

# Said Another Way

## Rethinking Entry-into-Practice Issues

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*I believe there is a resolution to the entry-into-practice issue that has been a divisive issue in nursing for almost half a century. This paper traces one historical route of how entry into practice became an issue, presents several present day suggested solutions to the issue, and finally gives a solution that I believe is credible, feasible, and would be a final solution to the issue. The final solution calls for the Bachelor of Nursing Programs and the American Nurses Association to work together to develop nursing graduates that are specialists upon graduation from the nursing program.*

I believe with all my heart that there is a reasonable resolution to the entangled issue that has ensnared nursing in its tentacles for over 50 years. The issue to be resolved is of what level of education should be required before a person is entitled to sit for the National Council of State Boards of Nursing (NCSBN) licensing exam. Entry into nursing practice is a controversial issue because there is a disagreement within the ranks of nursing as to what specific type of degree must be required for a nurse to be competent to be able to practice. Additionally, factions of nurses believe that nursing must require the same level of education, that of a bachelors degree or higher, as the minimum requirement to align with other health professions. The present education requirement supported by the NCSBN is that a person must show "graduation from or verification of completion and eligibility from a state-approved registered nursing program" (NCSBN, 1999), which allows individuals to sit for the exam if they have graduated from a diploma, associate, or bachelor degree program. Fondiller (1980) noted that this issue is perhaps the greatest deterrent to moving the profession forward. In this paper, I will analyze a comprehensive review of the past events that contributed to the current status of this divisive nursing issue. I will present an overview of the current prevailing suggested solutions on what type of education is required for entry into the practice of the nursing profession.

Finally, I will propose a strategy for a resolution to the entry-into-practice dilemma.

### Review of Past Events

For a complete understanding of the entry into practice debate, it is necessary to review the roots of the issue. I will review the history of the licensing exam, approval of registered nursing programs, and the role of the National League of Nursing (NLN) in the approval process.

The American Nurses Association's (ANA) role in the entry-into-practice issue will be discussed. I will also present a brief overview of the history of nursing education, noting the collision course and eventual collision of the above factors.

Professional licensure involves regulation by government to protect the public from individuals practicing without the requisite skills and expertise. Nursing licensure in the United States is governed by states that also maintain a nursing registrar. Registration involves the recording of eligible practitioners in good standing with the state and does not involve inquiry into competence and the scope of practice. Licensure of a nurse is the process by which an agency of state government grants permission to an individual upon finding that the applicant has attained the essential degree of competency necessary to perform a unique scope of practice (NCSBN, 2003). This process requires the predetermination of qualifications necessary to perform a legally defined scope of practice safely and an evaluation of licensure applications to determine that the qualifications are met.

Qualifications for nurses include meeting the specific requirements of the state board of nursing and passing the National Council Licensing Exam for Registered Nurses (NCLEX-RN). State boards of nursing have been delegated the authority to license nurses through the process of legislative rules and regulations and to prepare, administer, and grade the NCLEX-RN. Because states license nurses and because there are 51 state legislatures, it is important to recognize the

potential difficulty this might create in the entry-into-practice issue. Fifty-one legislatures must be convinced that changes are necessary in the entry-into-practice issue for there to be unified entry into practice.

New Zealand became the first country to enact a nursing licensure law in 1901, with North Carolina becoming the first state to enact a registration law in 1903 (NCSBN, 2003). New York became the first state to define a scope of practice for nurses and to adopt a mandatory licensure law in 1938. It wasn't until the 1970s that licensure for RNs throughout the United States became mandatory because World War II slowed down the process. I believe that the results we are now witnessing, of multiple entries into practice, are partially a result of this lengthy process of mandatory licensing. My reasoning is this: if all states had mandatory licensing before the advent of the Associate Degree in Nursing (ADN) nursing programs in 1952, more control by a cohesive national council of boards of nursing might have prevented the present state of affairs.

The NLN was established in 1952 (Fondiller, 1980). Forerunners to the NLN were the National League of Nursing Education (NLNE), the National Organization for Public Health Nursing (NOPHN), and the Association of Collegiate Schools for Nursing (ACSN). All of these organizations advocated that basic nursing education be moved into the system of higher education from hospital-based schools. The NLN was entrusted with the responsibility for nursing education concerns.

Prior to the establishment of the NLN, the NLNE was responsible for grading of nursing education. A frequently cited report, the Goldmark Report, surveyed the health care professions between 1924 and 1934 revealing over 2000 nursing schools (Fondiller, 1980). NLNE, as a result of this report, began the accreditation of nursing schools, pushed for nurse educators to direct those schools, and determined to continue its strong support of university jurisdiction of nursing schools. NLNE, a former part of the NLN, truly was the foremost organization to determine which nursing schools followed a specified curriculum and develop-

ment requirements, thus, which schools became accredited. This is an important point, as I believe the NLN is directly responsible for the current state of entry into practice. I will develop this belief next.

Although nursing education was clearly in a chaotic state at the time the NLN was founded (Fondiller, 1980) it was at this time in 1952 that strong leadership was needed to monitor the beginning ADN program and to monitor hospital schools of nursing. NLN was given clear recommendations in 1953 from Margaret Bridgman, education consultant to the NLN, to heighten the qualification for professional nursing through the representation of the completion of an upper-division major in a degree-granting institution (Fondiller, 1980). It could be argued that the NLN was a new organization and clearly not ready to focus on entry-into-practice issues, but the NLNE, a former part of the NLN had clearly pointed out the need for a higher institutional nursing program. I believe that what was needed in 1953 was an organization that was not so much interested in building its organization, which NLN was apparently intent upon, but one that continued to closely monitor nursing education.

NLN missed a chance to avert the present state of entry into practice upon making their statement on nursing education in 1953. NLN leaders did not want to offend the American Hospital Association (AHA) or the American Medical Association (AMA) who held the support of the league's accreditation program. As a result, NLN leaders softened their statement on nursing education, which was to move nursing education into colleges and universities, because such a statement was likely to evoke schisms, and offend hospital administrators. Instead, the NLN focused on improving nursing education and nursing service, not on the right of one institution or another to conduct an educational program (Fondiller, 1980).

Between 1952 and 1960, the serious internal conflict over educational preparation for nursing within NLN and the nursing profession continued. In 1956, although the NLN Committee on Perspectives recognized the need to redesign the system of nursing education, they

decided to devote their attention to what nurses needed to know for the next 20 years (Fondiller, 1980). They decided this because they saw their role as not one of judging the merits of changes being advocated or predicted for the education of nurses, but to sound the alert to factors that might impede the changes. The decision to not judge the merit of changes has contributed to the present state of affairs.

In the late 1950s, ANA began to increase its attention to nursing education, frustrating those in the NLN and beginning the collision course between the two organizations. Indeed, in 1960, the ANA committee on Current and Long-term Goals presented the famous proposal that ANA should promote the baccalaureate program so that in due course it would become the basic foundation for professional nursing (Hanson, 1960). This proposal became the official position of the ANA and a declaration to the nursing world that ANA was entering into the field of nursing education. NLN members felt this infringed upon an area that rightfully belonged to them. ANA continued to promote the baccalaureate degree when in 1964, delegates voted to work towards requiring the baccalaureate degree as the educational foundation for professional nursing practice (ANA, 1985). Nearly 40 years later, I consider these delegates to have been far-sighted and risk takers during this period of tumult.

ANA developed a position paper supporting the systematic replacement of licensed practical nurse (LPN) programs with programs for beginning technical nursing practice in community colleges (ANA, 1965), further frustrating NLN, which had developed a department for practical nursing. It is this position of the ANA that began the attempt to differentiate the technical nurse with an associate degree from the professional nurse with a baccalaureate degree even though this was not the original intention of ANA. NLN proposed that there be a redefinition of functions within the nursing community and that no time limits be imposed for any transition to occur (NLN, 1965). The collision of the two organizations had now occurred.

This differentiation of definitions of a nurse has been a debate among nurses involved in the entry-into-practice issue for decades and, I believe, has slowed the progress of making the baccalaureate the required degree. It is difficult, if not impossible to define differences in nursing, technical or professional: if the entry into the profession requires only one test, if employers of nurses are not required to adhere to differentiation of nurses, if nurses do not practice differently and if NLN accredits all types of nursing programs. Adding to the complexity of this debate is what to label the nurse prepared at the diploma level since there were only two types of nurses included in this debate. Although ANA believed it was relieving the nursing education dilemma by replacing LPNs, I believe that this position statement only continued to add to the delay of an entry into practice resolution.

ANA and NLN, historically two of nursing's most powerful organizations, have continued to be in conflict over the entry-into-practice issue. Although there have been attempts by both organizations to resolve the issue, neither has been strong enough, nor have pulled together at the right times, to negotiate all the issues that need to be resolved before the entry-into-practice issue can be resolved. What has been accomplished since 1965 is the almost complete eradication of hospital-based schools, which is perhaps not a long time to wait for this transition to occur. What must happen in the future for the resolution of the entry-into-practice issue is that there must be a differentiation of practice, different accreditation of nursing programs, and different state licensing tests based on education. It is only when these issues can be addressed and the problems associated with these issues be solved that the entry into practice issue will be laid to rest.

### **Current Prevailing Suggested Solutions**

When suggested solutions to the entry-into-practice issue are brought up for discussion, there is usually an embroiled emotional reaction (Lindeman, 1997). Lindeman noted that it is time to stop using entry into

practice as a wedge issue that separates nurses within the profession. She noted that when society embraces privatization as the answer to every problem, when the nursing job market becomes tight, when competencies for nurses change quickly, and when health care is market-driven, this issue is brought back to the forefront. I believe this issue is about to be brought back to the forefront at this time in nursing history.

One suggested solution for how to end the entry-into-practice debate centered on the attempt to differentiate nursing into technical nurses and professional nurses. This would have been fairly straightforward to define if, as ANA intended, LPNs were defined as the technical nurse and nurses with a BSN degree were the professional nurse. However, what has now become debated is that the associate degree be the technical nurse and the professional nurse be a graduate from the baccalaureate program. As noted previously, this solution has not proved to be effective.

Shaming those with less than a baccalaureate degree appears to be one strategy for resolving the issue. Recently, the Associated Press reported that University of Pennsylvania researchers found that low levels of education, coupled with low nurse staffing levels could translate into thousands of preventable deaths nationwide (Tanner, 2003). Their study found that hospitals with fewer than 10% of nurses with bachelor's degrees had death rates of nearly 3% for selected surgery patients compared with 1.5% death rate at hospitals where more than 70% of nurses had bachelor's degrees. Manthey (2002) suggested that nurses simply "declare" that entry level into basic nursing be the baccalaureate level. She suggested that the strategy should be to require that every associate-degree graduate have a plan in place before they take state boards that would be placed in their employee file and reviewed at the time of their evaluations. Motivation for the ADN nurse to progress would be "their own second-class citizen angst" (Manthey, 2002, p. 7).

The Pew Foundation recommended educational diversity, a professional nomenclature, or a single title for each level of nursing preparation, and career

ladders, or differentiated practice responsibilities (Lindeman, 1997). What this would entail is that every nursing school would agree to graduate a single-titled nurse, every large employer would implement similar clinical ladders, and nursing leaders from every organization would agree to the same differentiated practice responsibilities. To state that this would be a daunting task is an understatement.

The Association of California Nurse Leaders (ACNL) has taken the position that by 2010, the BSN will be the entry-level degree for all new nurses to sit for the NCLEX in California (Barter & McFarland, 2001). An articulated system of nursing education would be developed so that students who start at a community college could earn a BSN in 4 years. The ACNL includes 900 nursing administrators, managers, educators, and consultants. They noted that when compared to other health care professions such as pharmacy, physical therapy, and occupational therapy, nursing educational requirements are outdated. The strategy of the ACNL consists of education of all those involved in the change, building coalitions with the California Board of Nursing, funding organizations and educators, and changes in state regulations to require the BSN for practice. Additionally, since the majority of nurses in California are ADN graduates, facilitation of educational opportunities would be continuous. ACNL members are encouraged to hire BSN graduates to positions within their organizations. The success of this resolution has yet to be determined, but if it were successful, only one state would now require the bachelor degree for entry into practice. Additionally, California must take notice of what has occurred in North Dakota.

North Dakota established the baccalaureate degree as the minimum educational requirement for RN licensure in 1987 through legislative action. This strategy has been seen as the best solution for the entry-into-practice issue. Although it is tempting to think that legislators can be convinced that legal action will solve the dilemma, it is a colossal mistake to think they won't change their minds. This year, North Dakota passed a bill requiring the board of nursing to grant

full licensure to nurses granted transitional licensure when they did not meet educational requirements and to approve programs of less than 4 academic years of study for RN preparation (Mooney, 2003). Thus, it behooves nursing to agree within its own ranks on a strategy for the solution of the entry-into-practice issue before taking the issue to the legislature.

### **Strategy for a Resolution**

Before a strategy for a resolution is proposed, it is important that I make a statement of what I believe the entry into the practice of nursing should be. I believe that nursing needs to continue to support the position that the baccalaureate degree be the requirement for entry into practice. This being said, I have observed my own disillusionment with this becoming a reality in the near future. Thus, what I am proposing is a transitional strategy, designed to start the differentiation of practice and to encourage those groups that I believe are best suited for solving the dilemma. Those best suited are educators in BSN nursing programs and ANA.

My strategy is as follows. BSN programs must work together to generate a curriculum that will verify that all students have completed the nursing program and are eligible to take the NCLEX the semester before graduation. Because of this, all BSN students will have an RN license approximately 1 month into the last semester, providing they pass the exam. They will continue for the rest of the semester as RNs. Course work will consist of working 30 hours a week in a specialty area of practice while taking a didactic course of 6 hours a week in that specialty area. Upon graduation, students would receive certification from ANA in that specialty area if they pass the specialty exam provided by the ANA.

My rationale for this strategy begins with the testimony that for decades, associate degree nursing programs have provided evidence that a student with this education does acquire the necessary knowledge base to pass the NCLEX exam. In fact, with the present

system in place and with the present accessibility to online courses, it is not difficult to conclude that a national curriculum is possible. It is also not difficult to imagine that this would be at the associate level because the majority of nurses hold this degree. It is a frightening conclusion that there might be only one curriculum for nurses and that it be that which is taught at the associate level of education.

Further rationale for this proposed solution is that ADN and diploma nurses have successfully practiced in every area of nursing such that it is hard to argue that they have less skill or competency than do BSN graduates. I am aware of very few positions that require that the new graduate have a BSN degree. Presently, when an employer hires a new graduate they are prepared to orient nurses with all types of degrees.

Finally, it would be very difficult, time consuming, and possibly only a temporary solution to attempt to change every state legislature to mandate that entry into practice be at the BSN level. Additionally, it is of the utmost interest to ANA and BSN programs and not ADN programs to change practice requirements, thus they should be the ones at the helm of the change. These groups would be in total control of the proposed changes and would not be at the mercy of NCSBN or any other institution since the changes would be made only in the ANA and BSN programs.

At this point of the discussion on the rationale for my solution, I feel it is necessary to review curriculum expectations. In 1937, the NLNE's second revision of the curriculum for schools of nursing, prepared by the curriculum committee under the direction of Isabel M. Stewart, noted this: "In considering what conditions to include in the curriculum, it was agreed that no school could give definite instruction and experience in the care of all types of patients and all diseases" (NLNE, 1937, p. 27). The NLNE continued with their explanation, noting that students should have instruction and experience in the care of typical conditions selected from all the main groups of patients. I agree with this basic educational requirement for nursing. But it now seems as though basic nursing instruction must include

every politically correct topic, every possible situation the graduating nurse might encounter, biological terrorism instruction, environmental safety, community health, and so on. I believe it is time to return to the basic requirements of knowledge for nursing graduates. The NLNE also recommended that training offered in the undergraduate nursing school must prepare nurses who are in direct contact with patients. I agree with this. It would be refreshing to return to NLNE's 1937 beliefs when they noted that to avoid crowding in the curriculum, one can lengthen the period of professional education, eliminate some of the less important material, or economize time through better teaching and more intensive study. I believe the solution for the entry-into-practice issue I propose will begin to eliminate the "what one might ought to know" and get back to teaching "what needs to be known." Baccalaureate educators would be the first to put this into action and would be examples to other educators as to what a basic nursing education should be. By teaching basic nursing in a three-semester basic nursing course and then allowing students to take the NCLEX, nursing will be forced to return to what a nurse has to know. I foresee the new basic curriculum as being a possible source for the "national curriculum" that was referred to earlier in this paper, whereby all schools, connected through Internet and other means, will utilize one basic curriculum.

Further support for the above idea is found in Fehy's 1977 comment regarding undergraduate education. Fehy stated that undergraduate curriculum cannot hope to transform a student into a competent nurse who is all things to all people. Undergraduate education cannot hope to inculcate all the essential knowledge plus new specialties being developed every day. If this was true in 1977, it is even truer today. BSN educators must take a stand in this belief and pare down the curriculum as it is presented to students today or nursing education will be completely diluted. By admitting that a basic nursing education can be completed in three and a half years and a specialty requirement be added in the last semester, nursing

will openly admit that it has expanded its own boundaries. Nursing will admit that every nurse is not created equal upon graduation but must become certified to practice competently in a specialty area.

This leads me to a side issue in my rationale for my proposed solution. Nursing schools originally based their curricula on the simple "job analysis" of nursing duties (Gelinas, 1946). Today, the NCLEX is based primarily on periodic job analyses (Smith, 2002). This is leading nursing down a dangerous circuitous road. I agree with Guinee (1966) when she noted that as schools have met the suggested standards and received approval of a program by the NCSBN, these molding influences are desirable when they are used as incentives to improve a program. These influences are undesirable when too much emphasis is placed in the curriculum on preparing students to pass state board examinations instead of the attainment of the objective of the particular program. As nursing programs change to meet the requirements of passing state boards which are based on job analysis, I fear nursing curricula will eventually be only based on what is occurring in the health care environment. Thus, instead of nursing determining what the curriculum needs to be, employers of nursing will determine what nurses are taught. In its purest form, it is good that nurses are prepared to step into a predetermined role. However, as a nursing profession, I believe that nursing should determine its own curriculum. The power that nursing education programs have given to the NCSBN, by requiring that all nurses pass the same NCLEX test, is too great. I believe that BSN educators must curtail this empowerment. By adding additional specialty education to the curriculum, BSN educators will begin to decrease the power of the NCSBN.

### Phase One

To begin the implementation of the proposed solution, ANA, with its continued position of making the baccalaureate degree the entry-into-practice requirement, must coordinate with all BSN programs

in the United States. ANA must align with BSN programs not only in its continued position statement, but also within the leadership of both organizations. It is evident that leadership at a crucial time in nursing history played an important contributing role in the present entry-into-practice state. This historical perspective must not be ignored. Leaders from ANA and the BSN programs, although in constant flux, must forge a strong bond. This will require frequent scheduled meetings between the two organizations with steadfast objectives and working together to meet the objectives.

#### **Phase Two**

ANA must be willing to look at its present requirements for certification. Presently ANA requires practice for 2 years as a full-time registered nurse. Additionally, ANA certification requires 30 direct patient contact hours within the last 3 years and a minimum of 2000 hours of clinical practice (ANCC, 2003). Because working 30 hours a week for 14 weeks is only 390 hours, ANA must be willing to substitute the required hours with the 6 hours of didactic learning the student would receive in the last semester.

#### **Phase Three**

BSN educators must take a close look at the present curriculum requirements and alter them such that only basic nursing topics are required. Only those courses that would contribute to the passing of NCLEX and those courses required by the state, AACN, and NLN would be included in the curriculum. A majority of BSN educators must gather for this purpose in large conferences. It is anticipated that these educators could meet this requirement within 1 year.

#### **Phase Four**

The timing of the implementation of the proposed solution would be such that implementation would be within 3 years. In the first year, ANA and BSN educa-

tors would meet to discuss the details of the proposal. Then both groups would separate to complete what areas each group needed to revise. Finally, students would pass through the revised curriculum. In the third year, students would sit for the NCLEX in the final semester of their nursing program.

#### **Phase Five**

With ANA and BSN programs aligned and ready to change, the proposed solution would be ready to be implemented by 2007. In 2005, a national information campaign will announce the changes and the expected results. ANA and BSN programs will be situated by this time to implement the changes and to promote the advantages of the proposed transitional solution for the entry-into-practice issue.

#### **Advantages**

The most important advantages to this proposed solution is that it is feasible and that it could be implemented within a few years. Curriculum changes generally take 2 to 3 years for students to cycle through the courses. For ANA to change the requirements to sit for the certification exams it is anticipated that this would take about 2 years, such that new materials could be printed. There would be very few needed changes to the content of the exams, thus this part of the solution would be fairly uncomplicated.

Another advantage to allowing students in BSN programs to sit for the NCLEX before graduation is that students would graduate with specialty practices, thus beginning the differentiation of practice at the beginning of their careers. BSN graduates would hopefully be better prepared than ADN graduates in their specialty areas, making them more marketable. Additionally, BSN graduates would see the immediate results of a baccalaureate degree, encouraging them to continue to grow in their specialty.

As the complexity of health care continues, more and more topics are being forced into the nursing

curriculum. Educators must realize that students can retain only so much information. An advantage of the proposed solution is that the specialty topics would be given a place within the curriculum during the last semester but only for those that will need the information for their immediate practice.

### Potential Barriers

Potential barriers to the proposed solution include those that might affect ANA, BSN programs, and the public in general. For ANA, it might mean that they would affront associate and diploma nurses as it would more closely associate with BSN programs. It is feasible that ADN and diploma nurses will decry the deferential treatment and this association. However, ANA has long promoted the concept that entry into practice be at the BSN level. By following the proposed solution, ANA might draw more nurses into its membership by dropping the entry-into-practice issue and leaving diploma and associate nursing programs to continue as they are.

Bachelor degree programs may find it difficult to change their curricula. It is hard for some educators to let go of cherished course work. I see the issue of educators changing the curriculum as the greatest barrier to the proposed solution. It might be difficult for one college to agree on content needed to pass the NCLEX, let alone all BSN programs in the country. It must be remembered, however, that NCLEX content is available to the public and that educators would now desire to teach only that content required by NCLEX. Additionally, educators might favor teaching students that plan on specializing in one area and be grateful that now the specialty could be handled in detail.

Another barrier to this solution might mean students will not finish the BSN degree. It is possible that students want to start making money and acquire neither a BSN degree nor any other degree, but would still be RNs. A possible solution to this is to simply allow this type of nurse to exist. These nurses would expect to feel pressure to continue to finish school, much like students

feel now, such there would be very few of these RNs. It is debatable that these RNs might further confuse the public.

### Summary

The entry-into-practice issue needs to be put to rest. Nursing needs to be freed from the bonds of entanglement. Having nurses graduate from BSN programs that are primed to take specialty certification exams and experienced as nurses is a step to accomplishing this. By not being confrontational with other nursing programs and by avoiding legislative action, BSN educators and ANA will be progressing in their desire to see nursing proclaim the baccalaureate degree as the required degree.

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