SECTION 1  The Dynamics of Professional Development

KEY TERMS AND CONCEPTS
Student responsibilities
Writing tips
Test-taking strategies
Professional appearance
Elements of professionalism
Specialized education
Critical thinking
Creative thinking
Reflective thinking
Altruism
Autonomy
Religious orders of nurses
Kaiserworth
Florence Nightingale
Mary Seacole
Primary care
Case management
Unlicensed assistive personnel
Consilience
Nursing science
Nursing art
Associate degree
Diploma
Baccalaureate degree
Graduate education
Three entry levels into professional practice
National League for Nursing
American Association of Colleges of Nursing
National Student Nurses’ Association
American Nurses Association (ANA)
National Council of State Boards of Nursing
Sigma Theta Tau International
Styles model of professionalism
Ethical code
Ethical principles
Ethical dilemma
Licensure
Usual and prudent action

LEARNING OUTCOMES
By the end of this chapter, the student will be able to:

1 Outline the responsibilities of the professional nursing student.
2 Identify strategies for thriving in the nursing education environment.
3 Identify characteristics of professional practice.
4 Compare and contrast technical and professional nursing.
5 Specify how history affects current professional nursing.
6 Explain how the Nursing Code of Ethics affects a nurse's practice.
7 Discuss major ethical principles that formulate the basis for the ethical dimensions of professional nursing practice.
8 Outline a method for making ethical decisions in clinical practice.
9 Identify the legal parameters of practice and how they affect clinical practice.
Sue graduated from an associate degree nursing program 3 years ago. She has been working on a medical surgical unit at the local community hospital as a night change nurse. One of the local college students has been working with Sue over the summer and will finish her BSN next spring. Sue thinks that perhaps she should go back to school and earn her BSN for job security reasons. In talking with her nurse manager, Sue says, "I am a good nurse, even though I don't have a BSN. I don't see how more education will make me more professional, but I see where it may make my charge nurse position secure." What are possible consequences to Sue's statement? What are possible ways to respond to Sue? What would be the consequences of each response identified?

The words "nurse," "nourish," and "nurture" all come from the Latin root "nutrire" (Merriam-Webster's Collegiate Dictionary, 1994). People link these words together and thus frequently consider all caregivers "nurses." Many historians have traced the roots of modern nursing to religious orders of men and women, persons who followed the military into battle, rich matrons who visited the ill and disabled in their homes as penance for sins, and mothers and wet nurses who raised children for the affluent. The profession of nursing struggles with defining itself as an art or science.

Nursing offers a specialized service to society. In the American Nurses Association Social Policy Statement (1995, p. 6), the following four "essential features of contemporary nursing practice" appear:

1. Attention to the full range of human experiences and responses to health and illness without restriction to a problem-focused orientation.
2. Integration of objective data with knowledge gained from an understanding of the patient's or group's subjective experience.
3. Application of scientific knowledge to the processes of diagnosis and treatment.
4. Provision of a caring relationship that facilitates health and healing.

Learning how to fulfill the elements of professional nursing takes time, patience, and perseverance. Historical and recent events have resulted in blurred boundaries between the medical and nursing practice. Because nurses with associate degrees, diplomas, and baccalaureate degrees take the same licensure examination, it is difficult to articulate the differences between technical and professional nursing practice. This chapter describes the challenges encountered by professional nursing students, delineates professional characteristics of nursing, reviews nursing history to provide an understanding of current nursing practice, and outlines dimensions of professional practice with an emphasis on ethical and legal obligations.

CHALLENGES TO THE RETURNING PROFESSIONAL NURSING STUDENT

The legal system and health care agencies hold students to the same professional standards as professional nurses. As persons assume new roles, they undergo personal transitions. Sometimes the transition process results in a wide array of physiological, psychological, sociocultural, and spiritual responses. When competent registered nurses return to school, family members, friends, and co-workers may be sources of support or distress.
Nursing Student Responsibilities

Education can be viewed as the cultivation of intelligence (Martinez, 2000). To make professional transitions, educational efforts focus on refining previously learned skills and establishing theoretical foundations for professional practice. Theory-based practice enables the professional nurse to understand complex situations and anticipate potential problems in the clinical setting.

Communication Skills (Reading, Speaking, Listening, and Writing)

Reading constitutes a major component of the continuing education experience. Success in any program requires reading assigned material. Nursing faculty identify aliteracy (the ability to read, but refusal to do so) as a major obstacle for students. Along with academic success, reading stimulates the release of neurotrophins, which are growth factors that stimulate neuron proliferation and brain vascularization. They also may be responsible for strengthening neural pathways (Martinez, 2000).

Finding time to read remains a challenge in today’s busy world and especially for nursing students juggling multiple roles. Students studying printed and electronic media require effective reading skills. Trying to read and digest each word printed on a page (or screen) is inefficient reading. Often, beginning and returning students strive to remember every detail from assigned readings. When students master the skill of reading for major ideas within a passage, reading becomes more efficient (Dunham, 2001).

In educational settings, effective speaking and listening are essential. Students listen to faculty members as they share their nursing expertise. Many times faculty ask questions to verify student mastery of concepts. Sometimes, this teaching strategy forces students to think and respond quickly. Taking time to think before responding to questions enables students to organize their thoughts and select the best words to use.

When questions arise regarding course concepts, assignments, and professional practice, nursing students need to know how to ask questions effectively. Fear prevents them from asking questions in many cases. Question formulation also requires having the skills to communicate what is not fully comprehended (or understood). If a person cannot formulate a clear question, there is no shame in admitting that one does not understand. Sometimes, the most difficult task to master is learning what question needs to be asked.

In ideal educational situations, students and faculty members interact with each other as colleagues. The faculty design educational experiences, but students bear the responsibility for learning. Unfortunately, students bring patterns of communication with faculty with them from previous educational experiences. In traditional education, faculty members may serve as authoritarian experts who create oppressive climates, engage in polemic discussions, and set educational goals for behavior changes or skill acquisition. In educative-caring education, faculty members hold the same status as students, create liberating climates, engage in illuminating dialogues, and set educational goals focused on innovative, participatory learning (Bevis & Watson, 2000). Egalitarian interactions with faculty members provide students with experience in establishing collegiality. Frequently, long-term friendships result when students and faculty members connect.

Clinical practice requires that professional nurses listen to and verbally respond to clients, visitors, and other health care providers. Detailed information about listening in the context of the nurse-client relationship is discussed in Chapter 19. Others frequently judge a nurse's professional competence by the nurse's speaking skills. Nurses also use public speaking skills when giving professional presentations.
Along with well-developed speaking and listening skills, professional nurses need well-developed writing skills. Professional nurses write letters, electronic mail messages, memos, policies, procedures, evaluation reports, and articles, in addition to their documentation of patient-care activities. Handwritten communication continues to provide essential client-care documentation for situations not covered by computer programs. Finally, development of writing skills remains a hallmark of higher education. Writing encompasses critical and reflective thinking (Broussard & Oberleitner, 1997).

Written course assignments provide opportunities for nursing students to refine writing and thinking skills. Most writers make multiple drafts of their works. Success on written assignments requires understanding the goal of each assignment, setting a timeline for completion by the designated deadline, allowing time for multiple drafts, and having a trusted friend or family member proofread the work. At times, incomplete understanding of the assignments serves as an obstacle to success. In addition to verifying that course objectives are being met, students who question assignment guidelines help to refine such guidelines for future students.

After a student verifies the purpose of the assignment, the critical challenge is focusing on a topic. Topic refinement becomes an essential step because of the wealth of available information found in the nursing literature. Using computerized or printed indexes available at the library streamlines the collection of information on the assignment topic. The amount of information to be collected varies, depending on the nature of the assignment. Students who encounter difficulty in finding information on a topic can seek assistance from a librarian, which will save time and reduce frustration in obtaining relevant information for assignments (Dunham, 2001).

Authors develop nonfiction prose using description, narration, exposition, and argumentation. Authors use description to create a dominant impression. When story telling is the goal, narration serves as an effective tool. Exposition is used when authors want to show the how and why of something. Authors use the following tools for expository writing: (1) exemplification (illustrations or examples), (2) process analysis (step-by-step instructions), (3) comparison/contrast (similarity and differences), (4) analogy (comparison of something unknown with something familiar), (5) classification (identification of common features), (6) definition, and (7) causal analysis (cause-and-effect relationships). Finally, writers use arguments to present objective rationale to support a position (Fondiller, 1992).

Most educational or collegiate teaching programs select a standard format for preparing written assignments. Students enrolled in specific programs should purchase the publication manual for the selected format. Students also may find Internet sites that provide assistance with questions related to a specific format for written assignments.

Before putting ideas in a specific format, a writer can create an outline, which provides an effective means for verifying that ideas have solidified, all required material has been collected, thoughts have been organized, headings are related to the work, no gaps are present in the work, and proper support is available for the main points (Fondiller, 1992).

Finally, authors select words to convey messages clearly and concisely. Reading serves as a vehicle to expand vocabulary that can be used in writing (Fondiller, 1992; Martinez, 2000). Dictionaries and thesauri provide a rich source of words for use in writing. Many dictionaries provide summaries of grammatical rules for written language. When writing is done using a word processing program, many writers use spelling and grammar checking features. Some writers find it useful to read aloud written passages (Dunham, 2001). However, nothing supersedes proofreading by another person.
Professional Image and Physical Appearance
Besides effective communication, physical appearance plays a role in projecting a professional image. Recently, nurses have abandoned the starched white uniform for a more casual appearance. The nursing cap fell out of fashion in the 1970s. Most nurses have traded white uniforms for different colored scrub suits for increased comfort, decreased boredom from wearing white all the time, and enhanced feelings of power because white traditionally has been associated with purity and a subordinate role. Clean, pressed scrub suits and dresses present a professional appearance. Care should be exercised in selecting the pattern of scrubs because some may not be appropriate to specific clinical settings.

Because nurses work at promoting health, cleanliness and safety become priorities when preparing for the work of nursing. Clean uniforms, manicured hands, and clean uniform and shoes decrease the spread of infections. Dangling earrings and necklaces serve as hazards for nurses if they encounter contused, combative clients. Tongue piercing impairs the clarity of a nurse's speech. Visible body piercing and extensive tattooing create distress for some clients.

Organizational Skills for Educational and Professional Success
Scholastic success requires organizational skills. Before students are admitted into a nursing program, they are screened by the nursing faculty for success potential. Schools provide support services to help students succeed. Previously learned organizational skills transfer readily for effective balancing of personal and professional responsibilities.

Information Management
Sifting through volumes of information in printed or electronic media is challenging for all nursing professionals, not just students. Detailed new information about specialty areas of practice surfaces quickly. Scientific discoveries and changes in health care delivery systems also add information. Reliable information sources include governmental, university, and nonprofit organizations. Peer-reviewed journals provide more reliable information than do other types of journals. Caution should be exercised when considering information from for-profit sources. Alexander and Tate (1998) offer techniques for evaluating web-based resources. They outline five criteria for critiquing website information because websites can be a "virtual soapbox" for any person or organization. The following five aspects of a website should be assessed before using information from it in assignments:

1. Accuracy: freedom from error and reliability
2. Authority: the qualifications of the author(s) and whether or not any fact-verifying procedures are used
3. Objectivity: freedom from biases or attempts to sway the viewers
4. Currency: dates of initial and updated information entry
5. Coverage: the breadth and depth of topic coverage and if the information conflicts with other forms of media presentation

Alexander and Tate (1998) also caution that hyperlinks may send viewers to websites of lesser quality and suggest always viewing the home page of the information source to verify the credibility of the source. Finally, Alexander and Tate caution website users about the instability and susceptibility of web pages to unauthorized and accidental changes.

Students and professional nurses spend much time sorting through large volumes of mail, e-mail, publications, advertisements, and professional information. Going through information immediately as it arrives eliminates clutter. Setting priorities for action enables students and nurses to meet deadlines for professional (license renewal, assignment deadlines, renewal of in-
surance policies) and personal obligations (family life, community service, holidays, birthdays, anniversaries). Time spent organizing personal libraries and files saves time in the future. Discarding obsolete and unused items on a regular basis keeps resources current, and filing items facilitates finding them when they are needed (Dunham, 2001).

**Test-Taking Skills**

Testing serves as a means for validating student learning. Test items come in a variety of forms: multiple choice, true/false, matching, short answer, and essay. Most nursing students find test taking stressful. Previous test experiences affect current test performance. Adequate test preparation increases the chance of test success. Many students find establishment of a study schedule helpful. Adequate test preparation includes reading all required class readings, attending class, asking questions during class, taking notes, reviewing learning objectives for each class, reviewing class materials frequently, attending test reviews (if available), and talking with faculty members to verify the student's understanding of course content before the examination. Some students also find participating in a peer study group helpful. Other students prefer to study alone. Depending on how they learn best, some students make audiotapes of class sessions (if permitted), outline readings, recopy notes, and create study cards (Dunham 2001). Nothing allays test anxiety better than adequate preparation.

Some students become very anxious during exams. Sometimes test anxiety impedes performance. Every person uses different techniques to alleviate stress. Some ways to alleviate test anxiety include arriving 15 minutes early to the testing site, practicing relaxation techniques (deep breathing exercises, visualizing success, guided imagery), skimming notes and textbooks, and talking with classmates. Some students find peer interaction increases test anxiety (Dunham, 2001). Aromatherapy, such as smelling essential oils of lavender or vivitar, also allays anxiety for some students.

Instructors construct tests to measure student mastery of course objectives. In professional nursing programs, instructors write most test questions at an application level. When taking an exam, students should verify that they understand what the test item is asking. Strategies to approach each test item vary according to its structure. For multiple-choice items, care should be exercised to read the stem of the question. When reading the response items, frequently one or two choices seem ridiculous and thus can be safely eliminated. Because nursing process and setting care priorities seem to be a dominant theme in nursing exams, students who consider them usually perform better on exams (Dunham, 2001). The myth of a student's first answer most likely being the correct answer may not hold true for nursing examinations (Nieswiadomy, Arnold, & Garza 2001).

**Research Brief 1-1**


The investigators of this study wanted to identify how frequently baccalaureate nursing (BSN) students changed answers on exams and what was the success rate in attaining the correct answers by changing answers. One hundred twenty-two BSN students attending a public university agreed to have their tests reviewed in a medical surgical nursing and a mental health nursing course after program graduation. Computerized test answer sheets were reviewed for evidence of erasures and changing answers for a total of 540 test items (280 medical surgical nursing test items and 260 mental health nursing test items).
Results revealed that all but three students changed answers during these exams. Six students did not change answers on the medical surgical nursing exams and eight students did not change answers on the mental health nursing exams. The range of changes was 0-46 items. When answers were changed, 86.1% of the changes resulted in increased test scores, 6.7% of the scores remained the same, and 6.7% of the changes resulted in a reduced test score. Smaller numbers of items changed during one exam increased the chances of yielding a higher test score.

Implications of the results of this study for nursing students include the following: The myth of changing answers of multiple choice tests in BSN nursing programs may not be accurate. Changing items may be beneficial to improving test performance. However, changes should only be made to a few items during any one exam. Students should also review answer sheets with test items to verify that the proper answer has been marked. If errors are found, corrections should be made. Nursing students may not want to heed the advice of nursing faculty who caution against students changing answers during multiple choice test-taking situations.

Other forms of test items include matching, short answer, and essay. When confronted with an essay question, students who take time to outline answers usually answer the question completely and concisely. Sometimes students believe that writing large amounts in response to an essay question may generate sympathy from the instructor grading the exam and result in earning more points. However, instructors frequently find flawed thinking and errors in long written responses and deduct points.

Personal Time Management
Time becomes a premium when assuming a student role (especially for the nurse returning to school who has employment and family responsibilities). Balancing professional, student, and family responsibilities is an art. Family members often feel neglected as nurses (and students) fulfill professional obligations. Some nurses and students find it useful to schedule special time to attend to the needs of family and friends. Taking such breaks helps nurses and students maintain mental and spiritual health (Dunham, 2001).

Learning to say no and asking for help without feeling guilty are essential time-management techniques. Delegation of household tasks (such as cooking, cleaning, and laundry) to others frees time for study while providing the family member with an opportunity to learn or refine life survival skills (Dunham, 2001). At graduation ceremonies, sometimes graduates present a spouse, parent, child, or significant other with a degree to recognize that successful education required a team effort. Finally, networking with one's colleagues can result in time-saving techniques. In one nursing program, nursing students published a book containing quick, easy recipes and sold the cookbooks as a fundraiser to finance student community service activities.

PROFESSIONAL CHARACTERISTICS
Although nursing has been considered a profession for many years, an assessment of the characteristics of a profession reveals that nursing fails to attain a purely professional field and is more accurately classified as an "emerging profession." Table 1-1 outlines the characteristics of a profession and how the profession of nursing fulfills them. Nursing fails to fulfill all criteria for the characteristics of a profession. These professional characteristics fall into various categories. Some of the key characteristics of a profession include specialized knowledge base, standardized formal education, autonomy, control over work, specialized competence, self-regulation, collegial subculture, and public acceptance (Freidson, 1994; Miller, Adams, & Beck, 1993). Nursing re-
<table>
<thead>
<tr>
<th>Professional Characteristic</th>
<th>How Nursing Meets the Criteria of a Profession</th>
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<tr>
<td>Authority to control its own work</td>
<td>Nurses work for physicians or health care agencies unless engaged in private advanced nursing practice.</td>
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<tr>
<td>Exclusive body of specialized knowledge</td>
<td>Nursing pulls from a variety of fields to provide holistic nursing care. Nursing research generates new scientific knowledge for practice.</td>
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<tr>
<td>Extensive period of formal education and training</td>
<td>Currently, there are three levels of education entry into professional nursing practice: associate degree, diploma, and baccalaureate nursing programs.</td>
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<td>Specialized competence</td>
<td>Nurses demonstrate assessment skills; possess an understanding of pharmacology, various branches of physical sciences, pathophysiology, diagnostic tests, surgical procedures; and have skills to manage the technical equipment used in client care. Many nurses hold certification in specialized areas of nursing practice.</td>
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<tr>
<td>Control over work performance</td>
<td>Nurses make independent judgments based on client situations and area of practice. Some nurses work in organizations that use shared governance and quality management frameworks.</td>
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<td>Service to society</td>
<td>Nursing care focuses on the client system. Caring for others serves as a major theme for most nursing theories. Nurses receive middle-income pay for taking care of others.</td>
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<tr>
<td>Self-regulation</td>
<td>Nurses abide by the Nurse Practice Act of the state in which they practice. Individual state boards of nursing regulate nursing practice.</td>
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<td>Credentialing systems to certify competence</td>
<td>Nurses take the National Certification Licensing Exam developed by nurses which measures minimum competence for safe nursing practice. Nurses obtain certification in specialized areas of nursing practice from nurse specialty organizations. Some states require continuing education for continued licensure.</td>
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<tr>
<td>Legal reinforcement of professional standards</td>
<td>All nurses are held liable for their actions based on what the usual and prudent nurse would do in a given client care situation. Individual state boards of nursing have the power to restrict the practice of nursing within a state.</td>
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<tr>
<td>Ethical practice</td>
<td>The American Nurses' Association has published The Nurses' Code of Ethics, last updated in 1995.</td>
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<tr>
<td>Creation of a collegial subculture</td>
<td>Professional nursing organizations offer networking opportunities. Shared governance and clinical practice partnership models enhance collegiality among staff nurses and nursing administration.</td>
</tr>
<tr>
<td>Intrinsic rewards</td>
<td>Many nurses derive a deep personal satisfaction from making a difference in the lives of clients and families one person at a time. Some nurses view the profession as an opportunity to practice religious beliefs on a daily basis.</td>
</tr>
<tr>
<td>Public acceptance</td>
<td>Nursing was ranked in the top 10 most respected professions (ANA, 2001).</td>
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requires intellectual characteristics, deep personal commitment and specialized skills to serve society, autonomous decision-making, and mutually shared values.

**Intellectual Characteristics**

The professional nurse possesses the following three intellectual characteristics:

1. a body of knowledge on which professional practice is based;
2. a specialized education to transmit this body of knowledge to others; and
3. the ability to use the knowledge in critical and creative thinking.

**Body of Knowledge**

Professional practice is based on a body of knowledge derived from experience (leading to expertise) and research (leading to theoretical foundations for knowledge and practice). This knowledge base contributes to judgment and rationale for modifying actions according to a specific situation. However, nursing education often emphasizes scientifically substantiated methods for responding to particular kinds of client situations. This limited approach to education could explain why many nurses seem unwilling or unable to apply knowledge to clinical problem solving, thereby contributing to dependence in practice. Frequently, nurses (especially novices) seek the "right" answer and do things the way they have always been done. For example, clients may be discharged without self-care teaching because the physician failed to write specific orders for client education, and pain medications may be withheld because "4 hours haven't passed since the last dose of medication."

Liberal arts education serves as a hallmark of professional education. A liberal education "leads to a greater personal and professional contribution to nursing and society" (Bottoms, 1988, p. 124) and to a continued development of personal values and coherence of knowledge. Desired outcomes of baccalaureate education in any major toward which liberal arts education components contribute include the development of thinking and communication skills, historical consciousness, understanding of science, exploration of personal values, appreciation of fine art, and appreciation of ethnic diversity (Association of American Colleges, 1985). Knowledge and skills derived from a liberal education enhance the nurse's ability to adapt knowledge and skills to novel situations. In addition, liberal arts education courses provide the opportunity for future nurses to interact with students with other majors who may become future health team members or clients.

Whether nursing has a unique body of knowledge or applies knowledge borrowed from the fields of medical, behavioral, or physical science has been a matter of debate. In the early days of nursing, nurses derived knowledge through intuition, tradition, experience, or by borrowing it from other disciplines. However, in recent years, nursing theorists have developed models and framework that hold unique relevance to nursing. (See Chapter 7, "Patterns of Knowing and Nursing Science.")

**Specialized Education**

Before entering the nursing profession, nurses experience specialized education. Currently, candidates with three common levels of nursing education qualify to take the same professional nursing licensing exam, the National Council of State Boards of Nursing Licensure Examination (NCLEX). These three programs (associate degree, diploma, and baccalaureate degree) accept high school graduates as students. Education for other health care professions (pharmacists, social workers, physical therapists, occupational therapists, chaplains, and physicians) requires post baccalaureate education. Some leaders in nursing have proposed requiring a master's degree (or even a doctorate) as the educational entry level for professional nursing. In the mid-1980s, a project to differentiate practice for associate degree-prepared nurses (ADNs) and baccalaureate degree-prepared nurses (BSNs) was undertaken. The agreed upon role competencies appear in Table 1-2.
(Primm, 1987). Associate degree nurse competencies center around providing nursing care to persons with similar alterations in health in structured settings while using developed policies, procedures, and protocols. Baccalaureate degree nurse competencies include independent thinking and providing nursing care to persons with complex and differing health alterations within a variety of structured or unstructured settings. Baccalaureate degree nurses also assume responsibility for developing research-based care protocols; managing resources within structured settings; and coordinating care for persons with complex, interactive health care needs.

In the 1990s, the PEW Health Professions Commission (1995, p. 34) proposed focusing "associate preparation on the entry-level hospital setting and nursing home practice, baccalaureate on the hospital-based care management and community-based practice, and master's degree for specialty practice in the hospital and independent practice as a primary care provider." The Commission also emphasized the importance of strengthening career mobility paths within the nursing profession for ADN and diploma nursing school graduates (PEW Health Professions Commission, 1998).

Most professions require postgraduate education. However, according to the Division of Nursing (1994), only 31% of registered nurses received initial nursing education in a baccalaureate-
ate program. Of the 59% ADNs, only 14% returned to school to earn a baccalaureate nursing degree. Pharmacists, physical therapists, occupational therapists, social workers, and dietitians receive graduate education before beginning professional careers. Multiple entry levels into the nursing profession compounds the struggle for nursing to attain a professional stature. Those educational levels and roles are outlined in Table 1-3.

Most nurses make decisions to solve problems as they work with clients, families, and communities. Sometimes, there is a tendency to act hastily on the basis of both inadequate information and insufficient brainstorming to generate alternative approaches. Consider the following situation.

**Problem:** Which of the following actions would you take with a patient who keeps his television on beyond the hospital policy stated time for lights out and quiet?

1. Possible Action 1: Tell him that he must adhere to hospital policy and turn off the television.
2. Possible Action 2: Allow him to watch as long as no one else is inconvenienced. **Discussion:** Before deciding, the professional nurse would collect more information. The nurse needs to know if the client watches television as a method for anxiety reduction, if this is his

| Table 1-3 Graduations from Baccalaureate, Associate Degree, and Diploma Nursing Programs |
|-----------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Years                            | Baccalaureate | Associate Degree | Diploma |
|                                  | Number        | Percent of total | Number | Percent of total | Number | Percent of total | Number |
| 1980-1981                        | 4,031         | 13%              | 917    | 3%              | 25,071 | 84%              | 30,019 |
| 1985-1986                        | 5,698         | 18%              | 3,349  | 10%             | 26,072 | 74%              | 34,909 |
| 1970-1971                        | 5,698         | 17%              | 3,349  | 11%             | 26,072 | 75%              | 34,909 |
| 1975-1976                        | 5,698         | 18%              | 3,349  | 11%             | 26,072 | 75%              | 34,909 |
| 1980-1981                        | 24,370        | 21%              | 16,534 | 31%             | 22,005 | 46%              | 46,045 |
| 1985-1986                        | 24,370        | 21%              | 16,534 | 31%             | 22,005 | 46%              | 46,045 |
| 1990-1991                        | 24,370        | 21%              | 16,534 | 31%             | 22,005 | 46%              | 46,045 |
| 1993-1994                        | 24,370        | 21%              | 16,534 | 31%             | 22,005 | 46%              | 46,045 |
| 1995-1996                        | 24,370        | 21%              | 16,534 | 31%             | 22,005 | 46%              | 46,045 |
| 1997                            | 24,370        | 21%              | 16,534 | 31%             | 22,005 | 46%              | 46,045 |
| 1999                            | 24,370        | 21%              | 16,534 | 31%             | 22,005 | 46%              | 46,045 |


usual way of unwinding before sleeping, if he just likes to rebel against rules, or if he is used to staying up all night because of work shifts. Sound nursing decisions require that the nurse identifies reasons behind the problem and generates logically and reasonably based decisions.

Nurses use nursing process, a sequential, logical thinking process as they deliver nursing care to clients and families in a variety of settings. Nursing process is a problem-solving approach that consists of five steps. Figure 1-1 depicts the steps of nursing process. Once the final step is complete, the process repeats itself. Effective use of nursing process requires critical, creative, and reflective thinking.

Critical Thinking
Critical thinking has cognitive and affective characteristics. Critical thinking imposes standards (Paul, 1992) and prevents nurses from engaging in illogical thinking. As critical thinkers, nurses "exhibit these habits of mind: confidence, contextual perspective, creativity, flexibility, inquisitiveness, intellectual integrity, intuition, open-mindedness, perseverance and reflection. Critical thinkers in nursing practice have the cognitive skills of analyzing, applying standards, discriminating, information seeking, logical reasoning, predicting, and transforming knowledge" (Scheffer & Rubenfeld, 2000, p. 357). Critical thinking strengthens the ability of nurses to make effective clinical judgments.
Creative Thinking

Although considered an essential component of critical thinking (Scheffer & Rubenfeld, 2000), creative thinking generates alternative approaches to clinical situations. Creative thinking requires an ability to think outside of what usually is done and results in novel approaches to client care. If not tempered with critical thinking, solutions generated with creative thinking may be hazardous. Nurses engage in creative thinking when confronted with clients who have complex integrative health problems that require an individually designed plan to attain desirable care outcomes.

Reflective Thinking

Reflection plays a key role in professional actions. Consider the following clinical situation: Mrs. S. had advanced multiple myeloma and lives in constant pain. She has started receiving a morphine drip for pain control. Along with her pain, Mrs. S. dreads the thought of living with uncontrolled pain. She is anticipating pain relief. However, she is fearful that the morphine drip will not ease her pain. As the nurse institutes the morphine drip, she remembers the pharmacological action and potentially adverse effects of the morphine. She decides to stay and talk with Mrs. S. as the drip is started to allay her anxiety. As the nurse talks with Mrs. S., she offers to perform a back massage or therapeutic touch, knowing the theoretical benefits of these two nursing interventions. When thinking about and using theory in daily practice, nurses engage in reflection in action (Schon, 1983). Reflection in action occurs when nurses think about theoretical and scientific principles while delivering client care (Clarke, James, & Kelly, 1996; Kim, 1999; Powell, 1989).

Another form of professional reflection advocated by Schon (1983) is reflection on action. Reflection on action occurs when the professional practitioner considers practice aspects other than the moment of the action (Clarke et al., 1996; Schon). While the nurse plans a report for the next nurse who will be providing care to Mrs. S., she reviews which interventions were effective and considers other interventions to try in the future. Reflection on action enables the practitioner to develop a deeper understanding of practice and provides a vehicle to learn from experience (Clarke et al.; Schon). Journal writing also provides practice with reflection on action.

Practice Components

In efforts to increase access, cost effectiveness, efficiency, and productivity, the health care system has transformed itself through "redesigning" and "re-engineering" efforts. Greenberg (1994) specified several rules for health care re-engineering centered on organizing health care around client outcomes, rather than tasks; cross-training staff; and shirting from specialized to generalized providers. In efforts to reduce operating costs, many acute care institutions trained and hired assistive personnel who assumed more complex, skilled tasks, such as urinary catheter insertion, oxygen administration, and phlebotomy. Ironically, these programs added to health care costs, with the additional expenses of training, supervision, and unoccupied time, and increased patient morbidity and mortality (Zimmerman, 1995).

The newly expanded roles of unlicensed assistive personnel (UAP) add to the complexity of the professional nurse's role. Safe delegation of tasks becomes a major focus of the nurse's daily workload. Delegation of tasks to unlicensed personnel increases the chance for harm, complexity of the nurse's job, and need for improved problem-solving skills in nurses. The professional nurse bears the "final accountability for the appropriateness of the delegation decision, adequacy of nursing care and UAP actions and outcomes" (Zimmerman, 1995, p. 209).
As a result of managed care and re-engineering efforts, 60% of American nurses are employed in inpatient or outpatient hospital departments (United States Department of Labor, 2000). Forecasts indicate that the hospital of the future will focus on four key specialty areas: trauma, sophisticated diagnostics, critical care, and complex operative procedures unsafe for ambulatory care. Movement of practice away from hospitals may result in opportunities for nurse entrepreneurs who identify areas to provide nursing services in outpatient or community settings.

The shift from inpatient acute care to ambulatory community care settings forces nurses to develop new skills to meet the challenges of outpatient care. Ambulatory care requires the nurse to develop expertise with enabling operations (safe and efficient work environment to serve clients), technical procedures (assisting with invasive and noninvasive diagnostic testing), continued use of nursing process (developing long-term client care plans), telephone communication skills (especially telephone triage), client advocacy (verifying receipt of correct health care and community support services), client teaching (self-care instructions for health maintenance, and pre- and postprocedure care), and expert practice (serving as a preceptor for new nurses). These skills remain within the traditional repertoire of professional nursing. However, client education emerges as being more important than it was in the past. Professional nurses must expand their knowledge on assessing client learning needs and abilities and pay careful attention to following through to verify client understanding of self-care. Along with increased skill in client education, nurses must stay abreast of new technology and available community resources.

Service to Society
Since the beginning, nursing has been associated with serving others. Many students still enter nursing "to help people," an image of the nurse shared with the public.

However, the intrinsic motivation "to care" is only one way to look at caring emphasized in the nursing literature. Morse, Botterff, Neander, and Solberg (1991, p. 122) have identified the following five conceptualizations of caring: (1) caring as a human trait, (2) caring as a moral imperative, (3) caring as an affect, (4) caring as an interpersonal interaction, and (5) caring as a therapeutic intervention. Obviously, caring encompasses more than just intuitive concern for others. Several theories of nursing use caring as a major concept or central theme.

Professional service to society requires impeccable integrity, individual responsibility for ethical practice, and lifelong commitment. Some nurses view nursing as a job, rather than a professional career. Approximately 75% of employed nurses work full time (United States Department of Labor, 2000). Many nurses leave the profession permanently or temporarily to rear children. Some nurses work to supplement family income, and others work because they provide the sole or primary family income. Sometimes, professional commitments become secondary to other concerns. Nurses seeking job security avoid "rocking the boat" when confronted with less-than-ideal nursing practice situations. Employing agencies occasionally exploit these nurses. Regardless of difficulties, including high client-to-nurse ratios, rotating shifts, reassignment to provide adequate coverage on an unfamiliar unit (floating), and constant change in client assignments, some nurses make do and maintain the status quo. For these nurses, the service orientation shifts from the professional responsibility to individual clients and the welfare of all clients to the welfare of the employing institution.

Service to others involves ethical responsibility. The nurse must have the integrity to do what is right, often in situations that cause real moral dilemmas. Codes for nurses have been developed by the International Council of Nurses and the American Nurses Association (ANA). These codes emphasize that nursing care recipients have basic rights and that the nurse's primary responsibility is to the client.
Service to society requires legal assurances that practitioners are competent. Credentialing systems, such as licensure, provide a means to certify minimal competence for safe practice by a person legally permitted to use the title "registered nurse." State nurse practice acts also provide legal reinforcement against incompetence by specifying the legal definition of nursing practice, minimal education preparation for licensure, and penalties for illegal, unethical, or negligent practice. Upon initial state licensure, the nurse receives a copy of a state nurse practice act. Copies of a specific nurse practice act can be obtained in print form from the State Board of Nursing (a fee usually is charged). Most State Boards of Nursing post the most recent nursing practice act on a website, where it can be downloaded for free.

Autonomy means that practitioners have control over their functions in the work setting. Autonomy involves independence, a willingness to take risks, and accountability for one's own actions, as well as self-determination and self-regulation. The autonomous practitioner also is obliged to collaborate with others for the benefit of the client.

For the past 50 years, most nurses have worked in institutional settings in which authority rests in administrative positions within a hierarchical organization. In contrast, medicine has maintained political power and professional credibility through technical competence and specialized knowledge. Nurses have sought status through increased rank in the hierarchy, rather than through expert practice. As changes in health care delivery move toward managed care in community health settings, new threats to autonomous nursing practice arise. Nurses must advocate for clients to ensure that health care access, equity, and quality are not compromised by a system emphasizing cost control.

Unfortunately, nursing lacks a collective professional identity. Although 2.1 million nurses currently practice in employment settings (United States Department of Labor, 2000), nursing has been fragmented into splinter groups, in which nurse administrators may exploit nurse employees, ADNs and BSNs struggle against each other for professional recognition, specialty nurses compete for resources, and even nurses on the same unit fight with each other over such things as work schedules, client assignments, shift responsibilities, and the best ways to manage difficult clients and families. As each subgroup expends energy to protect its turf, the profession loses the ability to present a united front. Failure to unite results in political incompetence, professional powerlessness, and public confusion. A major goal for nursing must be the development of a united strength that can translate into legislative power to increase professional autonomy and provide for direct third party reimbursement for nursing services.

This section has focused on the composite character of the nursing profession. The following section examines the historical roots of nursing to gain an appreciation for the evolution of the nursing profession.

HISTORICAL ROOTS OF THE NURSING PROFESSION

By reviewing the history of the nursing profession, nurses identify how actions taken by their predecessors have affected current practices. Some historical decisions have created divisiveness within the profession. Other decisions have resulted in the development of one of the most respected professions in modern times (American Nurses Association, 2001). Nursing forged a path to holistic health care even before medicine made it popular. An examination of nursing history provides professional nurses with an understanding of the profession's unique place within the health care arena.
Ancient Nursing History (Before 1 AD)

According to late 19th century literature, humans learned a variety of therapies for treating injuries from watching animals. Treatments learned included the licking of wounds (a form of an antiseptic dressing), applying pressure to control bleeding (from apes), amputating extremities when ensnared in traps (from rats), licking salt (from deer, cows, and antelope), wrapping wounds in spiral fashion (from birds), applying splints (from snipe), traveling great distances to soak in healing water (from deer), ventilating living space, and entombing the dead (from bees). When the belief in the spirit world commenced, primitive humans believed that certain members of society had special connections to the spirit world. These persons possessed special powers that could ease suffering, enhance healing, and cure diseases (Nutting & Dock, 1935).

Many years before the Christian era, the ancient Hindus linked hygiene to health. Details of nursing are recorded in Lesson 9 of Charada-Samhita. This Indian record describes the following four qualifications for a nurse: knowledge of drug preparation skills; cleverness; devotion to patients; and purity of body and mind (Nutting & Dock, 1935). These early nurses primarily were men, and nursing was viewed as sacred service that only the purest of body and mind could perform (Jamieson & Sewall, 1954; Kalisch & Kalisch, 1995; Nutting & Dock, 1935). Early nursing interventions included nutritional therapy, adequate ventilation, dean environment, musical therapy, and meaningful conversation while attending to the basic physical needs of others (Nutting & Dock).

Other ancient references to nurses appear in a variety of writings from various parts of the world. Ancient Buddhist texts from Ceylon also describe accounts of good deeds and philanthropy. Literature describing ancient health care in Egypt alludes to "thousands" of temple priestesses whose duties included the care of the sick. In Greece, society relied on slaves to care for the infirm. Writings from Hippocrates record reliance of care assistants upon whom he bestowed the title of co-worker (Nutting & Dock, 1935). The Romans reserved the best medical and nursing care for the soldiers who were cared for by women and old men of irreproachable behavior (Kalisch & Kalisch, 1995; Nutting & Dock).

In northern Europe, the ancient Teutons had wise women who went out early and late in the day to gather herbs, which they knew to have medicinal and remedial qualities. This practice may have been the earliest prototypes of the witch of myth and legend. According to Finnish mythology, the ancient healers practiced "white magic" that was primarily medicinal in nature. Like the northern Europeans, the Gauls and Germans highly regarded women. They believed that women could communicate with the gods more easily than could men. These women possessed great knowledge and skill in medicine and surgery when treating wounded soldiers, delivering infants, and caring for livestock (Nutting & Dock, 1935).

Christian Influences on the Development of Nursing (1-1500 AD)

As Christianity swept across the globe, caring for the sick and poor became a moral obligation and a means to attain everlasting life. The earliest women workers in the Church who were concerned with nursing were deaconesses and widows. The virgin, presbyteress, canoness, and nun appeared later (Kalisch & Kalisch, 1995; Nutting & Dock, 1935). In early times, many of the nursing duties were performed by men. Early converts to Christianity, especially the ladies of leisure, viewed comforting the afflicted as a sacred duty. The deaconesses attended to the sick in their homes. In 60 AD, Phoebe, a deaconess and friend of the apostle Paul, assumed clerical and secular duties. She became the first parish worker, friendly visitor, and district nurse and is credited as being the mother of visiting nursing (Nutting & Dock).
Early church deacons and deaconesses sought out those in need, established a system of visiting nurses, and sometimes brought the ill into their homes for care. Eventually, public homes opened for strangers and contained separate areas for weary travelers, the ordinary traveler, and one for the poor and the infirm. As early as the second century, Roman converts to Christianity transformed their homes into places to care for the sick and poor. Roman matrons organized and delivered care to persons in need. Nutting and Dock (1935) credit this work to the matrons named Marcella, Paula, Eustochia, Blesilla, Proba, Laeta, Lucina, Fabiola, Principia, Ansella, Lea, Melanie, Albina, and others. Nursing the sick was seen as a proper penance for past sins and solace for unhappy lives (Nutting & Dock). A glorious record of the religious nursing orders of men and women flourished for a thousand years. Through life in religious orders, women found freedom from social fetters and distasteful arranged marriages. They were free to conduct satisfying work and cultivate intellectual desires (Kalisch & Kalisch, 1995; Nutting & Dock).

By the 13th century, monks and nuns were said to have higher medical knowledge than the rest of society (Nutting & Dock, 1935). The Benedictine sisters continued to expand the knowledge of medicine and practice both medicine and nursing. Monks and nuns conjointly cared for the sick. The monks cared for men; the nuns cared for women (Nutting & Dock).

Perhaps the emergence of a German nun, Hildegard, was the beginning of female dominance in nursing. When she was 8-years-old, Hildegard was brought to a convent to live. At the age of 30 years, she became the head of a convent. She possessed extraordinary intellectual powers and amassed great knowledge of medicine and nursing that she gained through her observation and care of patients. Between 1151 and 1159 she wrote volumes devoted to medical works that include accurate physiology related to reproduction, circulation, and the nervous system. Although her work primarily addresses the art of medicine, she wrote about key nursing principles (Nutting & Dock, 1935).

During the Crusades, hospitals were built on the routes to and in Jerusalem, where men delivered care to travelers and battle-scarred warriors. Several orders of knights, such as The Knights Hospitallers or Knights of St. John of Jerusalem, The Teutonic Knights, and The Knights of St. Lazarus, began as nursing orders but added military duties as the need for warriors arose. In England, the Order of St. John consisted of men devoted to human and charitable work, including formation of cottage hospitals and convalescent homes and providing nursing training for the sick poor (Kalisch & Kalisch, 1995; Nutting & Dock, 1935; Jamieson & Sewall, 1954). In the 11th century, two hospitals were built in England—one for men and women with various ailments and one for lepers. Brothers attended to the sick men, and sisters attended to the sick women. The hospital for lepers (St. Giles) was run by the Order of the Poor Clares. Around 1148, ladies of noble birth added attending the sick as a desirable social duty (Nutting & Dock, 1935).

In the 12th century, nursing became part of the manual labor performed by several orders of sisters in France. The Roman Catholic Church canonized some of the sisters devoted to nursing. In addition to Catholic orders of sisters devoted to nursing, secular orders of sisterhood also emerged. In France, one hospital was staffed with women who were either widowed or had repented from a previously impure life (Nutting & Dock). The Augustine sisters provided nursing care in a hospital in Paris.

The Auguste order routinely handed down information of how to care for the sick. In 1212, the Church passed statutes to regulate the nursing orders. Nursing orders for both men and women were decreed to take permanent vows of poverty, chastity, and obedience. During the 14th century, nursing experienced decline when funds designated for the care of the sick were diverted to war; persons caring for the ill experienced low morale from the unrelenting toil; re-
religious orders focused on accumulation of money and possessions; a syphilis epidemic occurred; hospitals became centers of fatal infections; and conflict among the religious orders became widespread (Nutting & Dock, 1935).

**Renaissance and Colonial American Nursing (1500-1860)**

In 1505, King Louis XII decreed that jurisdiction of the hospitals be given to secular directors. In 1526, the rectors of a hospital (located in Lyons, France) directed hospital staff to wear a white uniform because the women came to work in scandalous apparel. In 1562, the uniform changed from white to a black dress, white linen apron, and unstarched white cap. By the middle of the 16th century, the rectors introduced stringent regulations and required nursing service members to become part of a religious order. The male nurses (who were brothers) wore a blue robe and silver cross. Female nurses also wore robes of various colors to denote the various sisterhood orders. At this time, a woman left nursing only to marry or to care for aging parents. During this time, two notable nursing orders of men flourished. They worked in hospitals, visited the sick at home, and distributed herbal medications (Nutting & Dock, 1935).

In England, degeneration of religious life occurred during the 16th century. Cities assumed control and responsibility of hospitals. Ordinary lay servant and attendants who had little knowledge cared for the infirm. A matron who had some knowledge of how to run a hospital supervised them. The matron was responsible for finding persons to care for the sick. Frequently, the care attendants came from jails or debtor prisons. Under this system, the profession of nursing suffered great degradation. Patients received care from heartless attendants and sisters (also called servant nurses) who were required to work 12 to 48 hours continuously. Charles Dickens's description of the untrustworthy and drunken Sairey Gamp depicted the quality of nursing of the times. In some cases, patients nursed each other as the servant-nurses slept (Nutting & Dock, 1935).

As the new world was settled, the French and Spanish opened hospitals. The Jesuits opened a hospital for settlers and the Canadian Indians. The Indians shared remedies for scurvy with the French. Likewise, the Jesuits shared their knowledge of medicines with the Indians. As hospital labors for the nuns grew heavier, the native women, who quickly grasped the concept of charitable practice and brought great physical strength to the hospital from surviving in the wilderness, assisted them (Nutting & Dock, 1935).

In the American colonies, the growth of hospitals was slow. Frequently, the captain of the ship served as deacon and his wife assumed midwife responsibilities. Early treatment for illness in the English colonies consisted of prayer and superstitious practices. When hospitals opened in New York and Philadelphia, prison inmates provided nursing services (Jamieson & Sewall, 1954).

The 1700s mark the beginnings of hospital reform. John Howard, a former prisoner, embarked on a career as a prison reformer that eventually evolved into hospital reform. In 1789, Howard wrote about the deplorable state of hospitals throughout Europe and England, especially those run by local governments. He noted that the hospitals staffed by religious orders tended to be quiet, neat, and clean and careful attention was paid to patient hygiene and infection prevention measures (Jamieson & Sewall, 1954).

In 1821, Pastor Theodore Fliedner arrived in Kaiserworth, Germany, as the pastor of a financially depressed congregation. Fliedner founded a hospital for two purposes: he wanted to care for the sick, and he wanted to provide a field of work for deaconess instruction. In 1836, Gertrud Reichardt, a physician's daughter who helped with her father's practice, became the first nursing probationer. Under the leadership of Fredrike Fliedner (the pastor's wife), the hospital tended the sick, and probationers received clinical and theoretical instruction on the art of nurs-
ing. Upon completion of their education, the newly ordained deaconesses provided relief work for the poor, imprisoned, or those who needed help (Jamieson & Sewall, 1954; Nutting & Dock, 1935).

The deaconesses from Kaiserworth established an honorable reputation that spread worldwide. Kaiserworth deaconesses established themselves in Europe and the Middle East. In 1850, Fliedner took several deaconesses to Pittsburgh, Pennsylvania, where they staffed a hospital. The movement progressed to Milwaukee, Wisconsin, where the Deaconess Home and Hospital was founded.

At the end of the 18th century, nursing manuals began to appear. Some contained common sense information, and some were scientifically based. Dr. J. G. Pahler's manual gave specific examples of instruction on how to arrange and care for a sick room, procedures for various treatments, instructions for use of equipment, and maintenance of written records. Along with procedures, Dr. Pahler's manual emphasized the importance of attending to patient psychological needs. Dr. Franz May's manual provided more general approaches to patient care and emphasized the importance of maintaining the health of the caregivers. Dr. May also established a course of instructions for care attendants in Mannheim, Germany. Other educational programs opened in Germany. An evangelical hospital in Germany supplied nurses' training. In 1836, Pastor Johannes Gossner favored the word "pflegerin" (nurse) as a title for care attendants in Prussia.

During the American Revolutionary War, Catholic nuns were the only organized group of nurses. Women followed husbands to the battlegrounds and provided nursing care to soldiers who were wounded or infirm. Many homes and barns became hospitals. In 1786, the Quakers established the Philadelphia Dispensary, which was financed through public donations. Physicians from the Dispensary practiced disease prevention. In New York, a residential insane asylum was founded in 1798. In Canada, the Augustinian nuns from France established hospitals, visiting nurse programs, schools, and orphanages (Jamieson & Sewall, 1954).

The Nursing Society of Philadelphia was founded in 1836 and primarily provided home maternity service. The Nursing Society selected its nurses from applicants who displayed stable character and who had experience as familial heads. In 1850, the Society opened a home and school in which systematic instruction was given on cooking and obstetrics. Students also were exposed to clinical practice in homes (Jamieson & Sewall, 1954).

The Movement of Nursing Toward a Respectable Profession (1850-1917)

Efforts at social reform flourished in the late 19th century. The reform of nursing evolved from efforts to reform prisons and hospitals. Florence Nightingale led the efforts to reform patient care and sowed the seeds of establishing nursing as a profession despite being a member of "good society" and her mother's fear of physical harm and moral decay from working with persons with unclean minds and unhealthy bodies. During European trips, Nightingale explored the option of starting a community of trained nurses after visiting with nuns in Rome. Mrs. Fry, a friend of the family, informed Nightingale about Kaiserworth upon learning about her interest in nursing. In 1850 and 1851, Nightingale attended Kaiserworth, where she was instructed in the art of nursing (Jamieson & Sewall, 1954; Nutting & Dock, 1935).

At the age of 34 years, Nightingale attained a position as the superintendent of a small institution on Harley Street in London that provided shelter to homeless women and nursing services to sick governesses. After a cholera epidemic, the British became involved with the Crimean War and discovered that they had no sisters to assist with injured and infirm troops. In 1854, the British government appointed Nightingale as the superintendent of the nursing staff. She and 38 other women went to Scutari, Turkey, where they found two hospitals in deplorable
condition. Nightingale pleaded with her friends in England to send money and supplies. After she
and her nurses provided a clean, well-ventilated environment and nutritious meals for the
patients, the mortality rate declined from 40% to 2% (Jamieson & Sewall, 1954; Kalisch &
under Nightingale evolved into a health service in which both the physical and psychosocial
needs of the ill were considered. She wrote letters for soldiers, employed wives who had accom-
panied spouses to the battlefield, and made night rounds in the wards with a lamp.

During the Crimean war, Nightingale met Mary Seacole, a Jamaican nurse volunteer who
also provided nursing care to the soldiers. Seacole also saw the need for holistic outreach nursing
services to civilians who had been injured or displaced because of the war. She set up a hotel where
she provided shelter, relaxation, and excellent food. When guests became ill, she prescribed
medicines that she had learned about from her grandmother and mother. After the war, she
dedicated her life to elevating nursing to a respectable profession (Wheeler, 1999).

In 1855, important British citizens established the "Nightingale fund" to enable Nightingale to
establish a school to train an elite group of women in the art of nursing. She expected these
women to teach nursing to the entire world. In addition to establishing a formalized program of
nursing education, Nightingale continued her efforts at reforming hospitals, public health, and

Public health nursing prospered from 1900 until the outbreak of World War I. The patient
home served as the major location for nursing practice because hospitals had become places to
receive charity, contract infection, and die. As news of Nightingale's successes spread, hospitals
began practicing the principles of hygiene, and nursing became a respectable career.

As nursing became more acceptable, women volunteered during the Civil War to be nurses.
American women transformed the ballrooms of their homes into wards for the injured and infirm
soldiers. Louisa May Alcott wrote about her tragic experiences caring for soldiers. Mother
Bickerdyke diligently searched to find living soldiers who had been placed in the lines of the
dead. Clara Barton used her own resources to provide necessities and supplies to care for those
injured or displaced from battle from both sides. Dorthea Dix was appointed as the superintendent
of female nurses in the Union Army and founded the first American Army nursing corps. Along
with female volunteers, the Young Men's Christian Association members volunteered to serve as
nurses (Jamieson & Sewall, 1954).

After the Civil War, numerous social reform movements emerged. Along with Florence
Nightingale, several American women influenced the reform of health care and nursing. In 1893,
Lillian Wald and Mary Brewster opened Nurses' Settlement House in New York City. They used the
term "public health nurse" to describe the trained nurses who responded to nursing needs
outside of the hospital. These nurses responded to the call from individuals and physicians to
provide home nursing services. The program provided services, regardless of the ability of recipients
to pay. In 1895, Wald and Brewster moved to larger accommodations, which became known as
the Henry Street Settlement House. By 1900, 20 district nursing organizations employed 200
nurses across the United States (Roberts, 1954).

Nursing During the Early 20th Century, the World Wars,
and the Post-World War II Era (1900-1960)

The hospital and medical reform movement resulted in dramatic changes in patient care. Physician
demand for educated nurses caused the untrained attendants who had dominated hospital nursing to
be replaced with nursing students. Because of the lack of trained nurses, graduates of nursing
programs found themselves in supervisory positions or as home private-duty nurses.
Hospitals with nursing students used them as staffer contracted their services with families and pocketed the money for services rendered. The typical private nursing case lasted 3 weeks and required the nurse to live with the family and be available for 24 hours a day. The average wage earned was $1,200 per month. As nurses aged, they lacked the stamina required for all-night vigils and the hard work required for safe, effective patient care (Goldmark, 1923).

In 1903, North Carolina established guidelines for professional registration of nurses, the first state to do so. Requirements included graduation from an established diploma nursing school. New Jersey and New York quickly followed. By 1912, 29 states and the District of Columbia had registration requirements for nurses. To renew initial registration, nurses were given a 3-year grace period to practice, after which they were required to take a licensing exam that emphasized dietetics, patient comfort, skilled handling of patients, and general management (Dock, 1912).

The United States entered World War I in 1917. Unmarried trained nurses entered the Army and Navy Nurse Corps. Along with trained nurses, volunteers from well-to-do families served as nurses' aides at their own expense after taking intensive Red Cross courses. The government launched a publicity campaign to recruit women into nursing. Advertisements glamorizing nursing appeared in newspapers and magazines. However, on the battlefields, the nurses encountered the horrors of injuries sustained from bullets and poisonous gas. At times, the ratio of nurse to patient was as high as 1 to 60. Nurses often were required to perform surgery to save lives. Finally, the influenza epidemic of 1918-1919 compounded the need for more nurses at home and abroad (Kalisch & Kalisch, 1995).

In the 1920s, nursing sustained an image problem. The reasons for nursing's lower prestige included that 95% of nurses were women; most nursing leaders were unmarried; society's strong emphasis on the woman's role as wife and mother; and portrayal of nursing as an ideally altruistic self-sacrificing profession in a time that focused on frivolity and self-indulgence (Jamieson & Sewall, 1954; Kalisch & Kalisch, 1995).

By the 1920s, most trained nurses were employed as private duty nurses. However, with the advent of technological advances in patient care, more patients were being admitted to hospitals for treatment and surgery. The hospitals relied on student nurses to care for patients, despite that graduates of nursing programs remained unemployed and in dire financial straights. In 1939, the National League for Nursing reported that the typical hospital connected with a school of nursing during 1938 employed an average of 10 graduate nurses for general duty or bedside nursing.

During the Great Depression, some hospital staffs consisted of trained nursing graduates willing to work for room and board. As the economic state improved, some hospitals kept these trained nurses as staff members, despite resistance from other hospitals. As scientific knowledge related to medical practice increased, the demand for hospitals to employ graduate nurses increased. A limited number of nurses found employment with the new aviation industry as nurse-stewardesses. Other nurses participated in the Civil Work Administration and Works Progress Administration programs and became employed in public hospitals, clinics, and in public health agencies. During the Depression, the media portrayed nurses as attractive women who sacrificed personal desires for their profession (Kalisch & Kalisch, 1995).

By World War II, graduate nurses had become accepted members of hospital staffs. When hospitals discovered that hiring graduate nurses could cut costs, many nursing schools closed. However, as news of war loomed in Europe, the government took steps to promote the entry of young women into nursing. Recruitment methods included advertisements in printed media and the Nurse Cadet Program (Kalisch & Kalisch, 1995). As registered nurses joined the military, a civilian nurse shortage resulted. Hospitals employed civilian workers who held certificates from the Red Cross and hired the volunteers who had been helping nurses with nonprofessional duties.
After World War II, the United States experienced a great time of economic growth. Companies offered health insurance as a fringe benefit for workers. Insurance reimbursement of hospital care resulted in a proliferation in the number of hospitals and expansions of well-established ones. Because of this, hospitals also became profitable and provided a central location for proliferating medical technology. However, the nursing shortage increased as more hospital beds became available. Workplace reforms led to an 8-hour day and a 40-hour work week. In addition, many nurses left practice to pursue marriage, better pay outside the profession, and more autonomous positions in industry or public health.

Research Brief 1-2

The author analyzed primary and secondary sources from 1945 to 1965 published by the American Nurses Association, the American Hospital Association, and the United States Department of Labor along with monographs on nursing, hospitals, women's history, and women's labor. Results of the analysis showed disagreement between nurses and hospitals on the etiology of the nursing shortage. Hospital administration blamed the nursing shortage on the return of women to the home and dismissed low salaries and poor working conditions as the cause. To confront the shortage, hospitals relied on licensed practical nurses and auxiliary personnel to perform nursing care activities that once fell into the realm of professional nursing practice. This new form of nursing proved financially advantageous to hospitals. Nurses took action in the form of the 1946 American Nurses Association Economic Security Program to increase salaries and improve working conditions. In spite of increased union activity for other workers during this time, efforts at unionization of nurses failed to gain momentum.

Implications for Current Practice
For generations, nurses have been paid poorly and have endured poor working conditions. This deters persons from entering the profession. Hospitals and health care administrators continue to argue that increasing salaries would create economic hardships for them. Recent efforts have expanded the use of unlicensed assistive personnel to fill the gaps in the current nursing shortage. Use of unlicensed assistive personnel comes with increased supervisory responsibilities for the professional nurse resulting in reduced time in patient contact. Nursing shortages will continue to persist until salaries increase and working conditions improve. Nurses need to develop a program to unite in order to improve pay and working conditions to assure an adequate supply of professional nurses to meet future health care needs.

**Nursing in the Modern Era (1960–1999)**

The 1960s
In the early 1960s, the health care system consisted primarily of independent, not-for-profit hospitals, small independent physician offices, and neighborhood pharmacies and medical supply stores. Nurses primarily worked in hospitals, public health agencies, and physician offices. Society and nurses viewed nurses as being subservient to the physician (Kalisch & Kalisch, 1995).

Biomedical advances proliferated, leading to expensive technologies to save lives. Complex surgical procedures, new pharmaceuticals, and new technology increased the cost of health care deliv-
This increased the need for highly educated, clinically competent professional nurses for patient care. By this time, employers offered health care insurance as a standard benefit to workers. In 1965, the government introduced Medicare and Medicaid to provide health care coverage to the poor and elderly. Demand for hospital care and nursing rose dramatically (Kalisch & Kalisch, 1995).

The 1970s
Inflation and unemployment increased in the 1970s. Consumers revolted against tax increases. To decrease the economic burden of supplying health care, the government employed mechanisms to monitor health care delivery to Medicare and Medicaid recipients. Although ineffective, mechanisms such as utilization review to reduce lengths of hospital stays and physician peer review programs became common practice. The need for nursing services in inpatient settings continued to rise. The increasing complexity and specialization in client care needs resulted in the birth of and increased membership in professional nursing specialty organizations.

The 1980s
Costs for health care continued to skyrocket during the 1980s, despite a weak economy. More expensive and sophisticated diagnostic equipment and treatments became common as new advances in health care were discovered and consumers demanded them. In 1983, Medicare introduced a prospective payment system known as diagnosis related groups (DRGs). The goal of the program was to reduce cost rate increases for hospital care in institutions participating in Medicare by reducing hospital length of stays. By the end of the decade, hospitals experienced decreased profits, as beds remained empty. Hospitals consolidated, resulting in a decreased demand for hospital nurses. Patient acuity in hospitals increased, thereby requiring that highly competent nurses care for patients. Primary nursing became the dominant nursing care delivery system. Primary nursing brought the professional nurse back to the bedside. In primary nursing, the registered nurse planned individualized care, implemented the plan, and provided health education for hospitalized patients and families. Patients were sent home to recover from surgery and illnesses once their conditions stabilized. An increased demand for nurses working in home health and ambulatory health care surfaced.

The 1990s
By 1990, "95% of insured employees were enrolled in some form of managed care, including fee-for-service plans with utilization management, preferred provider organization or HMOs" (Bodenheimer & Grumbach, 1995, p. 87). Hospitals, physicians, and insurance companies joined forces and created integrated health care networks. Physicians increasingly formed large practices, whereas commercial companies dominated insurance coverage through managed care plans. For-profit companies took control of many nursing homes, home health care companies, and multihospital system networks. Third party payers dictated reimbursement rates to hospitals. Eighty-five million Americans remained uninsured, underinsured, or enrolled in Medicaid (Ginsberg, 1995). Insurance providers employed management tactics to avoid enrolling potentially high users of health care services and to limit use of expensive inpatient care.

As hospital and home health care agencies lost profits, efforts to control costs of services resulted in reducing professional nursing staff. Use of unlicensed assistive personnel (UAP) became popular despite evidence that registered nurses improved patient care quality (Brooten & Nay-lor, 1995). The change in skill mix reduced professional nurse positions and further devalued registered nurses (Buerhaus, 1995).

In efforts to improve quality of care and reduce length of inpatient care by minimizing variance in care-providing procedures, hospitals began using clinical pathways. These clinical pathways stan-
standardized the hospital length of stay for persons having the same procedures or hospital admissions for the same illness. Standardized pathways reduced the individualization of nursing care plans.

Work redesign efforts expanded the responsibility and job scope for nonprofessional staff. UAPs replaced registered and licensed vocational (practical) nurses. With minimal on-the-job training, UAPs perform the basic tasks of ensuring patient hygiene and ambulation, taking a patient's vital signs, and determining patient intake and output; in some institutions, UAPs also perform phlebotomy, electrocardiogram testing, bladder catheterization, and simple dressing changes. In addition, some institutions assign social workers, housekeeping personnel, dietary workers, respiratory therapists, and clinical laboratory staff to a nursing department under the supervision of a nurse manager. As a result, the professional nurse (RN) role changed from one of direct care provider to one requiring delegation of patient care to others. Instead of spending time with patients, the RN supervised care given by UAPs. The RN role shifted to one of a manager who focused efforts at patient outcome evaluation.

To assure efficient and effective use of health care resources without sacrificing client satisfaction and care quality, health care providers and insurers developed case management systems. Case management systems varied in setting and implementation. Table 1-4 outlines seven common components contained in all case management models.

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<th>TABLE 1-4 Common Components of Case Management Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Component</strong></td>
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<tr>
<td>Client identification and outreach services</td>
</tr>
<tr>
<td>Client assessment and diagnosis</td>
</tr>
<tr>
<td>Planning of services and resource identification</td>
</tr>
<tr>
<td>Linking clients to required services</td>
</tr>
<tr>
<td>Coordination and implementation of services</td>
</tr>
<tr>
<td>Service delivery monitoring</td>
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<tr>
<td>Client advocacy</td>
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<tr>
<td>Evaluation of services and outcomes</td>
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</tbody>
</table>
Social workers served as the first case managers. However, when they realized their limitations to see the entire patient situation, health care institutional administration and social workers turned to nurses for assistance. In addition, case management required thought processes frequently used by nurses in clinical practice. Early efforts at case management improved patient outcomes, increased consumer satisfaction with care, and decreased health care costs (Cohen & Cesta, 2001).

**Nursing in the Postmodern Era (2000 and Beyond)**

Scholars debate when the postmodern era began. Some say the postmodern era began in the 1960s; others claim it began with the introduction of the computer and Internet. Another group says the era started with the questioning of scientific method as the best approach for discovering answers to the questions surrounding humanity, the environment, and health-related issues. The emergence of phenomenology as an accepted form of research also indicates less reliance on science. Wilson (1998) introduced the term "consilience" to describe the unity of knowledge. Consilience represents the point at which scientific, artistic, ethical, spiritual, social, environmental, and personal knowledge intersect. Nursing represents a unique profession that has blended art and science since its inception.

Currently, professional nursing finds itself in a state of flux. Scientific advances promise increased complexity and costs of health care. Society considers holistic care as standard practice. Limited resources for health care drive its delivery. As the population of the United States grows older and lives longer, nursing services are in high demand. The gap between the rich and poor continues to widen, resulting in an increase in governmental funding for health care services. Sources of health care insurance for consumers of health care come from employment, private purchase, or the government. Forty-four million persons have no health insurance. Twenty-eight million persons participate in Medicaid programs. By virtue of education and practice, nurses are the best-equipped health team members to assume the gatekeeper and advocacy roles required of case managers. Nurse practitioners have demonstrated the ability to deliver high quality health care economically without compromising care quality. Hospitals currently employ 66% of working registered nurses. Nurses also work in nursing homes, clinics, and community health settings (Pew Health Professions Commission, 1998a).

Nurses, who work in a variety of different settings, find that the complexity of information in any given practice area requires continuous education. Professional nursing organizations provide opportunities for additional education in a specialized practice field. An Internet search revealed more than 130 professional nurse organizations. Specialty areas include critical care, oncology, neuroscience, holistic, parish, maternal-child, psychiatric, and administration. Although certification by a recognized nursing specialty organization attests to knowledge and skill in the special area of practice, few positions require certification, and many fail to provide financial rewards for professional certification. However, many individuals consider certification prestigious and view it as a means to improve the image of nursing.

In addition to being knowledgeable in a specific practice area, nurses realize the importance of being versed in current consumer health care practices. Many alternative or complimentary health care practices affect current medical therapies. Some complimentary therapies, such as aromatherapy, guided imagery, therapeutic touch, and massage, ease some adverse effects of conventional medical and surgical therapies.

**THE EVOLUTION OF AMERICAN NURSING EDUCATION (1893-PRESENT)**

Efforts to standardize training for nursing began in the Victorian era. Some persons believed that education would damage female reproductive organs. Women who had to work found so-
daily acceptable employment as retail clerks, factory workers, governesses, or domestic servants. Nursing was considered an unacceptable profession and reserved for women paupers from workhouses or those who served prison time for drunkenness, vagrancy, or prostitution.

However, the example of Florence Nightingale's service in the Crimean War elevated the profession. Society began thinking of nursing as an art that "must be raised to the status of a trained profession" (Kjervik & Martinson, 1979, p. 22). Graduates of Nightingale's program in England traveled abroad to establish professional nursing schools.

Although she established a theoretical model for nursing practice, Nightingale proposed that nurses should follow protocol, rather than use independent thinking. She emphasized that nurses should be taught how to carry out physician orders. To maintain discipline among nurses, Nightingale delineated a strict nursing service hierarchy. Good character superseded intellectual ability, and good reasoning skills were ignored when applicants to the Nightingale nursing school were selected.

American Hospital Training Programs and Diploma Schools
In the United States, nursing training programs started simultaneously with the acceptance and availability of college education for upper-class women. As medical education moved into the postgraduate university, nursing education became established as apprenticeship training under the control of physicians and hospitals. The first nursing training programs were established in 1872 and 1873 in Boston, New Haven, and New York City. By 1880, 15 programs existed. Within a decade, 432 programs had graduated 3,465 nurses (Burgess, 1928).

The early hospital training schools had some autonomy in setting the nursing program of study. They rapidly became dependent on hospitals for financial support because they lacked independent budgets and endowed funds. Eventually, they became nursing service departments within the affiliated hospitals. Students worked 7 days a week, 50 weeks a year, for 1 to 2 years in exchange for on-the-job training, a few lectures, and a small allowance. Staffing the hospitals with students and faculty proved financially advantageous, and hospitals without training programs quickly established them. From 1880 to 1926, the number of hospital-based nursing programs increased from 15 to 2,155 (Burgess, 1928). The proliferation of nursing programs resulted in widespread variance in nursing education quality. Linda Richards, a graduate of a Canadian nursing program and the first trained North American nurse (who graduated in 1893), led reforms at a minimum of 12 major American nursing programs (Jamieson & Sewall, 1954). Isabel Hampton Robb questioned the qualifications of nursing faculty and spearheaded the first educational program for nursing faculty at Teacher's College in New York in 1901 (Dock, 1912). Widespread concerns about the safety of nursing and medical care arose among the public. Reforms in nursing education followed reforms in medical education. In 1910, Flexner reported widespread problems with the quality of medical education; the report resulted in drastic reforms. Nursing leaders of the time hoped that results from the report would result in nursing education reforms. In 1923, a report by Goldmark and other studies and surveys done at the time indicated that the root of most of the difficulties related to nursing training stemmed from the nursing schools' dual purpose of providing education and nursing service. Unfortunately, these studies resulted in limited reform.

During the 1960s, the National League for Nursing denied accreditation of hospital diploma schools that used students to staff hospitals. Hospital-based diploma schools remained the dominant educational pattern for registered nursing until the early 1970s.

Associate Degree Programs
In 1948, reports by Brown (1948) and Ginzberg (1948) specified that professional nursing education should be removed from hospitals and transferred to the collegiate setting. In 1951, Mil-
dred Montag published a doctoral dissertation that proposed education for the technical nurse should occur in community college settings. She proposed that the technical nurse education should be a terminal degree and that technical nursing should attain a unique and semiprofessional identity. Upon graduation, the technical nurse would be completely prepared for hospital or nursing home employment. After a decade of research on the concept, community college nursing programs flourished. Eventually, most graduate nurses came from such programs. Graduates of associate degree programs took the professional nursing licensure exam as graduates from diploma and baccalaureate nursing programs.

Baccalaureate Programs
In 1893, the School of Medicine at Howard University established the first nursing diploma program within a university setting. The program, designed for African American students, lasted only one year before being assumed by Freedmen's Hospital. The University of Texas recognized nursing in the early 1890s and gave an endowed professorial chair to Hanna Kindborn, who lectured to both nursing and medical students (Dock, 1912). In 1909, the University of Minnesota established a 3-year diploma nursing program within the College of Medicine, thereby being the first to offer nursing as a college major. In subsequent years, colleges adopted the pattern of combining academic and professional courses that led to both a diploma and bachelor of science degree in nursing. Students attended academic courses at the university and received professional nursing courses using the apprenticeship model at the hospital (Dock, 1935; Jamieson & Sewall, 1954). In 1923, Yale University established an independent nursing program that had its own dean and endowed funds. Other universities that established baccalaureate nursing programs included Case Western Reserve University (1923), the University of Chicago (1925), and Vanderbilt University (1930). As nursing education moved to the collegiate setting, physicians voiced opposition to higher education for nurses because they perceived intelligence and theoretical knowledge as handicaps for nurses following orders to care for patients (Kalisch & Kalisch, 1995). Until the 1970s, few nurses graduated from baccalaureate nursing programs.

Three Entry Levels to Professional Nursing
Candidates with three different levels of nursing education qualify to take the same professional nursing licensing exam. The lack of a standardized education creates barriers for nursing to attain a professional status. To the public, a nurse is someone who cares for the ill in hospitals, the elderly or disabled in long-term care facilities, or promotes wellness in community-based programs. Table 1-3 outlines graduation from baccalaureate, associate degree, and diploma nursing programs. Between 1971 and 1980, total enrollment in baccalaureate degree programs declined, but RNs seeking the baccalaureate nursing degree increased 38% (data derived from the National League for Nursing Data Book, 1982). In 1994, more than 40,000 RNs (graduates of associate degree and diploma programs) attended baccalaureate nursing programs, comprising almost 28% of the total baccalaureate enrollment (National League for Nursing, 1996). However, most graduate nurses come from associate degree programs, in which education is focused on technical nursing.

Graduate Nursing Education
By 1996, the National Advisory Council on Nurse Education and Practice projected that 9% of RNs would hold masters or higher degrees. Approximately one-third of these degrees would not be in nursing. The low number of master's and doctoral prepared nurses is becoming acute, especially as older nurses with advanced degrees retire and fewer younger nurses pursue formal ed-
ucation beyond the baccalaureate degree. (See Chapter 6, "Career Development," for areas of professional nursing practice that require graduate nursing education.) The lack of nurses with advanced education has resulted in shortages of nurses with skills to effectively engage in the fields of nursing administration, education, and research.

Education Accrediting and Student Organizations

National League for Nursing
The mission of the National League for Nursing (NLN, 1995, p.l) is "to improve education and health outcomes by linking communities and information." The NLN achieves its mission through collaborating, connecting, creating, serving, and learning. The NLN emphasizes the following nine goals.

1. Provide leadership in redesigning the delivery of nursing education and health care delivery through community-focused models.
2. Develop and advance the educational models most appropriate for emerging health care needs and services.
3. Promote and monitor the quality, accessibility, and appropriateness of nursing education programs.
4. Transform the teaching-learning environment for nursing and health care.
5. Promote access to information and resources that will enhance the positive health status of diverse communities and individuals.
6. Expand nursing's research agenda to include innovative educational models, community-focused education, and health outcomes of diverse communities.
7. Increase and diversify membership.
8. Develop NLN as a knowledge-based educating organization.
9. Ensure NLN's economic growth and fiscal soundness.

The NLN remained the only national accrediting body for all basic and graduate nursing programs in the United States from 1952 to 1995. In 1996, the NLN established an accrediting commission (the NLNAC) as an independent entity for accrediting nursing education programs. Along with program accreditation, the NLN provides a voluntary peer-reviewed accreditation program for home health agencies and community nursing services.

Along with its accreditation activities, NLN provides consultation services, continuing education programs, analysis of statistical data related to nursing education and nursing manpower resources, various examination and testing services, information about legislative affairs affecting nursing, and a variety of information packages to affect nursing image and recruitment. NLN Agency membership is available to nursing education institutions and providers of nursing other health care services. However, anyone expressing an interest in the improvement of nursing or health care may join the NLN as an individual member.

American Association of Colleges of Nursing
The American Association of Colleges of Nursing (AACN) membership consists of deans and directors of baccalaureate and higher degree nursing programs. In 1997, AACN established two separate entities: a commission for baccalaureate and higher degree program accreditation called the Commission on Collegiate Nursing Education (CCNE) and an alliance of all professional nursing organizations to streamline credentialing of advanced practice nurses. Criticisms of AACN include aggravating tensions among education programs offering various nursing degrees, limiting membership to deans and directors, and emphasizing the importance of the bac-
calaureate degree as a minimal entry level for professional nursing (Gelman, Bellack, 6c Berk-
man, 1999).

**National Student Nurses’ Association**
The National Student Nurses’ Association (NSNA) is an inclusive student association with
members from associate degree, diploma, and baccalaureate nursing programs. The student
members finance and run the organization. As an autonomous organization, NSNA goals ac-
cording to the group's mission statement (1994) are to

- Organize, represent, and mentor students preparing for initial licensure as RNs, as well as
  those nurses enrolled in baccalaureate completion programs;
- Promote development of the skills that students will need as responsible and accountable
  members of the nursing profession; and
- Advocate for high quality nursing care for all persons.

The NSNA offers a wide variety of activities and services to implement its mission. The As-
sociation participates on committees of the NLN, American Nurses Association, and the Inter-
national Council of Nurses. The NSNA Foundation administers a scholarship program and pub-
ishes the journal *Imprint*, the newsletter *NSNA News*, and a variety of reports and handbooks. As
members of NSNA, students enjoy discounts on health insurance, publication, conference attendance
fees, and state board review courses.

**National Council of State Boards of Nursing**
The National Council of State Boards of Nursing (NCSBN) and individual State Boards of Nursing
(SBN) bear the responsibility for protecting the public from fraudulent and unsafe nursing practice.
The NCSBN assumes the responsibility for development and administration of the professional
nursing licensing exam (NCLEX) (Bower, 1999). Along with licensure examination, the NCSBN
keeps records on nursing license suspensions, tracks professional nursing demographics, and
spearheads an effort toward interstate licensure. State governors usually appoint SBN members. Each
SBN accredits nursing programs within a given state. In collaboration with the American Nurses
Association and other advanced nursing practice groups, the NCSBN and SBN set guidelines for
licensure of advanced practice nurses at state levels (Bower, 1999).

**American Nurses Association**
The American Nurses Association (ANA), the oldest professional nursing organization in the
United States, was officially established in 1911 (Flanagan, 1976). Membership criteria require
professional nursing licensure. The level of professional education is not considered in the criteria
for membership. When professional nurses join the national organization, they obtain mem-
bership at the state and local district levels. The ANA represents nurses in all 50 states, the District of
Columbia, Guam, and the Virgin Islands. Individual nurses also may join individual state nurses
associations. The ANA offers a wide variety of services to members and plays a key role in
promoting healthy workplaces for nurses. The ANA participates in the following activities:

- Accredits continuing education programs;
- Provides voluntary individual certification for areas of specialized practice through the
  American Nurses’ Credentialing Commission (ANCC);
- Supplies data for research and analysis;
- Engages in public policy analysis, political education, governmental relations maintenance, and
  political action activities;
- Implements economic and general welfare programs;
• Publishes handbooks, the newsletter *The American Nurse*, and the journal *American Journal of Nursing*,
• Holds membership in the International Council of Nurses; and
• Offers special services for members, including discounted malpractice insurance, retirement plans, and reduced rates for conference attendance.

The ANA established the ANCC as a separately incorporated center for credentialing services. Eleven certification boards bear responsibility for programs and policies relating to a specialty area of nursing practice. Eight of the boards officially recognized the American Board of Nursing Specialty Organizations as meeting national standards for certification. In 1995, the ANCC offered examinations in 28 specialty areas. State Boards of Nursing issue advanced practice nursing licensure to nurses who have become certified by ANCC in an advanced role or specialty practice area.

Through the ANA’s Congress on Nursing Economics and Nursing Practice, standards and programs are developed for nursing education, practice, research, organized nursing services, economic security, employment, and human rights. State ANA groups participate in national nursing issues by membership in various national nursing councils that meet regularly to discuss issues and concerns related to specialty practice areas, such as computer applications, community health nursing, medical-surgical nursing, mental health nursing. The ANA also sponsors activities of The American Academy of Nursing, The American Nurses Foundation. The ANA is a member organization of The International Council of Nurses.

*Sigma Theta Tau International*

Four nursing students at the University of Indiana formed Sigma Theta Tau in 1922. Sigma Theta Tau International (STTI) became an international honor society for nurses in 1985. The organization has 130,000 members in more than 383 chapters; members reside in 75 countries. International chapters are located in Australia, South Korea, Canada, Pakistan, Taiwan, and Brazil. STTI holds membership in the Association of College Honor Societies.

To become a member, a nurse must demonstrate superior scholastic achievement, professional leadership potential, or marked achievement in the nursing field. Organizational membership occurs exclusively by invitation. In addition to student members, community members may be inducted. STTI contributes to the advancement of nursing via small grants, conferences, and publications. The organization publishes the printed journal *Image: The Journal of Nursing Scholarship* and the electronic journal *The Online Journal of Knowledge Synthesis*. STTI also sponsors writer's seminars, has a media development program, and bestows awards for outstanding contributions to nursing practice, research, education, creativity, leadership, professional goals, and chapter programming. Individual chapters present educational programs awards and scholarships. In 1989, STTI dedicated The Center for Nursing Scholarship and the Virginia Henderson International Nursing Library, a state-of-the-art electronic library and information resource center (Vance, 1999). Through promotion of nursing scholarship and leadership, STTI hopes to shape the nursing profession into the future.

**Conclusions Related to the Evolution of Nursing Education**

The development of nursing for recognition as a respected profession remains ongoing. In the last 100 years, great strides have been made to standardize the nursing curriculum for professional nursing. However, the three entry levels of education are a major barrier to professional status. Societal trends have affected recruitment efforts into the profession of nursing. Advances in science provided an opportunity for the nursing profession to establish its own scientific body.
of knowledge. However, because nursing blends logic with emotions and science with art, professional nurses are challenged to provide individualized holistic care to clients. The trend away from the hard science provides nursing with an opportunity to capture the essence of nursing as a holistic healing art based on scientific evidence. The development of multiple nursing organizations impedes the ability of professional nurses to speak with a united voice, results in duplication of services, and fosters competition for membership (Bower, 1999). In many ways, nursing continually fights the same battles within the profession.

The historical evolution of professional nursing identifies how nursing has struggled to gain professional status. However, characteristics of the individual nurse as a member of the profession exemplify what Styles (1982) calls "professionhood."

THE PROFESSIONAL NURSE

For some nurses, nursing practice serves primarily as a way to earn money. Other nurses display a genuine commitment to serving clients and the profession. Differentiating a job from a professional career can be a difficult task. Sometimes, a nurse vacillates between thinking of nursing as a job and thinking of it as a professional career of which to be proud. Over time, being a professional nurse may become embedded into one's personal identity and being.

Characteristics of Professional Nursing Practice

According to Styles (1982, p. 57), professional practice requires a "deep and abiding awareness of purpose and direction in place of a specific set of objectives or standards." Styles has explored the idea that involvement, motivation, and commitment are separate components of a person's sense of vocation. Styles defines commitment as the "intimacy of the perceptions about nursing to the core of the very self." (p. 107). Attainment of a professional self-identity requires great personal involvement before nursing becomes part of one's life.

Styles (1982, p. 60) suggests that it is time to "reinstate the service ideal in its proper primary relationship to our science and practice on the one hand, and to our legitimate claims to self-determination and reward on the other." Components of this service idea include a profound sense of purpose, a true sense of capability, and a deep concern for others demonstrated as caring. According to Koldjeski (1990), caring requires valuing and a willingness to be involved with another person; experiencing life with the other person; instilling faith, concern, and love in another; and fostering self-actualization. A concern for others or genuine altruism may not be sufficient to form a professional purpose. However, it is basic to a service ideal. Whether a person could be a professional nurse without possessing genuine warmth and compassion for others is questionable.

The concept of a professional includes accountability and autonomy for personal actions. Accountability means that nurses must answer for their behavior. (See Chapter 16 "Professional Nurse Accountability.") However, autonomy means that the professional has the freedom and authority to act independently and to control one's own life and not the lives of others. For example, an autonomous nurse might make a judgment about a client's possible health "problems(s)" but would work with the client to identify the client's perceptions and priorities.

Unfortunately, nurses collectively have been characterized by feelings of inadequacy, powerlessness, frustration, and subservience. Reliance on other health care professionals (primarily physicians) for care orders provides an avenue for avoiding accountability when client care results in poor outcomes. Competition for status within the profession interferes with the development of a collegial spirit and shared respect. As a result, nursing has been largely a labor force to provide client care, rather than a significant influence on the health care delivery system.
As part of the health care team, nurses collaborate with other health care professionals. True collaboration involves the potential for equally valued contributions by all parties, yet the typical medical curriculum provides physicians with little experience with or knowledge of colleagues in the other disciplines. Most nurses have much less education than other health care professionals, especially physicians. Thus, nurses may not always be viewed as equal colleagues. By emphasizing cooperation and collaboration, nurses have used their potential power to maintain the very system which has oppressed ... rather than change the system" (Ashley, 1973, p. 638). However, recent recommendations from the PEW Health Professions Commission (1998) designate that health care professionals receive interdisciplinary education.

**Ethical Dimensions of Professional Practice**

Values provide the foundation for ethical dimensions of professional practice. Caring emerges as a shared value within the nursing profession. Clients trust nurses with their lives. Professional nurses must never violate this sacred trust. Nurses serve as caregivers and client advocates. Sometimes, these duties conflict with each other. Nurses have a duty to the individual, society, and their profession (Bandman & Bandman, 1995; Bower, 1999). As science and technology advance and resources dwindle, nurses confront difficult, complex, and conflicting issues as they practice. Ethical systems provide nurses with a set of values and behaviors to use when situations arise without clearly right or wrong answers. By studying ethics, nurses identify their own biases and values. A code of ethics assists nurses to make decisions when confronted with ethical dilemmas.

**Nursing Ethical Codes**

Nurses frequently encounter ambiguity as they practice. Issues arise that have conflicting values, rights, and obligations. Bandman and Bandman (1995, p. 46) state, "Effective nurses function as moral agents." When acting as moral agents in these situations, nurses assume responsibility and accountability for attempts to do no harm. Nurses assume responsibility for action when they assume blame or credit for their own actions. Accountability encompasses the ability to provide sound reasons, explanations, and defenses for actions taken (Sullivan & Christopher, 1999). Nurses encounter many practice situations with multiple correct actions and answers. When this occurs nurses agonize about which of the imperfect and alternative choices would serve the best interests of the client.

For ethical decision-making, nurses use several codes of ethics. Common principles appear in original versions of the International Council of Nurses Code for Nurses, Ethical Concepts Applied to Nursing (1973), and the American Nurses Association Code for Nurses and Interpretive Statements (2001). The International Council of Nurses updated the Code in 2000 and the ANA revised theirs in 2001. The following common principles appear in the ethical codes: (1) respect for human dignity and uniqueness, (2) protection of confidential information, (3) acts to safeguard persons receiving nursing care, (4) responsibility and accountability for nursing actions, (5) maintenance of nursing competence, (6) use of informed judgment, (7) participation in research and other activities to generate new nursing knowledge, (8) participation in activities to improve and implement nursing standards, (9) integrity of the nursing profession, and (10) collaboration with other health care professionals and citizens. Ethical codes define professional standards but fail to state specific guidelines for nursing actions in a given situation. Most professional nursing organizations have established ethical nursing codes which can be purchased in document form or accessed on the Internet. Ethical codes are morally, not legally, binding. Moral decisions made by nurses rely on each nurses conscience.
**Ethical Principles**

In daily practice, nurses use a variety of ethical principles. Commonly used ethical principles and the nursing care issues surrounding them are presented in Table 1-5.

Sometimes even these closely related ethical principles conflict with each other. Aiken and Catalano (1994, p. 26) outline the following three categories of ethical rights that apply to all persons in an ideal world:

1. Welfare rights (also called legal rights) are rights based on legal entitlement to some good or benefit. Laws guaranteed these rights. For example, U.S. citizens have a right to equal access to housing regardless of race, sex, or religion.

2. Ethical rights (also called moral rights) are rights that are based on a moral or ethical principle. Ethical rights usually do not have the power of law to enforce the claim, although, over time, popular acceptance of an ethical right can give it the force of a legal right. For example, health care is really a long-standing privilege for Americans that is sometimes viewed as a right.

3. Option rights are based on a belief in the dignity and freedom of human beings. Option rights give individuals in free and democratic societies the freedom of choice and the right

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**Table 1-5 Ethical Issues Encountered by Professional Nurses in Practice**

<table>
<thead>
<tr>
<th>Ethical Principle</th>
<th>Definition</th>
<th>Practice Dilemma(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sanctity of human life</td>
<td>Human life as the most important characteristic of being human.</td>
<td>Quality versus quantity of life&lt;br&gt;Pro-choice versus pro-life&lt;br&gt;Capital punishment&lt;br&gt;Withholding life sustaining treatments&lt;br&gt;Euthanasia and assisted suicide</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Individual freedom to make rational and uncoerced decisions</td>
<td>Lack of client knowledge about available treatments&lt;br&gt;Cooerced power&lt;br&gt;Paternalism&lt;br&gt;Cognitively impaired individuals&lt;br&gt;Individual decisions that interfere with another person's rights</td>
</tr>
<tr>
<td>Veracity</td>
<td>Truth-telling</td>
<td>Whistleblowing&lt;br&gt;Concealing a chemical or physical abuse pattern&lt;br&gt;Falsification of legal document to cover errors&lt;br&gt;Covering up reasons&lt;br&gt;Informed consent</td>
</tr>
<tr>
<td>Distributive justice</td>
<td>Allocation of limited resources</td>
<td>Managed care&lt;br&gt;Reduced access to care based on inability to pay for services&lt;br&gt;Judicious use of high-tech equipment for prolonging life&lt;br&gt;Deciding who gets resources based on fitness, cost-benefit analysis, equal chance, equal share, or equal consideration</td>
</tr>
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to live their lives as they choose, as long as they stay within a set of prescribed boundaries. For example, people may wear whatever clothes they choose as long as they wear some type of clothing.

Nurses have a moral obligation to share all relevant information and alternative actions with clients so that informed choices can be made. Obligations to the client supersede obligations to institutions, physicians, and nurses. In some situations, nurses may be forced to abide by the client's decision for treatment even though it conflicts with their personal values. When this occurs, nurses find themselves in an ethical dilemma.

Ethical principles provide nurses with a guide for decision-making when confronted with ethical dilemmas. Each situation must be thoroughly analyzed, and options for action must be generated. Each option must be weighed according to its potential outcome. Deciding on the best action usually is agonizing. However, nurses also may seek guidance from other health care professionals when no clearly right decision for a given situation surfaces. Many health care providing institutions have established ethics committees to address ethical dilemmas within their walls. Nurses also may consult with clergy or ethical experts before making difficult decisions.

<table>
<thead>
<tr>
<th>Ethical Principle</th>
<th>Definition</th>
<th>Practice Dilemma(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respect for personal beliefs</td>
<td>Accepting individual beliefs as a basis for decision-making</td>
<td>Religious preferences not to subject self or family to “impure” acts. Conflicts of research evidence on personal health habits.</td>
</tr>
<tr>
<td>Justice</td>
<td>Do only good</td>
<td>Balancing what is morally right with what is legal and practical. Highly individualized for each situation and shares actions with many of the principles presented above.</td>
</tr>
<tr>
<td>Truth</td>
<td>Making privileged information known</td>
<td>Reporting health problems that interfere with safe driving to state officials. Telling families about poor prognosis before informing clients. Disclosing alternative lifestyles.</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Keeping promises</td>
<td>Not keeping one’s word. Failing to follow up with what one says one will do.</td>
</tr>
<tr>
<td>Veracity</td>
<td>Treating clients fairly</td>
<td>Treating clients differently based on their ability to pay or other sociocultural characteristics. Singling out special clients for extra nursing care. Denying health care access to anyone.</td>
</tr>
</tbody>
</table>
Legal Dimensions of Professional Practice

The legal system protects consumers from unsafe nursing practice. Along with licensure, the legal system holds nurses responsible for professional actions.

Licensure

Licensure refers to "a form of credentialing whereby permission is granted by a legal authority to do an act, without such permission, action would be illegal, trespass, a tort, or otherwise not allowable" (Loquist, 1999, p.105). A professional nursing license is a legal document that certifies that an individual has met minimal standards for qualified practice. As a state function, licensure protects citizens from unsafe or incompetent health care providers. Upon licensure, nurses become registered in a particular state to practice professional nursing. Registration denotes the "enrolling or recording the name of a qualified individual on an official roster by an agency of government," (Loquist, 1999, p. 15).

Requirements for licensure as a registered nurse (RN) appear in each state's nurse practice act (NPA). Most NPAs contain information related to reasons for licensure, nursing definitions, licensure requirements, licensure exemptions, reasons for license revocation, endorsement provisions for nurses licensed in other states, development of a state board of examiners, nursing board responsibilities, and penalties for practicing nursing without a license or not in accordance with the state NPA (Kelly & Joel, 1995).

All states use the National Council Licensure Examination for Registered Nurses (NCLEX-RN) as criteria for professional licensure. The test focuses on client needs and nursing process. To be eligible to take the exam, nursing students must be a graduate of a state-approved school of nursing and be approved by the State Board of Nursing. Since 1993, a computerized exam has been administered, thereby allowing individuals to take it at any approved testing site. Passing the exam not only permits licensure and registration in the state in which the exam is taken, but also permits later registration in other states if desired. Nurses do not need to take the exam again for licensure in more than one state. Licensure by endorsement requires completing forms and paying fees to states when the nurses want to practice nursing in more than one state. Although licensure is permanent (unless it is revoke for illegal or immoral behavior), registration must be renewed periodically (usually every 1 to 2 years) by paying a fee to each state in which current registration is desired.

All 50 states have mandatory licensure. This means that anyone who practices nursing according to the legal definition of practice must be licensed. States make exceptions in the following cases: (1) nursing students who practice under the supervision of a professional nurse in their course of study, (2) federal government employees, and (3) persons performing nursing duties in emergency situations. Only North Dakota requires baccalaureate nursing education for RN licensure. All other states license and register graduates of all educational programs.

With the advent of using computer technology to provide health care, the National Council of State Boards of Nursing has initiated a model for multistate regulation of the nursing profession. Under the mutual recognition compacts, a state permits nurses from other states with the state compact in place to practice nursing within the state without an additional license. Nurses are required to practice nursing according to the NPA of the state where the client care occurs (Loquist, 1999).

In the 1980s, momentum appeared to be developing for mandatory continuing education in every state. However, according to a 1995 survey, only 25 state boards of nursing had continuing education requirements for license renewal, and 33 state boards had continuing education requirements for reentry into active practice (Annual CE Survey, 1996). In addition, concern has
been expressed with the lack of data linking continuing education with improved patient care outcomes. Colorado is the only state to have repealed mandatory continuing education for licensure renewal (Hewlett & Eichelberger, 1996). Most states have reviewed their NPAs several times since they were written in the early 20th century.

Legal Professional Responsibility

Licensure as a RN carries with it the responsibility for safe and competent practice. If injury, unnecessary suffering, or death should occur as a result of care delivered by a nurse, the nurse may be held legally responsible for malpractice of negligence. *Merriam-Webster's Collegiate Dictionary* (1994 p. 705) defines malpractice as “1. a dereliction from professional duty or failure to exercise an accepted degree of professional skill or learning by one (as a physician) rendering professional services which results in injury. 2. an injurious, negligent, or improper practice.” Negligence is defined as “failure to exercise that care that a prudent person usually exercises” (*Merriam-Webster's Collegiate Dictionary*, p.777). States expect all licensed professional nurses to act reasonably and prudently and judge their actions based on a nurse with the same education and experience within a given situation. With the advent of increased use of unlicensed assistive personnel, prudent nurses verify the outcomes of delegated tasks. The more common forms of negligence found in nursing include client falls; client burns; errors with medication administration (wrong medication, dose, concentration, client); error with blood administration; ineffective communication with clients, their families, or other health team members; failure to assess and take appropriate actions; failure to detect defective equipment; and failure to use reasonable judgment.

Nurses assume legal responsibility for their own actions. In most cases, nurses work as employees of an institution and execute physician orders. Legal responsibility for the nurses’ actions also may rest with the institution and client physician under the legal rule respondent superior. Under this rule, the master (institution or physician) bears responsibility for the servants (nurse’s) actions.

Catalano (1995) identifies the following four doctrines upon which negligence is based: respondent superior (master-servant), borrowed servant and captain of the ship, ostensible agency, and *res ipsa loquitur* (let the action speak for itself). Under the respondent superior doctrine, the employer is held liable for injury along with the employee for cases of employee negligence. RNs who also are students are considered employees of a clinical agency if they work there for pay. Usually, the school contract with the clinical agency specifies that basic nursing students are not employees of the agency and must carry their own malpractice insurance (many schools carry a blanket policy that covers students and faculty). However, precedent cases have found institutions (as well as students and faculty) responsible for students acting as agents of the institution in the provision of nursing care during clinical education situations.

Courts have held nursing students personally liable and accountable for errors that have occurred during clinical instruction. For cases addressing alleged negligence, the court determines and establishes the standard of care against which student actions are evaluated. The court considers student experience and the amount of education when setting the standard. This is based on the standard of reasonable care, which is concerned with the degree of skill and knowledge customarily used by a competent practitioner of similar education and experience in the community. However, when functioning as professional nurses during clinical learning experiences, students are held to the same standards of care as RNs performing the same task or duty. Students bear the responsibility for adequate clinical preparation and for asking for faculty assistance if questions arise regarding how to proceed with a patient care activity.
Ethical and legal considerations may overlap at times. The Tuma case, widely reported in the literature in the early 1980s provides an example. Tuma, an RN, taught nursing in an associate degree program. She assigned a student to care for a woman who had been told by her physician the day before that she had terminal leukemia. The physician offered chemotherapy as the only hope to prolong life. After the woman consented, Tuma and the student prepared the woman to receive chemotherapy.

Because the woman had lived with the leukemia for 12 years with the help of prayer and natural foods, she appeared very upset about receiving chemotherapy. As Tuma initiated the treatment, she discussed alternative treatments for leukemia with the client. The client then requested Tuma to return later to discuss options with her children. Tuma returned that evening, but she failed to inform the physician of her educational interventions. The client's children reported the discussion to the physician, who complained that the nurse had interfered with the client-physician relationship. In addition, Tuma instructed the nursing student to "forget" about the discussion held with the client related to treatment options. As a result, the nursing program suspended Tuma from her job and the state court suspended Tuma's license for 6 months. Ultimately, Tuma took her case to the state supreme court, which upheld her appeal on the grounds that the state's nurse practice act failed to define Tuma's actions as unprofessional conduct.

This case raised concerns because it seems to indicate that the nurse does not have a legal right to inform clients about medical treatment alternatives, even when clients request more information. Tuma had administered the chemotherapy, so physician orders had been followed. However, the real case focused around Tuma's deliberate action of withholding vital information from the physician as she had become aware that the physician failed to present all available treatment options before obtaining informed consent. The lower courts identified failure to alert the physician about client concerns about chemotherapy as interference with the client-physician relationship.

Nurses must know and function within the legal parameters of nursing practice in their state. If nurses have ethical or legal concerns about medical treatment, they must share them with medical and hospital authorities. Nurses may refuse to carry out a treatment but must not attempt to circumvent the physician by interfering with treatment without the physician's knowledge. Nurses and physicians must collaborate, not compete, with each other.

Developing a Professional Image
Development of a professional image requires many personal and behavioral changes. Changes in behavior can occur without a change in attitude. Through the process of education, individuals should experience attitudinal and behavioral changes as they acquire new knowledge. Nurses who view themselves as professionals approach client care differently from those who view themselves as technicians. As the level of nursing professionalism increases, nurses assume a variety of professional nursing roles as they deliver client care.

Professional Nursing Roles
Nurses assume many roles as they practice professional nursing. The most familiar of these is the role of the caregiver. Nurses use nursing process, clinical skills, genuine compassion, and a broad knowledge base to provide holistic health services to clients. Nurses become critical thinkers when they identify a nursing diagnosis from a cluster of client data, engage in clinical decision-making, and analyze research findings before using them in practice. Nurses listen to client concerns and remedy information gaps as they assume the counselor-teacher role. When clients need protection from others or help navigating complex health-related situations, nurses assume
the role of client advocate. Nurses serve as change agents when they engage in policy development or use research findings as a basis for new ways to practice nursing. As nurses manage human and material resources for care, they serve as coordinators. Finally, because nurses bring an equally important and unique perspective to client care, they become colleagues with other health care team members.

**CONCLUSION**

The process of becoming a professional nurse involves change and growth throughout various stages of a career. Nursing history provides a foundation for understanding how the profession became what it is today. Nurses can use history to avoid repeating the mistakes of their predecessors. History provides nurses with role models who had the courage to enact societal and political change to shape the profession. Through educational and occupational experiences, the nurse develops attitudes, beliefs, and skills as knowledge expands and deepens. Effective implementation of the roles associated with professional nursing practice requires deep commitment, broad knowledge base, refined communication, networking skills, and keen insight into one's personal values, strengths, and weaknesses.

**INTERNET EXERCISES**

This chapter has provided a broad overview of the profession of nursing. These Internet Exercises will enhance your understanding of the chapter material and help you appreciate what it means to be a professional nurse.

**Exercise 1**

1. Visit http://www.internurse.com. View pictures and read more about the nurses who shaped the profession of nursing by clicking on the word "History" on the screen. Listen to the voice of Florence Nightingale. Write a paragraph or two describing your thoughts and feelings about visiting the site. Please also include information related to your perception of nursing history since reading and visiting this website. Share this information with your nursing colleagues in class or at work.

2. Visit the website www.riursingworld.org, the official website of the American Nurses Association. Analyze the benefits and costs of membership and view the most recent form of the ANA's Code of Ethics with Interpretive Statements.

3. Using the search engine of your choice, type in any specialized area of nursing practice and see if you can find a professional nursing organization to support nurses practicing in that field of nursing. Analyze the benefits and costs of membership. Compare and contrast two professional nursing organizations.

4. Visit the website www.ncsbn.org. Identify key issues surrounding safe nursing practice. While there, visit your State Board of Nursing website and identify key information about license renewal, announcements, and news.

**INTERNET RESOURCES**


Center for the Study of the History of Nursing: http://www.nursing.upenn.edu/history. Visit the grave sites of nursing historical figures and read about their contributions to the profession.

Women's History: http://womenshistory.about.com/homework/womenshistory/cs/nurses. Read about key historical nursing figures and learn about contributions of minority nurses to the profession.


Sigma Theta Tau International: http://www.nursingsociety.org. Read about Sigma Theta Tau history, membership criteria, membership services, efforts to promote nursing scholarship, and visit the Virginia Henderson Library.

National League for Nursing: http://www.nln.org. Learn about NLN history, membership services, and standards for professional and vocational nursing program accreditation, testing services, and research initiatives.

American Association of Colleges of Nursing: http://www.aacn.org. Read about AACN's history and mission and get a hyperlink to the Commission for Credentialing of Nursing Education for program accreditation standards for baccalaureate and graduate nursing educational programs.