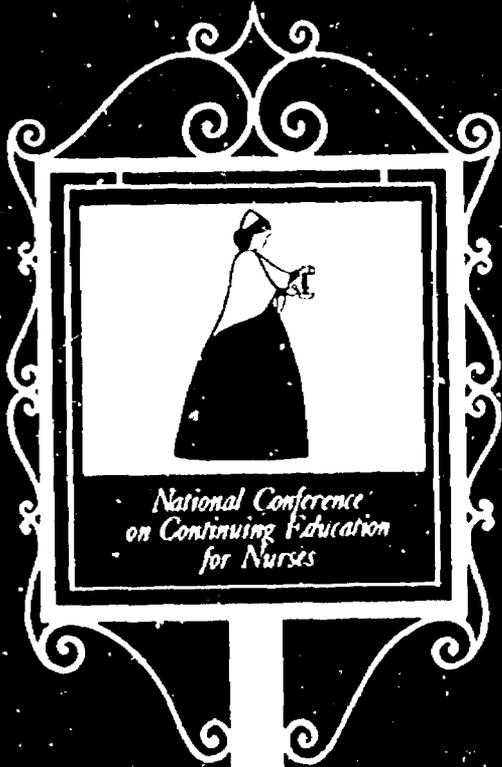
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ABSTRACT

As underlined in papers and group discussions, the growth of nursing continuing education (NCE) requires a fuller commitment within the profession to the ideal of lifelong learning, improved self-diagnosis of needs, and a profession wide program of continuing career development. A national survey of existing NCE programs shows a predominance of full time directors (27 with master's degrees, four with doctorates, one baccalaureate); numbers of full time nurse faculty range from three to 23. Recourse to budgets, fees, grants, and tuition for financial support varied widely. One program's experience of how to get funds stressed the importance of identifying needs and securing a strong diversity of sources. NCE participation studies at the University of Wisconsin and elsewhere reveal (among other things) strong motivation to undertake and persist in NCE programs, especially among nurses who pay their own fees. Meanwhile, such new concepts as health teams, career ladders, and a continuing education core curriculum are emerging. (The document includes an overview of regional nursing programs in several states, telephone instruction and other audiovisual technology, and issues in program evaluation.) (LY)

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Proceedings Book

*National
Conference on
Continuing Education
for Nurses
sponsored by*

*The School of Nursing
of the
Medical College of Virginia
Health Sciences Division of
Virginia Commonwealth University*

*The Motor House
Williamsburg, Virginia
November 10-14, 1969*

ED0 42992

PROCEEDINGS BOOK OF THE
NATIONAL CONFERENCE ON
CONTINUING EDUCATION FOR NURSES

Sponsored by

THE SCHOOL OF NURSING
of the
MEDICAL COLLEGE OF VIRGINIA
HEALTH SCIENCES DIVISION OF
VIRGINIA COMMONWEALTH UNIVERSITY

November 10-14, 1969

The Motor House

Williamsburg, Virginia

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PREFACE

The First National Conference on Continuing Education for Nurses became a reality after two years of planning. The chief credit for its success belongs to the many nurses from all over the country who were concerned with Continuing Education as an assumed responsibility in their college and university nursing education programs. These nurse educators provided the moral support, sustained enthusiasm, and many offers of assistance so necessary to provide the thrust toward the ultimate goal. Letters poured in reacting favorably to the idea of "getting together" to share developments relative to Continuing Education. This had never been attempted before on such a large scale. Programs which had been in operation for a number of years, those new and recently organized, and even those in the embryonic stage were all interested and represented.

As the Regional Medical Programs began to become operational during the planning period, Continuing Education programs for nurses and allied health personnel broadened to an even greater degree. Therefore, nurses concerned with these programs were added to the invitee list along with those directly involved with college and university Continuing Education in nursing.

The proceedings will provide a complete coverage of the first "happening" which was a pleasant learning experience for all in attendance. The second national conference is now in the planning stages.

The Medical College of Virginia, Health Sciences Division of Virginia Commonwealth University School of Nursing Program on Continuing Education was merely the "catalyst" in acting as the exciting role of host. Special thanks are due to the national nursing consultants, the Conference Steering Committee, the Williamsburg Conference Management and Conference Staff for their untiring efforts in providing for a pleasant and productive meeting.

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NATIONAL CONFERENCE ON CONTINUING EDUCATION FOR NURSES

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THE PROGRAM

MONDAY, NOVEMBER 10

- 8:30-9:30 a.m. REGISTRATION Motor House Lobby
- 9:30-9:45 a.m. INTRODUCTIONS Betty H. Gwaltney, R.N., B.S., M.A.
Chairman, Department of Continuing Education
Virginia Commonwealth University School of Nursing
- 9:45-10:00 a.m. WELCOME Dr. Doris B. Yingling, Dean, Virginia
Commonwealth University School of Nursing
- 10:00-10:45 a.m. "Continuing Education for the Professions"
Dr. Malcolm S. Knowles, Professor of Education
Boston University, School of Education
- 10:45-11:00 a.m. Break
- 11:00-11:30 a.m. "Continuing Education in Nursing - Where We Are,"
Report of a National Survey of Continuing Education
Programs in Nursing, Betty H. Gwaltney
- 11:30-12:00 noon Discussion
- 12:00-1:30 p.m. Lunch - on your own
- 1:30-2:15 p.m. "Administration and Organization of Continuing
Education Programs in Nursing," G. Marjorie
Squires, R.N., B.A., M.A., Coordinator - Adminis-
trator Continuing Education in Nursing University
of California, Los Angeles
- 2:15-4:00 p.m. WORKSHOPS (3) Topic: "Administration and Organi-
zation of Continuing Education Programs in Nursing,
Including Staffing and Securing Faculty"
Group I - Leader, Helen Pazdur, R.N., M.S.
Group II - Leader, G. Marjorie Squires, R.N., B.A., M.A.
Group III- Leader, Signe S. Cooper, R.N., B.S., M.Ed.

TUESDAY, NOVEMBER 11

- 9:00-10:00 a.m. "The Adult Learner," Dr. Eugene I. Johnson, Professor of Adult Education University of Georgia and formerly Executive Director of Adult Education Association of the U.S.A.
- 10:00-10:15 a.m. Break
- 10:15-11:00 a.m. "A Profile of the Registered Nurse Learner," Signe S. Cooper, R.N., B.S., M.Ed., Chairman, Department of Nursing University Extension the University of Wisconsin
- 11:00-11:30 a.m. Discussion
- 11:30-12:45 p.m. Lunch - on your own
- 12:45-2:00 p.m. WORKSHOPS (3) Topic: "Identifying the Learning Needs of Adult Learners and Establishing Priorities for Programs"
- 2:00-5:00 p.m. Tour of Colonial Williamsburg
- 6:30-7:30 p.m. Reception - The Cascades One Courtesy of the Upjohn Company

WEDNESDAY, NOVEMBER 12

- 9:00-10:00 a.m. "The National Nursing Organizations' Role in Continuing Education for Nurses"
1. Dorothy T. White, R.N., Ed.D., Director, Department of Nursing Education, American Nurses' Association, Inc.
 2. Joan E. Walsh, R.N., B.S.N., M.Ed., Consultant in Nursing Education National League for Nursing
- 10:00-10:15 a.m. Discussion
- 10:15-10:30 a.m. Break
- 10:30-12:00 noon "Funding Sources and Rationale for Such Sources"
- Moderator: Mrs. Faye Peters, R.N., B.S., Virginia Regional Medical Program Nurse and Allied Health Officer
1. U.S. Public Health Service, Gretchen Osgood, R.N., B.A., M.S., Assistant Director, Division of Nursing, Bureau of Health Manpower

2. Regional Medical Programs, Dr. Veronica Conley, Chief, Allied Health Section, Division of Regional Medical Programs
3. Comprehensive Health Planning, Ruth Spurrier, R.N., M.P.H., Director of Nursing, Kentucky State Department of Health

12:00-1:15 p.m. Lunch - on your own

1:15-2:00 p.m. "How We Do It - One Program's Funding Experiences", Susanna Chase, R.N., Ed.D., Director Continuing Education Program, University of North Carolina, School of Nursing, Chapel Hill

2:00-4:00 p.m. WORKSHOPS (3) Topic: "Funding Continuing Education"

THURSDAY, NOVEMBER 13

9:00-9:45 a.m. "Growth and Development of One Continuing Education Program," Elda Popiel, R.N., B.S., M.S.N., Director, Continuing Education Services University of Colorado School of Nursing

9:45-10:00 a.m. Discussion

10:00-10:15 a.m. Break

10:15-12:00 noon WORKSHOPS (3) Topic: "Developing Philosophy and Objectives for Continuing Education Programs in Nursing"

12:00-1:15 p.m. Lunch - on your own

1:15-4:00 p.m. "The Use of Educational Media in Continuing Education" Melvin Shaffer, Presiding, Director, Department of Visual Education, Virginia Commonwealth University, Speakers:

1. Dr. James Lieberman, Assistant Surgeon General, Director, National Medical Audiovisual Center, Atlanta, Georgia - "The Future in Biomedical Communications"
2. G. Marjorie Squaires - "An Approach to Post-graduate Nursing Education by the Medium of Television"
3. Signe S. Cooper - "The Use of the Telephone in Continuing Education"

FRIDAY, NOVEMBER 14

- 9:00-9:30 a.m. "Evaluation of Continuing Education Programs in Nursing," Emily Tait, R.N., B.S., M.A., Director, Continuing Education, Saint Louis University School of Nursing
- 9:30-10:30 a.m. Discussion
- 10:30-12:00 noon Summary and recommendations for guidelines to be included in the conference report. Recommendations for coordination, regionally and nationally, and for future sponsorship.



CONTINUING EDUCATION FOR THE PROFESSIONS

Malcolm S. Knowles, A.B., M.A., PH.D.
Professor of Education
School of Education
Boston University

The purpose of this session is to develop a context in to which the total conference can be placed. Since the beginning point of such a context is the curiosities and concerns about continuing education for the professions which you, the participants, bring with you. I think we should start with them.

Dr. Knowles asked the audience to form groups of three or four persons, pool their concerns, and then have one member of each group report them to the total audience.

The following concerns were reported by members present:

1. Is there any evidence that continuing education really pays off-makes any difference-and are there any good models from other professions, as well as from nursing, of evaluation procedures that work?
2. What is the state of the art in determining needs of education in selecting the most efficient or effective methods of education and financing continuing education?
3. In undergraduate education, elementary, secondary, and collegiate education, there is coordination through the uniformity of the institutions. In continuing education, there are many agencies doing continuing education. How can their efforts be coordinated so as to have a more coherent program?
4. How can you create a more receptive attitude in the adult learner?
5. How can you motivate the adult learner, particularly the nurse, to be more deeply involved in her continuing education?

6. How do you prevent obsolescence, particularly with the rapid shifting of the nursing profession and the nurses within departments, etc.? How do you deal with the wide heterogeneity of the populations that you have to be concerned with in continuing education such as levels of education, levels of experience, this sort of thing?
7. What is the unique function of the nursing profession in its continuing education as contrasted with other facets of continuing education?
8. Do you really need a separate nursing continuing education program or can it be amalgamated and can the nurses' needs be served by the general continuing education programs of colleges and universities?
9. What will be the role of the university in continuing education programs? What do we mean by continuing education?
10. What resources are available for independent, individual self-continuing education?
11. How do you reinforce prior learning and keep it from getting stale, so to speak, rather than just be concerned about introducing new learnings?
12. Should credit be given or not for continuing education?
13. What is the distinction, if any, between continuing education and in-service education?¹

I won't attempt to deal with these concerns directly in this session, since they suggest lines of inquiry for the total conference. But they provide a focus for my remarks in trying to lay a foundation for this inquiry.

First, I'd like to try to put continuing education into the larger context of the revolution that is taking place in education as a whole system.

A new force has been introduced into the dynamics of civilization that requires an entirely new set of assumptions about the purposes and nature of education. This force is so new and so

¹ The concerns stated by the members enclosed in brackets were taken from audio tapes at the request of Doctor Knowles to be included in the text of his speech.

subtle that it is only beginning to be discerned by a few of the more sensitive analysts of culture. This force is, very simply, the fact that the time-span of cultural revolution has for the first time in history become compressed into less than the lifetime of an individual.

Alfred North Whitehead heralded the appearance of this phenomenon in 1931 with these words:

"Our sociological theories, our political philosophy our practical maxims of business, our political economy, and our doctrine of education, are derived from an unbroken tradition of great thinkers or of practical examples, from the age of Plato in the fifth century before Christ, to the end of the last century. The whole of this tradition is warped by the vicious assumption that each generation will live substantially amid the conditions governing the lives of its fathers and will transmit those conditions to mould with equal force the lives of its children."

"We are living in the first period of human history for which this assumption is false. . . . The note of recurrence dominates the wisdom of the past, and still persists in many forms even where explicitly and falacy of its modern application is admitted. The point is that in the past the time-span of important change was considerably longer than that of a single human life. Thus mankind was trained to adapt itself to fixed conditions. But today this time-span is considerably shorter than that of human life, and accordingly our training must prepare individuals to face a novelty of conditions.²

The present generation of adults is the first generation in the history of civilization that is having to live in a world that is different in its essential character from the world into which they were born. The consequences of this fact for education have come to dominate much of Margaret Mead's thinking, as reflected in this passage:

"Within the lifetime of ten-year-olds the world has entered a new age, and already, before they enter the sixth grade, the atomic age has been followed by the age of the hydrogen bomb. . . . Teachers who never heard a radio until they were grown have to cope with children who have never

² Alfred N. Whitehead, "Introduction," Wallace B. Donham, Business Adrift, pp. 8-9. New York: McGraw-Hill Book Company, 1931, By permission.

known a world without television. Teachers who struggled in their childhood with a buttonhook find it difficult to describe a buttonhook to a child brought up among zippers From the most all-embracing world image to the smallest detail of daily life the world has changed at a rate which makes the five-year-old generations further apart than world generations or even scores of generations were in our recent past, than people separated by several centuries were in the remote past. The children whom we bear and rear and teach are not only unknown to us and unlike any children there have been in the world before, but also their degree of unlikeness itself alters from year to year."³

No wonder Dr. Mead was forced to conclude that the purpose of teaching has now changed from teaching what we know to teaching what we don't know!

Some Required New Assumptions About Education For Children and Youth

The introduction of this new force into our culture--the compressing of the time-span of major social change into less than a single lifetime--requires a whole new set of assumptions about the education of both youth and adults. It is necessary to examine those regarding children and youth first, since they largely determine the requirements for the education of adults.

1. The purpose of education for the young must shift from focusing primarily on the transmission of knowledge to the development of the capacity to learn. Traditionally, the central purpose of education has been to transmit culture from one generation to the next. And always before this purpose has served society well, since our ancestors were born into a world that they could rely on to be essentially the same when they died. What they learned from their

³ Margaret Mead, The School in American Culture, pp. 33-34 Cambridge, Massachusetts: Harvard University Press, 1959. By permission.

fathers about how to think, what to think, how to make a living, and how to relate to other people proved to be adequate throughout their own lifetimes, and they had to add very little to these learnings to equip their sons and daughters to live adequately throughout their lifetimes.

But in the modern era much of what we learned in our youth becomes, at best, inadequate or, at worst, obsolete and even untrue by the time we have to apply it in adult life. This phenomenon is highly visible in regard to science education; it is widely accepted now that a scientific education is good for about seven years. The phenomenon is also highly visible in regard to vocational education: automation and technological advances render thousands of workers obsolete almost daily. The phenomenon is less visible, and perhaps therefore more insidious, in regard to other human competencies. Ways of thinking about art, music, literature, and drama that we of the current generation of adults learned in our youth ill equipped us to keep up with the sequence of intellectual revolutions that have occurred in the last quarter century. Attitudes that we learned at a time when world power was controlled by a Caucasian peoples are no longer functional in a world in which power is shifting to colored peoples. In fact, the very bases of understanding ourselves as human beings shift like ocean sands as the researchers of psychology, sociology, anthropology, medicine, and other human sciences uncover new facts and insights about us.

If it is true that the time-span of cultural revolution is now less than the lifetime of a human being, the needs of society and the needs of individuals can no longer be served by education that merely

transmits knowledge. The new world then requires a new purpose for education: the development of the capacity in each individual to learn, to change, to create a new culture throughout the span of his life. Certainly knowledge must continue to be transmitted, but no longer as an end in itself--only as a means to the end of mastering the ability to learn. The central mission of elementary, secondary, and higher education must become, then, not teaching youth what they need to know, but teaching them how to learn what is not yet known. The substance of youth education, therefore, becomes process--the process of learning; and accordingly the substance of adult education becomes content--the content of man's continually expanding knowledge.

2. The curriculum of education for the young must shift from subject-mastery basis of organization to a learning-skill basis of organization. If youth are to be taught how to learn over what to learn, then learning activities will have to be organized as ever broadening and deepening sequences of inquiries in which the students find answers to their own questions. The curriculum will be organized around problem-areas or questions rather than around fragmented subject areas. Fortunately, excellent starts have already been made in organizing certain sequences in this way, especially in mathematics and some sciences.⁴ But a school curriculum that has changed only in degree and not in kind from the medieval trivium and quadrivium still has a major resolution ahead of it before it can meet the requirements of the modern world.

⁴ For examples, see the following pamphlets in the series on "New Dimensions in Higher Education" by the United States Office of Education: No. 1, "Independent Study"; No. 2: "Effectiveness in Teaching"; and No. 7: "Quest for Quality." Washington, D.C.: Government Printing Office, 1960.

3. The role of the teacher must be redefined from "one who primarily transmits knowledge" to "one who primarily helps students to inquire." This shift will, in turn, require a new kind of training for teachers, in which relatively less emphasis is placed on the acquisition of huge volumes of subject content to great emphasis on understanding the processes of learning and on gaining skills in guiding (and serving as a resource to) students conducting self-inquiries.

4. A new set of criteria must be applied to determine the readiness of youth to leave full-time schooling. If knowledge is doomed to obsolescence every few years, then it is no longer valid to test the readiness of a student to graduate by testing how much information he has acquired. Rather, it would seem that three radically different criteria are required.

First, has the student mastered the tools of learning? To measure a student against this criterion will require instruments that will provide data that would answer such questions as these: Can he read up to his capacity? (It is estimated that the average high school and college graduates today can read only at half their trainable capacities--yet reading is the primary tool of continuing learning.) Can he think symbolically? Can he ask questions that get at the heart of the matter and that can be answered through inquiry? Does he know how to collect and analyze various kinds of data? Does he understand the basic concepts, and can he use the basic methods of the various intellectual disciplines? Can he communicate effectively with populations that are relevant to his welfare? Is he familiar with and able to use the important sources of knowledge?

Second, has the student developed an insatiable appetite for learning? If he is leaving formal schooling feeling that he has finished a full meal at the table of knowledge, then he is not ready to graduate; he needs more education. But if he is leaving with an overwhelming sense of dissatisfaction with his inadequacies and a burning desire to overcome them, he is prepared for the adult world.

Third, does he have a definite, but flexible, plan for continuing his learning? Certainly before his final year is completed every student should have skilled guidance in (1) diagnosing his individual needs for continuing learning, (2) identifying the resources available to him in the community for satisfying these needs, and (3) building a personal program of further learning that will possess continuity, sequence, and integration. It would help to symbolize the concept of learning as a lifelong process if every institution for the education of youth would convert its graduation ritual into an exchange between the student, who would hand the president a scroll detailing his plans for continuing learning, and the head of the institution, who would hand the student a certificate stating that the institution has taught the student all it knows about how to learn but will continue to make its resources available to him for further inquiry.

The second major consideration is to try to put continuing education into the context of new developments in learning theory and educational technology.

Very simply, I think the biggest obstacle to the achievement of the full potential of adult education has been that it has been tied to, and hamstrung by, the concepts and the methods of the traditional education of children. Isn't it true that what we, who teach

adults, know about teaching is what we have learned either from being taught as children or what we have been taught to teach children? What we know is pedogogy, which is a word that comes from the same stem as "pediatrics"--the Greek word "paeda," meaning child. All education has been equated with pedagogy--the art and science of teaching children. Even in our own literature you will find references to the "pedagogy of adult education." Although semantically a contradiction, this phrase is descriptive of an unfortunate reality. For the fact is that most adult teaching has consisted of teaching adults as if they were children. This has been our hamstring.

But now things are changing. We have been accumulating a growing body of insights and knowledge from both research and experience. We have learned that adults are different from children as learners in certain very critical ways. And we have been developing a new technology--methods, techniques, and materials--that is tailored to these unique characteristics of adults as learners. Furthermore, we have started, first in Europe and now in America, to give a new label to this technology to distinguish it from the technology of pedagogy. This new label is "andragogy," which is derived from the Greek stem "andr-" meaning "man" or "grownups." As I see it now, this new technology of andragogy--the art and science of helping adults to learn--is based on certain crucial assumptions about the difference between children and adults as learners. (Now let me just in parenthesis say that I believe many of the things which we have learned about how to help adults learn better also apply to children; and those of you who are teaching at the elementary, secondary, and college levels should keep your ears open, because there may be some things

that you would find applicable to working with children. After all, children are in the process of becoming adults, and the characteristics of adulthood start developing at various points during childhood and youth.) Perhaps as many as a dozen assumptions about these differences constitute the theoretical foundation of andragogy, but let's simply illustrate the process by which a new technology comes into being by examining only three of them.

The first, and by far the most important, difference between adults and youths as learners, I believe, is that of their self-concept. A child first sees himself as a completely dependent personality. He sees himself in his first consciousness as being completely dependent upon the adult world to make his decisions for him, to feed him, to change his diapers, and to see where the pin is sticking. During the course of his childhood and youth, that dependence is reinforced as decisions are made for him in the home, at school, in church, or the playground, and everywhere he turns. But at some point he starts experiencing the joy of deciding things for himself, first in little matters and then in more important ones, and by adolescence he is well along the way toward rebelling against having his life run by the adult world. He becomes an adult psychologically at the point at which his concept of himself changes from one of dependency to one of autonomy. That's what I think we mean psychologically by adulthood. To be adult means to be self-directing. Now at the point at which this change occurs, there develops in the human being a deep psychological need to be perceived by himself and by others as being indeed self-directing. And we tend to resent and resist being put into situations in which we feel that others are imposing their will on us. This is

the concept that I think lies at the heart of this new technology of andragogy. Andragogy is based upon the deep insight that the deepest need an adult has is to be treated as a self-directing person, to be treated with respect.

What is the technology that comes out of this concept? I can think of several implications. I think a first implication is the great importance of the provision of a climate in a community or in an institution that smacks of adulthood. Now, how is a climate of adulthood established? Well, let's take this climate here. What are the characteristics of this atmosphere that make you feel either childish or adult? Can you name some for me? All right, one is a physical setup in which you are comfortable and can talk with one another in informal groups. The chairs aren't in rows facing a podium. Another is that you could choose where you would sit--you had freedom of choice; another is that you were given dignified name cards so that people could identify you as a unique individual. I'm sure we could go on and build a long list, but we have illustrated that the symbols of childness that adults react to most negatively are regimentation, lack of respect for them as unique persons, being talked down to, lack of concern for human needs such as comfort, and depersonalization of relationships. These kinds of things may sound awfully trivial; but to a person who feels that his adulthood is disrespected, these are very important. They are symbols of how he is perceived, and if he feels he is perceived like a child, his resentment will get in the way of his learning.

I think a second implication for this new technology of adult education has to do with who diagnoses what I should learn. It is a

very critical question to me as an adult whether I determine what I need or whether some authority figure is going to tell me what I need to learn. Now, one of the rich areas of ferment in our field is the invention of new approaches to what I think of as self-diagnosis. Some very imaginative procedures are being invented for involving the adult in performing, then looking at his performance in comparison with other people's performance, and finally making his own judgement about where his own strengths and weaknesses are. Such activities as role playing, critical incident process, simulation exercises, skill practice exercise, group observation, and self-rating scales, are used for this purpose. Engaging of the adult in the diagnosing of his own needs for learning is a very important part of the technology of andragogy.

A third element in this technology has to do with the planning process. Traditionally, all the planning of student learning is done by the teachers, or by the curriculum committee, or by the state department of education. In adult education, responding to this deep need to be self-directing, a great deal of attention is beginning to be paid to ways of involving the adults meaningfully and relevantly in the planning of their own learning.

It is my observation that those programs that involve their participants in planning what they will learn and how they will learn it are much richer and more vital than those that do not. But I have a hunch that we could find better ways of doing this.

Probably an even more important implication, in terms of andragogy, is the involvement of adults in the carrying out of their own learning--in engaging in mutual self-directed inquiry. I have been doing quite a bit of experimenting in Boston University with my

graduate classes using what I call learning-teaching teams. We have the students organize themselves into teams, each of which takes responsibility for learning all it can about a unit of a subject and then sharing what they have learned with the rest of the students, with faculty members serving as a resource to the teams. For one thing, students listen a lot more attentively to their fellow students than they do to me. Their eyelids start drooping after about fifteen minutes when I try to do all of the teaching, but when a fellow-student team gets up to share what they have learned, their ears stay flopping for a good hour. So, I think better learning takes place when you involve the learners in teaching each other. Second, it makes a lot of difference in their ego-involvement. Do they get hooked! For example, I have never assigned a page of references that might be helpful to them. The loudest complaint which I have received came from my faculty colleagues concerning the amount of reading I make my students do. They are doing so much reading for my classes that they don't have time to do the reading these other professors want them to do. The fact is that by engaging in their own self-directed inquiry, they get so deeply involved that other things become less important to them.

Finally, an implication of the concept of being self-directing has to do with evaluation. Probably the most crushing blow to any self-respecting human being is the act of another person giving him a grade. This is not evaluation in educational terms; in fact, it has nothing to do with learning. If anything, I think it is anti-learning. Evaluation andragogically is really re-self-diagnosis. What we do at the end of a learning experience with adults, according to

andragogical principles, is to engage them in a process of re-assessing the remaining gaps between the competencies they want to have and the competencies they do have. So the techniques of evaluation according to andragogy are the same as the techniques of self-diagnosis that were described earlier.

A second characteristic in which children differ from adults is in experience. Adults have accumulated more experience than children and youths by virtue of having lived longer. Adults are richer resources for learning. But this difference in experience goes deeper than mere quantity. A curious phenomenon occurs regarding how a person feels about his experience. Experience to a youth is something that happened to him--a series of almost external events. If you ask him who he is, he will define his self-identity in terms of his family, his school, his community, etc.--the identity that has been given to him from outside. But an adult will define himself in terms of his experience. His self-identity is derived from what he has done. Accordingly, we adults are very jealous of the worth of our experience, and wherever we find people devaluing our experience, not paying attention to it, not incorporating it in the educational plan, we feel rejected as people. It is not just our experience that is devalued; if a teacher doesn't make use of my experience in a classroom, I, Malcolm Knowles, am being devalued, because my experience is me. And those of you who are working in basic education know this is even doubly true of under-educated people, because what else do they have but their experience?

Consequently, andragogy is shifting from transmittal techniques toward experimental techniques. This is not to say that we do not use

transmittal techniques; there are occasions when transmittal techniques are most effective means for accomplishing a given educational objective. But there has been marked shift away from such transmittal techniques as lecturers, assigned reading, even canned audio-visual presentation, to experimental techniques that make use of the learner's experience such as simulation exercises, laboratory training, case method, critical incident process, community action projects, and the wide variety of discussion techniques. "Action learning" and "participative learning" are printed in bold face in the lexicon of andragogy.

Third, adults and youth differ in their time perspective. In most aspects of life, a youth's time perspective is one of immediacy. A youth has a very hard time postponing the satisfaction of present desires. He can't wait to get that candy bar or that ice cream bar; he wants it now. With adults it is the opposite. In most aspects of life, adults are accustomed to postponing their satisfactions; they are accustomed to saving for the Christmas fund and vacation and all that sort of thing. But in regard to learning, the time perspective of children and adults is reversed. In regard to education, youth's time perspective is one of postponed application. Almost all of what I learned in grade school and in high school--and in fact in college--I learned not with much hope that it would be very useful then, but that it would accumulate into a reservoir of knowledge and skills that would be useful when I got to be an adult. My orientation to learning as a youth was one of postponed application, and therefore my attitude toward learning was subject-centered. If you had asked me what I was learning I would have rattled off subject matter titles: history, government, religion, mathematics, language, and so on. I would have said I am learning subject matter.

But an adult's time perspective in regard to learning is one of immediate application. The reason an adult enters into education is to be able to better deal with some life problem about which he feels inadequate now. He wants to learn something tonight that will help him better deal with some of his problems tomorrow. As a result, an adult's orientation to education is problem-centered. If you ask an adult what he is learning, he will almost always use a verb and a phrase describing a life problem: "I am learning to be a better mother or a better supervisor," or "I'm learning to speak more fluently, or to converse more brilliantly, or to vote more intelligently."

One technological implication of this difference is that the organizing principle for the curriculum of adult education involves problem areas rather than subject categories. In adult education across the country, the curriculum for adults looks increasingly different from the curriculum for youth. Let me give you some of the labels that we are using in adult education: "Education for Aging," "Consumer Education," "Leisure Time Education," "Home and Family Living," "Supervisory Training," "Management Development," and "Liberal Education." Contrast these with such subject categories of youth education as "Science," "Philosophy," "Language," "History," "English," and the like.

Another technological implication of this difference is the importance in the actual learning experience of starting the learning with the problems and concerns that the learners bring in with them. The first thing that adult educators typically do in a classroom situation is to take a problem census. They have their adult students identify what it is that they are curious about or worried about or

concerned about. Then they build a learning program around these curiosities and concerns. Accordingly, andragogy is a student-centered, problem-oriented technology.

When you get right down to it, this is the way the education of children should be too.

Finally, let me suggest some implications of these two main thrusts affecting our field for the continuing education of nurses.

For one thing, a climate that is conducive to a commitment to lifelong learning will have to come to pervade the profession of nursing. This climate will have to start with the way undergraduates are taught in schools of nursing, with the symbols attached to their graduation, and with the kinds of resources and rewards for continuing education they experience throughout their working career.

For another thing, better processes for self-diagnosis of needs for continuing learning will have to be developed. The nursing profession will have to engage nurses continuously in updating their models of competence, through its journals and conferences. And better tools for helping them assess their present level of performance in the light of these models will have to be invented.

In the third place, a profession-wide program of continuing career development will have to be mounted that will help individuals carry on individuated programs of self-development based on their self-diagnosed needs and readiness to learn and utilizing a wide variety of resources for both individual and group study.

May I say in closing that I think the nursing profession is further along the road to such a program of continuing career development than any other profession I know, and for this very reason is in the best position to make a final breakthrough.

"CONTINUING EDUCATION IN NURSING - WHERE WE ARE" -
REPORT OF A NATIONAL SURVEY OF CONTINUING EDUCATION PROGRAMS IN NURSING

Betty H. Gwaltney, R.N., B.S., M.A.
Chairman, Department of Continuing Education
Medical College of Virginia Health Sciences Division
Virginia Commonwealth University
School of Nursing

On April 25, 1967 a letter was directed to Deans and Directors of all the NLN accredited colleges and university schools of nursing in the country from the Director of Continuing Education in Nursing, Medical College of Virginia School of Nursing, to propose a National Conference on Continuing Education for Nurses (see letter in Appendix II). The response was overwhelming with 103 lengthy letters of endorsement to such an idea. Forty-five deans indicated they had a director or someone responsible for Continuing Education programs in nursing. Thirty-seven had no director but were definitely interested in a conference and endorsed continuing education and twenty-one had no program and were not interested at that time. Due to the enthusiastic nature of the response we felt committed to follow through. The rest is history.

The proposed conference was scheduled twice and postponed, as funds we were seeking to support the effort were not forthcoming. A local planning committee, made up primarily of men, gave the necessary encouragement to plan the biggest and best conference ever to be held on Continuing Education for Nurses and to start with no money in the bank. Earlier, the Regional Medical Programs had just begun to emerge in the fifty states and since this group

had become so closely associated with college and university settings the invitation list was extended to all RMP nurses.

During these two years valuable and encouraging support came from our national nursing consultants on the project - Alice Ingmire, California, Signe Cooper, Wisconsin, G. Marjorie Squires, California, and many others. They were like unseen "cheerleaders." Signe Cooper shared a report from a workshop for RMP Nurses at the University of Wisconsin held in March 1968, which also attracted some nurses in continuing education nursing programs in colleges and universities for a one day "piggy back" conference. Emily Tait also shared information about a one and one half day regional conference covering nine states sponsored by St. Louis University Continuing Education Nurses Program.

In preparation for the National Conference, a questionnaire survey of all continuing education programs was constructed and tested. It was then sent to all college and university nursing programs.

The questionnaire survey attempted to validate the assumption that, although full time continuing education programs in nursing sponsored by college and universities or schools of nursing were not numerous, most schools of nursing felt a responsibility for leadership in extending continuing education to practicing registered nurses. The questionnaire results and related correspondence supported this assumption. (See attached sample)

The questionnaire did not lend itself to statistical analysis. However, the following is a summary of data as collected from forty-one respondents. Eighteen questionnaires contained information too

meager to collate effectively. Some letters were written by Deans to remind us they had no program of substance but were interested and wanted to be kept informed.

The majority of reporting schools employed full-time directors of continuing education for nurses. Twenty-seven directors held Master's degrees, four held doctoral degrees and one a baccalaureate degree.

The additional nurse faculty members engaged full-time in programs ranged from 3 to 23. Most of these nurses held Master's degrees. Part-time School of Nursing faculty participation ranged in number from none to "all eligible to teach" (46). The majority of full-time directors, (12), indicated they also had some responsibility for teaching in basic and higher degree programs. No percentage of time was asked for. Twelve Directors were members of the Adult Education Association of the U.S.A. and only four reported membership in the Council on Medical Television.

The questions on administrative structure revealed the majority were associated with the school of nursing administratively. However, some joint relationships with university-wide extension and adult education programs were reported and others were within structures strictly tied to health sciences divisions.

Most of the programs had written philosophies and objectives and some submitted samples as requested. All but three had some type of permanent or rotating committee to assist in overall planning. The committee members were made up primarily of both faculty and outside resources. In addition, separate committees were organized to plan for each program offered.

Funding sources for continuing education came from school of nursing budgets, separate budgets and grants, fees and tuition. A few indicated they were compelled to be self-supporting to exist. Grants received during 1966-67 ranged from zero to thirteen. Fees and tuition ranged from \$2.00 to \$300.00. Fees and tuition varied within the university according to length and quality of program. The largest sum of grant money reported for one school during 1966-67 was \$287,500.

All but two schools utilized both school of nursing and outside nurse resources as faculty. All but one reported interdisciplinary approaches to teaching.

Seven schools offered credit for continuing education courses. Twenty-five offered "no credit" type programs. Credit was reported most often by schools offering extension work and "credits" in some courses were not related to degrees.

In reply to the question regarding use of specialized media in teaching, all varieties were included.

In answering the question, "Have you engaged in any research or studies in the area of continuing education for nurses?" The following schools reported:

University of Wisconsin

1. A study of continuing learner in nursing (September 1, 1962, August 31, 1963) as reported in the December 1966 Nursing Outlook.
2. A survey of inactive nurses enrolled in refresher courses was in progress (September 1967, December 1968).
3. Evaluation of the effectiveness of the Nursing Dial Access Program was in progress.

University of North Carolina

Study to determine whether the preparation of a nurse for coronary care has an effect on the condition of patients at discharge from coronary care units in the state, in collaboration with the School of Public Health, Department of Epidemiology, and the Regional Medical Program.

Syracuse University

Following the programs "Improved Management Skills: An Approach to Better Patient Care," the Department of Psychology did the evaluation of the programs. (A study and evaluation of the effectiveness of the program.)

St. Louis University

Limited local survey of education needs (1965 and 1968).

Committee on Continuing Education Study on Evaluation Form data (1968).

All respondents engaged in joint planning for programs with voluntary health agencies, State Nurses' Associations, State Leagues for Nursing, with other colleges and universities, and RMP's. Less than half indicated they planned jointly with State Hospital Associations and State Medical Societies. Only three stated they were involved in planning with Comprehensive Health Planning units. Other agencies mentioned were State Boards of Nursing, state and county health departments, and regional planning bodies such as SREB and WCHEN.

The number of separate programs sponsored by respondents totaled nearly 400. The range was from one to sixty-nine. Most reported

repeating from one to five programs annually. The range of time involved per program was from one half to forty days. The range of numbers of persons attending programs was from six to 350.

The general topic requested most often for programs was in the area of management skills. Clinical nursing received a lower rating from the reporters. The occupational groups which were rated as being served best by continuing education programs were general duty nurses (23), head nurses (20), supervisors (19), instructors (15), public health nurses (14), nursing service administrators (9), nursing education administrators (5), clinical specialists (3), school nurses (2), with occupational health nurses and private duty nurses being reported in rank order last. Office nurses were not mentioned, and Inservice personnel were inadvertently left out of the listing.

Although no significant conclusions can be drawn from the survey, it is interesting to note the variety of responses to all questions. The characteristics of continuing education programs in nursing would seem to relate closely to the university setting in which each program operates, e.g., the universities' philosophy, commitment to continuing education, financial resources, and availability of faculty.

Malcolm Knowles in presenting a paper at the Twentieth Conference of the Council of Member Agencies of the Department of Baccalaureate and Higher Degree Programs told the group that today every public university and many private urban universities as well as private nonurban universities, have programs in continuing education. The survey of collegiate schools of nursing revealed that nursing has

lagged behind in this field. More extensive leadership in nursing is needed to accept what the university itself has accepted as an appropriate responsibility - opportunities for continuing education throughout the life span.

MEDICAL COLLEGE OF VIRGINIA SCHOOL OF NURSING
CONTINUING EDUCATION PROGRAM

Questionnaire

For Academic Year of 1968 to Present Time (1969)

Administration and Organization of Continuing Education Programs in Nursing

- | | Yes | No |
|---|----------------------|---------------------------------|
| 1. Is there a nurse director for continuing education for nurses? | ___ | ___ |
| 2. If not, is a nurse faculty member responsible part-time? | ___ | ___ |
| 3. If the answers to 1 and 2 are "no" do you anticipate employing a full or part-time nurse director in the future? | ___ | ___ |
| 4. What is the highest degree earned of nurse director? | | |
| | <u>Baccalaureate</u> | <u>Masters</u> <u>Doctorate</u> |
| 5. How many other nurse faculty members are engaged full-time in the program? No. _____ | | |
| 6. What is the highest degree earned of faculty assigned to continuing education?
No. _____ No. _____ No. _____
Baccalaureate Masters Doctorate | | |
| 7. How many nurse faculty members participate part-time? Approximate No. _____ | | |
| 8. Does the full-time director have responsibility for teaching in the basic nursing program or higher degree programs? | ___ | ___ |
| 9. Is the director a member of the Adult Education Association of the U.S.A.? | ___ | ___ |
| 10. Is the director a member of the Council on Medical Television? | ___ | ___ |
| 11. What type of administrative structure do you have? | | |
| a. Is there a separate department for continuing education for nurses? | ___ | ___ |
| b. Is it under the school of nursing administratively? | ___ | ___ |
| c. Or college or university Department of Continuing Education? | ___ | ___ |
| d. Or School of Medicine Continuing Education Program? | ___ | ___ |
| e. Or Department of Health Sciences or interdisciplinary setup? | ___ | ___ |
| f. Other _____ | ___ | ___ |

- | | Yes | No |
|---|-----|-----|
| 12. Do you have a written philosophy for the continuing education program? (please attach to your reply) | ___ | ___ |
| 13. Have you established objectives for the program? (please attach to your reply) | ___ | ___ |
| 14. Do you have a permanent or rotating committee to assist in overall planning?
Is the committee made up of | ___ | ___ |
| a. faculty members? | ___ | ___ |
| b. outside resources? | ___ | ___ |
| c. mixture of a and b? | ___ | ___ |
| 15. Do you organize planning committees for each workshop or program?
Or some programs? | ___ | ___ |

Funding

- | | | |
|--|-----|-----|
| 16. Do you have a budget for your program or department? | ___ | ___ |
| 17. What is your source of funds? | | |
| a. School of Nursing budget | ___ | ___ |
| b. Separate budget | ___ | ___ |
| c. Grants | ___ | ___ |
| How many grants did you receive during 1966-67? _____ | | |
| d. Fees and tuition | | |
| Give range of fees during 1966-67 _____ | | |
| e. Other sources of funds (please specify) | | |
| _____ | | |
| f. What did the sum total of your grant money amount to? | | |
| _____ | | |

Faculty

- | | | |
|--|-----|-----|
| 18. a. Do you utilize only school of nursing faculty for instruction? | ___ | ___ |
| b. Do you employ outside nurse resources as faculty in addition to your own? | ___ | ___ |
| c. Do you use interdisciplinary teaching using other than nurse faculty? | ___ | ___ |

Credit

- | | | |
|--|-------|-----|
| 19. Do you offer credit courses under continuing education? | ___ | ___ |
| a. Toward what degree | _____ | |
| or | _____ | |
| b. For what purposes? | _____ | |
| | _____ | |
| 20. Do you offer non-credit programs <u>only</u> (workshops, short-term courses, etc.) ? | ___ | ___ |
| 21. Do you award a certificate of completion for non-credit courses (five days in length or longer)? | ___ | ___ |

Methodology

Yes No

22. What specialized teaching media do you employ?

- a. Tele lecture ___ ___
- b. Radio lecture ___ ___
- c. Educational TV (video tapes) ___ ___
 - (1) closed circuit ___ ___
 - (2) open circuit ___ ___
- d. Other (list) ___ ___

Research

23. *Have you engaged in any research or studies in the area of continuing education for nurses?

___ ___

Joint Planning

24. Do you engage in joint planning for programming with any of the following?

- a. Voluntary health agencies (Heart, Cancer TB and Respiratory Diseases, etc.) ___ ___
- b. State Nurses' Association ___ ___
- c. State League for Nursing ___ ___
- d. State level with other colleges and universities ___ ___
- e. Regional level with other colleges and universities ___ ___
- f. State Hospital Association ___ ___
- g. State Medical Society ___ ___
- h. Regional Medical Program ___ ___
- i. Comprehensive Health Planning ___ ___
- j. Other (list) ___ ___

Characteristics of Programs

25. How many different programs are you sponsoring during 1968-69? _____

26. What was the range of time involved? ___ days to ___ days

27. Range in number attending each session _____

28. What general topic was requested most often for programs? _____

29. What occupational group do you feel you served best? (in rank order)

- | | | | |
|---------------------|-----|----------------------------|-----|
| Head Nurses | ___ | Occupational Health Nurses | ___ |
| Supervisors | ___ | Public Health Nurses | ___ |
| General Duty Nurses | ___ | Clinical Specialists | ___ |
| Nursing Service | ___ | Private Duty | ___ |
| Administrators | ___ | | ___ |

*Please elaborate on reverse side

Nursing Education
Administrators
Instructors

Other

Yes No

30. Are any of your programs repeated each year?
How many?

____ ____

Additional Comments:

Signature

ADMINISTRATION AND ORGANIZATION OF CONTINUING EDUCATION IN NURSING

G. Marjorie Squaires, R.N., B.A., M.A.
Coordinator-Administrator
Continuing Education in Nursing
University of California, Los Angeles

Continuing Education is the organized and planned presentation of appropriate educational experiences at a professional level which is usually university oriented and directed at the exploration of new ideas, trends, developments, and the exposure of new dimensions which improve the individual's professional competence and should exert a broad and long range effect on his practice.

Those of us in universities cannot wait for a new generation of nurses to solve our nursing problems, nor can we view continuing education as a future luxury. We must take the initiative and develop the kinds of programs for all practicing professional nurses that are needed to fill the gaps of knowledge and skills in our practice today. Since each University Extension department is an innovative and creative arm of the University, it is ideally constituted to provide the needed programs.

All of us present, representing Universities, Regional Medical Programs, and other educational institutions, are here because we recognize the growing need for continuing education. I would like to begin by discussing with you some of the major causes of the urgency of this need for all health professions.

Knowledge Explosion

The knowledge explosion in behavioral and physical sciences has made our traditional educational preparation inadequate to meet the needs of health care services today. The traditional hospital training in nursing is particularly remiss in that it cannot prepare nurses for community health sciences, and yet the very nature of the health problems of modern society demand that health services go to the people in their homes, schools, places of work through community agencies.

New Awareness of Needs of Underprivileged

There is an awakening concern with the poor of the inner city, the ghettos, and the rural areas. We, as health workers, need to learn to serve their needs, not as authorities but as catalysts. We must acquire attitudes towards these people, respecting their mature wisdom equally with our professional skills. We must cease to condone the long clinic lines, the depersonalization, the talking down, the inhumanity in our services to the poor. We must develop new approaches for helping the poor to help themselves. Several demonstration projects have shown that a community with financial help, consumer participation and the aid of health professionals can deliver health services to people who have never had them before. Many nurses want to become involved in this kind of work, but to do so effectively they must be equipped with new attitudes, knowledge, and skills.

Increased Demand For Health Service

More and more people are demanding health services as their right because our communication facilities make them aware of the value of health and the possibilities of attaining it. Private health insurance, medicare, and medicaid make people expect adequate health care. We have neither the physical facilities nor the personnel to meet these expectations. Continuing Education, therefore, must find and teach ways to utilize effectively those agencies we do have and to upgrade the abilities of existing members of the health team.

Technological Change

Another major cause is technological advancement. Nurses are asked how they can learn to accept the responsibility and become skilled in the use of new machines for diagnosis and treatment. Will we accept the use of computers to relieve professional nurses of non-nursing activities, particularly in the information-flow process? Are we making good use of the technological advancements in the educational field? Continuing Education definitely has a responsibility to prepare nurses to be machine oriented and to achieve this orientation without losing their essential sensitivity to people.

Hospital Bottleneck

The traditional role of the hospital has been the cure of the sick. Hospitals therefore tend to have their eyes turned inward on the patients and on medical research. The resolution of modern health problems demands that the hospital become the focus of

community health services and prepare the health team that will deliver their services in the homes, schools, factories, and community clinics. These changes will require nurses to operate more independently and with greater initiative. This emphasis will reflect a shift toward health maintenance activities and away from the current preoccupation with curative activities.

Changes in Health Care Systems

An example of planned change is the Neighborhood Health Centers approach. The success or failure of these centers, nurses believe, will be in direct proportion to the extent to which all health workers - not just nurses - become acquainted with residents, their homes, and their problems. Once out in the community, there is understanding.

Neighborhood Health Centers can be the most exciting and hopeful development in the delivery of health services since the emergence of the modern hospital. If they are accepted, they can't help but relieve the outmoded, over-extended hospital-centered system which dominates the professionals, intimidates the poor, and practically bankrupts the rest of society. In neighborhood centers, care is more accessible, more personal, less fragmented, and more comprehensive in much simpler settings. Thus, it is less expensive both in health and in dollars, whether paid for by the patient, the insurance company, or the government. For the next decade or more, while whole new systems of education for health professionals are being developed, Continuing Education must provide skills, knowledges, and attitudes which will make this transition possible.

Changing Nursing Education

Traditional nursing education with its rigid discipline, set of skills, and bundles of knowledge did not equip nurses professionally for this changing world. The skills of many nurses have become familiar ruts and some of us are not prepared to move from the "handmaiden" role to a new knowledgeable, resourceful, and creative role in nursing practice. The supply of baccalaureate nurses is slowly increasing, bringing a totally different kind of thinking to bear on the problems. These new graduates are not bound by tradition or awed by authority. They are discovering that the system is not as hard to beat as it appears and that new ways can be more fulfilling than some of the old ways. These are persons who have learned to ask questions of themselves and others. They have enough confidence in their knowledge and their intuition to suggest changes, and enough imagination and sophistication to carry them out. Most of all they care enough to do something about what bothers them. Many of them are young, and youth today is more inclined to be undaunted by the system and has not had time to be molded into inertia.

Our community college graduates are confused as to their role. Many of them are young, interested, and capable of obtaining further education to the professional nursing level. Each should be helped to reach her optimum level of nursing practice. For some, this will mean assistance to baccalaureate, master's, and even doctoral study. For others, it will mean provision of courses in specialized areas of technical nursing skills.

Some of the brightest thinkers are those who are just coming back to active practice from the housewife rank. They have the

security of age, experience, and successful living in the community, and they bring with them a mature realism. They are not afraid to ask questions, and they expect answers that make sense. They are investing effort in order to nurse, but in return they want personal fulfillment. We are losing some of this potential manpower because of unchallenging refresher courses and the rigidity of the hospital systems and of the hospital nursing hierarchy.

Status of Women

Another important cause is the changing status of women. Because of educational and technological advancement and many other social factors, women are more free to pursue careers and are asking for independence, freedom, and self-fulfillment. Nursing can well become an independent profession with a discreet and organized body of knowledge. Women members of the national sociological and psychological associations are talking of better use of women-power, antidiscrimination against women, and autonomous roles with men in all fields. Nursing is not alone in its ferment.

CONTINUING EDUCATION - NEW WAYS TO GO

Some emerging concepts would help improve patient care if they could be nurtured by Continuing Education.

Core Curriculum

The first is the Core-Curriculum concept which has already been accepted in some centers for the health sciences. In core-curriculums, all health science students take their basic social and physical sciences

together for perhaps the first year or two and then branch off into their specialties of medicine, dentistry, pharmacy, nursing. As they proceed in their specialties, they would continue some courses and experiences together to further this concept. Core-Curriculums help professional groups not only to learn but also to maintain good communication with each other. Graduates of such schools feel peers on the health team and, therefore, work cooperatively in resolving problems. The intelligence and knowledge of the different disciplines can be utilized.

Health Team

The health team concept is closely related to the core-curriculum idea, but we cannot await the emergence of more relevant systems of education to move in this direction. Continuing Education should be attempting to find ways to help every health professional feel the value of his or her contribution to the caring process. Knowledge of another's work and awareness of one another as individuals create an atmosphere in which each one can make his optimum contribution.

In the newer Community Mental Health Programs, we are seeing a distinct breakthrough in this area. Nurses are fully accepted as members of the health team and are making effective contributions most satisfying to both patients and to themselves.

The University Continuing Education Departments are in a unique position to develop the kind of postgraduate offerings that would further these concepts of core-curriculum and health team. This not only would improve patient care but also would prevent duplication of efforts, thus making the best use of available resource personnel.

The Community Colleges have a responsibility to further these two concepts of core-curriculum and team approach on the technical level. This should be done in close collaboration with the health agencies who are going to utilize the services of the graduates.

Ladder

The third concept which would be useful in resolving these problems is the "ladder" on which capable students and practitioners could move from the bottom to the top of the profession. Nursing courses need to be developed to move the aide to the LVN, to the technical nurse, to the professional nurse, to the clinical specialist, and even to the doctorate, if ability and motivation sufficed. Each person should have the right and the means to realize her full potential.

Continuing Education should facilitate this passage from one level to another without lowering standards. This can be done by the careful study and re-designing of curriculums, keeping standards at the forefront but not allowing tradition to dominate. Continuing Education should be involved in the planning and provision of courses to move people along the way. I would like to hear this question discussed this week as there is a great interest in it among nurses practicing without degrees.

Financing Continuing Education

There is always with us the vexing problem of money. How are these approaches to be financed? As you know, the Continuing

Education Department of UCLA is entirely a self-supporting agency. It has no budget from the University itself. We do develop federal grants that partially support some programs, but the writing of these takes much time, skill, and ingenuity and is not always successful. In my opinion, grants are only worth the effort when we need to experiment with entirely new and creative ways to change nursing practice.

More and more we see agencies assuming the financial responsibility for their own staff members. If we are going to improve nursing practice, it will be necessary for every health agency to develop realistic educational budgets to meet these needs of their staff members and to pay their salaries while they are away studying.

Some nurses are able to obtain scholarships, stipends, or loans of some kind though these, too, are growing more scarce. Fortunately, this is off-set to some extent by an increasing willingness on the part of individuals to pay their own way. If salaries rise and incentives increase, this tendency will be fostered. As people appreciate what they pay for, this would probably be a good thing both for the individuals concerned and for the courses.

Motivating Nurses for Learning

Our student body consists primarily of working adults whose continuing studies must be within formats appropriate to their requirements. Many of them are working mothers with many responsibilities, who are not aware of the possibilities of change. They are unable to leave their jobs or homes to explore the new exciting

avenues available to them. So we have a responsibility to develop new means for motivating them and meeting their continuing education needs.

Unfortunately, not much is known about the nature of motivation, and I have no sure answer to this question, so I will share with you some of my practical experiences.

Television

Everyone of us knows of some nurses who have not been out of their four walls for twenty years. Yet, I have seen some of these come to watch "the magic box!" I am referring to the television series "Speaking of Nursing," which is still in its infancy. This is a new and stimulating approach, but it is of optimum value only when it is presented as an educational experience, using the various study guides and discussion leads which have been prepared to accompany each program. For instance, in one hospital where a tape on the loss of a body part was shown without the use of any orientation, study, or question and answer period, a dentist who attended indicated that it was of no value to him. If it had been presented as planned, it is possible that he would have related the concept of loss of a body part to the extraction of teeth and the provision of dentures. What could be a more traumatic experience?

New Media

Self-learning techniques such as the use of teaching machines, videotape recorder playback, loops, films, and so on can effectively stimulate the learner to teach himself. All these techniques,

however, must themselves be taught as they need the supervision of experts. Continuing Education could do much to provide these experts and thus stimulate the use of these new media.

Live-In Conferences

Live-in Continuing Education Conferences are motivating approaches that have not yet been fully explored. These conferences allow nurses to move to conference settings where they will not be disturbed by their usual responsibilities and can spend a week or so in an intense education involvement with others. During the intervals between conferences, they are encouraged to attempt to innovate some of their new knowledges, attitudes, or behaviors within their own work settings. Many of the graduates of these short term courses have been stimulated to return to school for formal education. Some means must be found to offer such courses in every geographic area so that all nurses have the opportunity to participate.

Guidance Counsellors

It may be that many nurses do nothing because they do not know what to do. They do not know what their potential is. They do not know what courses are available, nor which ones would be suitable for them, nor how to proceed to get into them. The University might overcome this problem by preparing guidance counsellors to help nurses make plans for their professional advancement. These counsellors could be supported by all levels of educational institutions or agencies and be available for individual counselling of nurse members. They would help nurses avoid useless experiences and work toward

sound, fair, realistic, and measurable goals to meet the objectives for the improvement of patient care.

In turn, Universities have to offer the kind of Continuing Education that will help nurses work toward occupational goals to avoid the narrowness of the job concept and build toward career goals.

Despite the fact that the health service industry depends largely upon what people do for people on a one to one basis, there is much evidence that there will be vast changes in the years ahead. The innovations in health technology which will most affect health manpower in the next ten years are most certainly those now being designed or adapted for use in patient care facilities. They will involve various kinds of manpower changes, including changes in job control and emergence of new jobs, as well as some labor savings. How relevant is the education for specific tasks that are now performed for the allied health occupation? Colleges have been urged to teach the practical or what the world of work needs. But this probably must be stubbornly resisted in favor of the teaching of principles and concepts. One of the most prominent problems facing any college or university today is that of educating the student in ways or means that minimize or postpone his obsolescence once he is out of school.

Re-licensure

What then of the nurses who are unaffected by any of these inducements? There remains, of course, the 'carrot and stick' approach by which those who do are not rewarded finally are punished by loss

of their registration. It is to be hoped that the re-licensure laws will re-introduce realistic standards, meaningful in terms of better patient care, and will be devised to meet these standards and not to evade them. This could in itself create an unprecedented demand for courses of all kinds that Continuing Education must be prepared to meet.

If this comes about, the Boards of Nursing Education and Nurse Registration would serve as the formal bodies to define the criteria for an organized program for re-licensure to practice as well as creating the means to enforce standards upon all individual nurses.

In conclusion, then, we see that there are many areas of neglect and injustice in our society which demand the attention of health personnel. The educational system always lags behind the social need, but in the present situation our problems are so urgent that the future of our society hangs upon their speedy resolution. We cannot await the development of a new educational system for the health professions. Continuing Education, however, is more relevant than the overall system because it takes adults where they are and supplies the knowledge, skills, or attitude changes they immediately need.

We must develop new open systems for Continuing Education. Universities should assume the leadership role in working closely with colleges, health agencies, and practicing nurses in the development and organization of systemized, new approaches to continued learning.

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THE ADULT LEARNER

Dr. Eugene I. Johnson
Professor of Adult Education
University of Georgia

The field of adult and continuing education is still an emerging field of study. It has, I am sure, more of a future than a past. Perhaps my first task--and a very pleasant one--is to welcome you to the field. You are following the pattern that many groups have followed in defining first a general focus for your interest and then seeking to develop a suitable mechanism to enable those of you who share this focus to draw on the common experience of the field, the experiences of others working in your area of interest and to obtain the support and respect to carry your program forward.

Some Significant Benchmarks in the Field

While adult or continuing education has existed, in some form or other, as long as man has been on this planet, it is only in this century that we have begun to study the process of adult learning and to seek systematically to improve educational opportunities for adults. The first formal courses in adult education were offered in the 1920's. And the first two Ph.D. degrees in adult education were awarded in 1935 by Teachers College, Columbia.

to Wilbur Hollenbeck and William Stacey, both of whom have now retired but continue to contribute distinguished service to the field. From that beginning, some seventy institutions of higher education now offer some work at the graduate level in adult or continuing education. Of these, approximately 20 now offer the doctor's degree. The University of Georgia program, which began only two years ago, offers both the master's and doctor's degrees and already has close to forty students in one or the other of these programs.

While professional societies have long paid attention to the needs of their members for continuing education, a growing emphasis on continuing education for professional people is largely a product of the decade of the sixties. The Adult Education Association of the U.S.A. responded to this new thrust in 1965 by authorizing the establishment of special interest section on Continuing Education for the Professions. Many other professional groups--doctors, public health workers, dentists, engineers, to name a few--are struggling with the same kind of conceptual and organizational problems that you face at the moment and will watch your progress with respect and understanding.

The Field is a Fragmented One

Because the field of adult education has developed as a peripheral interest of institutions of education or around topics or areas of special concern, it is a fragmented field. There are now more than 20 national organizations seeking to serve agencies or individuals in various sections of the field. There are probably

a dozen other informal groups that have not established any formal organizational mechanism. While this situation creates some problems as far as communication and cooperation are concerned, it does constitute evidence of the enormous vitality of the vineyard in which we labor.

While we can take satisfaction in the fact that the yeast of adult or continuing education is working in many different places, we face a fairly formidable task of developing effective cooperation and organization for the field as a whole if the resources available are to be widely and effectively used. By resources, I refer to research, financial support through governmental activities and foundations as well as institutional policies, the existence of a small but growing body of adult education generalists able to work across the field, and such specialized resources as the ERIC (Educational Resources and Information Center) Clearinghouse in Adult Education at Syracuse University in New York.

The major organizations currently serving the field have attempted sporadically to create mechanisms for interagency cooperation. The latest of these is the Committee of Adult Education Organizations (CAEO), established in 1965 as a result of a meeting convened by Syracuse University. This organization has several accomplishments to its credit, notably the establishment of the ERIC Clearinghouse, representation on the United States National Commission for UNESCO and liaison with such major educational bodies as the American Council on Education and the Educational Commission of the States.

The CAEO is convening December, 1969, in Washington, D.C., the first national conference of all the major adult or continuing education organizations. Known as the Galaxy Conference, the series of meetings is expected to bring in excess of 3,000 adult educators to the city of Washington. It is expected to provide the field of adult education with a national platform from which it can speak with a single voice. It is also hoped that the field will make some organizational progress in the wake of the Galaxy Conference.

Another important study of the organizational problems of the field is one just completed at Syracuse University by Robert Blakely and Ivan Lappin. I commend the results of their study to you. The organizational problem is one that must be approached with great care because no monolithic design will serve the interests of a field as diverse as this one.

Continuing Education Represents Applied Research

Much of our knowledge about the adult learner and the process of adult learning is based on attempts to apply research that originated in such other fields as psychology, sociology, anthropology, geriatrics, and medicine. The research of Edward L. Thorndike of Columbia University, conducted largely in 1928, is illustrative of this trend. Thorndike proved once and for all that you can teach an old dog new tricks. His studies show that there is no significant loss in learning ability during the adult years, until a person becomes senile. This, of course, may occur at different points in the lives of different individuals. Some persons tend to become senile in their 40's and early 50's and

others carry on into the 80's and even into the 90's. Thorndike's research indicated a small annual drop in learning, but subsequent studies have established that the apparent drop is associated not with ability to learn but with the rate of learning. Adults learn more slowly than youngsters, but they do not lose their ability to learn. The important point is not to draw a line between adults and younger people but to recognize that the rate of learning is one of the great number of individual differences that persons who design continuing education programs must take into account.

Significant educational developments have been based on such studies as those of Paul Lazarsfeld who intensively analyzed the factors causing people to determine their ultimate choices in a presidential election. His findings were reported in a fascinating book, published almost 25 years ago under the title of The Peoples Choice.

The purpose of education is to change people's behavior. There is a long sequence involved in changing overt behavior such as smoking, patterns of recreation, etc. Hence, educational objectives may focus on any of these steps--the acquiring of information, the development of understanding, the acquiring or improving a skill. We tend to speak of all of these objectives as related to "changing behavior." It is important to keep that in mind because people often are confused over the difference between overt and covert behavior.

The purpose of most research conducted in the field of adult and continuing education has been to determine factors or procedures



that will be helpful in changing behavior or to demonstrate the process for doing so. Speaking tangentially, I suppose the characteristic that separates educational attempts to change behavior from other attempts is that educational theory stresses involving the individual in an understanding of the process and his acceptance of the basic values that may be involved. This is quite a different process from manipulation and the art of propaganda, even though those approaches also seek to change behavior.

Adult Education Research Based
Primarily on English Speaking
Countries Experience

Most of our current ideas about designing educational experiences for adults are based on the experience of the English speaking countries of the world. One or two major ideas have been borrowed from non-English speaking countries-- for example, the folk schools of the Scandinavian countries-- but generally, our practice is limited to the experiences available from those other countries that speak the same language we do.

Last month, I spent a very short period of time in Northern Europe and was impressed with some extremely significant educational work going on in both Sweden and Finland. In neither case was the work labeled "educational" nor was it associated with formal educational institution. Both countries have been remarkably successful in bringing together in a residential community people of quite different occupational and economic backgrounds.

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It has proved to be very difficult to do this in the United States. One look at the suburbs of any major city shows the extent to which economic stratification prevails in the United States. Indeed, many thoughtful observers feel it is easier to accomplish horizontal integration across racial lines, where no significant differences in economic or educational levels exist, than it is to accomplish vertical integration where great differences in economic circumstances prevail. It may be easier to get black and white doctors, nurses, lawyers, etc., to accept each other, to work together and live in the same community than it is to get doctors and assembly line workers in an automobile plant to live in the same community, even though no racial differences exist. Outside of work, they create different worlds for themselves.

Not so in Finland--at least not in the magnificent New Town of Tapiola about 15 miles north of Helsinki. There I saw people of widely different backgrounds living side by side. It was impossible to tell from the quality of a man's housing anything about his income or occupation. Inquiring about this, I was told that Tapiola conducts an educational program from the time people are accepted as renters or home purchasers in the community. There is obviously some valuable experience for us here, and I intend to go back next summer and study it in greater detail.

With the reminder that most of our research is reported only for English-speaking countries, let me cite some of the main sources to which you may want to refer.

E. L. Thorndike, whom I have already mentioned, and his significant experiments with adult learning in 1928.

In 1959, Edmund de S. Brunner compiled the first Overview of all the research in adult education conducted up to that time. This was published by the Adult Education Association of the U.S.

For the next ten years, the summer issue of the quarterly journal, Adult Education, has carried a review of all of the significant research in the field conducted during the preceding year.

Beginning in 1969, the newly established ERIC Clearinghouse in Adult Education at Syracuse now publishes an annual Register of Research. The body of applicable research has grown to such a point that it is no longer feasible to attempt to confine it in a single edition of Adult Education. Furthermore, with the excellent research facilities that the ERIC Clearinghouse has, much more relevant research is being located today than was the case in earlier years.

The work of D. Wechsler and Irvinghorge established beyond challenge that adults do not lose their learning ability this side of senility, if spced of learning is eliminated as a factor in judging results.

Houle, White, London, and others have completed studies revealing significant characteristics of large numbers of adult learners. However, the most definitive study of the adult learner is that contained in the work entitled Volunteers for Learning, published by the National Opinion Research Center in 1963 and based on the results of a national study conducted by Ralph Johnstone.

The Adult Education Association of the U.S.A. established over a decade ago a Commission on Research which annually presents significant studies of the preceding year during the Association's annual conference. Several members of this commission, notably Alan Knox, now at Teachers College, Columbia, organized the National Seminar on Research in Adult Education. This Seminar will meet for the 10th time in Minneapolis

in late February of 1970. The annual Research Seminar provides both an opportunity to learn about significant research conducted during the preceding as well as to develop research skills.

Perhaps the most significant recent book pulling together what is now known or believed to be true about the nature of adult learning is that of Jack Botwinick, now at Washington University in St. Louis, but at the time of his studies, Professor of Medical Psychology at the Duke University Medical Center of Durham. Published under the title of Cognitive Process in Maturity and Old Age, comprehensively with learning theory, problems of measurement, types of learning, problem solving and creativity and theories of forgetting. In general, one can say that in the four decades that passed between Thorndike's early work and Botwinick's compilation, steady progress has been made towards understanding the infinite variety of factors that affect the ability of adults to learn a wide variety of skills under different circumstances. Progress has also been made in bringing these widely scattered findings into a conceptual scheme to inter-relate various findings and to define areas of needed additional research.

I repeat again. Nothing in the past forty years has challenged the truth that Thorndike established--adults continue to learn. The net result of research since 1928 has been to increase our knowledge of how they learn and our ability to formulate better educational experiences for them.

Factors Affecting Adult Learning

You now have, as you carry forward the task of organizing learning experiences for people in the nursing profession, a number of studies that establish some of the variables you may wish to keep in mind. For example, different studies have shown that the following factors effect motivation and the circumstances under which adults learn.

The physical setting--or the learning environment.

The physical condition of the adult participant.

The time available for the learning activity.

The nature of the task.

Anxiety and other emotional factors.

Perceptions of the relevance of the learning task
to the learner's needs and interests.

Social and economic factors, such as income level,
location of the learner's house, his friends, etc.

The amount of previous education that an individual
has had.

Attitudes toward the agency or institution offering
education.

Let me take a moment or two to indicate the importance of
some of these variables.

Adults are reluctant and slow to learn apparently irrelevant
material. For example, children and teenagers oddly enough will learn
nonsense syllables fairly readily. Not so adults.

Numerous studies in the field of nutrition show the extent
to which permanent damage to the body including the brain can result
from poor nutrition during the first three years of an infant's life.
Studies of cultural deprivation have also indicated the stultifying
effect of a limited environment on human intelligence. It is impor-
tant to take with a large grain of salt all claims about the constancy
of intelligence. From the standpoint of designing programs for the
adult learner, the major significance is to recognize the difference
between individuals in their ability to learn certain tasks and the
difference in the same individual from one time to another and one
setting to another.

Some Major Implications for Organizing Learning Experiences for Adults

Now let me turn to some aspects of designing learning experiences for adults. Perhaps Malcolm Knowles has already emphasized some of these to you. Certainly he has in his new book coming out early next year, entitled The Modern Practice of Adult Education.

Physical Comfort. The learning environment should be comfortable but not so comfortable as to induce torpor. Chairs should not be uncomfortable; fresh air is important; good lighting and adequate provision for those who have difficulty hearing or seeing must be stressed. For those who smoke, ashtrays should be provided or, at a minimum, fairly frequent breaks allowed.

Relevance of the learning task. It is important to establish the relevance of new learning tasks to the existing needs and interests of the learner. For that reason, the instructor must know something about the background interests of the students or he cannot relate new learnings to those that already exist. The concept of career ladders--that is, organizing new skills or understandings in a sequence that must be mastered in order to move upward in a career pattern--is one method for making learning relevant. Projects selected by participants is another method for enabling adults to focus new learning tasks on goals that are desirable to them.

The concept of immediacy. Adults expect a prompt return from their learning ventures. People get interested in acquiring

new vocational skills because they seek a promotion or a better job. Parents want to learn how to help their children when their children have problems and not some ten years before or after that time.

Involvement. Adults need to be involved in establishing the educational objectives for a particular learning task--that is, how much and what they hope to learn in a specific time period. (a class, a course, an evening, etc.) Each adult in a group also needs some opportunity to select an emphasis which is close to his own program areas of special competence or interest.

Attitudes. All I can say about the complex question of attitudes at this point is to be aware of them and to beware of them. Learner attitudes are tricky factors, and they can make or break many programs of continuing education. As I have said before, the attitudes may be toward the instructor, the institution, the physical setting, one's fellow participants in a learning experience, the topic, or any of a variety of other things. A sensitive teacher will take the time to find out what attitudes are present in a group and learn how to adapt the learning tasks to them.

Adult needs. Adults are no different from children and teenagers in needing many of the psychological rewards that give a sense of fulfillment to life. Some of the more significant needs are for security, personal acceptance, recognition, and success. These personal needs must be satisfied or they will block achieving educational objectives.

Motivation. I know you are all aware of the problem and importance of motivation. The only comment I would add to what I have already heard is to underline the existence of many possible kinds of motivation that will cause an individual to value an educational task. Discover as many motivations as possible and inter-relate them in meaningful ways. For example, the need of some individuals for personal acceptance can be the starting point of building a complex of motivational factors. I observed this process in helping large numbers of individuals to establish discussion groups (or viewing posts) to observe and participate in educational television broadcasts in the city of St. Louis. Many individuals in the viewing posts were initially not interested in the educational purpose but came to the group in search of social acceptance. Gradually, an educational motivation developed, and this became stronger than the initial motives for participating in the group.

Summary

By way of summary, let me reiterate six guidelines for working with the adult learner. (1) Understand the needs and interests of adults and focus the educational program on these. Remember you are teaching people not just skills. (2) Set realistic levels of aspiration. (3) Establish clear goals. (4) Break up long range objectives into accomplishable units. (5) Provide knowledge of results as quickly as possible. (6) Always provide for the involvement of the adult in formulating, guiding, and evaluating the program.

The future is a promising one and I wish you well.

THE CONTINUING LEARNER IN NURSING

Signe S. Cooper, R.N., B.S., M.Ed.
Chairman, Department of Nursing
University of Wisconsin, Madison

A familiar quotation reminds us that "every man who rises above the common level has received two educations: the first from his teacher; the second, more personal and important, from himself." This paper is concerned with that second education, specifically with some of those activities relating to certain aspects of self-education.

Cyril Houle in his book The Inquiring Mind points out that "the desire to learn . . . is not shared equally by everyone," but that certain people can be identified as continuing learners. Those of us responsible for programs of continuing education must be concerned with identifying the "inquiring minds" in nursing.

It is important to the nursing profession not only to identify those nurses who are continuing learners but also to promote methods to assist them in their seeking of knowledge. It is also important to explore means of encouraging those less motivated to continue to learn.

In the not too distant past, faculty of schools of nursing taught with the implied, if not stated, assumption that they were teaching the student everything she would need to know the rest of her professional life. This unfortunate approach has repercussions even today, for it is not usual to hear a nurse say, for example, that

she hasn't "cracked a book" since she was graduated from nursing school.

It is imperative that schools of nursing change their educational approach to help students recognize the need for life-long learning for the practitioner, and we are now seeing some evidence that this is happening. Students must also be helped to discover the many sources available today to assist nurses in their educational pursuits.

I believe that it would be useful if an intensive study of the continuing learner in nursing could be done. I am not sure how these nurses could be identified, but if they could, such a study would be of great value in planning continuing education programs in nursing.

Individual nurses who are continuing learners no doubt learn in a variety of methods: in caring for patients in thoughtful and questioning ways, by asking questions and in discussion with their professional colleagues, by reading professional literature, and by attending meetings and conferences appropriate to their own professional goals. I believe, perhaps unfairly, that these individuals are the exception rather than the rule in nursing. Of course, this cannot be documented, but observations of many nurse practitioners suggest this. One indication might be the percentage of nurses who subscribe to, and read, The American Journal of Nursing. A few years ago this was about 20 per cent of American Nurses Association members; I wonder if there has been much change in recent years.

One more general observation: it might be appropriate to do an in-depth study of those of us who are responsible for continuing education. What do we do about our own continuing education? Are we

really continuing learners? And if we aren't, ought we not be in another area of nursing? I raise these only as questions, but I sincerely believe that the person teaching in educational programs for graduate nurses must have a personal commitment to her own continuing education.

I do not pretend to be able to know how to identify the continuing learner in nursing, but will describe some general characteristics of nurses who participate in certain kinds of educational pursuits.

Description of the Study

I will describe a study of nurses who enrolled in workshops, institutes, and conferences offered by the Department of Nursing in University Extension (then known as the University of Wisconsin Extension Division) for a period of one year: from September 1, 1963, through August 31, 1963.

In addition to these offerings, the Department of Nursing offered special classes, which vary somewhat in length. Enrollees in these offerings were not included in the study. None of the programs in the study were offered for credit.

During this year, 333 nurses enrolled in the programs offered. Information was obtained from all but six enrollees; thirteen enrollees attended more than one conference, so the total number of nurses in the study was 314.

The data was obtained from a rather extensive application blank, which was completed by the enrollee before she participated in the program. (Copies of the questionnaire-application blank and of the study are available if anyone is interested; for those who are

interested in less detailed information, the study is described in Nursing Outlook, December, 1966).

By their participation in the program, these nurses indicated an interest in continuing their education, and this is our criteria of the nurse as a continuing learner. (We recognize that this may not be adequate, since the nurse's motivation for attending may have been extraneous to the program, but, in our study, we give her the benefit of the doubt).

Let me now point out the other limitations of the study:

1. It covered only one year and we had no way of determining if this were a "typical" year.
2. The content of the programs offered obviously influence enrollment, and, therefore, our sample population may not be a representative one.
3. This was not a study in depth; much more information about enrollees could have been included.
4. The sample (314) may not be adequate for valid conclusions. The information obtained about enrollees was, of course, not an exhaustive one. Only those pertinent variables with special significance for program planning were considered.

In our search of the literature, we could find no comparable studies on nurses as continuing learners. There will be some in-depth studies on nurses as continuing learners from the University of British Columbia. This was reported at the International Conference on Continuing Education held in Montreal in June at the time of the Congress of the International Council of Nurses.

Findings

What are the characteristics of the nurse who attends University of Wisconsin Extension Nursing Programs?

The average enrollee is:

1. A Wisconsin resident
2. Married
3. Over the age of 40
4. Employed full time
5. Employed as a head nurse
6. Has been employed in nursing more than ten years
7. Has been in her present position less than one year
8. Works in a hospital of 50-100 beds
9. Is a graduate of a Wisconsin diploma program in nursing
10. Is a member of the American Nurses Association
11. Participates in other learning activities
12. Participates in social, educational, civic, or religious organizations

Let us now consider each of these characteristics in a little more detail.

1. She's a Wisconsin resident.

(Parenthetically, we had only one man in this study, so I will refer to the nurses as "she"). This finding relates to our method of publicizing programs. We recognize our approach to be a provincial one, for we are cognizant of the values gained in sharing ideas and experiences with nurses from other states. We are a tax-supported institution, and since we are unable to meet the needs of the nurses in our own state, most of our programs are not nationally publicized.

2. She is married.

Over half (54 per cent) of enrollees were married, in comparison with 65 per cent of Wisconsin nurses who were married in 1963. Eight out of ten has children; one-fourth of those with children have children under the age of five. The difference is a reflection of the priority of family responsibilities over professional ones, but many take advantage of educational offerings in spite of these responsibilities. The finding suggests a high degree of professional commitment as well as motivation for learning. It also suggests the need for providing educational opportunities near the nurses' home.

3. She is over the age of 40.

(57 per cent were 40 or over, contrasted with 41 per cent of comparable nurse population). The proportion of those over 40 was higher than the proportion of all Wisconsin registered nurses in this group. This suggests that this age group has greater learning needs than others, or it may reflect a lack of interest by younger nurses. We may need to search for ways to motivate the younger nurse, or to provide opportunities for her nearer her home. (Since the younger nurse is more likely to have small children).

This finding also suggests the need for understanding the special learning problems of the nurse. She is more familiar with traditional approaches to learning and may need encouragement and assistance to profit from participation sessions.

4. She is employed full time.

The great majority (88 per cent) of enrollees were employed full time, compared to the 80 per cent of all nurses who were then employed full time in Wisconsin. (This number was increased nationwide to 29 per cent, according to Nurses, 1966).

This may mean that employing agencies take less responsibility for the continuing education of the part-time nurse. Also, if she works part-time she has other responsibilities; therefore, the finding is not a surprising one. There are, however, serious implications for patient care unless the employing institution's in-service program is meeting this nurse's educational needs.

5. She is employed in a head nurse position.

Nearly one-third of the nurses who enrolled in the program were employed as head nurses; the next largest group was the staff nurse, comprising about one-sixth of the enrollees (in contrast, figures for 1962 showed only 12 per cent of nurses registered in Wisconsin were head nurses, while almost 70 per cent were staff nurses).

What do these figures mean? That head nurses have greater learning needs? Or that it is easier for them to get away from their positions? Or that the content was more appropriate for them? Or that employees are more willing to pay their way to attend meetings? It might be appropriate here to point out that three-fourths of our enrollees had their fees paid by their employing institutions.

6. She has been employed in nursing more than ten years.

Over two-thirds of enrollees had been employed in nursing ten years or longer. Again, a question might be asked why does it appear that the longer the nurse has been engaged in nursing, the more likely she is to seek continuing education. Does the more experienced nurse feel more pressures to seek additional preparation? Or is the young graduate too busy establishing herself in her career, making a home, raising a family?

7. She has been in her present position less than a year.

Although our continuing learner is not new to nursing, she is relatively new to her position; nearly one-third of the enrollees in this study have been employed in their present position less than a year. It is possible that the new position stimulates further learning.

8. She works in a hospital of 50-100 beds.

Nearly one-half of enrollees were employed by general hospitals; nearly one-third of them were employed in hospitals of 100 beds or less. (At the time of the study 60 per cent of Wisconsin hospitals were in this category, but, of course, these hospitals have fewer nurses than larger institutions).

There may be a number of explanations for this finding, but it appears logical that it may be related to the lack of an adequate in-service program in the small hospital.

9. She is a graduate of a Wisconsin diploma program in nursing.

I shall not elaborate upon this finding except to say that our figures did not indicate that the graduate of a collegiate nursing program did not feel any greater need for continuing to learn than did graduates of other nursing programs.

10. She is a member of the American Nurses' Association.

(Fifty-six per cent compared to 32 per cent of Wisconsin nurses). Nurses who seek to keep themselves professionally informed tend toward participation in nursing organizations, perhaps because they see this as one other approach for keeping informed, or we may conclude that the continuing learner appears to have a greater professional commitment than other nurses.

11. She participates in other learning activities.

Nine out of ten enrollees read professional nursing periodicals. Comparative data is difficult to find, but it might again be assumed that this means that the continuing learner uses many avenues to keep abreast.

12. She participates in social, educational, civic, or religious organizations.

In spite of heavy family responsibilities--or possibly because of it--nurses who are continuing learners are heavily committed to community responsibilities. One-third of all enrollees participated in more than one of these types of organizations while one out of ten participated in all four.

One additional finding will also be discussed briefly.

Over half (54 per cent) of these enrollees traveled fifty miles or more to participate in the program. Since this means at least 100 miles of total travel and since many of these nurses have family responsibilities, one can assume a fairly high degree of motivation for learning.

In spite of this, we believe there is considerable merit in providing learning opportunities for the nurse nearer her home. I shall discuss this point in more detail on Thursday when I discuss teaching by telephone.

From these findings, it seems apparent that careful consideration must be given to the special learning problems of the older nurse. Since this nurse is oriented to traditional types of teaching, those conducting continuing education programs in nursing must be skillful in using modern methods of teaching.

The teacher must also be skillful in helping nurses learn by sharing experiences, but often the older nurse is unable to appreciate her own contributions or reluctant to express her ideas.

Earlier I touched upon the responsibility of all schools of nursing to emphasize the importance of life-long learning. Learning to locate and use available educational resources should be a part of every nursing curriculum.

In recent years there has been considerable emphasis on the inactive nurse, the older nurse, etc., that perhaps there has not been enough emphasis on the learning needs of the younger nurse or the new graduate. It seems important to help this practitioner to an early recognition of 'avenues of continuing education' and the early establishment of meaningful learning patterns.

Careful attention ought to be given by nursing administrators to the selection of those nurses who attend educational meetings. Too often it seems as if the same people are permitted to participate. Is this because they are the ones who ask to go? Might not it be better for the institution if others are encouraged to participate? And would not the total educational endeavor be better for the institution if it were carefully planned for? Perhaps priorities could be established for those nurses who are less able to pay, (e.g., staff nurses, part-time nurses), those relatively new or recently returned to nursing, and those who accept their professional obligation by attending certain meetings under their own auspices.

Nurses who seek to keep themselves professionally informed do so in a variety of ways. This study has explored only one facet of continuing education; it is obvious that the professional practitioner must become increasingly self-directed in her learning efforts.

THE NATIONAL NURSING ORGANIZATIONS' ROLE IN
CONTINUING EDUCATION FOR NURSES

Dorothy T. White, R.N., Ed.D.
Director, Department of Nursing Education
American Nurses' Association, Inc.

Our task today is a difficult one in many respects, however, the mere fact that we are here together, the National League for Nursing, the Continuing Education educators, and the American Nurses' Association speaks to a feeling of unity. We know that knowledge is growing so rapidly in nursing practice and nursing education that we must find a way to help the educators and practitioners to meet nursing's responsibility to the patient. The social significance of the problems that nursing faces today cannot be doubted. It is with a sense of urgency that we convene today. Many of you have had long experience in Continuing Education. You find that there is much evidence nationally of new and increased interest in Continuing Education, not only for nurses but for all members of the health team.

The time has come for the American Nurses' Association to urge its membership to assume responsibility for Continuing Education as one of their primary educational activities. We believe the administration of the Association should take the initiative in developing mechanisms which will assist its members with their programs of Continuing Education through establishment of a National Committee whose membership would be composed of knowledgeable persons in Continuing Education. This committee could serve as an information resource to the members in their function and inter-relationships

concerned with Continuing Education. It would also assume responsibility for the planning of a dynamic program and establish guideline and standards in Continuing Education.

I think if I would try to say what the ANA role is in Continuing Education, at this point in time, I would have to say we could be identified most closely with a line in the Broadway play "Mame" - "Open a new window, open a new door, travel a new highway you've never been down before".

THE ROLE OF THE NATIONAL LEAGUE FOR NURSING IN CONTINUING EDUCATION FOR NURSES

Joan E. Walsh, R.N., B.S.N., M.Ed.
Consultant in Nursing Education
Department of Baccalaureate and
Higher Degree Programs
National League for Nursing

According to the Certificate of Incorporation of the National League for Nursing, January 26, 1952, the objective of the organization is to:

"Foster the development and improvement of hospital, industrial, public health and other organized nursing service and of nursing education through the coordinated action of nurses, allied professional groups, citizens, agencies and schools to the end that the nursing needs of the people will be met."

One way in which this objective has and will continue to be met is through the National League for Nursing's activities in the area of continuing education for nurses. These continuing education activities are many and varied.

The programs planned regionally and nationally for the six agency councils are prime examples of the National League for Nursing's involvement in continuing education for nurses. The Council of Associate Degree Programs, the Council of Baccalaureate and Higher Degree Programs, the Council of Diploma Programs, the Council of Hospital and Related Institutional Nursing Services, the Council of Public Health Nursing Services, and the Council of Practical Nursing Programs all plan programs that are designed to further develop the potential

of the individual worker and improve the service provided to the public. You, who are representatives of university nursing programs, are probably most familiar with the council programs of the baccalaureate and higher degree group.

At present there is one council for individual members of National League for Nursing, the Council on Community Planning. Through this council nationally, and through the constituent leagues locally, many activities and programs are planned that are educational in nature and that contribute to the professional development of the League members.

In addition to council activities and biennial convention programs, the National League for Nursing sponsors various other meetings from time to time. This year, for example, a special conference on rehabilitational nursing was convened in New York City. This program was planned as a form of continuing education for nurses in the rehabilitative aspects of nursing care.

Of course, many nurses seek to continue their education through programs of formal education. The National League for Nursing provides information about all types of nursing education programs. From the Department of Baccalaureate and Higher Degree Programs one can obtain information about baccalaureate programs, masters programs, and doctoral programs. Through the Department of Associate Degree Programs and the Department of Diploma Programs information is provided to the practical nurse about formal educational opportunities that are available to her. The quality of all these formal education programs is a vital concern of the National League for Nursing. The League is

well known for its school improvement activities; i.e., its consultation program and its accreditation services to schools.

As you probably know, the National League for Nursing also publishes many materials that would be useful to the individual nurse in her own self-improvement endeavors and to those who are involved in offering formal continuing education programs.

(Catalogues describing these publications are available on request from National League for Nursing). One publication specific to this discussion is: Nursing Education-Creative, Continuing, Experimental. This publication contains papers presented at the Twentieth Conference of the Council of Baccalaureate and Higher Degree Programs held in Philadelphia in 1966. The official organ of National League for Nursing, Nursing Outlook, is also useful.

Various teaching aids and resources are available from the National League for Nursing. Through the ANA-NLN Film Service, films, tapes, filmstrips, slides, etc., can be rented and/or purchased for use in educational programs. Catalogues describing these resources are available on request.

At the present time the Film Service is conducting a national survey of all available related audio-visual materials. One of the purposes of this survey is to provide a centralized source of information about screened and evaluated audio-visual materials on nursing that have already been developed. When this survey is completed in January, 1970, a comprehensive listing of the materials, with annotations, will be published.

In addition to these teaching resources available through ANA-NLN Film Service, the National League for Nursing had developed a

programmed instruction series on rehabilitation aspects of nursing. This series is geared to meet the continuing educational needs of the staff nurse in the care of her patients. By the fall of 1970, there will be a series of programmed instructive materials available on nursing in tuberculosis. This is sponsored by the Nursing Advisory Service of the National Tuberculosis and Respiratory Disease Association and the National League for Nursing. The Nursing Advisory Service has sponsored, in addition, conferences on teaching resources for instructors in university schools of nursing, has planned and conducted short-term courses on tuberculosis and respiratory disease nursing, and has participated in seminars and workshops. Nursing seminars have been held in conjunction with each National Tuberculosis and Respiratory Disease Association national meeting. The Advisory Service is very active in continuing education.

Since the National League for Nursing believes that no one educational program can provide the nurse with all the preparation she will need for her life's work, and since National League for Nursing is committed to the improvement of nursing service and nursing education, National League for Nursing has been and will continue to be, active in the area of continuing education for nurses.

FUNDING SOURCES AND RATIONALE FOR SUCH SOURCES

Gretchen A. Osgood
Assistant Director, Division of Nursing
Department of Health, Education, and Welfare

The Professional Nurse Traineeship Program was authorized in 1956 with the express purpose of improving patient care through preparation of nurses in leadership roles. The program provided student support for long-term training of teachers, supervisors, and administrators. The training was not necessarily degree oriented.

By 1958 when the first conference to evaluate the accomplishments of the program was held, the traineeship program had halted the precipitous decline of enrollments in graduate programs, had begun to increase full-time enrollments, and had stimulated recognition that good leadership makes or breaks a nursing service; for every member of the nursing service reflects the attitudes of top management.

One of the recommendations of this conference was to provide short-term training in administration and supervision for personnel already employed who were unable to engage in full-time study. Accordingly, short-term training was initiated in 1960. Under this program, grants are awarded to sponsors offering short-term training courses. Sponsors may be public or non-profit private educational institutions, professional organizations, health agencies, and regional bodies. Funds may not be granted to sponsor for regular university courses, including extension courses, or for inservice

education programs for employees of a single agency. Courses must be shorter than a university term of six weeks or less but must provide at least five days of full-time study. Courses may be offered in single or multiple sessions. A single session course consists of an uninterrupted period providing not less than five and not more than thirty days. A multiple session course consists of more than one session for the same students.

Like the long-term traineeship program, short-term training courses should focus on ways in which a nurse can improve performance as a teacher, administrator, supervisor, health nurse or senior public health nurse. Because the courses are of short duration, the emphasis should be on developing a few selected skills in teaching, in management of patient care, or in gaining clinical competence. Courses focusing on clinical content should afford opportunity for practice in patient care situations.

Funds provided under this program are for traineeships only. This includes both tuition and student support. The amount charged for tuition may be applied to the cost of training. This includes the cost of providing faculty, supportive services, and whatever material is essential for the conduct of the course. Support for the trainee consists of a stipend of \$12 per day for a period of instruction if temporary change of residence is required.

A candidate who has received twelve months of traineeship aid for long-term study under the Professional Nurse Traineeship Program may not be considered for a short-term traineeship except when it is demonstrated that the particular training is necessary for the specific position in which the applicant is engaged or committed. A nurse may

receive more than one short-term traineeship and remain eligible to apply for a long-term traineeship.

In 1963 a second evaluation conference was held to examine the accomplishments of both the long- and short-term traineeship programs. The conferees noted that there was evidence, based on reports of sponsoring agencies, that trainees had gotten new ideas for improvement of patient care. Employers reported that former trainees had effected changes in their work in situations that resulted in better nursing practice. It was also encouraged to note that there were instances reported that nurses who had participated in short-term courses had enrolled for full-time academic study in colleges and universities.

A significant recommendation for this 1963 conference was the addition of clinical specialists to the categories of eligible trainees. The addition was made because of the influence they exert on students and staff and because of their unique contribution to patient care.

Just as changes have been made in the program to make it responsive to changing needs, now certain questions need to be raised to keep the program relevant.

From the refresher program, we know that less is done for the practicing nurse than for the inactive nurse returning to practice. In addition, inservice staff education programs are apt to be spotty and more apt to be job-specific than to prepare the nurse for filling broad responsibilities or assuming professional responsibilities of greater depth. We know that the nurse's skills rapidly become obsolete, and that she must be a perpetual student if she is to maintain and deepen her clinical competence. The scope of the problem in keeping nurses up-to-date is enormous when one recognizes that the working life of a nurse is well over twenty years.

These are some of the problems that the staff of the Division are considering and on which we would like your reactions:

1. How can we use the experience we have gained in refresher programs for continuing education?
2. What kinds of continuing education are necessary for nurses in leadership positions?

Applications that are coming to us, suggest that nurses in administrative positions need additional help in human relations and in communicative skills; that nurses in supervisory positions (especially those in nursing homes and small hospitals) need assistance in planning programs for staff education; and that nurses engaged in teaching wish help in planning programs and curricula in associate degree programs.

3. How can Federal funds best be used for continuing education?

Over the years the Division has supported a number of short-term programs for which the need is evident. The classic example is short-term training courses in rehabilitation nursing. However the funds tied up in supporting programs, such as these, make it impossible to support new types of short-term training. Should the Federal role be to supply seed money to get new ideas underway leaving the sponsor to find other sources for continuing support?

4. How can the recently broadened project grant authority (under Title II of the Health Manpower Act of 1968) be used in conjunction with the Professional Nurse Traineeship Program, so that the project is supported through special project grants?

Examples of projects that could be supported are ones dealing with curriculum improvement, with experimentation, with new methods of teaching, and with new methods of utilizing nursing skills.

5. How can projects be developed in relation to statewide, or regional planning so that we can exert real impact on nursing services and nursing education?

The staff of the Division is thinking about these questions. We hope that those of you who are actively engaged in continuing education will think about them too, and that you will share with us your problems and your ideas.

REGIONAL MEDICAL PROGRAMS AND CONTINUING EDUCATION

Dr. Veronica Conley, Chief
Allied Health Section
Division of Regional Medical Programs

Well over a half century ago, Sir William Osler, one of medicine's great leaders, did much to establish the patterns within which continuing education for the health professions have developed. His recommendation of a quinquennial "brain-dusting" is, in essence, more imperative today than it was during his lifetime. Every fifth year, Osler suggested, the physician should, for a period of time, discontinue his practice "to return to the hospital and to the laboratory for renovation, rehabilitation, rejuvenation, reintergration, resuscitation, etc." Sir William was a dynamic man not adverse to repetition in order to emphasize a point. His suggestion raised understandable questions among his listeners such as "What of wife and babies, if one has them?" To this, Dr. Osler answered "Leave them!" "Heavy as are your responsibilities to those nearest and dearest, they are outweighed by your responsibilities to yourself, to the profession and to the public."

CONTINUING EDUCATION EMPHASIS

Regional Medical Programs since their authorization under P. L. 89-239, signed by President Lyndon B. Johnson in October 1965 with the specific intent of improving the nation's health resources for the diagnosis and treatment of heart disease, cancer, stroke, and related diseases, have been pursuing continuing education with much

the same fervor that characterized William Osler's lifetime practice of medicine. Using Sir William's term, RMPs have been engaged during the past few years in a "brain-dusting" of considerable magnitude among physicians, nurses, and other health related professionals. In the early planning phases of the programs, it became apparent for several reasons that continuing education activities would assume a prominent role. In the first place, such program-emphasis was consistent with a widely held view that the mandate to translate science into service could be accomplished effectively within the frame works of continuing education-- a route suggested in the legislation. Furthermore, coordinators readily discovered that such educational activities were not only much needed but also readily accepted by the health professions as an appropriate activity for regional medical programs. As the interest of the professions increased, continuing education proved to be an effective mechanism in developing cooperative arrangements, not only among physicians but also among nurses and, to a somewhat lesser extent, among the allied health professions.

DEFINITION AND CRITERIA

As more and more RMPs identified priority needs in the educational areas, it became obvious that, first, a definition of continuing education was needed, and second, a restatement was needed to define that fact that the primary educational intent of the legislation has been interpreted administratively as essential in the area of continuing education. Therefore, the following operational definition of continuing education was accepted: "Continuing Education is represented by those education endeavors which are above and beyond those normally considered appropriate for qualification or entrance into a health profession or an occupation in a health related field."

Furthermore, continuing education activities must not be designed principally to qualify one for a degree, diploma, or certification but should lead to: 1) the assumption of new responsibility in the already chosen career field; 2) the updating of knowledge and skills in the chosen career; 3) additional knowledge and skill in a different but basically related health field. These activities do not provide for career change.

In order to further assist the Regions in the setting of priority needs, the following criteria were adopted for determining those continuing education activities most suitable for funding:

1. The activity must be shown most suitable for funding.
2. Evidence should be presented to show that such activities do not already exist, or that they do not exist in sufficient numbers.
3. The goal of the continuing education activity must be to maintain or update knowledge and skill in order to improve the level of practice of the already qualified health professional.
4. The activity must relate to the categorical nature of the program and be part of a comprehensive plan to enhance regional capability in the care of patients with heart disease, cancer, stroke, and related diseases.
5. RMP funding is not to be used to replace existing sources of support for educational activities.

More recently, the Task Force on Continuing Education, which met during the National Allied Health Conference in Asilomar, California, in May 1969, made observations on the role of Regional Medical Programs in continuing education. This multi-professional Task Force made up

of representatives from RMPs administrative staffs cautioned that such programs must avoid duplication, fragmentation, competition with, or pre-emption of, existing continuing education activities. It suggested cooperative planning and co-sponsorship with on-going programs. It further observed that continuing education programs need to be defined, planned, and presented in the local communities using the existing resources and talent and that shared learning experiences among the many different types of health professions be facilitated when appropriate.

THE SURGEON GENERAL'S COMMITTEE

The eventual magnitude of RMP's involvement in continuing education, which appeared to be inevitable on the basis of the high degree of early interest, gave rise to concern over possible gaps, overlaps, and duplication within the Public Health Service. At that time, at least fifteen program components had available funds assigned to continuing education. In order to work toward a more efficient organization of these programs, an Ad Hoc Committee was appointed by the Surgeon General in March 1967. One of the early observations of the Committee was that "overlaps and duplications" within the system were more apparent than real. While the similarity of mandates to various programs and the descriptions of their activities in these areas would suggest that overlap and duplication were possible, the Committee was impressed with how little was actually occurring.

The final report of the Committee concerned itself with organizational relationships within the U. S. Public Health Service and with problems in continuing education similar to those cited in almost

every other major study. Its other recommendations included the need for more attention to the continuing education needs of the sub-professional health workers and to methods of encouraging greater participation in, and commitment to, the inter-disciplinary and multi-professional approaches to continuing education by educational institutions, organizations, and agencies.

CURRENT STATUS OF RMPs

There are at present fifty-five Regional Medical Programs covering the nation. Of these, all have had planning grants while forty-four programs are operational. The remainder are expected to achieve operational status within the next year. At least thirty-five RMPs have one or more Continuing Education Task Forces and a growing number of directors and coordinators for continuing education on the core staff. An overview of all RMPs reveals that the project emphasis continues to be in continuing education. Among the categorical areas, heart disease is receiving the greatest emphasis, nurses and physicians are the health professionals most involved. Table 1 shows that over fifty percent of all projects supported in the forty operational programs are in the area of continuing education. Another thirty-six percent can be added, if the "demonstrations of patient care" projects are included since the majority have educational components. Table 1 further shows the relative prominence of heart disease oriented projects as compared with the other categorical diseases.

(Table 1 follows)

TABLE 1

44 OPERATIONAL REGIONAL MEDICAL PROGRAMS
Distribution of Current Project Funding
by Categorical Disease and Activity
(Funds Available as of November 17, 1969)

<u>Primary Activity Emphasis</u>	<u>Projects</u>	<u>Total Funds incl. Indirect Costs (in thousands)</u>	<u>Percent of Total Project Funding</u>
Education and Training	292	\$24,517.9	52
Demonstration of Care	139	16,506.7	36
Research, Development, Planning Studies **	<u>59</u>	<u>5,335.5</u>	<u>12</u>
TOTAL (Projects)	490	\$46,360.1	100
Program Dir., Prof. Serv. Pl. and Coord.	---	<u>32,059.5</u>	
		\$78,419.6	
 <u>Categorical Disease</u>			
Heart	151	\$12,848.2	28
Cancer	75	5,498.3	12
Stroke	53	6,011.8	13
Related (kidney, diabetes, pulmonary*, etc.)	40	4,079.1	9
Multicategorical and general**	<u>171</u>	<u>17,922.7</u>	<u>38</u>
TOTAL (Projects)	490	\$46,360.1	100
Program Dir., Prof Serv. Pl. and Coord.	---	<u>32,059.5</u>	
		\$78,419.6	

*24 are respiratory, funded at about \$3.3 million; 13 cardiopulmonary resuscitation training are included in heart (\$700,000).

**Multicategorical refers to projects which mention heart, cancer, stroke and related diseases as a group (rehabilitation, multiphasic screening, public and patient education, prevention, etc.); general includes over-all program oriented feasibility studies, bio-engineering development, developing and testing communication systems, disease oriented program planning, etc.

DRMP Office of Health Data
Statistics and Analysis
November 28, 1969

Among the continuing education projects involving a single profession, expenditures for nurses and physicians in a total of forty-four operational programs approximate one another as illustrated in Table 2 and Graph 1. Fifteen percent of all continuing education funds (\$3,562,000) is expended on physician-oriented projects, and fifteen percent (\$3,553,400) support projects which involve the nursing profession only. Another \$8,132,200 is used to support projects involving more than one profession.

(Table 2 and Graph 1 follows)

TABLE 2

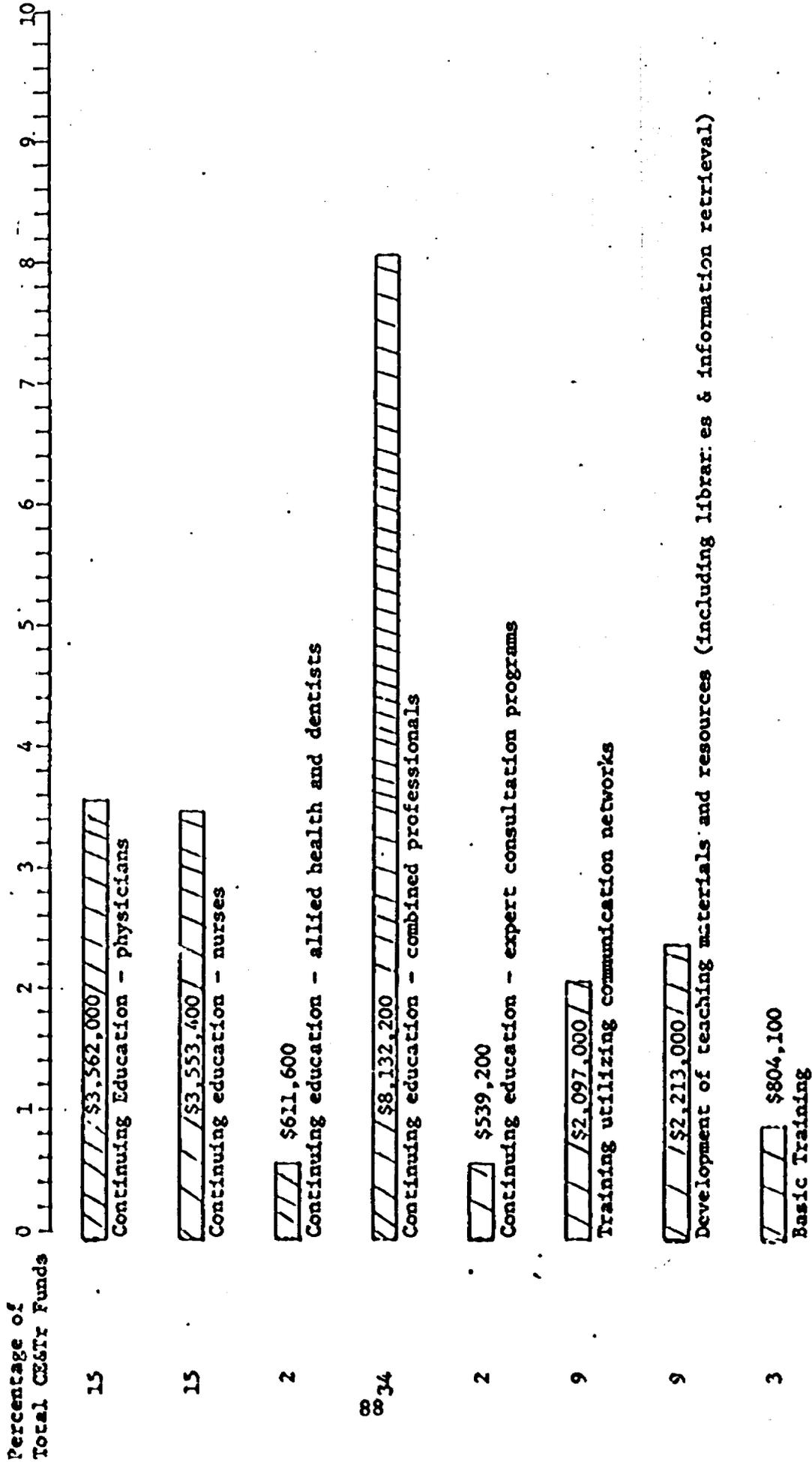
CONTINUING EDUCATION AND TRAINING OF PERSONNEL BY MAJOR ELEMENTS
 Total Costs of Operational Projects in 44 Operational RMPs as of 10/31/69

<u>Element</u>	<u>Direct Costs</u>	<u>% of Total CE & Tr. Funds</u>
<u>Continuing Education and Training</u>	<u>\$24,206,800</u>	<u>100</u>
Physicians	3,562,000	15
Nurses	3,553,400	15
Allied Health and Dentists	611,600	2
Combined Professionals	8,132,200	34
Expert Consultation Programs	539,200	2
Training Utilizing Communication Networks	2,097,000	9
Development of Teaching Materials and Resources (including) libraries and information retrieval)	2,213,000	9
Basic Training	804,100	3
Third Faculty and Directors of Medical Education	938,700	4
Patient and Public Education	502,900	2
Other	1,252,700	5

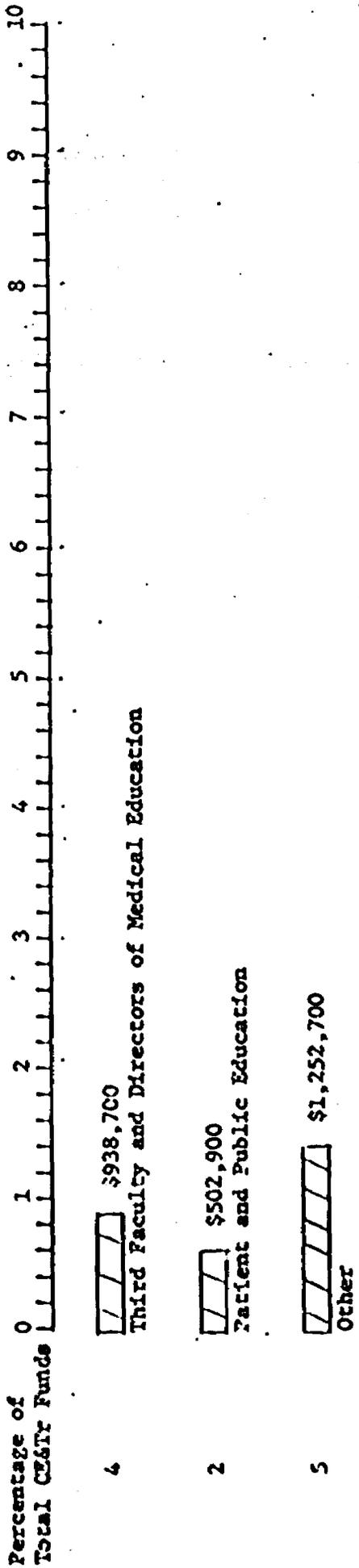
OP&E
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GRAPH I

CONTINUING EDUCATION AND TRAINING OF PERSONNEL BY MAJOR ELEMENTS
Total Costs of Operational Projects in 44 Operational RMPs as of 10/31/69



GRAPH I - continued
CONTINUING EDUCATION AND TRAINING OF PERSONNEL BY MAJOR ELEMENTS
Total Costs of Operational Projects in 44 Operational RMPs as of 10/31/69



OVERVIEW AND OBSERVATIONS

After almost five years of experience, several general observations on Regional Medical Programs and continuing education are appropriate:

RMPs have noted the "episodic" nature of much of continuing education and have made it possible for such educational activities to be truly continuing through funds for planning and for relatively prolonged support. The apparent lack of planning for long-range comprehensive programs may reflect the general paucity of funds for this dimension of education. Most professional organizations cannot support such programs themselves, and federal as well as private funds are generally not available for planning or prolonged support of continuing education activities.

RMPs have recognized the general lack of prepared teachers in the field of continuing education. The following comment by one of the country's leading medical educators may well be applied to all professions: "It seems to me that our greatest need in continuing education is for people who know more about education, who are interested in facilitation of learning rather than simply conveying new information. We must abandon the notion that because a man is well trained as a cardiologist, he is also qualified as an educator." In an attempt to provide more qualified teachers the Division of Regional Medical Programs has negotiated five contracts in as many university settings to increase the number of health professionals that may participate. These contracts support training for thirty-two students per academic year with the ultimate goal of courses of study which will lead to a Ph.D.

or Ed. D. degree, a Master's degree, one year of post doctoral study, and/or one year of additional training. These contracts also provide for workshops and for short and long-term training courses.

RMPs have been encouraging critical review of the relevance of continuing education programs to the practitioner's everyday patient-care needs. Since continuing education is not an end in itself, but rather a means to improved patient-care, the lack of continuity between knowledge and its utilization represents a serious deficiency. The following reminder of the need for continued surveillance of the relevancy of program to practice by no means applies only to medical continuing education. Referring to the failure of activities to relate the needs of patients, one leading educator stated: "If we stopped every post graduate course and every medical meeting in the country for one year, I do not believe there would be a lessening in the quality of patient-care. In fact, it might even improve because physicians might stay home doing the things they know they ought to be doing now rather than listening to others tell them about the thing they should do in the future."

(One approach to relating continuing education more directly with patient needs is seen in one metropolitan RMP which is supporting four planning workshops on stroke. Participants, drawn from thirty-five institutions, include physicians, nurses, occupational and physical therapists, speech pathologist, psychologists, and social workers. Out of these workshops, the RMP hopes to arrive at a plan that will maximally utilize all available facilities, manpower, and other resources thus providing better care for the stroke patient in the metropolitan area.)

RMPs are encouraging multi-professional activities wherever possible. Buttressed as they are by cooperative arrangements between all health professions, RMPs provide the ideal climate for experimentation in this area. A growing interest in multi-professional continuing education activities is becoming obvious. In the rural areas of one Region, physicians and nurses are trained together in intensive coronary-care courses. Nurses and dietitians attend the same course in another; while hospital administrators, nursing supervisors, and physicians join together for workshops in still another. The Cardio-pulmonary Resuscitation training projects include a wide variety of professions. Television, telelectures, two-way radio, and other communication projects may be directed toward different professions during any single presentation.

RMPs are attempting to provide educational opportunities for all levels of health workers - supportive personnel as well as professionals. Among the health professions, continuing education opportunities appear to be more numerous for physicians than for nurses and other allied health professions. By the same token within the latter professions, administrators, supervisors, and teachers have more opportunities for continuing education than practitioners. And, below the professional level, which includes vast numbers of health workers responsible for direct patient-care, the quest for continuing education opportunities is a constant and frustrating one.

COMPREHENSIVE HEALTH PLANNING

Ruth Spurrier, R.N., B.S., M.P.H.
Director of Nursing
Kentucky State Department of Health

Since most of our speakers today have been talking geographically, nationally, and regionally, perhaps it would be better if my discussion on Comprehensive Health Planning were limited to Kentucky.

To my best knowledge, we have very little money for continuing education that would come from Federal Sources. Our comprehensive health planning program in Kentucky was instituted about two years ago. The Governor appointed a Statewide Planning Council of fifty-one people, a majority of whom were consumers of health services. We were fortunate in having two nurses, five or six physicians, dentists, pharmacists, senators, mayors, and other professional people on this council. The State is now in the process of establishing fifteen regional councils. There is no money, I understand, at the present time to fund regional councils for personnel. Therefore the hiring of personnel for the regional councils is done gratis through Public Health Departments and various other agencies. A state staff is paid from the Governor's office. The authority, too, is with the Governor's office in our State. The Comprehensive Planning Commission is composed of the Governor, The Commissioner of Mental Health, the Commissioner of Public Health, The Commissioner of Finance, and an individual appointed by the Governor who is head of all Kentucky developmental activities.

Two years ago, the Kentucky Nurses' Association was directed by its membership to do a blueprint on nursing education. From this study, we developed recommendations for the future. Since there is no Master's program in nursing in the State, the establishment of such a program was number one priority. The Governor accepted the total report of the Nurses' Association and appointed an interdisciplinary task force that includes the Hospital Association, the Association of Licensed Practical Nurses, representatives of Vocational Education, the Kentucky Medical Association, and the Kentucky Nurses' Association. This interdisciplinary group also accepted the need for a Master's program as the highest priority in nursing education. So today a very important decision will be made: the State-wide Planning Council will be asked to support the establishment of a program for a Master's degree in Nursing at our University. If they go on record as supporting it, I believe the money will be forthcoming, and this program will be developed in the very near future.

In reviewing the steps outlined by the nursing committee and the task force, it was necessary first to develop and maintain open communications with allied professions. Statements were made, such as, "Why spend money on a Master's Program?" "All we need are nurses to take care of the ill." However, lay people in our small group, horrified at the reports of the level of nursing education in the State, decided to support our priorities and help to influence the recommendations of the allied health groups.

Another recommendation made by this group studying nursing was

in the area of continuing education. We have an excellent person whose objective is to get this moving this year in conjunction with the State Nurses' Association.

We have discussed the state council, now let's think about the fifteen regional areas of planning in the State. What is their relationship to the State Comprehensive Planning Council? I am sure you know about the Frontier Nursing Service, which has been training nurse mid-wives for more than thirty years in one of the regions. An additional nursing education program is now proposed in this region. It will be called, "The Family Nurse." Interested persons first started this program within their own county. From there it was presented to the regional council made up of eight counties. When accepted by the regional council it was approved by state council and the state contacts were made with Federal and State funding sources.

Another example of activity of regional councils is in relation to the development of Associate Degree programs in nursing. Many community colleges, universities, and church-related schools want to sponsor AD programs. The regional councils are helping to plan for and often discourage the development of Associate Degree programs where faculty and clinical resources are not available.

In general there are a variety of vested interests which could be discussed, with appropriate action recommended by the fifteen regional areas for comprehensive health planning in Kentucky. For example in continuing education the ETV programs could be better utilized. ETV stations are strategically located throughout our

State. We had one refresher course in nursing, and it was very well received.

Another developing idea in health programs is the "career ladder." Educators sometimes ask why we have two, three, four, and five year programs within a plan for continuity from one to another.

Nurses should be encouraged through regional planning to determine their own continuing education needs and to take part in the planning of their own professional development.

HOW WE DO IT--ONE PROGRAM'S FUNDING EXPERIENCES

Susanna Chase, R.N., Ed.D.
Director Continuing Education Program
School of Nursing
University of North Carolina, Chapel Hill

Introduction

Reconciling the lure of opportunistic short-range financing with the need for thoughtful long-range planning is the basic dilemma of my colleagues in Continuing Education that is shared by nursing everywhere to one extent or other. In fact, I suspect this phenomenon is rather widespread among our colleagues in Continuing Education for all the health professions, thus complicating our efforts toward coordinated program planning that zeros in on the most crucial educational needs.

From where I sit, as director of Continuing Education in the School of Nursing at University of North Carolina, it seems we try to conduct current projects, to follow up completed projects, to relate existing needs to the requirements of known sources of funds, to submit proposals for future projects, and so forth, in a never-ending concurrence of multiple activities. (I seldom sit--it is more like running on a treadmill.) You remember the experiment with the machine in the physiology laboratory that proves that you get nowhere except tired as resistances are increased. There never seems to be leisure time to identify the most important targets, to explore

new sources of funds, or to develop the sound basic policies that make a true program out of a collection of courses.

Most of our funding problems relate to this treadmill phenomenon, I think, and it may be helpful to take a look at a few specific examples. First, though, let me describe the way our continuing education office is organized and the way it relates to the rest of the University.

Organization and Personnel

The School of Nursing at University of North Carolina at Chapel Hill provides three programs, undergraduate, graduate, and continuing education; continuing education has been a program since 1964 and is considered an integral part of the School. We are fortunate to be located on a campus where we have a vice-chancellor for health sciences and where all components of the Division of Health Sciences are in close proximity. In addition to our School, there are Schools of Medicine, Dentistry, Pharmacy, and Public Health; The Health Sciences Library; the North Carolina Memorial Hospital; and such centers as the Health Services Research Center and the Carolina Population Center. We have all of this plus the intellectual resources of the entire University.

Each of the five schools features continuing education. We are all organized somewhat differently, but we talk with each other. In July, a new Office of Continuing Education in Health Sciences was established on our campus to help coordinate continuing educational efforts. Hopefully some of the problems of financial strategy can be aired in this new forum.

The program in the School of Nursing is staffed by three full-time professionals and one secretary. In addition we have part-time professional teaching services from two nurses who relate to us via the Regional Medical Program. That's the basic staff at the moment, but we do make use of special ad hoc instructional staff and, of course, future grant awards will generate additional personnel. Our Dean is interested in continuing education, and we have great moral support as well as administrative support from her office. I would say our most annoying personnel problem is in the area of clerical services--for instance, simple typing jobs too often create delays in projects that represent a considerable investment of professional time.

The professional staff and I hold faculty appointments in the School of Nursing and have various responsibilities in this connection, such as serving on committees, some teaching, and the like. We also are involved in other activities not directly related to the planning and management of our continuing education offerings. For example, I accept occasional speaking engagements. I'm involved in decisions at School of Nursing and Division of Health Sciences level. Recently, I spent a great deal of time establishing a "standard charge" for program offerings. I have several routine reports to complete, such as the one to our new central Office of Continuing Education in Health Sciences. As a result, I don't spend nearly enough time talking with people throughout the state--enough, though, to identify many different perceived needs that we don't have a chance to explore properly and consider in our program planning.

This brings me back to my treadmill phenomenon. Perceived needs are only in the back of our minds as we conduct current offerings and make decisions about grant proposals and rush to meet submittal deadlines, when they (the perceived needs) should be in the forefront. Ideally, they should be the starting points. My Puritan conscience is troubled that too often we don't ask the question, "Would consulting do the job better than a workshop?" Or, "Could someone else do the job more effectively than we can?" Proper evaluation is another thing that is buried under the treadmill. It is not that we are not doing a good job, because I think we are. It is that I yearn to do so much better.

Projects and Problems

Our current continuing education offerings in nursing at University of North Carolina are each somewhat different, one from the other, in character and operational detail. Subject matter covers public health nursing, pediatric nursing and clinical nursing, and ambulatory patients. There is an offering for directors of nursing services, one for faculty in diploma nursing schools, and one for supervisors of cardiac units. These six are funded only for the current year. Five are supported with federal funds, one of which involved a matching component (which we handle in a rather involved but creative way). Only one current offering is privately supported via the tuition route. The only other private sources are somewhat indirect; e.g., we have some private scholarship funds. There is very limited state support. Now, I think there are four basic funding problems illustrated here, and I would like to say a word about each of them.

1. Disproportionate Federal Dependence

There is strength in a diversity of income sources--this is certainly a sound financial principle that we are not following. I am hardly going to complain about the wonders which federal financing has made possible--in fact, I scream as loudly as any of us in protest against cutbacks and in support of new and expanded federal programs. And I'm not complaining about the federal leadership that encourages us to apply for grants in a given area of national need. What bothers me is that there is no opportunity to explore and develop other sources of income to the extent that we should. We are not truly fulfilling the intent of much federal seed money, for too often we are not able to support a repeat offering, seizing instead the opportunity for another new federally supported one-shot deal.

2. Lack of Long-Term Security

If a continuing education program is to be a continuing program, there must be a secure financial base. Our program does not have this security. All our support is short-term, and we are in a continual scurry to find more support. Perhaps this situation is the principal reason for my treadmill. Certainly I'm confident that relief from this pressure would enable us to get moving with the kind of planning and evaluation that our continuing education activities in nursing at University of North Carolina need in order to develop into a true program with a solid base of educational philosophy. I wonder how many of my colleagues elsewhere are confronted with the problems of

haphazard short-term financial support, and I hope we can talk about it in the workshops this afternoon. We can learn from each other.

3. Lack of State Support

Although we are a state university, the continuing education activities in the School of Nursing are not supported by state funds. We are self-supporting--in a sense we have to finance our own salaries. There is, I believe, considerable evidence of our contributions to the university on which to justify some support from this source. Here again my crazy treadmill is going too fast for us to get off long enough to study this evidence and organize it in a meaningful form. There are no doubts many other sources of state support besides the university, for example, the state health department, and I would very much like to explore these possibilities.

4. Limited Private Support

Great untapped resources no doubt exist, but we have not begun to explore the possibilities for private support from individual donations, foundations, associations, and industry. At this time we have only indirect support from private sources, such as the scholarship funds I mentioned. As for our personal entrepreneurship in selling services and materials, we have done very little except through charging tuition--but with this we have had great success. I'd like to tell you in some detail about one of our experiences, because I think it illustrates some sound principles and some unexpected aspects that are suggestive for future financial planning.

Out of these problems, we have had one innovative success!

A Success Story

Last March several of us formed an informal unaffiliated seminar. To be exact, six of us, five of whom are consultants in agencies serving nurses and hospitals in the state, began meeting once a month just to keep each other informed. We discuss what we see as being needed, we weigh pros and cons of program changes we are making. This group was instrumental in our "success story." I can't thank our consultants' seminar enough for the help it has given this one continuing education effort.

The idea arose in the informal seminar. Then I consulted with our continuing education THINK committee and several others. Then we took the leap. We engaged an ad hoc professor and teaching staff, we planned the course, we had brochures printed, we mailed, the North Carolina Hospital Association mailed, the Consultant group encouraged and recruited, and the course, "Director of Nursing Service--Her Role in Management," was launched. Three experiments were going on simultaneously within this one course: (1) cooperation with other agencies--the North Carolina Hospital Association, the North Carolina Regional Medical Program, and a community college; (2) offering a course away from Chapel Hill--taking it closer to some of the participants; and (3) asking the student to be completely financially self-supporting--tuition and stipend.

A month before the first session I had to decide--do we or don't we go ahead? Inquiries had been coming in; only 28 nurses had mailed checks. The Hospital Association, more than the School of Nursing, received pleas for financial help to assist participants in meeting the expenses. I had calculated that we had to have an

enrollment of 35 in order to meet the expenses of offering the course (which includes maintaining our Program). We had only 28. The visiting professor had agreed to finalize our contract a month before the course started. On the slim 28 checks received and the ability of the seminar consultants to identify nurses they knew intended to enroll, I said, "Yes, we will go ahead." In the mail, later that day, two more checks arrived.

The outcome was that by the starting date of the course, 42 applications had been received. The last two were not accepted--the faculty was not prepared to handle more than 40 students. Thirty-eight arrived at the workshop. The students' motivation was entirely different than any we had ever experienced. We had no students who had been "sent" by the hospital administrator; they all "came" each for her own individual reasons. At the end of the week, an enthusiastic group of tired students went home; plans for interim projects were beginning to take shape. The faculty of four was exhausted.

Without realizing we were doing it, we took the course to a town with little distracting activity, consequently, the participants and the faculty were forced to interact with one another. It turned into a most intensive course. The second session will be held in the spring, in the same town, at student request. We send a monthly mailing to each participant during this interim.

The community college helped us with publicity, library, and visual-aid hardware. The Hospital Association helped with recruitment and supplied one faculty member. The Regional Medical Program also provided one faculty member and helped in recruitment. The consultants' seminar recruited students. My Continuing Education

Program provided two faculty members, including the visiting professor, and handled all the administrative aspects of the course.

Thus, we learned a great deal about cooperation in developing and conducting a course and about the geographic location for this kind of activity. But what impressed me most is what we learned about student motivation and willingness to pay. Most of the participants met their expenses with only partial help from their employers. At least one student paid all her living expenses as well as her tuition out of her own pocket. As I mentioned earlier, the School of Nursing has been given some private scholarship money. The uniqueness of the gift is that students from all three of our Programs are to be included in the scholarships. With this help now available to Continuing Education for a few of the students, we are proceeding with plans to offer the course again this spring for a new group of participants; our faculty planning committee was held just this past week.

We will continue with the innovations that were of value, and we plan to offer this course once each year for the present, but continually evaluating and making changes as they are indicated.

We are convinced that the motivation we have tapped must continue to be tapped. Involving other agencies, although a known principle, was a new and rewarding experience for us. And our own respect for ourselves has changed now that we see we are worth money! It is money that talks, you know.

Conclusions

As I think about our problems and our successes at the University of North Carolina, it seems clear we are making progress in defying

the treadmill. We have accepted the challenge of how to convert the treadmill into a caterpillar road machine, with a continuous track that digs into the hard dirt, instead of an exercise treadmill, where the effort is in making the track move but the exercisor does not get ahead.

To make this conversion, our approach is, first, identify needs for programs; second, find a strong diversity of funding sources (including the participants as one potential). When one is threatened by the dollar sign, it is necessary to seek psychological support, and for this our program has the School of Nursing, the Division of Health Sciences, and the THINK Committee. With these supports, we are beginning to bulldoze the treadmill; we are digging into the dirt with the road machine. The many other supporting groups give us ideas for financial help that our own anxiety prohibits us from seeing. Then we take chances. (We call them calculated risks.)

Our goal is to build a cohesive program with a solid philosophical and financial base. We will seek grant support for identifiable projects within this continuing education program, making a concentrated effort for project support that will be more than a year at a time. Ultimately we hope to have income that is before the fact of enrollment in a course, rather than after it. The sources of such support are still unclear, but I am confident they can be developed, because we have our road machine headed in the right direction. Writing this paper, has given me a new perspective on our funding programs, and I hope that sharing these thoughts may be helpful to you, my colleagues, in Continuing Education for nursing.

HOW ONE CONTINUING EDUCATION PROGRAM DEVELOPED

Elda Popiel, R.N., B.S., M.S.N.
Professor and Assistant Dean
Continuing Education
School of Nursing
University of Colorado

The Program Planners of this conference have asked me to talk about how the Continuing Education Program at the University of Colorado School of Nursing was developed. My first reaction to this question is to say, "It grew, just like Topsy." This reaction, of course, is facetious and superficial as well as untrue. Many hours of "blood, sweat and tears" went into the development of the program and numerous persons were involved in the development.

But it seems to me that the most important aspect in the development of a continuing education program is firm, solid and continuing support from the administration of the health agency involved. In our case, this agency was the School of Nursing. When I say firm, solid and continuing support, I mean financial support as well as a belief in and a responsibility for the concept of continuing education. A University School of Nursing must see continuing education as one of its prime responsibilities to its graduates and to its community. There must be hard monies involved in this support. For instance, at the University of Colorado the salaries of the person responsible for continuing education, two other staff members, and a secretary all come from the School of

Nursing budget as well as all office space, equipment, and physical facilities necessary to house the operation.

The continuing education staff at Colorado University insists that not everyone could be a director of a continuing education program and perhaps they are right. I do know that a continuing education director must be able to live with and tolerate ambiguity as well as have the ability to think about and to do two or three things all at the same time. Being a director of continuing education requires an acceptance of constant change, constant variety, constant accuracy, rapidity of thought and action, efficiency, delegation, and, above all, organizational ability. This job also requires the director to be an arbiter in dealings with the varied views and ways of persons with whom one must work to carry out a successful program. Above all, one must have faith that once you have written the grant proposal to the best of your ability and have chosen your program planners and your resource persons well, the money and the people involved will come through, and a successful program will be the result.

To explain how the continuing education program at the University of Colorado School of Nursing developed, I would like to divide the rest of the presentation into six areas. Then I would be glad to answer other questions if time permits.

1. Introduction and Background
2. Assessment of Education Needs and Setting Priorities
3. Establishment of Philosophy and Objectives
4. Evaluation

5. Selection Faculty, Program Planning Group, and Resource Persons
6. Summary (Points on how to develop)

I. Introduction and Background

Although the present program of continuing education in nursing began in 1957, this program has roots reaching back to 1941 and 1942 when the University of Colorado School of Nursing became an autonomous school. In 1943, from one to two extension courses were offered to practicing nurses each semester, either in the Metropolitan Denver area or in an outlying area. Two or three summer workshops of one or two weeks were presented by interested faculty members. It was not until the middle nineteen fifties that a faculty member was designated as the person responsible for all continuing education programs.

In 1957, the Continuation Education Seminar of the Western Council on Higher Education for Nurses (Branch of WICHE) was founded. It was here that many of us in the West, who now are responsible for continuing education programs, received most of our initial experience in designing, implementing and administering continuing education programs in nursing. From 1957 to 1960, I participated in the WCHEN pilot project in continuing education for nurses. This project was financed by the W. K. Kellogg Foundation and was designed for nurses in leadership positions.

In 1960, federal funds for short-term nursing education became available through the Division of Nursing Bureau of Health-Manpower, United States Public Health Service, Washington, D. C. The funds made an expanded continuing education program possible through WCHEN (a

component of the Western Interstate Commission on Higher Education).¹ These federal funds also made it possible for each University School of Nursing to write grant proposals and request funds for various continuing education programs. Our first solo ventures were a three-week course on "Rehabilitative Nursing Care," and another on "Designing, Implementing, and Improving In-Service Programs in Health Agencies."

Some of our programs at the University are broad in nature, while others are narrowly focused on a specific concept or specialty in nursing. (Such as our core program which focuses on crisis nursing). Programs vary from one or two days to four weeks in length; some provide a continuing experience for the same participants for a period of a year or more. Some of the planned programs are for specific geographic areas, and the conference is held in that area.

II. Assessment of Educational Needs

One of the first tasks of a continuing education staff and its advisory committee is the assessment of the educational needs of practicing nurses.

As a director of continuing education one needs to realize the importance of early recognition of changes in science, technology, legislation, research, economics, and public demands which will affect what nurses need to know to give effective and comprehensive patient care.

In 1957, I was completing my course requirements for a Master's in Nursing with emphasis on Nursing Administration and a minor in

¹ Rita Darragh, et al Continuing Education in Nursing (To be published by WICHE, Boulder, Colorado, 1970).

education. Because of my appointment as a teaching fellow in the continuing education programs at the University of Colorado School of Nursing, I was allowed to explore the continuing education needs of the nurses working in hospitals in Colorado for my thesis requirement. From this study the Continuing Education Staff and our advisory committee (staff at that time in 1959 consisted of myself as director 60 per cent of the time, one half-time assistant, and a clerk typist) were able to document some very specific educational needs of practicing nurses in Colorado. These needs covered areas such as, communication skills (verbal and non-verbal), interpersonal relationships, specific nursing skills, ability to work with groups, personnel evaluation, problem solving, counseling and interviewing, knowledge of community resources, and how to be an effective change agent.² The continuing education staff, the advisory committee and representative members of the School of Nursing developed our priorities for continuing education programs from the survey, and from our own knowledge about nurses practicing in Colorado, from patients' needs and demands, and from developing patterns of care. Today another consideration in priority assessment is necessary and that is where the federal agencies are putting their emphasis in regard to continuing education.

I have mentioned the advisory committee above, so perhaps it would be wise to stop here and explain its purpose and functions.

The purpose of the Advisory Committee is:

1. To provide information about the kinds of programs that need to be developed.
2. To poll and assess needs of nurses for continuing education.

² Elda S. Popiel, An Investigation of Hospital Nursing Service Administration, (Unpublished thesis, University of Colorado, 1959).

3. To determine what learning experiences are needed to assist nurses to improve their practice.
4. To report on programs in progress; to offer suggestions.
5. To serve as liaison between the University of Colorado School of Nursing and the groups represented by members of the advisory committee.
6. To assist in establishing program priorities.

Requests from district nurses' associations, the Colorado State Department of Public Health, the State Board of Nursing, other health organizations, and consultation visits to health agencies are all means of assessing the continuing education needs of nurses in our area.

In 1963, the Colorado League for Nursing conducted a survey of the nursing needs of Colorado. The publication is entitled "Toward Statewide Planning for the Education of Nursing Practitioners in Colorado." This survey was utilized by the Continuation Education Services as another means of assessing the continuing education needs of nurses.

The Director of Continuing Education is one of the representatives to the Western Council for Higher Education in Nursing. The Council meets twice a year providing another opportunity to assess the continuing education needs of nurses. The WCHEN survey of the nursing needs of the West is another important resource in the assessment of continuing education needs of nurses.

The continuing education staff plans the overall program one year in advance and attempts to leave the program flexible enough to add or delete programs as changes, demands, and finances dictate.

Planning Committee For Each Group

A planning committee is selected for each separate workshop or intensive course. The professionals or health personnel in each planning group are selected on the basis of their particular area of competence, knowledge, or interest. These people supplement the resources for program planning and serve as conference leaders and small group leaders. In effect, the planning group becomes the staff or faculty for a particular workshop. Each planning group meets as many times as necessary to assist the continuing education staff to plan the content of the workshop, to select resource persons, and to contact clinical areas to be used.

The planning group assist the staff of the Continuation Education Services in setting up the criteria for the selection of participants. Final selection about the content and the methods of instruction of every course are the responsibility of the University of Colorado Continuing Education Services faculty.

We send questionnaires to the selected participants and ask such questions as:

1. Where do you feel you need the most assistance in your particular nursing area?
2. In what area of your nursing job do you feel most uncomfortable?
3. In what area of your nursing job do you feel most comfortable?
4. What problems do you anticipate in doing your nursing job?
5. What area of nursing care would you like to have covered in the workshop for which you have been accepted?

We also ask the nursing employers of our accepted participants such questions as:

1. What new knowledge do you feel this nurse needs to improve the quality of her nursing care?
2. In what areas does this nurse need to improve?
3. What do these nurses want to learn?
4. What new trends in this field of nursing should be brought to the attention of these nurses?
5. What should be reviewed?

The content of each workshop is designed by the workshop's planning committee with the expressed needs of the participants in mind.

III. Establishment of Philosophy and Objectives

In 1959, with the assistance of the Advisory Committee, the staff decided that we must define what we meant by Continuing Education and what we believed about continued education on the University level.

What Is Continuing Education

Continuing Education extends the instructional opportunities within a university to individuals not enrolled in a formal educational program. It is an organized effort in which the element of chance in learning is reduced by means of systematic learning, and it generally involves the active participation of the learner instead of passive listening, viewing, or random reading. Continuing education in nursing requires nurses to learn new content and skills as well as to review and to add to knowledge already gained, to investigate new approaches to attitude changes and to nursing care, and to strengthen their abilities in professional nursing. It is also the purposeful presentation of new ideas or new knowledge for the continuing education of nurses, and it fosters an exchange relationship between the institution and the participant.

The present philosophy has not changed perceptibly from the one written in 1959 because any philosophy for a program or department must conform to the overall philosophy of its parent organization. Our objectives, however, have changed and will continue to change as we look at our participants and their everchanging educational backgrounds. All the aspects of present day life, the health system which influence our programs, and the patients and their families with whom our participants work will influence our objectives.

The continuing education staff retreats for a week-end in the mountains each year to contemplate, revise, and change (if necessary) our overall philosophy and objectives.

From these core objectives we develop and project our future courses, conferences, and workshops.

Intensive courses, institutes, seminars, and workshops at the University of Colorado School of Nursing are designed to provide learning experiences that motivate the nurse to gain new knowledge; to prepare for and use new resources; to solve problems in on-the-job situations by utilizing new insights and knowledge; to plan and carry out projects; to evaluate interpersonal relationships; to evaluate the quality of nursing care given to patients; to redefine roles and adapt to the changing situations and forces that affect the practice of nursing; and to become an agent for change.

As a staff, we try to spend one day a month together to just discuss where we are, where we are going, how we see our jobs, and how we see ourselves supporting the working with one another.

IV. Evaluation (or Re-Diagnosis as Malcolm Knowles has called it)

In looking over our core objectives you will see that evaluation of each course and evaluation of the effectiveness of our overall program is of deep concern to us. It will continue to be of deep concern to us because the magnitude and complexity of measuring change of behavior in our participants and improvement of the nursing care of people through the initiation of change by these participants is a problem which must have further study.

We have various evaluation methods such as diaries, process recordings, tapes, reaction sheets, participant satisfaction ratings, and personnel relations surveys. Firo-B, pre- and post tests of knowledge, skills and attitudes, and specific ratings of achievement of course objectives by the participants. Six months or one year post-evaluations are also used.

Many of our programs have a consultation service as a part of the program. The on-the-job consultant to the participant does an evaluatum of the progress of the participant at the time of the consultation visit through interviews with employees, observations, etc.

Often a course will have a two or three session design with an interim project or back home assignment for the participant between the sessions. A written report of these interim projects or back-home assignments must be sent to the program director, or brought to the next session by the participant for a critique and becomes one more avenue of evaluation for the staff.

Seven years ago the WCHEN continuing education seminar members undertook an ambitious research program. From 1962 to 1964, the

members of the seminar were engaged in a regional research project which has been reported in the WICHE publication, The Effectiveness of a Leadership Program in Nursing. The major aim of the research was to investigate the effectiveness of the continuing education leadership program designed to improve the skills of nurses in administration, supervision and teaching.³ Although the research staff found the measurement of behavioral change in quantitative terms to be extremely difficult, the research project was valuable as an exploratory step, and we still use many of the evaluation tools we developed for this project.

Through these evaluations, we have found that changes are made, some challenges are met, some nurses or group of nurses are stimulated to gaze into the future, to see the handwriting on the wall and design, innovate or create ways of nursing care, of inservice, and then to make the necessary adjustments of knowledge, skill, and attitudes before the crisis is upon us. So instead of having to do a bootstrap or mop-up operation, nursing is ready for the next forward step.

V. SELECTION OF FACULTY, PROGRAM PLANNING GROUPS AND RESOURCE PERSONS

As I have indicated before we began on a small scale with each faculty member having other responsibilities than continuing education. But because of hard money support we had from the School of Nursing, WCHEN experience as well as money from WICHE, and the federal funds which became available we began to grow

³ Alice E. Ingmire, et al, Abstract of the Effectiveness of a Leadership Program in Nursing, (Western Interstate Commission For Higher Education: Boulder, Colorado 1967) p. 3.

from nine courses in 1959 to 54 courses in 1969, with the present faculty and staff as it is depicted on the organizational chart you have in your hands.⁴ (Explanation of chart)

A. Faculty

In selecting faculty it is important to look for nurses who have had some teaching experience but are willing to experiment with new teaching methods and new designs. They must be willing to understand and utilize what we already know about how adults learn and be willing to leave their programs unstructured enough that the needs of the participants are met. These faculty members must be able to work with all kinds of participants as well as diversified community groups.

When it is possible to have a faculty the size of the one at Colorado University, it is important to have as many different specialties in nursing represented as possible, as they complement one another and give assistance and support to all programs.

B. Program Planning Groups

The faculty member designated as conference leader or coordinator of a specific offering selects the persons she wishes to assist her in developing the objectives for the course--selection of content and plans for the course. The resource persons and members of the program planning groups are asked to be members of the committee because of the expertise they bring as well as being representatives of agencies or institutions who would be interested in sending participants to the continuing education program. During the sessions of the course,

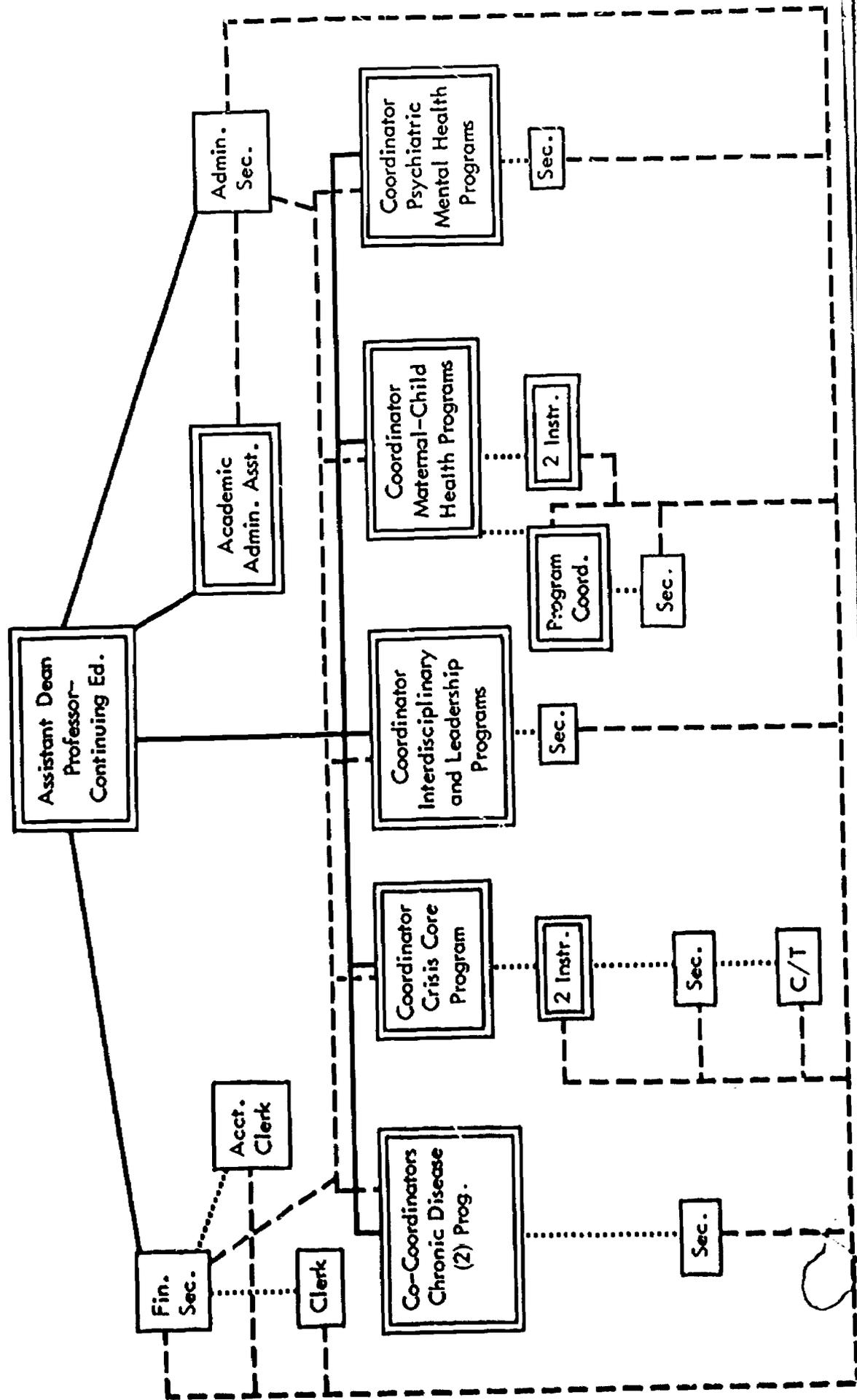
⁴ See attached chart for explanation.

..... COORDINATION



———— DIRECT RESPONSIBILITY

--- SUPERVISION AND DIRECTION OF SECRETARIES AND CONSULTANT TO COORDINATORS REGARDING OFFICE PROCEDURES



many, and occasionally all, of the program planning members will be the staff concerned with the implementation of the course.

We have found that an orientation of the planning committee is essential to insure the effectiveness of their participation in the implementation of a course.

One of the purposes of this orientation should be to reach a mutual understanding of the philosophy, objectives, and mechanics of the program and the role and functions of each committee member.

C. Resource Persons

In selecting resource persons, the conference coordinator or the Director of Continuing Education makes the final decision. The program planning group, prospective participants, and the advisory group may offer suggestions and assist in procuring resource persons, but the final decision must rest within the faculty of the continuing education department. The type of offering usually determines the disciplines from which the resource persons are drawn. Such things as size of budget, the capabilities of the persons selected, and whether or not they relate well to the adult learner will assist in making a choice of the resource person.

Participants as resource persons are vital to the success of any offering. They bring experiences and knowledge of vast magnitude which must be utilized and shared. Their ideas, suggestions, and comments promote a flexibility, adaptability, and vitality to the programs which could not be secured in any other way.

Summary

This was how one continuing education program was developed. No two programs can be developed in the same way. Some of the things that have worked for us will not work for you. The personalities, strengths, and weaknesses of the individual involved, the geographic area, the attitude and education of the population that will be the participants, the financial and administrative support, will all influence how the program develops.

But there are some steps that must always be taken in one way or another:

1. Stable financial as well as verbal and moral support from the administration of the agency involved.
2. Thorough and sound assessment of the educational needs of practicing nurse, their patients, and the catchment area to be served, and an establishment of priorities of course offerings.
3. Broad representation of health specialists on the faculty.
4. A knowledgeable and efficient secretarial staff.
5. Philosophy and objectives which reflect the purposes of the agency involved as well as your belief about continuing education and your own responsibilities. The development of behavioral objectives for each offering, and these objectives must be measurable and denote the behavior you expect in the participant after the course.
6. Well-planned and organized course content which meets the objectives, the needs of the participants and is kept flexible. Each course must contain three elements knowledge increase, teaching of new skills or improving present skills and attitudinal changes.
7. Willingness to experiment and use new and untried teaching methods, especially those methods which will get the participants involved in their own learning and the evaluation of their own growth.
8. Evaluation of program effectiveness and participant growth.

9. Continuing educators teach two kinds of information, new and review, and they teach these in the most effective way possible involving the trainees to the maximum degree.

The capable educator in continuing education programs recognizes the time and the place to use both directed and delegated learning. They build their programs to take full advantage of both modes of instruction. Anything but lecture participation involves personal commitment on the part of the educator and the learner. The major problem in learning is to achieve real communication. Tune in to the learner. We can only offer the opportunity to learn and provide a learning climate. It is the participant who learns.

George Bernard Shaw once said:

"Life is no brief candle to me. It is a sort of splendid torch which I have hold of for the moment and I want to make it burn as brightly as possible before handing it on to future generations."

This is my hope for continuing education in nursing. That we, the nurses working in continuing education today, will be proud of the continuing education torch we hand to the nurses of tomorrow.



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COMMUNICATIONS IN THE FUTURE

James Lieberman, D.V.M., M.P.H.
Director
National Medical Audiovisual Center
National Library of Medicine
Department of Health, Education, and Welfare
Public Health Service
Atlanta, Georgia

In these closing years of the 20th Century, emphasis will be on the delivery of health care--with new and different thrusts in every direction. The population has a right to expect to benefit from scientific advancement. Already we have all the problems, as predicted, from a quantum jump in population to an increased tempo in living.

It is against this backdrop that we look at the future in communications for retooling our minds.

A modern-day philosopher recently said to the students in his classroom, "Just remember this--tomorrow is the first day of the rest of your life." His point is an excellent one for all of us, but it is particularly apropos for a discussion today of communications in the future. Actually, where communications are concerned, we can go him one better--today is the first day of the rest of our lives. Because we have available to us at this moment enough communications equipment to keep us informed for the rest of our lives if we will find ways to apply it successfully.

Nowhere is the need to apply it more apparent than in the field of continuing education for the health professions. To your credit,

the nursing profession in this country has probably done more, with less, and for a longer period of time than any of the others in biomedicine to keep education a constant and continuing facet of their professional lives. However, even with such a record to be proud of, there is much to be done before nursing can rest on its laurels in the area of communication and continuing education.

Since you are at least a step ahead of almost everyone else, I can assume that most of you are familiar with the many systems in use today: television, open and closed circuit; motion pictures, 16 mm and cassette-packaged 8 mm motion pictures; slide series with and without audiotapes to accompany them; filmstrips projected vertically and horizontally, depending upon the type of equipment in use.

These are audiovisual teaching systems available now--but a whole truckload of them, threaded with film and plugged into the wall won't, by themselves, provide the education necessary to see us through tomorrow. The patterns we develop for their use are the important part of the educational future for audiovisuals.

A primary principle of working with communications media is that the tool must be designed specifically for the job at hand, and it must be used with skill if optimal results are to be achieved.

What is the job you want to do with audiovisuals in continuing education? This must be defined in all its ramifications before a solution can be sought. Specific pieces of audiovisual hardware should not be bought until the job has been defined, yet often sizeable funds have been spent for equipment that lies idle because either it was unsuited to the task, or there was no software available for use thereon.

When choosing a medium for continuing education, or a combination of media, the requirements of the individual situation must be clearly defined. The task should be identified for which the tool will be used and the conditions under which it will be used.

The problems are varied as indicated by reactions from many health professionals. The harried research specialist says, "By the time the students know enough about anatomy to understand what the school hired me to teach, they have graduated."

Or a professor adds, "I spend all my time answering questions like, "What's a tibia?"

The representative of a national organization has said, "For continuing education to reach our members, we must reach them where they are. Perhaps putting TV on golf carts would be the answer."

The instructor, hide-bound by tradition: "I believe in lectures and note-taking--if my students didn't spend their time in taking notes, there'd be no reason for their coming to class."

The administrator has his own special worries. "Why waste money on 8 mm projectors now, when next year there'll be other machines at half the price?"

Faculty members, from lack of experience or from fear, may see their roles distorted. "I would enjoy teaching, if it weren't for the students," said one.

Or, "I'm against audiovisuals because they're canned and anything that is canned loses the living experience!"

"The trouble with putting my presentation on videotapes is that I have to plan it in advance."

The quotations above are important because they represent real problems and concerns among the professionals. I am not surprised at resistance toward using audiovisuals, for in attempting to use those we have today, many instructors have met with justifiable frustration.

Four major factors contribute to the use or disuse of audiovisuals. First, audiovisuals will not be used unless their use is easy. The instructor has neither the time nor inclination to set up complicated audiovisual equipment, nor does he want the embarrassment of mechanical failure.

Let me illustrate a situation I encountered personally, one which I hope is not too closely familiar to you. The place: one of the leading professional schools in the United States. The occasion: a presentation to faculty and graduate students on the value of using audiovisual media. Prior to my arrival, I had been assured that both a projectionist and an excellent sound-motion picture projector would be provided. Upon arrival, I found the following: The person who made the commitment had left the country. The "projectionist" was a graduate student who had threaded the projector only twice before and had never threaded it for sound. I asked to borrow an overhead projector and was brought an opaque projector. I asked if the room had a public address system and was told "no". However, observing a microphone on the speaker's stand I followed the cord, which had been painted when the wall was painted years previously, to an amplifier, which I turned on. I asked to borrow a projection stand. When one arrived, on it was a dusty but new overhead projector with the operating instructions still sealed in an envelope. The light on the lectern wouldn't light. A quick check showed that the cord was

unplugged. As I inserted the plug into an outlet, I received a 115-volt shock! Was this a typical situation? Let us hope not. Yet, many of you may have had similar experiences.

Any nursing organization which wants its personnel to use audiovisuals should plan to provide a person--other than the instructor--who is responsible for the maintenance and handling of audiovisual equipment. If audiovisuals are to be used, their use must be easy; otherwise, they will gather dust.

In addition to ease of operation, the learning environment is important to whether audiovisuals are used. Learning spaces should be designed for learning; yet how often this is not the case.

At one school visited recently, there was no air conditioning. During warm weather, which was most of the year, one had a choice, while projecting audiovisuals of either a brightly lighted, hot classroom with open windows or an unbearably hot classroom with blinds drawn.

In another location, used for Continuing Education, there was the added dimension of noise both from an expressway and from huge exhaust fans in several of the windows.

One group meets for study before 7 a.m. by popular demand.

Additionally, a liberal assortment of pillars within any classroom or meeting place, though guaranteeing the stability of the roof, obstructs the view. Other schools may have other problems.

In another location, a lecture room is 25 feet wide by 125 feet long, with the floor tiered at an angle of approximately 45 degrees. I was advised, "Don't look at students beyond the first five

rows or you'll get a stiff neck." This room is affectionately called "The Pit," and the local story is that observers in the last ten rows suffer from epistaxis.

Unique? Not at all. In at least two other site visits where we were helping to prepare for the use of audiovisuals, there are similarly long, narrow classrooms but with level floors, giving a tunnel effect. In one, in order to see the instructor, the students rely solely on TV monitors.

In the other, the instructor stands near one of the side walls, with students seated in semi-elliptical fashion facing him. Those in the end seats can neither read the blackboard, nor see projected materials. And in one hospital, we found study carrels in an open corridor directly opposite a bank of elevators.

To some degree, many hospitals and schools--even the most modern--have similar problems. And the point remains: whether audiovisuals are used for undergraduate instruction or for continuing education, the environment in which these audiovisuals are used must be tailored to the use of such teaching media. Too often, and ridiculously, people must adapt to the physical environment rather than adapting the bricks and mortar to the needs of the people.

If audiovisuals are to be used as tools in any continuing education program for nurses, they must be available when and where they are needed.

This means easy accessibility and easy reference. Any plan for action should take into account the problem of locating what has already been done and is being done, both locally and nationally, and selecting those delivery systems which will make this material

available to the user with the least possible effort, perhaps through the local medical center library, medical school library, or hospital library.

Catalogs are one means of making accessible information about audiovisual material that is available. At the simplest level, there is a need for catalogs of material available within an individual school or medical complex. Learning of such materials is not an easy task. Instructors have slides tucked away in desks. These slides are often excellent, but unidentified. Many are work cataloging, duplicating, and being made available to others from a central point.

There is also a need for cataloging the wealth of material available nationally and internationally. For example, in both the areas of cancer and neurological-sensory disease, the National Medical Audiovisual Center's International Index contains over 1,200 listings. And a recent computer printout in the area of surgery took 900 pages. Available listings of this type need to be assembled and organized so that they are easy to use.

Finally, if audiovisuals are to be used, they must be tailored for each particular need.

At the highest level, comprehensive specialty catalogs should be prepared listing only those audiovisual materials which have been reviewed and at least subjectively evaluated by a group of nurses, or whichever body is given this responsibility in a Continuing Education program. The nursing school planning a series of presentations, the researcher seeking visual documentation, the practitioner with a particular problem, and the student seeking information; all could use such a catalog. The catalog would be designed to provide

information allowing the prospective user to judge the audiovisual's instructional potential for each particular group.

Who should undertake the task of locating and evaluating audiovisual material? Certainly, the job is too big for any one individual, or even one continuing education committee. A national group is in a better position to provide personnel, equipment, and time: resources critical to the development of effective communication materials. A broadly based and organized program is the only reasonable approach to solving the problem. In reviewing audiovisuals for the purpose of cataloging only those which are of value to a particular curriculum, one discovers areas for which little or no material is available-- thus each of the professions is in a position to identify needs for new materials. Moreover, until such a survey has been made, one cannot know that time and money spent on new productions will be wasted through duplication.

Once a need for new materials is ascertained, it is both possible and practical to produce audiovisual material at the local level with a minimum of means. A plan for action at the state or local level should include a study of the feasibility of producing materials that cannot otherwise be procured, for use with one of the more common delivery systems. The simplest system may be slides or slides plus audiotapes.

No relative newcomer will take to the idea of making his own materials unless it is easy for him to do so. Therefore, it might be worthwhile to establish for the state continuing education program a division of biomedical communication working in cooperation with, or in tandem with any existing departments of biomedical communication

in schools of nursing in nearby areas. Such a division would have as its purpose the provision of those skills and talents required to work with nurses in analyzing curriculum content and specific communications problems and coming up with means or products for their solutions. Such a division can also serve as the focal point for purchasing and maintaining audiovisual equipment, so as to insure ease of operation and compatibility throughout the state. The division might also be the focus for acquisition and distribution of audiovisual software--and for designing learning environments.

To give you an idea of what is already going on between audiovisuals and biomedical education, let us consider some ways in which schools and hospitals are making use of the newer media. Many of these will be adaptable to your own problems.

Problem: To get up-to-date information on the detection and diagnosis of oral cancer to dentists in rural Kentucky. It was assumed that the practitioner in the field would not have access to audiovisual equipment.

Solution: A set of 93 slides and a semi-programmed text, designed by Dr. Sheldon Rovin, University of Kentucky School of Dentistry, and a battery-operated slide viewer, were sent to each dentist.

The text asks the practitioner to examine a slide. It also provides him with information about the patient. The dentist is then asked a question. Answer choices are presented in a multiple-choice format. The dentist then turns to a subsequent page where his selected response is discussed.

If his response is incorrect, he is told why it is incorrect and is asked to select another response. If his response is correct, he is directed to proceed.

Problem: To provide a system in downtown Atlanta through which professional staff and students throughout the metropolitan area could participate in Grady Memorial Hospital's conferences, CPC's, guest lectures, etc., without having to travel to the hospital.

Solution: The Community Medical Television System which delivers live TV programs by line-of-sight broadcasts to hospitals and medical organizations within a radius of 25 miles with direct "hot-line" telephone service for questions.

In South Carolina, a somewhat similar system reaches physicians throughout the state--by cable to high schools and subscribing hospitals, and through open-circuit TV. In this instance, question-and-answer sessions are handled locally.

Problem: Training student nurses and ancillary personnel in certain rehabilitation nursing procedures.

Solution at NYU: A series of 36 8 mm sound motion pictures, cassette loaded for ease of use by persons without training in the operation of audiovisual equipment--with projectors placed at stations for use at odd hours, or when needed.

Problem: To provide 24 hours a day to physicians everywhere, information on the management of emergencies in practice.

Solution: "Dial Access" audiotapes at the University of Wisconsin. One person is always on duty who can receive a telephone request and plug a cassette-loaded audiotaped response into a special audio-playback.

Problem: To provide live audiovisually-supported instruction over distances without special video cable, often to a number of points simultaneously.

Solution: "Telelectures." Slides, motion pictures, or videotapes are mailed in advance for local showing on cue in support of a presentation. The speaker makes his presentation by telephone or two-way radio while watching a duplicate of the visual material and answers questions. Wisconsin; Albany, New York; and the Harvard University School of Public Health, to mention but a few, use this system.

Problem: To provide instructional experiences on the student's own time which require a variety of media.

Solution: Special learning carrels, in lab or in library, readily accessible to living or work areas. Student, who receives information or instruction by audiotape, film, videotape, or the printed word is involved in practical exercises, is directed to a variety of media, and is told whether or not his responses are correct. Examples: Anatomy at the School of Medicine, University of California in San Diego; physiology and pathology, Medical College of Virginia.

Problem: Consultation where patient and specialist are separated by miles.

Solution: University of Nebraska, 24-hour-a-day closed circuit, two-way television by cable between Norfolk and Omaha, over which practitioner and patient or ancillary staff talk; also, courses are conducted and patients and families can visit.

Another example: Again, CCTV: to connect Massachusetts General Hospital with Logan International Airport. From the airport, a nurse with a patient requiring emergency treatment can benefit from two-way communication with a specialist at the hospital who can see and hear the patient as the nurse performs the examination.

Problem: To save practitioners time in delivering routine information to patients or their families.

Solution: At Piedmont Hospital, Atlanta--sound/slide presentations in a "black box" that can be used in clinic areas or patient rooms. Automatic and repeating, the machine is turned on by a single button and turns off automatically.

Another Solution: From California--cassette-loaded sound motion pictures on pre- and post-natal care. The hardware starts with the push of a lever, turns off automatically. Self-contained, with ear-phones, if desired. Available commercially on a rental basis.

Problem: To reach practitioners and nurses throughout the states of Washington and Alaska with information in audio and still image form. System must be easy to use and capable of being programmed.

Solution: Placement of cassette-loaded 16 mm sound filmstrip projectors in hospitals throughout the region. Automatic audio stops after questions and allows students time to respond while picture remains on screen; student pushes "go" button to proceed.

Problem: Instructor conducts CPC's and nobody can see detail in x-rays on light box.

Solution: TV camera zooms in for close-up; contrast adjustment emphasizes details; all students can see. Similar solutions in oral surgery, gastroenterology, anatomy, with the added fillip in angiography that video tape can be replayed, slowed up, stopped for study or to emphasize an individual image.

The uses to which audiovisuals can be put are virtually limitless-- the limit set by our ingenuity and imagination. I would presume only

to offer the following advice based on my own experience and that of others:

1. Be flexible. Set tradition aside whenever necessary so that imaginative and innovative planning for continuing education may take place.
2. Explore new alliances--with academe, government, other professions. Don't worry about losing control of a program. If it's well formulated, you won't lose it.
3. Consider accessibility as the keynote of your efforts. Don't let anyone sell you a bill of goods--hardware or software--unless you really see the value.
4. Evaluation--beware of the professional evaluators who view evaluation as the sine qua non to all efforts. We must realize that there is little time to re-invent the wheel. There is a plethora of educational research covering most, if not all, of the questions now being asked about the efficacy of the media.

And finally, I am convinced as never before that nursing and the other health professions must develop a large cadre of nursing communications specialists, Departments of Nursing Communications in your professional schools, and active programs in your professional associations. The embryo nurse of today will either see or not see the effective use of the media in instructional programs of her institution. You can't starve this student and then expect her to use modern technology for lifetime learning. The habits of the formative

years will follow her through life.

As for the National Medical Audiovisual Center I represent, we would be delighted to sit down with your leadership at any time to explore ways in which the available monies might have a lasting impact on the quantity and quality of nursing care in the years ahead.

AN APPROACH TO POSTGRADUATE NURSING EDUCATION
BY THE MEDIUM OF TELEVISION

G. Marjorie Squaires, R.N., B.A., M.S.
Coordinator-Administrator, Continuing Education in Nursing
University Extension, Los Angeles
and
Lecturer, UCLA School of Nursing

Five years ago, University of California, Los Angeles, School of Nursing was invited by the Extension Department of Medicine and Health Sciences to participate in Postgraduate Education Through the Medium of Educational Television Broadcasting on their Scrambled Network System. With the support of our Dean Lulu Wolf Hassenplug, we agreed to explore these possibilities of attempting to meet the Continuing Education needs of some thousands of practicing nurses who were not able to leave their agencies to update their knowledge and skills.

We immediately did a survey of 200 hospital Nursing Service Directors and Inservice Directors with some 90% replying in the affirmative with some identification of nursing education needs. Our faculty committee studied the available literature on the subject, which was minimal, and concluded that in order to develop a sound educational offering, we should move cautiously. However, time was not with us and since the demands from practicing nurses exposed to the Medical offerings of the Medical Television Network, UCLA, were increasing at a fast rate, we were encouraged to jump in and get our feet wet. We were given the financial backing and the technical staff to help us develop four one-half-hour tapes which were to be on the air within an eleven week deadline. Most of our spare time and much effort went into the production of the tapes, study guides, pre and post tests, enrollment forms, etc. "Speaking of Nursing" was on the air and viewed by some 13,000 nurses.

At the completion of this series, we realized we had a "tiger by the tail" and should now take the time to assess the experience and begin to develop our offerings through a community approach. We organized a Southern California Nursing Television Advisory Board which met monthly at Television Station KCET in Hollywood. Membership on this Board represents faculties from all levels of nursing education, nursing service agencies, nursing inservice directors, professional and voluntary health agencies, television producers, and representatives from other health disciplines. Average attendance at these voluntary evening meetings is twenty-six with members flying and driving in from Ventura and San Diego and one representative from the San Francisco campus.

The objectives the Board defined were to pool the talents of nursing education and nursing service for the development and presentation of Educational Television offerings that would capture, on tape, high level instruction on a postgraduate level in attempting to meet the knowledge explosion. The Board sets up the criteria for selection of content, explores the use of television media and its implementation in nursing practice, and works with us in the production of programs. A nursing faculty member and a content specialist serve as consultants in order to guarantee high educational standards. A Review Committee is selected from this Board to evaluate any tape we produce, rent, or borrow before it is presented to the viewing audience.

Our programs were presented to the seventy member-hospitals of the Medical Television Network through the Educational Television Station, KCET, "scrambled," with a nursing coordinator in each

hospital assuming responsibility for the dissemination of publicity, seeing that the viewing facilities are adequate, selecting evaluators, taking roll call, and using the Study Guide provided for the fifteen-minute orientation prior to the showing and conducting a fifteen minute question and answer period following the viewing. These hospital coordinators are encouraged to invite nurses and allied health team members from all health agencies within their geographic area to participate with them in the educational offerings. We have had as many as 150 nurses at one time in a hospital presentation with as many as eight agencies represented. Our viewing audience has included nurses of all levels, nursing students, and member of other health disciplines.

Our program offerings have all been patient centered, and we use actual patients and health personnel in our presentations with the emphases on the demonstration methods. We have moved to the method of narration behind the scenes and are avoiding our early mistake in presenting lectures and panel discussions, keeping in mind our overall objective in developing content that is relevant to our viewing audience.

Our second year in business, we received financial backing from the Los Angeles County Chapter of the American Cancer Society for four tapes, the California Chapter of the National Dairy Council for one tape, and developed a large television grant which was not funded.

The third year, we were supported by the Medical Extension Television Grant. That year, the program expanded to include a Veterans Hospital program with the use of videotape recorder playback equipment in these hospitals and Medical and Nursing tapes sent out on a revolving system. Speakers and discussion leaders are

available to further enhance these offerings at the request of the Veteran's facilities.

The fourth year, we were included in the Regional Medical Program Grant and were fortunate in having a one-half time nurse faculty coordinator who was skillful in providing the kind of leadership needed to develop program objectives, identify content specialists, and serve as a consultant for production and implementation. However, the half-time position was not adequate for the responsibilities entailed. We produced eight tapes last year and are producing eight tapes this year with no nursing coordinator's position but only the use of nursing volunteer time and nursing consultant help.

Since this is now a California Network, we have involved the Regional Medical Program coordinating nurses who represent nursing needs in their areas and are concerned with the Continuing Education needs of the 137,950 registered nurses in the State. They have recommended a full-time coordinating nurse position in the television network, which is badly needed in order to uphold nursing education standards in the use of television as one audiovisual aide.

It might be helpful for me to identify some of the problems we have had to overcome during the years we have been involved in this program. Some of these problems are still with us.

1. Poor selection of program chairman who will not accept professional consultation from "anyone."
2. The concept of being a "star" - one production does not enable anyone to become expert'se.
3. Too much content.
4. Not enough depth in content.

5. Mike fright.
6. Questionable appearance as professionals.
7. No permanent staff.
8. The "sandwiching" of time of professional personnel.
9. Difficulty nursing education consultants have in working with technical producers upholding educational standards.
10. Poor viewing time.
11. No money delegated to nursing for implementation of program as part of the continuum for Continuing Education offerings.

In looking ahead, despite the difficulties we encounter, it is exciting to be a part of this fast developing technological field. One of the new approaches is the 8 mm. kinescope cartridge equipment, which I am going to use today in the presentation of a tape. This is a simple instrument anyone can use. It entails merely connecting, putting in the cartridge, and pressing two buttons.

Another new approach is Columbia's EVR System with the television tape cartridge and its possibilities for expanding new knowledge to every human being.

There are many other uses in Nursing Education for the television media. We take the Sony portable equipment out into the field for live-in conferences. We have used this successfully in counselling-interviewing offerings, and race relations group dynamics. Nurses are able to see first-hand how they communicate verbally and non-verbally and how they react to others.

You have been given the Study Guides, and we will now show the tape, "Environmental Effects of Cardiac Arrest" by our Network.

TEACHING BY TELEPHONE

Signe S. Cooper, R.N., B.S., M.Ed.
Chairman, Department of Nursing
University of Wisconsin, Madison

Those of you who attempt to cover great geographic distances know that many nurses spend much time and effort to attend workshops and conferences. In the study that I described previously, I indicated that over half our enrollees traveled fifty (50) miles or more to attend programs. This suggests a high degree of motivation, but collectively it represents a lot of effort.

Whether educational offerings are offered on-or-off campus, considerable time and effort is required in making arrangements. If it is possible to minimize these efforts to reach nurses in remote areas and to provide for more sustained learning experiences, it seems appropriate to do so.

Teaching by means of the amplified telephone call has become a widely used technique for disseminating and sharing information in educational, business, and industrial setting; so the system I shall describe is not new to many of you. In fact, I'm afraid you may be in the position of the daughter of a friend of mine. One day she asked her mother, "What does daddy do?" Her mother replied, "Why don't you ask daddy when he gets home?" The daughter responded, "Because I don't want to know that much about it."

The University of Wisconsin has a statewide educational telephone/radio system, which links more than 170 hospitals, university centers, and county court houses.

The network consists of private telephone lines leased on a full-time basis for teaching purposes. This arrangement eliminates the need for operators, switchboards, and so on, and greatly reduces the possibility of equipment failure or human error.

Each listening post on the circuit is equipped with a loudspeaker so that the program can be transmitted to many listeners in the same room. All that is required is that the speaker be turned on to hear the program.

Listeners can respond to questions or make comments by picking up the special telephone in the same room and talking into a regular handset. By picking up the telephone, the loudspeaker at that location is disconnected from the circuit. This also eliminates the discussion for all except the person holding the handset, so the person must put down the telephone or operate manually the switch on the top of the telephone cradle.

Our statewide system also includes a special FM radio arrangement, known as the subsidiary communication (SCA), and many listening posts have the equipment for receiving the program. These listeners can also react by telephone, but this requires calling collect by dialing a special number (from a regular telephone).

Not all the available listening posts are in use for any one program. In our present program for practicing nurses, we have 69 stations involved. Inactive nurses listen to their program from 86 different stations. This latter program is funded through the Wisconsin Regional Medical Program.

Using The Telephone Network

The particular advantage of the telephone system, compared with statewide educational radio, for example, is the use of two-way communications. To some extent, of course, what we can accomplish could be done on the radio, but only to a limited degree.

Usually a local moderator is assigned to each listening post. The moderator sees that the room is available at the assigned time and that the equipment is functioning. If slides are used, he also sees that a projector is available and working. Materials are mailed in advance of the program; the moderator distributes them to enrollees (although individual mailings are used for some programs). During the program he relays questions to the speaker, etc.

We have found the use of a brief outline with space for the nurse to take her own notes is a useful device. It gives the enrollee something to direct her attention to in the absence of the instructor. It helps identify unfamiliar words and terms. It also gives her something to refer to later and helps provide continuity of the individual sessions in a series.

We have used slides whenever they have contributed to learning, but the use of slides is expensive. We see no value, for example, of showing a chart via a slide when the same thing could be easily duplicated in the students' outlines. Also, we have found in some instances that listeners felt the noise of the projector interfered with hearing the program.

We believe that involvement and participation are essential to learning. We also believe that there are individual differences in how

people learn, and perhaps not all people can learn effectively with this approach.

Our program for inactive nurses might be used as an example of how we attempt to get involvement of the enrollees.

1. We believe that the more the faculty knows about enrollees, the more effective the programs they will be able to provide for them. Obviously, this is exceedingly difficult with our large enrollments, but we make every effort to get to know them. Each enrollee completes a one page application blank which includes basic information about her educational background, experience, etc. So we have this basic information available to us.
2. We encourage the nurses at each listening post to get acquainted if they did not know each other before, and perhaps to plan to get to each other's homes for coffee following the sessions. (I might note that one of the criticisms of our very first telephone conference was that we did not serve coffee. I'm still wondering if what they wanted was for us to develop a statewide coffee pipeline!) Where there are several enrollees, one person is assigned as a local moderator.
3. To encourage participation, we occasionally plan an "assignment" between sessions, although we don't call it that. This may range from reading to be done before the next session, locating local community resources, or answering a quiz prior to or following a session. Materials relating to the program are mailed in advance and enrollees are encouraged to read them before the presentation.
4. A Reaction Sheet is frequently included with the advance mailings. This is to provide clues to us about the appropriateness of the content. It also gives listeners an opportunity to raise questions if there wasn't sufficient time on the program, or if they are reluctant to ask their questions on the air. Considerable time is spent in answering individual questions between programs, usually by correspondence, but we believe this is an integral part of helping nurses learn.

Course Content

The first program offered by the Department of Nursing was titled "Call Nursing 1966" and was presented the second semester of the 1966-1967 school year. This program consisted of twelve

weekly programs of general trends and issues in nursing, including current developments in various clinical areas.

We learned that a twelve-week segment was a little too long for our listeners; someone touched on this earlier in this conference, and our findings concur with that speaker.

Subsequent programs have been based on suggestions from listeners; the length varies somewhat with content, though now many are planned on a one semester basis. The weekly series appeared to be too frequent: today we offer our regular program on a twice-a-month basis. In addition, a different series is offered on a monthly basis.

Program offerings have included a series on the newer drugs, one on nutrition, one titled "Rest and the Heart," and one on "Changing Concepts of Tuberculosis." This semester our regular series is on "The Nurse and Medical Emergencies." Next semester a series on "Cancer Care and Caring" will be offered. Once a month during the school year we offer a program on "New Knowledge in Nursing"; it consists of a presentation of nursing research by researchers. We are also doing a series for inservice coordinators.

One of our colossal failures was a program titled "Book of the Month Club." The idea of a review of a new book still appears to be a good one, but our experience was that this fell rather flat. We intended that participants read the book before the discussion; in reality, few of them did this. We arranged for the books to be available for listeners to purchase, and in some instances quite a number were secured after the program. However, since listeners had not read the book prior to the presentation, discussion was very limited.

As previously mentioned, we also provide a twice-a-month series to inactive nurses, with 550 nurses enrolled. This program is funded through the Regional Medical Program.

Obviously, not all content is appropriate to teaching by telephone; therefore, careful selection of content is important.

One other way in which we are using the telephone is for a once-a-month faculty meeting. Since Extension Nursing faculty members are in four different locations, this is very time saving.

Faculty are somewhat inhibited in discussion (since anyone could listen in on the line), but it is a good way to share information.

Problems

There are some rather serious problems in teaching by telephone, so I will discuss some of these.

1. Timing

There is no such thing as an ideal time. Initially we tried evening programs but this isn't very satisfactory to the nurse who commutes some distance to work; it may be difficult for her to return for an evening session. Now we present all our programs in the early afternoon (1:00 or 1:30).

Timing is always a problem and in the hospital setting; there are many uncontrolled factors. In the small hospitals, particularly, many factors interfere with the nurse's attending the program. For this reason, we replay our regular program which is given on Wednesdays the following two days: at 3:30 p.m. on Thursdays and 10:00 p.m. on Fridays. This is an attempt to reach the evening and night nurses.

2. Determining The Effectiveness of The Programs

We have yet to design an effective evaluation tool for these programs. We know that it is impossible to establish meaningful programs for large groups of nurses; we cannot be "all things to all people," but in many instances this appears to be expected of us. Thus, we get positive feedback from many listeners, while for the same program we get many negative responses. We know that learning needs are different in the various types and sizes of hospitals. We anticipate spending more time in evaluation in the future. We need to know what effect the program has on nursing practice.

3. Selection of Students

We have some special problems in selection of enrollees that relates to our particular system, so I will not go into detail. The hospital pays the fee rather than the individual nurse; then the Administrator encourages every nurse who can leave the unit to participate in the program. This often means sporadic attendance, a lack of continuity, and questionable value. We are attempting to work more closely with inservice coordinators to alleviate some of these problems.

We attempt to outline our objectives and purposes for each course as clearly as possible, but even so we have some enrollees who ought not be in the program. It is sometimes obvious that the agency does not select participants carefully; an example is the operating room nurse who felt that one entire series was a complete waste of her time. I'm sure it was for her and that she ought not to have attended.

4. Teaching The Faculty To Teach By Telephone

Most teachers depend upon some kind of feedback from students; the quizzical expression, the raised eyebrow, the half opened mouth, to direct their teaching. This helps them identify the need for

restatement, additional explanation, more illustrations to clarify their presentations. This feedback is not available to the teacher by telephone so she must learn new skills, such as using more effective and meaningful illustrations, anticipating students' questions, providing pauses to allow listeners to respond. (I must say it is the latter that gives me difficulty, since I am from the generation for whom a long distance telephone call meant someone had died, I get very nervous during long pauses, thinking how costly they are!)

Not all teachers enjoy teaching by telephone; others find it very challenging and are able to develop new and appropriate illustrative materials. Selection of teachers is an important facet of providing sound educational programs.

Nursing Dial Access

At the University of Wisconsin, we are also using the telephone in another way which I would like to describe briefly. This is our NURSING DIAL ACCESS system, funded through the Regional Medical Program. These are short (5-7 minutes) pre-recorded tapes on a variety of nursing subjects. They are played on a coustino recorder and may be requested at any time of the day or night. There is no charge to the individual nurse.

The system was modeled after one designed for physicians. At the present time, the nursing library consists of 68 nursing tapes, plus over 50 medical tapes. The library is being expanded on a variety of topics. Tapes used most frequently are: central venous pressure, the patient receiving chemotherapeutic drugs for cancer, fecal impaction, and the patient on anticoagulant therapy.

Nursing Dial Access has been a boon to the nurse who has difficulty attending educational programs. In contrast to the telephone conferences previously described, in this arrangement she can dial from her own telephone at home. She must know the special in-wats number to call and the number of the tape she wishes to hear. The program has been in operation for over a year and has been widely accepted. It appears to be of special value in getting information to those nurses living outside of metropolitan areas.

Conclusion

I have described two approaches to providing educational offerings to nurses: Telephone Conferences and Nursing Dial Access. Both of these approaches are particularly useful ways of getting new knowledge to nurses who do not have access to the many educational opportunities available to nurses in metropolitan areas. If nursing practice is to improve substantially, it seems imperative for educators to use the many technical advances available to them today.

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EVALUATION OF CONTINUING EDUCATION PROGRAMS IN NURSING

Emily Tait, R.N., B.S., M.A.
Director, Continuing Education
Saint Louis University
School of Nursing

While discussing evaluation in continuing education with others and reading on the subject, I have felt an awareness of an apparent failure to achieve something useful, in comparison with what most people and writers seem to think is needed. Somehow, I don't believe the actuality is as limited or below par as some seem to think. True, we have not gone very far in establishing measures; but, evaluation is much more than measurement. Don't misunderstand, measures are important; and, I hope we will find, or work out, more reliable, flexible, and valid measures in continuing education than we have up to now been able to utilize.

Many questions are facing us at this time. Some I will mention here. Perhaps we may wish to discuss them later.

1. Should we support accreditation in continuing education?
2. Is evaluation in "depth" (scientific evaluation) more time consuming and expensive than the teaching itself; therefore, impractical?
3. Should our evaluation system be person, or program (organization), oriented, or both?

Better evaluation may, in truth, be in the future. Some practices may be impossible to implement at this time. We may need to use the computer more skillfully. New methods may be researched

and utilized which will be found within the total improvement of health and health care for all people. We might also examine our ability to share knowledges and skills with others, to assume appropriate leadership, to take a rightful place in health planning and implementation with other health workers and disciplines, all exceedingly difficult to evaluate.

Whatever means we attempt, the basic starting point in the evaluation process is inherently based on our honest goals, not prestige centered, paper-impressive, or competition driven. We need to look carefully at our reasons for evaluating, recognizing the goals toward which the evaluation is directed.

The evaluation efforts at the school where I work, where we offer both courses and workshops, have an empirical and pragmatic approach, not a scientific one. This we base on the premise that health workers are adults, that they know what they want, and that they will move to get what they want. We offer a loose and flexible program to a mostly local area with the basic goal of helping the nurse, and often, the associated health worker, to cope better on the job. We think we are working toward this objective by helping them to realize their potential in achieving more fully the health goals of their area of interest. Knowledge of newer therapies and concepts in nursing development as well as liberalization of personal background is sought in our program to improve professional excellence. Big words, but we do try, as I know all of us in continuing education are striving.

Partial analysis of the registration form has been helpful. We could do more here. Signs that the program is meeting needs are seen in the continued large enrollment in courses and workshops, in the

waiting lists for some courses, and in the repetition, by request, of others. Indications are found in the distance that people are willing to travel to get what they want, in the number of enrollees who return year after year for more, and in the higher education level of the majority of the enrollees. The increasing numbers of our own faculty who are registering and teaching, as well as sponsoring workshops, are useful to us. Registration is telling us how many complete the courses and attend regularly.

During the first meeting of each course the students are usually asked to write their course expectations. Most instructors sincerely attempt to satisfy these expectations where it is possible and desirable. Questionnaires and rating scales, usually completed at the end of the offerings, are studied carefully. We look for new ideas on subject matter and content, for the effectiveness of the teaching aids, for indications of changes in attitudes and behavior, for expressions of increased feelings of self worth, and for the impetus in learning which may have been contributed by peers and colleagues. They are also useful in assessing faculty performance, methods of teaching, and the relevancy of the material to the participants.

We have learned to look at the degree of willingness or enthusiasm expressed by our community, professional and otherwise, when they are asked to give time and effort in serving our programs. We have invited them to help us plan for programs, sometimes to teach, and participate in many other ways. When they come, in turn, to us to request speakers, suggest programs, ask for help in a particular area of interest, we believe that this is indicative of the value

placed on our program. We are also served with guidelines for needed changes in publicity or content. When new activities are undertaken in the geographical area, such as the formation of a continuing education committee in the local district, state groups meeting with us to work on regional plans for continuing education, support (financial and otherwise) is offered by health groups, national, state or local. Well; this makes a statement, too.

During the three and a half years we have been functioning, we have conducted about one annual survey utilizing professional organizations, local institutions and agencies to reach nurses. The response has been so limited that we suspect that only a small portion of the nurse population is concerned in continuing education and is supporting our local programs. We are questioning the validity of surveys to learn nursing interests. This leads to the area of our lacks or gaps in evaluating. There is a need for research to learn more about who is continuing her education and who is not. What can we do to help both groups? Is our publicity adequate? What better measures can we develop for evaluation?

We believe that we might better use pre and post testing to learn more about any omissions, lack or failures. Perhaps we need better screening of enrollees for some courses. We would like to know more about what is happening on the job in relation to changes in service and attitudes affecting health care. Telephone interview might be valuable here and is being attempted. What help can the consumer, the patient and the client give us in our efforts for continuing education? What is getting through to the consumer, the

community, the health services as a result, at least in part, of our efforts? Finally, we need to examine how well we are anticipating needs, and to what extent we are offering what is wanted.

SOME uses of the evaluation process have been indicated. Since they may be helpful for our discussion which will follow in a few moments when we will consider METHODS OF EVALUATION AND THEIR USE TO IMPROVE OUR PROGRAMS IN NURSING CONTINUING EDUCATION, I will review these:

1. We have been encouraged to utilize better teaching techniques, instructional aids, new approaches to learning, and to include controversial content.
2. We have obtained leaders by whom we have been able to interest quality instructors and resource people.
3. We have gained program ideas.
4. We have been able to change to more useful and interesting time and place settings.
5. We have learned some of the areas of concern and interest in the community and the profession, which have been basic to our planning and program implementation.

Stanford Ericksen, University of Michigan, in "The Teacher, the Book, and the Student's Private Knowledge" says, "Having completed the course, the student proceeds to do the only thing he can do, namely to combine (to a greater or a lesser extent) what he has been taught with self-selected bits that he has already learned elsewhere. He is, in effect, forming and maturing his own store of private knowledge." Our need now is to evaluate as best we can this "private knowledge" and its use in the world of work experience to learn if we are doing what we hope we are doing.

In brief, mechanistic, computer-type measures may be too time consuming and expensive for the results obtained. Let us look within

ourselves and our programs, using imagination, experience, education theory background, and the attitudes and feelings of all the people involved in our programs for meaningful and useful evaluation.

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ADDENDUM TO SESSION ON
"EVALUATION OF CONTINUING EDUCATION PROGRAMS IN NURSING"

Editor's note:

Although the entire speech and discussion period were recorded on audiotape, the editor regrets the tape was lost. However, three recorders were appointed to take notes and the following is a brief summary of Methods of Evaluation of Continuing Education programs in Nursing as taken from recorders' notes and the blackboard.

METHODS OF EVALUATION

Total Program Evaluation

Annual Report of continuing education programs - Evaluating progress
Popularity of courses
Review of objectives of continuing education programs - How well are they being met?
Changing of goals of total program
Accreditation Process - How continuing education fits in and meshes with baccalaureate and graduate education
Behavioral objectives and expectations shared with employees for evaluation
Faculty and participants self-evaluation
Adequate enrollment
Increased para-medical contacts
Adequate financial support
Numbers enrolled in programs not as important as quality of instruction given

More Immediate Evaluation Methods

Use of nursing audit
Student evaluation of teacher performance
Analysis of registration forms
Clinical evaluation - use of sealed envelopes - instructions to do a specific "job" - then observe and evaluate implementation by enrollee
Daily diaries kept by enrollees
Process recording
Pre and post testing
Questionnaire

Follow-up Evaluation Methods

Projects initiated in courses - "reunion" of participants to see what has reached state of reality

Post-conference "behavior" in terms of furthering of formal study
of enrollees through baccalaureate or graduate education
Advancement in position of enrollees
Increased involvement of enrollees in community activities
Consultation services requested
Use of observation tools in the clinical setting prior to educational
experience; then post-experience observation to identify changes in
patient care setting
Increase in referrals
Employer attendance at follow-up sessions
Timing of follow-up was considered important

General Comments

Conference participants agreed that evaluation is a continuous
process - all of the foregoing step by step evaluation methods
become a part of the total. Re-diagnosis, re-appraisal, re-
assessment is what evaluation really is.

INTRODUCTION TO WORKSHOP REPORTS

Five workshops were held during the conference. The topics listed below were those most frequently requested by conference participants for discussion in some depth.

1. Administration and Organization of Continuing Education Programs in Nursing, Including Staffing and Securing Faculty
2. Identifying the Learning Needs of Adult Learners and Establishing Priorities for Programs
3. Funding Continuing Education
4. Developing Philosophy and Objectives for Continuing Education Programs in Nursing
5. Evaluation of Continuing Education Programs in Nursing
(This subject was discussed by the entire conference group and appears as a separate report.)

Guidelines (see Appendix 1) were suggested by the conference steering committee to assist leaders and recorders in guiding discussions as well as to arrive at some common guidelines which might be helpful to new and ongoing programs.

However, leaders and group members were at liberty to depart from the suggested guidelines and conduct the workshop sessions according to the needs and wishes of each group. As a result workshop topics were approached differently which made it impossible for the editors to consolidate the reports. Therefore, reports appear separately as edited.

We thank the leaders and recorders for the final editing of each group report which appears in the proceedings. This was no easy task considering the voluminous data collected by recorders.

Where positive recommendations, stated as such, emerged from a group, the editors have underscored for reference.

REPORT OF GROUP I

Helen Pazdur, Leader

Marjorie Baker, Recorder

I Administration and Organization of Continuing Education Programs in Nursing, Including Staffing and Securing Faculty

In discussing administration and organization, more thorough coordinated planning is needed in order to avoid duplication, allow for various levels of educational needs and decide "who does what" on a state and national level.

The variety of levels and needs cannot be met just through universities and state colleges. Inservice departments also need to be included in the master plan of assisting in educational needs. The group agreed it was difficult to define "Inservice" and "Continuing Education" - where did one begin and the other end? There were conflicting ideas about where these two facets would be a continuum. A suggestion was made to follow guidelines of the A.N.A. position paper.

Along with problems of coordinated services was the added disadvantage of a lack of funds for faculty in Continuing Education programs in colleges and universities. It was suggested that Continuing Education departments integrate the Continuing Education program within the total program in order to insure adequate faculty to teach and to acknowledge that Continuing Education is necessary and important as well as degree programs.

To adequately implement a comprehensive program (local, state and/or national), an ad hoc advisory committee which would set guidelines would be a great asset.

II Identifying the Learning Needs of Adult Learners and Establishing Priorities for Programs

The group discussed criteria needed to assess the learner's needs. Some of the suggestions in identifying needs were to look at the intended participants' motivation, i.e., job or licensure requirements, need for new knowledge and skills to function effectively such as newer dimensions in coronary care and burn cases; her outside responsibilities (family); and her level of skill and previous educational development. From this, the learner can be guided toward suitable courses that would be relevant and immediately useful. At the same time, this knowledge of the learner could very well be a guideline for priority courses in terms of needs of the learner.

Criteria for priority of courses were related to the relevancy of course, location of the course, i.e., rural as well as urban and the priority given to courses in greatest demand.

III Funding Sources and Rationale for Such Sources

The discussion involved sources of funds from state, local and national levels including private funding. There was little concern regarding the amount of control or power receiving funds from a federal agency but the concern was more towards meeting their (agency's) requirements.

A suggestion was made to have a "stable" and permanent source of funds so that the Continuing Education staff could devote their time and energy towards planning, coordinating and teaching courses as opposed to devoting time and energy toward being fund-raisers and grant writers. Ideally, a grant writer on the staff would enhance the quality of grant writing and free faculty.

The needs and motivation of the learner were discussed regarding supporting Continuing Education courses and the problems of paying fees if no stipends are available. If relicensure requirements in the future include certain courses to renew licenses, Continuing Education courses will automatically zoom into self-supporting programs. The implications would be many; one would be acquiring enough faculty to teach and the problems of teaching participants who are sent instead of choosing to attend.

Meanwhile, in order to assure that hospital administrators (who allow employees time off an/or pay for their courses) would continue this practice. A public relations board would be helpful in obtaining feed-back, evaluation and expectations of agencies whose employers participate in such programs. (It was commented that some faculty go through this process at the present time as a matter of evaluation.)

IV Developing Philosophy and Objectives for Continuing Education Programs in Nursing

(Part of the time for the meeting was devoted to filling out evaluation forms and consequently, we had less time to discuss a philosophy.)

A question was raised as to how one philosophy could incorporate all beliefs since this particular group was so large and diverse.

One suggestion was to develop a broad nursing philosophy for Continuing Education with the expectation that the individual institutions would modify and implement the philosophy as it was appropriate for them.

Some basic themes that would need to be considered in writing a philosophy for Continuing Education would include the ideas of change.

Summary

It was evident that each area of discussion involved so many issues and were so inter-related that only a very broad over-all discussion ensued.

The over-all theme that could be pulled from all of the discussions would be coordination and cooperation which is needed in all areas -- administration, funding programs, planning programs for the learner and developing a philosophy.

In summarizing, it is also difficult not to evaluate. The advantages of having had such a diversified group were obvious in obtaining a variety of viewpoints and exchange of experiences and ideas.

The disadvantage was that due to the time element and the large group, the conflicting viewpoints were not fully discussed nor settled. Consequently, we did not arrive at a general consensus of recommendations. However, feedback from individual group members conveyed the idea that on the whole, the participants valued the opportunity to meet with colleagues.

REPORT OF GROUP II

G. Marjorie Squaires, Leader

Dorothy Blume, Recorder

I Administration and Organization of Continuing Education Programs in Nursing, Including Staffing and Securing Faculty

ORGANIZATIONAL STRUCTURES IDENTIFIED

1. School of Nursing - Assistant Dean
Responsible to School of Nursing
2. Adult Education or Extension Division Academic Appointment with
School of Nursing
Responsible to Adult Division of Education
3. Continuing Education and School of Nursing
dual Responsibility
4. Regional Medical Programs. Usually Academic Appointments with
Universities

Mutual agreement that the University has the responsibility for Continuing Education and that programs must be built upon the philosophy and objectives of the University School of Nursing. Important that the University views Continuing Education first as an academic education adjunct and second as a service to the community. Regional Medical Programs staff nurses should work in collaboration with University Schools of Nursing but questioned the desirability of faculty appointments. There should be joint planning by all institutions of Higher Education, Departments of Nursing, Schools of Nursing, Regional Medical Programs Staff, and Inservice Educators and practicing nurses.

Recommendations

University Schools of Nursing support with hard money positions for Directors of Continuing Education.

Departments of Continuing Education in Nursing be elevated to the same rank as other departments in Schools of Nursing.

Administrative structure should be organized so that programs are made available in all geographic areas to all levels of practicing nurses.

Continuing Education and Inservice Education should collaborate in program planning, and must define differences.

Regional Medical Programs staff nurses have great potential for identifying needs for Continuing Education and should be more involved.

University personnel with knowledge of grant writing should be on staffs of Continuing Education in Nursing.

The Director of Continuing Education should handle all funding.

University Continuing Education Departments should explore all community resources for nursing faculty.

Nursing faculty should receive comparable compensation to other health disciplines' honorariums.

Continuing Education committee structure should represent all areas of nursing, all levels of nursing, representation from professional and volunteer health organizations, representation from the ghetto, the lay groups, etc.

II Identifying the Learning Needs of Adult Learners and Establishing Priorities for Programs

Concerns

Differences in needs of the young graduate and the older graduate.

Differences in approaches to or acceptance of new philosophies of adult learning.

Categorizing students as "non-adults" and not capitalizing on knowledge background of students.

Differences between career orientation and professional growth.

Nursing dilemma in identification of role models.

Ability to implement change frequently requires nurses to learn present positions.

What are the barriers involved in being successful change agents?

Tremendous difficulties academically prepared nurses have in practicing professional nursing as they were taught.

The "Ivory Towerish" aspects of University offerings.

Continuing Education does not meet needs of nurses in sparsely populated areas.

Recommendations

Nursing Service and Nursing Education must plan together in identifying needs for practicing nurses.

The newer philosophy of Adult Education must be made available to all nurses.

Communication barriers between Nursing and Agency/Hospital Administrators must be improved or patient care will become the responsibility of others.

New approaches developed for identifying changes in attitudes and behavior of nurses enrolled in Continuing Education.

Be more realistic in our expectations for change resulting from short-term offerings with no continuous support in the back-home agency.

Include broad based representation for program planning.

Define differences between Inservice and Continuing Education.

Define different levels of nursing practice.

Universities have a responsibility to encourage and support Inservice Education as one of their functions. Continuing Education in Nursing has a responsibility to work with the public in identifying and attempting to improve the health care delivery systems.

Stop being defensive.

Universities and Regional Medical Programs have to work together in coordinating offerings.

Revise mailing lists and lines of communications.

III Funding Sources and Rationale for Such Sources

Concerns

Difficulty in funding faculty and programs with "soft money."
Principle of assigning regular faculty the responsibility of Continuing Education on a rotating basis.

Time involved in preparing grant proposals and the need to develop the kinds of expertise needed to do this.

Lack of coordination and overlapping of offerings which creates problems in funding and is not meeting the needs of practicing nurses.
Need to develop better lines of communication with the funding agencies.
A realistic approach to "self-support" for professional growth.

Recommendations

Education must be a continuous process in the life of the nurse if health care needs of the people are to be met. It is the respon-

sibility of institutions of higher learning to provide, support and maintain educational opportunities for the nursing communities they serve.

To meet this obligation, it is recommended that Continuing Education be made an integral component of the nursing education programs in these institutions, using the same criteria for excellence, including faculty, staff, budget and facilities.

Another National Meeting on Continuing Education be held with representation from all institutions of higher education, nursing organizations, voluntary organizations, etc., invited to attend and to use a broader focus approach to solving the problems of providing Continuing Education offerings for practicing nurses and to begin to define roles for the respective groups.

States should begin to develop "Guidelines" for coordinated offerings and funding instead of American Nurses' Association assuming this responsibility. The group questioned the methodology to be used by ANA in developing guidelines and the scope that would be attained in ANA Guidelines.

IV Developing Philosophy and Objectives for Continuing Education Programs in Nursing

Concerns

What will the leadership be from American Nurses' Association with a position budgeted in Department of Education in Continuing Education?

How is the role of Continuing Education going to be defined by ANA?

How can we be helpful in working with ANA on establishing standards for Continuing Education?

The need to include all nurses in the planning for change, giving them the opportunity to express their concerns and fears in planning and implementation of the recommendations.

What organization we as a group desire as an umbrella, and what recommendations we should make to this group?

Recommendations

That the primary goal of Continuing Education programs be focused upon the development of programs which will be effective in facilitating changes in the care settings to improve the nursing care services in the institutions and community agencies which employ program participants by involving those who have the authority and responsibility to effect change.

Continuing Education in Nursing Programs must be involved as equal members of the allied health team in their approach to improvement of health care.

REPORT OF GROUP III

Signe S. Cooper, Leader

John Grellner, Recorder

I Administration and Organization of Continuing Education Programs in Nursing, Including Staffing and Securing Faculty

Two types of Continuing Education programs were represented in this group:

1. A separate department of Continuing Education with the collegiate school of nursing.
2. Representation within the University's Extension Division.

Example: St. Louis University

The Continuing Education Department is located with School of Nursing on same level as undergraduates and graduates responsible to Dean with Director appointed by Dean. Committee of Nursing faculty from various departments with School of Nursing plus the representatives of the Extension Division of the University provide program ideas. In addition, an Advisory Committee composed of community representatives, meets annually to offer ideas for Continuing Nursing Education programs. The Extension Division is responsible for handling the administrative aspects of the program.

Credit vs. non-credit courses:

Some programs included credit courses, but the majority did not. Some offered courses for non-degree credit. This was defined as meaning that permanent records were kept at the University to the effect that the student completed the course requirements; the "credits" are not applicable to a college degree. The group agreed that non-degree credit is confusing to students and Continuing Education departments should offer courses on a non-credit basis.

Continuing Education for Licensure

The question was raised but no agreement reached by the group. This question was discussed at a week-long conference in California, but no decision was reached.

Many practitioners need skill updating, need more information about newer knowledge, opportunities to learn about newer approaches to patient care. Credits and grades may take precedence over the

real purpose of the education experiences. What motivates the nurse to seek additional education?

Inservice Education

A question was raised about the difference between Inservice Education and Continuing Education. There was not agreement in the group but in general there was concensus that Inservice Education (e.g., in the hospital setting) is part of the individual nurse's Continuing Education.

Inservice Education was defined as those learning activities provided by an agency for its own employees. It was suggested that hospital inservice often times not more than individual hospital orientation.

Inservice educators should encourage staff to participate in University Continuing Education programs. In some places, community colleges are cooperating with hospitals in their on-going inservice education programs.

Organization

Several different types of organization were represented in the group. It was pointed out that this variety was appropriate at this point; each must be familiar with his own organizational framework and function within this structure. The trend seems to be toward establishment of departments of Continuing Education within the professional school.

Whatever the organization, the Faculty of the School of Nursing should participate as part of their responsibility. Nursing faculty should be paid for Continuing Education activity.

Responsibility of the Continuing Education Director should be to consider very carefully the faculty involved in Continuing Education. Not all faculty are effective teachers of adults.

Participation by faculty in Continuing Education helps them understand the reality situation, particularly the specific problems faced by practicing nurses.

Coordination of Programs

The whole area of coordination, local, state, and national was discussed, and problems raised. A major problem: who makes a decision on planning when two programs conflict?

A few state plans were mentioned briefly. Cooperation of local units with district nurses' associations is also essential.

II Identifying the Learning Needs of Adult Learners and Establishing Priorities for Programs

Qualification for Person Responsible for Directing Continuing Education Programs

Most nurses enter this field with little formal preparation. It was suggested we set up a multi-week conference to prepare individual for directorship of Continuing Education program. Colorado offered a workshop which a number of people felt was helpful. This program is to be offered next summer (1970).

As yet, there may be no well-established criteria for these positions. A background of adult education would be most helpful. When Mrs. Cooper looks for faculty, she asks what the potential member is doing about her own Continuing Education. Indiana University offers a Ph.D. in Adult Education with a minor in nursing. University of California at Berkeley also has such a program. Dr. Knowles noted that thirty-five nurses are enrolled in Ph.D. program in Adult Education at Boston University.

One important qualification was identified: the capacity to relate with the participants in Continuing Education. Director should feel that helping participants is most important. A faculty member who relates to the undergraduate student may not do as well with adults. Many people feel that university people are too "Ivory Tower."

Programming

A question was raised: Are you concerned with the individual practitioner or making inservice an extension of the Continuing Education?

Various programs for inservice were offered as examples. A need to teach the teacher (e.g., inservice educators) was identified. One example was the WICHEN sponsored three-day workshop on "Nursing Leadership." (Information not published yet)

A number of other examples of Continuing Education programs were outlined. The University of Wisconsin experienced a follow-up of programs offered annually to directors of nursing; these nurses meet on their own between annual sessions to continue the learning process.

Determining Learning Needs

Many ideas were expressed regarding the determination of learning needs. These are summarized as follows:

1. Suggestions from the Board of Nursing.

2. Licensure law and new legislation may provide clues to Continuing Education needs.
3. Various studies have been done in a number of states. Use of data in a selective manner to identify common problems.
4. Dialogue with hospital administrators and public health units.
5. On-going study of needs. Quick survey as well as in-depth research studies are appropriate.
6. Suggestions from advisory committees. Representatives on these committees are from the community, adult educators, as well as nursing members.
7. Active faculty members who are working with the community.
8. Staff nurses in hospitals and public health.
9. Conference with staff nurses. Example of "slip technique" was used. (See August, 1969, American Journal of Nursing.) Identified needs by staff nurses can be used to establish priorities.

One member suggested that titles are important. For example, a course named "Interviewing" drew little enrollment when it was re-named "Talking with Patients" so many enrolled it was necessary to set up three different sessions.

Grant projects: Important to determine specific learning needs as identified by the learners themselves.

Unmet and unidentified learning needs: This was identified as a problem. Staff involved in Regional Medical Programs are going into the field to try to identify health care needs.

Consumer Involvement in Health Care

Does the nurse involved in Continuing Education have a responsibility to help consumers identify their health needs? There was some disagreement on this question. Most felt this was not specifically a function for Continuing Education but a broader problem which should be built in various nursing activities (i.e., public health nursing).

Establishing Priorities

There seemed to be agreement that priorities might be different in various cooperative efforts in Continuing Education. This is the value of regional planning-sharing faculty, facilities, and other educational resources.

A question was raised about the educational preparation of the

faculty for various Continuing Education programs in nursing. Some participants felt that many hospital clinical nurses are not invited to work with university faculty on educational projects because of a lack of academic background. Most of the people in the group felt that good working relationships do exist in many places. One participant suggested that in many cases team teaching is useful; the nurses with clinical expertise are coached by those with more academic preparation.

III Funding Sources and Rationale for Such Sources

Some sources of funding were suggested by group members:

1. Funds through Title I of the Higher Education Act (if the state five-year plan includes health).
2. Funds through the National Institute of Mental Health.
3. Funds through Regional Medical Programs. Content of programs provided is somewhat limited.
4. Payment of fees by the nurse herself. There are differences in motivation when tuition is charged vs. program offered under a grant. School teachers are required to renew education every five years. Why should nurses expect institutions to pay their tuitions? One participant suggested teachers' salaries are based on credit hours of education; this situation is not similar in nursing. Another difference: many more courses available to teachers for credit. Participant suggested that nurses have a history of having room and board paid for; may result in their reluctance to pay their own way educationally.

Institution may pay for the nurse to attend programs, and she may leave shortly afterward. The institution must look at this as a contribution to nursing generally.

The question about fees was raised; there seemed to be a variety of tuition payments in the various institutions represented.

Responsibility of the University

Responsibility varies somewhat with the type of institution, its philosophy, and so on. In general, tax-supported institutions expected to provide public service (including adult education). Some suggestions included:

1. Institution has the responsibility to allocate money for Continuing Education.
2. Institution may seek private funds; one participant suggested that Idaho University attempted to tap philanthropic organization but found nothing available for Continuing Education. Medically associated industries may contribute but usually do so on an anonymous basis.

3. Federal short-term traineeship funds are available for selected programs.
4. Some scholarship funds may be available. Would part-time nurse participate more readily if scholarship were available? One participant suggested that alumnae grants may supply funds for certain programs.
5. Grant Quarterly: List of various funds and grants available. Check with local librarian in the medical school.

Various other ideas were expressed

If particular program suffers financial reverses, then that program may not be worthwhile to continue (or at least requires careful evaluation).

Some programs might be initiated on a small cost basis while searching for other financial support. It is difficult to make the reverse transition; that is, no charge at beginning then charge tuition later.

If nurse finds course is useful and meaningful, then she is more willing to pay tuition.

Even though a course is funded by a grant, it may be very expensive to the nurse, personally, (baby sitter, housekeeping services, travel, etc.).

Most institutions cannot rely on state or federal funding, since there have been many cutbacks at both levels. Non-funding by state or federal government will hit the private institutions hardest. One participant suggested that because of the money squeeze some private institutions feel that Continuing Education should be left to the tax-supported schools.

An important question was raised: How do we involve University Administration in further supporting Continuing Education?

It was suggested that undergraduate education be supported by university funds, but Continuing Education is often overlooked by administration, even though adult education is geared to the people who are actually paying taxes.

It was also suggested that in the future, universities would be involved in more Continuing Education activities. One participant stated that community colleges are developing large programs in Continuing Education. Two questions are: do universities want to give up leadership in Continuing Education in nursing? Are there different levels of Continuing Education in nursing?

Several members of the group felt that perhaps we are taking too negative a view of what nurses will pay for. If programs are given and people do not attend, perhaps there is something wrong with the program.

Grant Writing

Participant wants recommendations to USPHS about more time for submission of grants. January 1 and August 1 deadlines are not realistic and do not fit university schedule. USPHS representative came into group meeting and discussed some of the problems involved. She pointed out that new guidelines for Continuing Education proposals are available.

Long Range Projections

What will be the long-range impact of the knowledge explosion? This important question cannot be answered, but it suggests the importance of long-range planning for Continuing Education.

In Wisconsin, long-range projection made by faculty but very difficult because of the many factors involved. Participant said that the new preventive medicine concept will tie into the needs of Continuing Education in the future. Nursing Continuing Education may be forced to look at community needs in addition to professional needs.

Leader suggested that Continuing Education program must speak for itself when seeking state funds. Many problems must be faced and nurses must try to understand the dimensions of the problems involved in financing programs.

IV Developing Philosophy and Objectives for Continuing Education Programs in Nursing

In the last session, this group did not discuss the suggested topic, but instead made more recommendations for further action and activity.*

* All of these recommendations were representative of one workshop and did not represent the consensus of the entire conference group. However, the Appendix reports several conference recommendations which did incorporate the suggestions in recommendations 3, 4, 8, and 11.

Organizational structure relating to Continuing Education. How might this group of educators concerned with Continuing Education in nursing fit into the present structure? Many members expressed concern that yet another nursing organization might be established.

Two suggestions were made:

Recommendations

1. The National League for Nursing might form a council on Continuing Education.
2. Joint efforts of ANA and NLN on Continuing Education. This would allow others than nurses to participate in Continuing Education activities. This seemed appropriate.

Important to have such group as Directors of Continuing Education in Nursing meet under the auspices of the national groups; need to be within organized structure before planning purpose and objectives.

Recommendations (continued)

3. That an interim task force be appointed before the termination of this conference to plan the next national meeting of directors of Continuing Education, and
4. That the task force explore with both boards the prospect of sponsoring this group jointly within the structure of ANA, League for Nursing, or both, in some manner.
5. Definition of Continuing Education and Inservice Education.
6. That ANA Commission on Education defer writing a position on Continuing Education in nursing without consultation and collaboration with Continuing Education interim task force appointed from this conference.
7. Question of financing activity of task force. Suggestions: (a) out of budget, (b) assessment of the group, and (c) explore Kellogg funding.
8. That the task force (mentioned above) be represented geographically and functionally including university, inservice, etc., and from well developed and from beginning programs.
9. That the national directors of Continuing Education plan an annual meeting - possibly in conjunction with ANA or NLN Convention.

Coordination of state-wide Continuing Education.

This group expressed concern over coordination Continuing Education efforts on state, regional and national basis.

Representatives of Associate Degree Programs.

Recommendations (continued)

10. That representatives of associate degree programs be invited to attend if they are involved in Continuing Education or planning to initiate on-going programs in Continuing Education. Annual Meeting of Directors of Continuing Education.
11. That a meeting be held next fall - time and place to be decided by interim task force. One purpose of the meeting; the report of the task force on affiliation with national organization.

NATIONAL CONFERENCE ON CONTINUING EDUCATION FOR NURSES

Williamsburg, Virginia - November 9-14, 1969

Recommendations from Individual Participants

Purpose of Conference:

To provide opportunities for nurse educators in the rapidly developing field of continuing education, to update their knowledge and expand their competence in organizing, administering, planning, programming, financing and evaluating continuing education programs for nurses and to prepare guidelines for new and ongoing programs.

Objectives:

Opportunities will be provided for participants in the conference to --
Expand knowledge of adult learners and adult education methods and to make application to registered nurse learners in continuing education programs.

Share specific experiences which will enhance competence and skills in organizing, administering, planning, programming, financing and evaluating continuing education programs for nurses.

Demonstrate the use of newer educational technology in continuing education.

Prepare guidelines for new and developing programs in continuing education in nursing in relation to studies of current trends.

Suggest ideas for better utilization and sharing of personnel and other resources in state, regional, and national planning of continuing education programs for nurses.

1. Based on the purpose and objectives of the conference, of what value has the conference been to you personally?
2. What were your objectives in coming to the conference? Were they met and if so how?
3. What recommendations do you have for a follow up of this conference?
4. Would you recommend that representatives of Associate Degree Programs be invited to future meetings?
5. What is your recommendation for national sponsorship of nurse educators involved in continuing education programs for registered nurses offered by colleges, universities and community junior colleges?
6. Do you feel the need for a "position paper" on continuing education for nurses at this point in time?
7. If continuing education is seriously considered as a requirement for relicensure of nurses, do you feel colleges, universities and community junior colleges are prepared?

Recommendations
continued

8. What recommendations do you have for further implementing or improving regional coordination and communications?
9. What recommendations do you have for future funding for continuing education for nurses?
10. What recommendations do you have for state wide coordination of all continuing education efforts for nursing?
11. State any other recommendations, not suggested, that you may have.

The following is a sampling of responses from individual participants to recommendation number 1.

No. 1. BASED ON THE PURPOSE AND OBJECTIVES OF THE CONFERENCE, OF WHAT VALUE HAS THE CONFERENCE BEEN TO YOU PERSONALLY?

The main value derived from the conference seemed to be the opportunity to get together on a national level and share knowledge with others. Several participants stated that they were able to see more clearly the organizational structure, goals and needs of continuing education and felt that this conference gave them an opportunity to influence others.

The general consensus seemed to be that the participants felt the following objectives of the conference had been met:

To expand knowledge of adult learners and adult education methods and to make application to registered nurse learners in continuing education programs.

To share specific experiences which will enhance competence and skills in organizing, administering, planning, programming, financing and evaluating continuing education programs for nurses.

To suggest ideas for better utilization and sharing of personnel and other resources in state, regional and national planning of continuing education for nurses.

The participants did not feel that these objectives had been fully met:

To demonstrate the use of newer educational technology in continuing education.

To prepare guidelines for new and developing programs in nursing in relation to studies of current trends.

Recommendations
continued

No. 2 WHAT WERE YOUR OBJECTIVES IN COMING TO THE CONFERENCE? WERE THEY MET AND IF SO HOW?

Most of the participants came simply to broaden their knowledge of continuing education. Various reasons were stated, such as:

To get the national picture of what is going on in continuing education.

To get an overview.

To get the feeling of national trends.

To understand statewide structures for the continuing education systems.

To gain new ideas and methods.

To share experiences, concerns, ideas, philosophy.

Several participants came specifically to get ideas to be used in new and developing continuing education programs.

Understanding the relationship of Regional Medical Programs with continuing education was the objective of several participants.

Nearly all participants stated that they felt their objectives had been met, if not wholly at least partially. The programs and contacts with other participants were felt to be the most beneficial.

No. 3 WHAT RECOMMENDATIONS DO YOU HAVE FOR A FOLLOW UP OF THIS CONFERENCE?

That a national conference be held annually. (Suggested by 16 people)

That a task force explore possibility of affiliation with the American Nurses Association and/or National League for Nursing. (Suggested by 12 people)

That an interim task force plan the next conference. (Suggested by 7 people)

That groups for discussions be smaller. (Suggested by 4 people)

That the conference be shortened to three days. (Suggested by 4 people)

That a follow up conference be held in six months. (Suggested by 2 people)

That a conference be held in two years. (Suggested by 2 people)

Recommendations
continued

Question #3 (* single responses)
*

That a task force be represented geographically and functionally, including university, inservice, etc., and from beginning and well developed programs.

That various planning committee members be used to chair each session.

That a regional conference be held next.

That the next annual conference be held in conjunction with ANA and NLN Convention.

That the report of conference be published quickly and distributed to all participants.

That copies of proceedings be delivered to deans.

That copies of proceedings be sent to ANA and NLN.

That more printed material be available for participants.

That resource people attending conference who have had experience in some of the specific areas be used.

That careful consideration be given to problems identified by participants. Several university centers might be interested in studying these problems.

That a progress report be obtained from participants-- what they accomplished since this conference, how was the conference instrumental in achieving their accomplishments?

That major issues be explored in depth.

That each participant would add all other participants to her mailing list.

That speakers be better prepared and not speak "off the cuff".

That a structural organization of directors of continuing education be established.

That several areas for conference be explored--rotate sites.

That this group reconvene and discuss definition of continuing education and inservice education.

That leaders in staff development be involved in any follow up sessions so that hospitals and other agencies may better understand their relationship to the total effect and the need to improve their programs.

Recommendations
continued

Question #3

- * That Dr. Knowles ideas be followed up in discussion groups.

That at least one more meeting be held to establish objectives, prepare a position paper, then organize.

That the next conference be less broad in scope.

That the next conference be planned to take a broader look at the needs of continuing education.

That the next conference should be planned to provide some continuity to this one.

That the program content for the next conference should be developed from recommendations and/or unanswered questions.

That the next conference not be limited only to university continuing education, but should include all state colleges and community colleges.

That the nurse educators be involved and broaden our scope to meet needs of health care facilities and meet with allied health personnel, planning and implementing programs for health care personnel.

That a good look be taken at existing patterns of communication and coordination of continuing education.

That non-nursing organizations who are planning programs for nurses be made aware of the nursing responsibility and needs and get their cooperation and support.

That a centralized place be developed for continuing education information on potential program plans, new methodology, new audiovisual aids, etc.

That a regional conference develop guidelines through task force and study group.

That the definition of continuing education for the purpose of the next conference be broadened to recognize the individual and employer's responsibility, as well as the university's and that they be appropriately involved.

(* single responses)

Recommendations
continued

No. 4 WOULD YOU RECOMMEND THAT REPRESENTATIVES OF ASSOCIATE
DEGREE PROGRAMS BE INVITED TO MEETINGS?

Of the 74 participants answering the questionnaire, 47 said they would invite representatives to meetings, 19 said they would but had reservations, 4 would not and 4 answered ambiguously.

No. 5 WHAT IS YOUR RECOMMENDATION FOR NATIONAL SPONSORSHIP OF
NURSE EDUCATORS INVOLVED IN CONTINUING EDUCATION PROGRAMS
FOR REGISTERED NURSES OFFERED BY COLLEGES, UNIVERSITIES
AND COMMUNITY COLLEGES?

Most of the participants favored sponsorship with the American Nurses Association or joint sponsorship with American Nurses Association and National League for Nursing with the latter receiving the most votes. The following is the numerical breakdown:

Joint sponsorship (ANA-NLN)	21
Ambiguous or no response	20
ANA	17
NLN	2
Other:	
Adult Education Association of the U.S.A.	1
National Education Association	1
Other single opinions:	

I think colleges and universities should analyze their own needs but within a region. Some assistance from national organizations would be helpful but should not be the manager and total sponsor.

Feel that ANA, League, Federal Government, State Government, all have a responsibility in supporting and assisting with Continuing Education where ever and in what form it takes plan.

There should be extensive exploration of the various possibilities of National affiliation such as ANA, NLN, Adult Ed., Medical Ed., Allied Health, Comprehensive, State Nurses Assoc., Higher Ed., etc. The pro's and con's of each should be explored for future consideration.

I hope it could be under the umbrella of one of the present structures. There are too many umbrellas at present.

Not sure of precise meaning of this question. If you mean should this group be a department of NLN or ANA, I recommend the group wait.

Recommendations
continued
Question #5

We are not ready for this - I think we should meet on our own for a time or two yet before making such a decision.

Our group discussed setting up a task force from this group to explore this matter and I whole heartedly agree this is an excellent idea.

Rotate sites, individual responsibility - not a national sponsorship like ANA, NLN, HEW, RMP, etc.

Investigate joint NLN-ANA. Investigate AEA - this would be slower but ultimately achieves our desire for multidisciplinary involvement that might eventually rub off on basic and graduate nursing education.

A more structured and organized group would eventually be the outcome of national sponsorship; thus removing this tremendous burden from individual areas who represent the leadership in continuing education.

None as yet.

I'm not sure of the meaning of this question - sponsor financially or how? But I do think these educators should be university connected, supported and financed. This way there are fewer opportunities for pressure from high level government agencies who are unaware of needs of nurses and other health professionals.

No. 6 DO YOU FEEL THE NEED FOR A "POSITION PAPER" ON CONTINUING EDUCATION FOR NURSES AT THIS POINT IN TIME?

Thirty-one said they felt a "position paper" should be written now, 27 did not favor a paper at this time. Nine favored a "position paper" sometime in the future but not now. Seven answers were ambiguous.

No. 7 IF CONTINUING EDUCATION IS SERIOUSLY CONSIDERED AS A REQUIREMENT FOR RE-LICENSURE OF NURSES, DO YOU FEEL COLLEGES, UNIVERSITIES AND COMMUNITY JUNIOR COLLEGES ARE PREPARED?

Only one of the 74 participants said she felt colleges, universities and community junior colleges are prepared. Sixty-eight answered negatively, five answers were ambiguous.

No. 8 WHAT RECOMMENDATIONS DO YOU HAVE FOR FUTURE IMPLEMENTING OR IMPROVING REGIONAL COORDINATION AND COMMUNICATIONS?

Due to the diversity of answers all responses are quoted.

That strong nurse intervention through State Nurse Associations be considered. In some states it seems that if nursing is not too strong the physicians more or less decide what is best for nursing.

One agency or a coordinating committee.

Recommendations
continued
Question # 3

Sharing of program descriptions, possibly as simple as mailing announcements.

All areas should have a "WICHEN". All of us could put these participants on our mailing lists. At least an annual national meeting for continuing education directors.

Close cooperation of Continuing Education with Federal, State programs, agencies and associations such as RMP, CHP, State Nurses Associations, League, etc. Like idea of Advisory Committee.

Could there be a central clearing house for distribution of materials, etc.?

Closer working relationship with RMP and continuing education directors. Heard diversity of opinions as to how closely the two groups now work together. Both have so much to contribute to each other we can't afford "competitive" efforts.

Involve Inservice leaders and Directors of Nursing Services.

More efforts be made in these areas through periodic meetings for these purposes.

Larger budget for mimeo and postage. Regional workshops of length and depth on leadership and resources.

More description of efforts in the literature.

How about a regional newspaper prepared four times a year?

Start with coordinating councils with representation from all over regions. Pull in other people as appropriate and form sub-committee, etc., but keep coordinating council of a workable size and composition.

Periodic regional meetings for purpose of developing means of on-going coordination and communication with complete sharing among regions of their respective efforts. These meetings should be held separate from but along with statewide meetings for these and additional purposes, especially determining needs.

I do feel that programs should be planned from a core advisory group and all programs should be shared. Perhaps SNA could take a leadership role in this and work with other states or RMP persons who work with regional programs.

Regional newsletter - monthly or quarterly - or meetings.

Please try to work through existing organization - ANA (because it is the professional organization). Any more fragmentation will turn me off completely. SNA because some need help in setting up structure. Avoid

Recommendations
continued
Question #8

appointing people who have so many prestige needs that they can't put the overall objective first.

Planning committee.

Participating in own region such as "WICHEN", SREB, etc. for long range planning.

Something like "WICHEN" in other areas.

A change in attitude that nursing is not an empire within itself. The avenues for coordination and communication are open and we must take advantage of this. Recommend "broad" advisory councils, etc.

Central coordinating agency regarding programs, dates, times - local district, state organizations - to look at local needs and get going on meeting them.

Establishment of Regional periodic meetings which would include agencies who have people who are primarily concerned with nurse continuing education. Correspondence and journal articles would also be helpful.

In our state there is no effort being made. The first step would be for some organization - State Nursing Association, RMP, etc., to take responsibility to get ball moving to assign the responsibility to a person - or organization.

The nursing groups in each area or region should develop a plan for Continuing Education and coordination. This is being done through a MNA Committee in Michigan with wide nursing representation.

We need a clearing house on national level so all Continuing Education programs could be registered (just like clearing house for research studies) then, we could have an idea at least about program offerings.

Coordinating planning committee at state level of all heads of departments (educational), nursing organizations, and RMP nursing coordinators.

Continuing Education newsletter from or in each region. Could RMP be responsible for editing and publishing?

Utilization of resources presently available in established region. Areas with no structure explore ways of meeting this need.

Regional conferences using this conference as a prototype.

Professional publications or clearing house which encourage interchange. Perhaps ERIC for Adult Education could help. Regional meetings and groups such as "WICHEN" with an annual two or three day national meeting.

Utilization of communications of existing media. Provide for a central

Recommendations
continued
Question #8

distribution center on Continuing Education offerings and needs. State Nurses Association - College of Medicine, Community Center.

I would recommend that the remainder of the US develop mechanisms similar to "WICHEN" and SREB. I would discourage the Big Ten or C/C coordination since they omit many schools.

That there should be either one agency or one coordinating committee responsible.

Continue development of present regional groups - "WICHEN", etc. Development of statewide and intra or interstate plans for coordination of Continuing Education.

RMP could be helpful here. Few organizations have the opportunity to assume this responsibility.

No. 9 WHAT RECOMMENDATIONS DO YOU HAVE FOR FUTURE FUNDING FOR CONTINUING EDUCATION FOR NURSES?

Note: Thirty-four out of seventy-four responses indicated the need for "hard money" to finance Continuing Education on an equal basis with other educational programs in colleges and universities, e.g., to provide permanent staff and budget. All responses are recorded to provide the reader with all recommendations for reference.

Utilization of private health concerned agencies in the community for assistance.

Tuition - health agencies funding grants.

Assign registration or tuition costs. The agencies will pay for staff to attend worthwhile programs, as industry does.

HEW and Regional offices, foundations, industries, state public health offices, tuition and fees, hospital associations, health agencies.

"Sell your program" so well that it is accepted by administration.

Promote personal commitment for nurse practitioners. Develop a system more stable than support from federal funding.

University budgeting. By tuition and fees from participants. Special funding from government, Kellogg and similar organizations.

Push for hard money funding for faculty and staff. Nurses need to feel some responsibility - including money - for their Continuing Education. Several fee based workshops have been supported by the practitioner group.

Recommendations
continued
Question #9

Regional and national meetings should be funded - local groups basically funded by own institutions.

That institutions of higher learning view Continuing Education as an integral part of their offerings and support it with money and morally.

Put more responsibility on the individual, more publicity on Continuing Education. Let the public know about Continuing Education - what it is and what it does. Keep federal and state government aware of Continuing Education and purpose. Continuous and strong representation here.

Do some lobbying and get our Board of Regents and legislature aware of the need for funding Continuing Education programs in colleges of nursing. Get administrators of health care agencies to realize importance of Continuing Education and budget.

Local foundations, local industry.

I don't feel these Continuing Education departments in universities should be financially separated from the institution. These units should be budgeted departments. Additional, independent funds should be used for experimentation only.

Continuing Education be nationally accepted as part of the educational process of our people and acceptable for funds as all other programs in education are.

I believe to sell Continuing Education to state legislatures and get hard funds from there - a budget. Then get support and assistance from federal and local funds as indicated.

Nurse practitioner fees in accord with the school's tuition for part-time formal education and state funding of state ADN and higher degree schools Continuing Education programs in accord with schools' other programs.

Think that state universities schools of nursing should be encouraged to put greater emphasis in budgeting for Continuing Education activities. Continuing Education programs are so frequently the very last to be considered - State legislators should be encouraged to see importance of funding Continuing Education with hard money.

Use all possible sources of funding while we "sell" Continuing Education to nurses and health agencies while we work toward the time when at least some will be supported by individuals and agencies.

Private, industrial or federal funds to establish the program plus charges for all programs offered with the hope that the program becomes a regular part of the school budget and to a great degree self supporting.

As a regular part of nurse education funding included in any institutional support from state or federal government.

Recommendations
continued
Question #9

It would be very helpful if available funding sources were generally known. I had no idea RMP's had so much money available for programs. (This is showing a lack of communication.) I also feel colleges and universities need to help finance programs.

I cannot believe that all funding should come from the federal government. A multi-pronged approach is essential - and I personally believe more individual nurses should be encouraged to pay for some of the programs they attend themselves.

Traineeship, school and hospital budgets to include monies for Continuing Education. Education is expensive and if programs are "good" participants will pay their own way.

State legislatures must assume the primary responsibility. Continue federal funding. Trends indicate there is not much hope from philanthropic sources. Health Services Agencies must assume some responsibility. The individual nurse must assume some responsibility.

Faculty members as individuals should get into and work with the Volunteer Health Agencies, e.g., Heart. Those groups have money and will spend it. I want money for resident program at graduate level, let's be careful and not drain too much for Continuing Education.

Recommend trying to get hard money from existing agencies (educational institutions, RMP, etc.,) but I don't think they'll continue to carry us free unless we can produce better nursing care and prove that we do. Therefore research and evaluation built in from the start.

School of Nursing support. Student self support. State Support. Federal support. Health agencies support. Industry, etc.

I am not sure of what all is available now. Could this be available in the printed report?

Utilize all resources available, including the participant paying. But what is needed is some way for Continuing Education directors to find out the funding that is available and how to get to it.

Stable financial support from school of nursing budget through the university. I am seeking funds for the university through the hospitals and other health agencies for which we prepare nurses. So far, this support has been generous, continuous and stable. I believe they will support in the same way, at least a director to start with.

The agency within which the Continuing Education Department is established must take responsibility for a stable financial base. Then all other methods of funding can be used such as fees, grants, contributions, etc.

Recommendations
continued
Question #9

Agency (where continuing education program is) budgetary priority. Federal funding. Private foundations - increasing sophistication in use of these last two resources. Participants themselves - set fees at realistic level to pay for programs (one aspect of quality offerings).

Explore every possible source, many have been mentioned here this week.

Some subsidy to get started to prove the necessity to the Institution and ultimately through student fees and University support.

Funding from participants of this group for a possible task force. College budgets, increased tuition, program - grants.

The only reasonable source - for a multitude of reasons covered in the various discussions - to the federal government.

Greater university or educational organization support.

That nursing administration in School of Nursing sell the need for hard money to support a core staff for Continuing Education. That both private and public funds be used when and if available. That nurses be sold on self support of keeping up to date.

More emphasis on participant fees - less on federal funding.

This is part of responsibility of the practitioner as well as the employer.

Continuing Education be stressed as function of the university and be fully supported by the Schools of Nursing both financially and morally. Financial support for continuing education for nurses should be no different from that planned for any other group of interested citizens.

All avenues (governmental and private) should be explored.

Acquainting hospitals and educators with the problem and soliciting their help on a gratis basis, e.g., educators could participate; hospital administration could give time to participants. If I knew any others, I would be using them.

Depends on area again whether it be university, RMP, etc.

States appropriate more money to assure state universities more stable support for planning and providing Continuing Education. More exploration of private sources of funds on local level.

Prove its value in university and colleges through grants then seek hard money. Then involve all agencies and resources.

Recommendations

continued

Question #9

Diversified - cut dependency on federal. Also participant pay, state funds, scholarship solicitation for Continuing Education as well as basic locally, etc.

Same recommendations for Group #2 - budgets from parent schools and universities.

By consistent organization of "nursing" as a group we can be strong and demand as much funding as we deem necessary - due to fragmentation of our professional group our voice is weak. Thus, unnoticed by federal and private funding.

Private funding - effective approaches have not been used, community funding. Nurses should be encouraged to, at least, share in the cost.

None that haven't been stated. If it becomes mandatory for relicensure, perhaps fee for this could be raised and then agencies doing Continuing Education could be subsidized according to the number of nurses they enroll and help through Continuing Education activities.

Through combination of private, state and federal - how else? Until nurses accept responsibility for their own education (\$).

Financial support should be assured by colleges of nursing. Funds also from government sources and industry.

My suggestion would be have specific sources of funding for meeting specific needs. There would be no question as to who to appeal to. If the need is based on the RMP objectives - then use them for funding, etc. However, this way does depend on definite understanding of each resource objective and purpose. I don't know if this is feasible, but I'd like to think it is. Funding does seem to be the big thing. You may be wasting much time in funding because of the grant request writing and then it goes to the wrong source.

I feel universities must take a good look at their responsibilities to the community which in fact supports them; not financially but interest, specifically, the schools of nursing. My unsophisticated approach to this question is that the university should support a Continuing Education program - charge tuition for courses and not continue depending on federal funds which at best are temporary.

Any source available - especially stable - state, regional funds with nursing having a voice in programs, content, methodology of delivery.

I have not been necessarily involved with funding programs. Only thought I have is that the need for Continuing Education is increasing - as a requirement for relicensure it may soon become overwhelming - and costly; and when Continuing Education is mandatory or even if it's not, money should never be a deterrent to a participant. This begins to implicate government money, I think, more and more for traineeships, etc.

10. WHAT RECOMMENDATIONS DO YOU HAVE FOR STATEWIDE COORDINATION OF ALL CONTINUING EDUCATION EFFORTS FOR NURSING?

Editors note: Due to diversity of responses all are recorded.

That a continuing education committee or interest group be established in the state nurse association.

As Recommendation #8.

A state continuing education committee for nursing representative of all nursing education institutions and nursing service agencies. This could be a subcommittee of the statewide planning commission for nursing education.

Involvement with all state agencies of health in the planning. There is little or no duplication in our state as we are the university "expected" to provide continuing education.

A coordinating committee composed of representatives from consumers of nursing, representatives of health agencies, state nursing organizations, participants of continuing education programs, continuing education faculty of the university sponsoring continuing education and the like.

Use of existing organization - NLN in our case - has meeting of continuing education directors annually. Explore content, clear calendar and review problems. This has been moderately successful. RMP also has vehicle for this. In states where state supported schools offer continuing education coordination also is enhanced.

Plan for meetings where people concerned with continuing education in a state can get together and discuss what is being done. Present plans - future plans - newsletters - individuals corresponding.

Have a council to coordinate educational efforts.

The coordinating council with statewide representation mentioned before could do this. Should do this as a basic part of their responsibilities.

Each state name a coordinating council for continuing education - a possibility.

If there is only one university program in the state I believe it should be there, if more than one in different parts of the state then each could be responsible for distinct area - with exchange of programs or through planning sessions.

Same as #8. I do feel we should make a strong recommendation that there be statewide coordination. I feel it is essential and that in many states it is not being done.

If the State Nurses Association is a strong one - this would seem the logical group to bring about coordination. Otherwise, a state university should take the leadership and involve all groups concerned.

State Committee with large representation and a central core to direct it.

Recommendations
continued
Question # 10

Work more closely with the State Nursing Association and League. Nursing is too fractured, I am afraid, for the League with the Deans going "off by themselves" and the American Hospital Association ready and willing to lure other groups.

The State Nurses Association could take the leadership in this by establishing a committee on continuing education.

See # 8 - same idea of responsibility would apply.

We have a State Director of Nursing. She could have an associate director of continuing education - someone who would be responsible for statewide coordination. Her salary? From where paid? Use ANA and NLN membership and form committees to determine needs.

Coordinating council through higher education channels.

State nurses association serve as the "coordinating body" for exchange of information on what is available, what is being planned (short and long term) by voluntary agencies, organizations and educational institutions.

It must be locally determined on local strengths. I'd like to see alliance of SNA, university continuing education and RMP. After discussing here, I'd identify it as the "Popiel Plan". Starts as a communicating network and eventually the basic trust generated allows the mechanism to become coordinating. Also, since I believe that nursing continuing education must articulate with other health continuing education, I don't think SNA has the qualifications to assume primary role in this.

A statewide coordinating committee (smaller groups in populated areas) to include representative from other major health disciplines, consumers of health care services (patients), legislators, educators, education and health agencies, etc.

Representatives of all agencies and institutions who can provide some dimension of continuing education for nurses meet and explore and define roles and relationships to the overall continuing education problem for all levels of nurses. Develop a mechanism for identifying the ongoing and changing continuing education needs of nurses and the mechanism for development of courses by the appropriate educational institution.

Employ an individual and staff to coordinate existing activities. Provide this individual with a statewide committee representing all nursing institutions, organizations and agencies to call for information sources and support. See consultant service. Assess needs. Set priorities.

Feel that where the group can be coordinated it should be done. There should be some statewide plan to avoid duplication of efforts and encourage sharing.

Recommendations
continued
Question # 10

Consideration that this be a function of CCH Education (Statewide Coordinating Council on Higher Education) or Education Board. The establishment of a coordinating council made up of those persons engaged in providing Continuing Education plus consumers of continuing education. (Housed within Nursing Association, or RMP, or university depending on resources of the State.)

It will vary with states - and there may never be total coordination - and maybe this is good to a point - we don't want to smother but facilitate and stimulate without overwhelming. The best coordinating, catalyzing force in our State now is through the RMP. It brought all interested parties (individuals, agencies, and organizations) together involving them in planning and implementing, etc.

Real effort, not just lip service about the need, is required. State nurses associations can often take the leadership in this area.

Same as #8.

Representatives from within the state developing their own plan - no two needs alike.

People in the state must be aware of all that is available in the state first off, from the bottom up. Then after awareness, you can be more aware of what to expect and how these may be used. All involved must define their boundaries.

Same as #8. I think as continuing education is just an emerging, separate entity, it is a good opportunity to begin close, clearly defined relationships "from the bottom up" so to speak - to not allow duplication and conflict to ever develop to any degree. Need one central group to coordinate, communicate, advise.

No. 11 STATE ANY OTHER RECOMMENDATIONS, NOT SUGGESTED, THAT YOU MAY HAVE.

(Editors note: Many of the responses to No. 11 were repetitious and duplicated previous recommendations. Twenty-two gave no response. The Editor did extract eighteen answers which qualify under miscellaneous.)

That Continuing Education as a topic be considered by the ANA program committee as a topic for consideration at the convention, particularly in light of the relicensure issue.

That nursing aggressively pursue positions in allied health groups that will influence and affect change in health care delivery.

Continuing Education is great and I love it. However, we must direct our energies to get our education system ordered and set up as it should be. Likewise, we need to be careful or we will prevent the development of sound inservice in agencies. Employers must assume the responsibility for preparing nurses to do a job. If we work too hard, agencies may tend to look to continuing education for the answer. I want well educated nurses to come out of schools who have a commitment to self development. Universities can and are doing this, we must keep at this (educate good nurses).

Effort toward influencing nursing school administration to provide support for continuing education programs to develop. The faculty may see the need for structure other than a committee that changes yearly, but unless this is shared by the Dean and Executive levels of the school, development may not occur.

That members of the planning committee serve as models for the kind of continuing education personnel and program presentations we heard about this week.

a. Preparation of Directors and faculty (again see recommendation for Group III). b. Recruitment of young, dynamic, creative and open people for field.

Formation of a study group which will make recommendations for meeting educational needs of nurses from differing educational backgrounds and different types of nursing practice.

I believe there is a great need for programs on a regional and national level -- to convince Deans of Nursing and Directors of Schools of Nursing as to the importance of well balanced educational programs to include continuing education departments on equal status with undergraduate and graduate programs.

"Continuing education for nurses" seems so isolated -- could we not think in terms of the health disciplines? I feel that we need to be a "subcommittee", a "sibling" - the "family" is missing. How can we get the other siblings together who are needed to form the "family environment" in which the nurse functions.

We should not become a "Splintered" group but work very closely with our professional organizations - (ANA and NLN). 2. That a special task force be appointed to study the needs, definition of Continuing Education and Inservice Education. (a) This task force should explore with a Board of Directors from each professional organization the need of a joint effort. (b) The task force could also decide on another meeting of this group as to place, time, etc. (c) The task force should be geographically and functionally represented.

Need for more interdisciplinary exploration for continuing education educators, media specialist, health educators, etc., have contributions to make and nurses in continuing education have "expertise" to share with those concerned and involved in continuing education for health professions.

I recommend that all nursing continuing education departments explore and develop more courses which utilize an allied health approach in planning and in student enrollment -- in keeping with the "health team" approach to care. (Drs., nurses, P.T., O.T., social workers, dietitians, etc.)

This "improved patient care" that we constantly refer to has not yet reached John Doe, the patient. We must take a serious look at the reasons for a prolonged decrease in good patient care. It appears as though the gap between education and service is growing by leaps and bounds.

National Exchange of information regarding major programs. Sharing of innovative approach to continuing education. Newsletter to all involved in continuing education.

Build another conference on the base of this one. I, too, have a bias against "one shot" attempts without follow through. There is a need for planning continuing education programming that is University based -- there is also a need to plan continuing education programming that is not University based -- but that draws upon the rich resources of Universities. This conference was well planned and executed! Needs follow up.

Nursing and continuing education must look to larger picture of relevancy to changing modes of delivery of health services particularly responsive to community needs and away from professional orientation and good evaluation.

1. Focus concern on how to change the health care setting that the learner returns to. 2. Begin having a national definition of "nursing" and "quality patient care" or else we will be left wide open in defending many of our educational goals.

I think central coordination body at regional, state, national level should not be a nursing group, but multidisciplinary since this is supposedly the emphasis. The ANA or NLN seems to me to be too weak, not a dynamic enough group to take on coordinating responsibilities,

especially in continuing education where they do not have experts in the field. Any future conferences, workshops, etc., should identify objectives and people to participate in these. I was unaware of faculty/educator aspect of participants, and rather surprised to learn I was "not discouraged from coming, but not encouraged either."

NATIONAL CONFERENCE ON CONTINUING EDUCATION FOR NURSES

Williamsburg, Virginia - November 10-14, 1969

GENERAL RECOMMENDATIONS

1. That a follow up conference be held in 1970.
2. That the national consultants to this conference; namely, Signe Cooper, Wisconsin, Elda Popiel, Colorado, G. Marjorie Squaires, California, and the conference chairman, Betty Gwaltney, Virginia, serve as an interim committee before the proposed conference in 1970. And, that the American Nurses' Association and the National League for Nursing each be asked to appoint a representative to the committee, and, that the host for the next conference become chairman for planning. And, that additional representatives be added to the committee according to the recommendation from Workshop Group III.
3. That the interim committee extract all recommendations from group reports and take appropriate action.

Editor's note: All the general recommendations were endorsed, as amended, by the entire conference group.

COLLEGES AND UNIVERSITIES REPRESENTED AT
NATIONAL CONFERENCE ON CONTINUING EDUCATION FOR NURSES
WILLIAMSBURG, VIRGINIA - NOVEMBER 10-14, 1969

1. Adelphi University
2. Alabama, University of
3. Arizona, State University of
4. Arizona, University of
5. Berea College
6. Boston College
7. Boston University
8. California at Los Angeles, University of
9. California Medical Center, University of
10. Cincinnati, University of
11. Colorado, University of
12. Columbia University
13. Duke University
14. Emory University
15. Florida, University of
16. Georgia, Medical Center of
17. Georgia, University of
18. Goshen College
19. Indiana, University of
20. Iowa, University of
21. Kentucky, University of
22. Michigan, University of
23. Mississippi, University of
24. Missouri, University of
25. Nebraska, University of
26. Nevada, University of
27. New York State, University of
28. Ohio State University
29. Oregon, University of
30. Perdue University
31. Pittsburgh, University of
32. Rutgers University
33. Saint Anselm's College
34. Saint Louis University
35. South Carolina, University of
36. South Dakota State University
37. Spalding College
38. Syracuse University
39. Tennessee, University of
40. Texas, University of
41. Texas Woman's University
42. Utah, University of
43. Vermont, University of
44. Virginia, University of
45. Virginia Commonwealth University
46. West Virginia, University of

LIST OF REGIONAL MEDICAL PROGRAMS REPRESENTED
NATIONAL CONFERENCE ON CONTINUING EDUCATION FOR NURSES
WILLIAMSBURG, VIRGINIA - NOVEMBER 10-14, 1969

1. Alabama Regional Medical Program
2. Arizona Regional Medical Program
3. Arkansas Regional Medical Program
4. Colorado-Wyoming Regional Medical Program
5. Intermountain Regional Medical Program - Utah
6. Louisiana Regional Medical Program
7. Mountain States Regional Medical Program -- Nevada
8. New Jersey Regional Medical Program
9. North Carolina Regional Medical Program
10. Northeast Ohio Regional Medical Program
11. Northlands Regional Medical Program - Minnesota
12. Ohio Valley Regional Medical Program
13. San Francisco, California - Regional Medical Program
14. Stanford Regional Medical Program - Palo Alto, California
15. Texas Regional Medical Program
16. Washington-Alaska Regional Medical Program
17. Western Pennsylvania Regional Medical Program
18. WICHE - Mountain State Regional Medical Program - Idaho Section
19. Wisconsin Regional Medical Program, Inc.

STATES REPRESENTED AT
NATIONAL CONFERENCE ON CONTINUING EDUCATION FOR NURSES
WILLIAMSBURG, VIRGINIA - NOVEMBER 10-14, 1969

- | | |
|-------------------|--------------------|
| 1. Alabama | 19. Nebraska |
| 2. Arizona | 20. Nevada |
| 3. Arkansas | 21. New Hampshire |
| 4. California | 22. New Jersey |
| 5. Colorado | 23. New York |
| 6. Florida | 24. North Carolina |
| 7. Georgia | 25. Ohio |
| 8. Idaho | 26. Oregon |
| 9. Indiana | 27. Pennsylvania |
| 10. Iowa | 28. South Carolina |
| 11. Kentucky | 29. South Dakota |
| 12. Louisiana | 30. Tennessee |
| 13. Maryland | 31. Texas |
| 14. Massachusetts | 32. Utah |
| 15. Michigan | 33. Vermont |
| 16. Minnesota | 34. Virginia |
| 17. Mississippi | 35. Washington |
| 18. Missouri | 36. West Virginia |
| | 37. Wisconsin |

NATIONAL CONFERENCE ON CONTINUING EDUCATION FOR NURSES
THE MOTOR HOUSE - WILLIAMSBURG, VIRGINIA
NOVEMBER 10-14, 1969

ROSTER

1. Conference Staff

Betty H. Gwaltney, R.N., B.S., M.A., Chairman and Conference Director
Department of Continuing Education
Medical College of Virginia
Health Sciences Division
Virginia Commonwealth University School of Nursing

Faye Peters, R.N., B.S., Assistant Conference Director
Nurse & Allied Health Officer
Virginia Regional Medical Program
Richmond, Virginia

Kay Sommers, Secretary to Miss Gwaltney

Ellene Lowry, Conference Secretary

2. Local Planning Committee

Franklin Bacon, Dean of Students and
Associate Professor of Adult Education
Medical College of Virginia
Health Sciences Division
Virginia Commonwealth University
Richmond, Virginia

Dr. Benjamin Cullen, Assistant Director
School of Hospital Administration
Medical College of Virginia
Health Sciences Division
Virginia Commonwealth University
Richmond, Virginia

Betty H. Gwaltney, Chairman
Department of Continuing Education
Medical College of Virginia
Health Sciences Division
Virginia Commonwealth University
Richmond, Virginia

General W. C. Haneke, Administrator of
Research Grants and Contracts
Bowe House
Medical College of Virginia
Health Sciences Division
Virginia Commonwealth University
Richmond, Virginia

Local Planning Committee (Cont'd.)

John Mapp, Director
Evening Schools
Virginia Commonwealth University
Richmond, Virginia

Dr. Pinson Neal, Assistant Dean
School of Medicine
Medical College of Virginia
Health Sciences Division
Virginia Commonwealth University
Richmond, Virginia

Dr. Eugene Perez, Director
Virginia Regional Medical Program
700 Building, Suite 1025
Richmond, Virginia

Faye Peters, Nurse & Allied Health Officer
Virginia Regional Medical Program
700 Building, Suite 1025
Richmond, Virginia

Elizabeth Ryan, Assistant
Continuing Education in Nursing
Medical College of Virginia
Health Sciences Division
Virginia Commonwealth University
Richmond, Virginia

Melvin Shaffer, Director
Department of Visual Education
Medical College of Virginia
Health Sciences Division
Virginia Commonwealth University
Richmond, Virginia

Edward Springborn, Director
Comprehensive Health Planning - Virginia
Madison Building
Richmond, Virginia

Dr. Doris B. Yingling, Dean
Medical College of Virginia
Health Sciences Division
Virginia Commonwealth University School of Nursing

3. National Nursing Consultants

Signe S. Cooper
Chairman, Department of Nursing
University Extension
The University of Wisconsin
Madison, Wisconsin

National Nursing Consultants (Cont'd.)

Elda Popiel, Professor and Assistant Dean
Continuing Education
School of Nursing
University of Colorado

G. Marjorie Squaires
Coordinator-Administrator
Continuing Education in Nursing
University of California Extension
Center for the Health Sciences
Los Angeles, California

4. Speakers

Dr. Malcolm S. Knowles
Professor of Education
Boston University
School of Education

G. Marjorie Squaires
Coordinator-Administrator
Continuing Education in Nursing
University of California, Los Angeles

Dr. Eugene T. Johnson
Professor of Adult Education
University of Georgia and formerly
Executive Director of Adult Education
Association of the U.S.A.

Signe S. Cooper
Chairman, Department of Nursing
University Extension
The University of Wisconsin

Dorothy T. White, Director
Department of Nursing Education
American Nurses' Association, Inc.

Joan E. Walsh
Consultant in Nursing Education
National League for Nursing

Faye Peters
Virginia Regional Medical Program
Nurse and Allied Health Officer

Gretchen Osgood, Assistant Director, Division of Nursing
Bureau of Health Professions and
Education and Manpower Training
National Institutes of Health, PHS
Department of Health, Education and Welfare

Speakers (Cont'd)

Dr. Veronica Conley, Chief
Allied Health Section
Division of Regional Medical Programs

Ruth Spurrier
Director of Nursing
Kentucky State Department of Health

Susanna Chase
Director, Continuing Education Program
University of North Carolina, Chapel Hill

Elda Popiel, Professor and Assistant Dean
Continuing Education
University of Colorado
School of Nursing

Melvin Shaffer, Director
Department of Visual Education
Virginia Commonwealth University

Dr. James Lieberman, Assistant Surgeon General
Director, National Medical Audio-visual Center
Atlanta, Georgia

Emily Tait, Director
Continuing Education
Saint Louis University
School of Nursing

5. Workshop Group Leaders

Group I - Helen Pazdur, R.N., M.S.

Group II - G. Marjorie Squaires, R.N., B.A., M.A.

Group III - Signe S. Cooper, R.N., B.S., M.Ed.

6. Workshop Group Recorders

Group I - Marjorie Baker, Associate Professor, University of
Virginia, School of Nursing

Group II - Dorothy Blume, Director of Continuing Education,
The University of Texas

Group III - John A. Grellier, Coordinator of Medical Center
Programs, Saint Louis University

NATIONAL CONFERENCE ON CONTINUING EDUCATION FOR NURSES
THE MOTOR HOUSE, WILLIAMSBURG, VIRGINIA
NOVEMBER 10-14, 1969

ROSTER OF PARTICIPANTS

1. Adams, Ruth C., Program Director
Continuing Education for Nurses
University of Vermont
School of Nursing
538 Waterman
Burlington, Vermont 05401
2. Alcott, Louise, Education Specialist
Mountain States Regional Medical Programs-Nevada
956 Willow Street
Reno, Nevada 89502
3. Andrews, Marie S., Director of Continuing Education
Boston College
School of Nursing
Chestnut Hill, Massachusetts
4. Baker, Marjorie, Associate Professor
University of Virginia
School of Nursing
McKim Hall
Charlottesville, Virginia 22902
5. Blume, Dorothy, Director, Continuing Education
The University of Texas Nursing School
C. P. Hall
Austin, Texas 78712
6. Booth, Audrey J., Core Staff
North Carolina Regional Medical Program
4019 Roxboro Road
Durham, North Carolina 27704
7. Bowen, Geneva N., Assistant Professor
University of South Carolina
School of Nursing
Columbia, South Carolina 29208
8. Bunnell, Margaret, Director, Continuing Education Program for Nurses
Kutgers University
University Extension Division
Building 4077 - Kilmer Area
New Brunswick, New Jersey 08093
9. Carroll, Maura C., Chairman, Continuing Education in Nursing
University of California Medical Center
School of Nursing
San Francisco, California 94122

10. Cleary, Constance, Associate Professor of Nursing
Columbia University
622 West 168 Street
New York, New York 10032
11. Cravens, Cynthia, Instructor, Patient Care Education
Duke University Medical Center
Durham, North Carolina 27706
12. Dawson, Jane, Director of Continuing Education
Texas Woman's University - Dallas Center
College of Nursing
1810 Inwood Road
Dallas, Texas 75235
13. Dietrich, Betty J., Nursing Coordinator
Regional Medical Programs
727 Parnassus Avenue
San Francisco, California 94131
14. Ditchfield, Alda L., Head, Atlanta Center
Medical College of Georgia
School of Nursing
3280 Georgian Woods Circle
Decatur, Georgia 30034
15. Dubrule, Marian D., Chairman, Faculty Development Committee
St. Anselm's College
Department of Nursing
Manchester, New Hampshire 03132
16. Farrell, Honora K., Director, Continuing Education
Adelphi University
School of Nursing
Garden City, Long Island, New York 11530
17. Ferrell, Sister Patricia, Instructor
Spalding College School of Nursing
851 South 4th Street
Louisville, Kentucky 40203
18. Fleming, Juanita W., Resource Faculty in Pediatrics
University of Kentucky
College of Nursing
Box 19, Kentucky State College
Frankfort, Kentucky 40601
19. Gilmore, Laurene, Assistant Director for Education
Alabama Regional Medical Programs
1919 - 7th Avenue South
Birmingham, Alabama 35222

20. Goldberg, Enid, Assistant Director, Nursing Liaison Services
Western Pennsylvania Regional Medical Program
3530 Forbes Avenue
Pittsburgh, Pennsylvania 15235
21. Gough, Anne M., Chief, Nursing & Allied Health
Colorado-Wyoming Regional Medical Program
4200 East 9th
Denver, Colorado 80220
22. Grellner, John A., Coordinator of Medical Center Programs
Metropolitan College
St. Louis University
3673 West Pine
St. Louis, Missouri: 63108
23. Harris, Barbara M., Associate Professor
Emory University School of Nursing
1782 Vickers Circle
Decatur, Georgia 30030
24. Hebbeler, Evangeline Lorraine Angel
Program Development Specialist
Ohio Valley Regional Medical Program
P. O. Box 4025
Lexington, Kentucky 40504
25. Hill, Mary S., Director Continuing Education in Nursing
University of Pittsburgh School of Nursing
443 Scaife Hall
Pittsburgh, Pennsylvania 15313
26. Hocker, Dorothy L., Director, Continuing Education
The University of Tennessee College of Nursing
879 Madison Avenue
Memphis, Tennessee 38103
27. Horvitz, Ida A., Director, Continuing Education
College of Nursing & Health
University of Cincinnati
3110 Vine Street
Cincinnati, Ohio 45219
28. Huhnke, Frances S., Chairman, Continuing Education Committee
Arizona State University
College of Nursing
Tempe, Arizona 85281
29. Johnson, Eugene B., Director of Education
Northeast Ohio Regional Medical Program
10525 Carnegie Avenue
Cleveland, Ohio 44106

30. Jones, Evelyn Zetter, Consultant
Self-Employed
19 Prospect Street
Summit, New Jersey 07901
31. Kinney, Anna Belle, Assistant Professor
University of Virginia
School of Nursing
McKim Hall
Charlottesville, Virginia 22902
32. Knight, Cornelia S., Associate Coordinator
New Jersey Regional Medical Program
88 Ross Street
East Orange, New Jersey 07018
33. Korycinski, Jane
69 Cedar Avenue
Newport News, Virginia 23607
34. Kramer, Irma M., Director, Continuing Education for Nursing
University of Nebraska School of Nursing
42nd and Dewey Avenue
Omaha, Nebraska 68105
35. Kruse, Lorane C., Associate Professor
The Ohio State University School of Nursing
1585 Neil Avenue
Columbus, Ohio 43210
36. Kuhn, Rose Marie, Instructor, Continuing Education
University of Missouri
School of Nursing
Columbia, Missouri 65201
37. Lacy, Shelby, Nurse Coordinator
Athens General Hospital
797 Cobb Street
Athens, Georgia 30601
38. Lang, Norma M., Nursing Coordinator
Wisconsin Regional Medical Program, Inc.
110 East Wisconsin Avenue
Milwaukee, Wisconsin 53202
39. Larson, Carol, Allied Health Specialist
Continuing Education and Training Branch
Division of Regional Medical Programs
Bethesda, Maryland 20014
40. Larson, Laura G., Coordinator, Nursing & Allied Health
Mountain States Regional Medical Program
525 West Jefferson
Boise, Idaho 83702

41. LeBrun, Jeanne, Program Coordinator
Stanford Regional Medical Programs
703 Welch Road
Palo Alto, California 94304
42. Lindgren, Audrey, Nurse Consultant, Division of Nursing
Bureau of Health Professions
Education and Manpower Training
National Institute of Health
Bethesda, Maryland 20014
43. Lynch, Lillian, Assistant Professor
University of Arizona
College of Nursing
Tucson, Arizona 85721
44. Malbone, Carol, Instructor, Continuing Education
University of Utah College of Nursing
2215 East 2100 South
Salt Lake City, Utah 84109
45. Matthews, Ann F., Regional Institutional Consultant
Division of Nursing
Department of Health, Education & Welfare, Region III
220 Seventh Street, N.E.
Charlottesville, Virginia 22901
46. McClellan, Marilyn G., Assistant Director of Nursing Service
University of Rochester Medical Center
Strong Memorial Hospital
260 Crittenden Boulevard
Rochester, New York 14620
47. McCrary, Martha E., Assistant Director
Northeast Ohio Regional Medical Program
6712 Stafford Drive, Apt. 307
Mayfield Heights, Ohio 44124
48. McHenry, Ruth W., Chairman, Continuing Education in Nursing
Syracuse University School of Nursing
103 Waverly Avenue
Syracuse, New York 13210
49. Merrell, Eileen K., Education Specialist, Nursing
WICHE - Mountain States Regional Medical Program, Idaho Section
310 Idaho Street
Boise, Idaho 83702
50. Meyer, Helen A., Continuing Education for Nursing Staff
Louisiana Regional Medical Program
2714 Canal Street, Suite 401
New Orleans, Louisiana 70119

51. Mosemann, Orpha B., Director of Nursing
Goshen College
Goshen, Indiana 46526
52. Mosley, Laura C., Assistant Professor
Berea College
Box 380
Berea, Kentucky 40403
53. Mulcare, Catherine M., Assistant Director of Nursing Service
Cincinnati General Hospital
234 Goodman Street
Cincinnati, Ohio 45229
54. Nehren, Jeanette, Chief, Nursing and Related Personnel Section
Continuing Education Branch, Division of Manpower & Training
National Institute of Mental Health
5454 Wisconsin Avenue
Chevy Chase, Maryland 20015
55. Nelson, Joy, Head of Department of Continuing Education
College of Nursing
South Dakota State University
Brookings, South Dakota 57006
56. Ord, Betty R., Nurse Consultant
Arizona Regional Medical Program
100 W. Clarendon Road, Suite 1646
Phoenix, Arizona 85013
57. Orwig, Bernice I., Associate Professor of Nursing
University of Oregon School of Nursing
3181 S.W. Sam Jackson Park Road
Portland, Oregon 97201
58. Osborne, Jean, Director, Coronary Care Training Program
Intermountain Regional Medical Program
50 North Medical Drive
Salt Lake City, Utah 84112
59. Patray, JoAnn H., Director, Continuing Education
University of Florida
College of Nursing
Gainesville, Florida 32601
60. Pazdur, Helen, Lecturer
University School of Nursing
University of California Medical Center
San Francisco, California 94012
61. Fettit, Helen F., Professor of Nursing
Faculty of Medicine
Columbia University
622 West 168 Street
New York, New York 10032

62. Pemberton, Helen A., Project Assistant
Nursing Education Project
Southern Regional Education Board
Atlanta, Georgia
63. Pesek, Mildred, Professional Assistant
Texas Regional Medical Program
Methodist Hospital Planning Office
6723 Bertner Avenue
Houston, Texas 77025
64. Phelps, Theresa, Chairman, Continuing Education Department
State University of New York at Buffalo
School of Nursing
3225 Main Street
Buffalo, New York 14214
65. Price, Alice W., Manager of Nursing Services
Roche Laboratories
340 Kingsland Street
Nutley, New Jersey 07110
66. Retzer, Gertrude Y., Nurse Coordinator
Hospital Council of Maryland, Inc.
32 West Road
Towson, Maryland
67. Samarino, Edith, School of Nursing
University of Mississippi Medical Center
2500 N. State Street
Jackson, Mississippi 39205
68. Shultz, Carol P., Assistant Director, Patient Care Education
Duke University Medical Center
Durham, North Carolina 27706
69. Schweer, Jean E., Director, Continuing Education School of Nursing
Indiana University - Purdue University at Indianapolis
1232 W. Michigan Street
Indianapolis, Indiana 46202
70. Schowalter, Joyce M., Nursing Coordinator
Northlands Regional Medical Program
375 Jackson
St. Paul, Minnesota 55101
71. Shine, Patricia, Director for Nursing Affairs
Regional Medical Program for Western New York
2929 Main Street
Buffalo, New York 14214
72. Shores, Louise, Director Continuing Education for Nurses
Washington-Alaska Regional Medical Program
500 U. District Building
Seattle, Washington 98105

73. Siegel, Fanny F., Research Assistant
Teachers College, Columbia University
2 Lynwood Avenue
New Milford, New Jersey 07646
74. Simon, Margaret E., Chairman, Division of Medical Arts
University of Nevada, Las Vegas
4505 Maryland Parkway
Las Vegas, Nevada 89109
75. Skinner, Geraldine, Associate Professor
University of Michigan School of Nursing
1006 Catherine Street
Ann Arbor, Michigan 48104
76. Smith, Helen C., Dean
University of Evansville School of Nursing
P. O. Box 329
Evansville, Indiana 47701
77. Slack, Gearlean Swentzel, Director, Continuing Education
West Virginia University School of Nursing
Morgantown, West Virginia 26506
78. Sovie, Margaret D., Educational Director and Coordinator
Nursing Services
State University Hospital - Upstate Medical Center
750 East Adams Street
Syracuse, New York 13210
79. Sugrue, Joyce, Nurse Coordinator, Department of Continuing Education
South Dakota State University
College of Nursing
Brookings, South Dakota 57006
80. Walter, Jacquelyn S., Nursing Coordinator
Arkansas Regional Medical Program
500 University Tower Building, 12th at University
Little Rock, Arkansas 72204
81. Williams, Mary Edna, Director of Continuing Education
University of Alabama School of Nursing
1919 Seventh Avenue South
Birmingham, Alabama 35233
82. Zemlicka, Pearl, Assistant Professor
University of Iowa, College of Nursing
Iowa City, Iowa 52240

SUGGESTED GUIDELINES FOR WORKSHOPS

I ADMINISTRATION AND ORGANIZATION OF CONTINUING EDUCATION PROGRAMS IN NURSING, INCLUDING STAFFING AND SECURING FACULTY

What is the responsibility of a college or university for continuing education?

Where does continuing education fit into the overall structure of the college or university?

How does nursing fit into an overall structure for continuing education?

Would continuing education in nursing be best served through a separate department within the school of nursing? How do you provide for coordination with this structure?

Who should the Director for Continuing Education in Nursing report to administratively?

What are desirable qualifications for an administrator of a continuing education program in nursing?

What staff other than an administrator should a program in continuing education consist of?

What provision should be made to facilitate communications between continuing education in nursing and the school of nursing?

What kinds of faculty are needed in continuing education and where can faculty be procured?

Should faculty of the school of nursing be expected to participate in continuing education programs?

Should you have a committee to assist in overall planning for continuing education in nursing? What would be the ideal composition of such a committee? How often should this committee meet?

II IDENTIFYING THE LEARNING NEEDS OF ADULT LEARNERS AND ESTABLISHING PRIORITIES FOR PROGRAMS

What are the essential differences in characteristics of adult registered nurse learners vs. undergraduate students?

What recognition do you give these differences in teaching adult learners?

How do you utilize your knowledge of adult education in application?

Should you have a system for setting priorities in programming?

What methods do you use for setting priorities?

Should all programs be held on campus or in continuing education centers? If not, how do you regionalize your programs?

Do you have central services for production of announcements of programs? Otherwise, who is responsible for the preparation of publicity, mailing, etc.?

III FUNDING CONTINUING EDUCATION

Should there be a budget for continuing education in nursing?

Who determines the budget? Who administers it?

Should there be a separate budget for administration?

Should the various continuing education programs be self-supporting?

List sources for funding continuing education programs in nursing.

What are some of the problems involved in financing continuing education? Administrative? - Separate Programs?

Do you have assistance in grant writing? What kind of assistance do you need?

Do you keep separate accounts for each program offered? Who keeps these accounts?

IV DEVELOPING PHILOSOPHY AND OBJECTIVES FOR CONTINUING EDUCATION PROGRAMS IN NURSING

How do you derive a philosophy for continuing education in nursing within the framework of the school of nursing and university philosophies?

What elements should be considered in developing a philosophy for continuing education in nursing?

How should you use the philosophy in implementing the program?

Should you have overall objectives? And/or should you have objectives for each program?

V EVALUATION OF CONTINUING EDUCATION PROGRAMS IN NURSING

Should you be able to evaluate your total program in continuing education? How do you accomplish this?

Should you set up separate evaluation techniques for each program offering?

Should you attempt immediate evaluation from each trainee?

Should you aim for follow-up evaluation and how do you accomplish this?

Do you provide consultative services following any of your programs?

How often do you revise your evaluation techniques?

How effective is evaluation of your total program? Each individual program?

MEDICAL COLLEGE OF VIRGINIA SCHOOL OF NURSING
CONTINUING EDUCATION PROGRAM
Broad and 12th Streets
Richmond, Virginia 23219

April 25, 1967

Dear Director:

This letter is to introduce myself as Director of Continuing Education for Medical College of Virginia School of Nursing. In addition, I would like to propose that we Directors organize, rather informally, for the purpose of sharing program ideas and developments nationally related to continuing education for registered nurses.

Our program here at Medical College of Virginia is relatively new, but already we are overwhelmed by the multiplicity of projects confronting us. I am sure we all face the same problems of setting priorities, funding, selecting faculty, and meeting the variety of needs of adult learners.

We would like to get your reaction on the idea of a national conference for Directors of Continuing Education to be held in Virginia, in late 1967 or early 1968. We could invite nationally known persons in the field of adult education, as well as Directors of some of the more "sophisticated" programs in continuing education, to participate. We are fortunate enough to have a well equipped visual education department at Medical College of Virginia and could probably program some Educational TV during the conference period, plus demonstrations of other audio visual media. Provisions could be made for exhibits of various continuing educational programs represented.

This is merely an exploratory letter. But we would appreciate your reaction to the suggestions offered, and any other ideas you might have. If the response is favorable we will seek outside funding for the project.

In the meantime, I would appreciate being placed on your mailing list for information and materials related to your program in continuing education.

Sincerely yours,

Betty H. Gwaltney

Betty H. Gwaltney, Director
Continuing Education

BHG:ew

LETTERS OF INVITATION TO 1970 CONFERENCE

The following invitations were received to host the 1970 meeting:

1. Copy of excerpt from Ruth W. McHenry's letter.*

"Since the philosophy of continuing education is this School, is one of a continuing nature including anything beyond the registered nurse base, I have included bulletins of our degree programs as well as the non-credit informal work. The registered nurse, undergraduate program, and the graduate requirements may be found in the green bulletin. The School of Education grants the Master's degree; therefore, a School of Education catalogue is also enclosed.

Should this conference be an annual event, Syracuse University would like to extend an invitation to the conferees to come to Syracuse for the next meeting. In the spring or fall, anyone of its three conference centers in the beautiful Adirondacks would be ideal, or the Continuing Education Conference Center on campus may be used. We would be happy to involve others in the area in the planning and organization of such a conference to coordinate the efforts of all involved in continuing education.

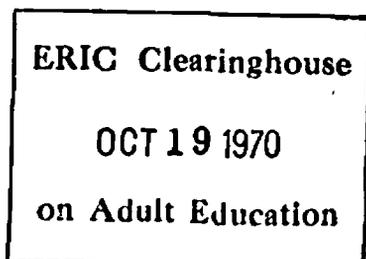
I am looking forward very much to a meaningful exchange of information at this conference and I shall bring some evaluation tools with me. I am deeply appreciative of your taking the leadership role in organizing this conference."

2. The University of Colorado School of Nursing would be happy to host a fall 1970 meeting of the National Conference for Directors of Continuing Education.

Elda Popiel

3. Come to Southern California next fall for a conference. Formal letter following.

G. M. Squaires



* Syracuse University will host the 1970 conference.