CHAPTER 70

Nursing Education's Ongoing Debate over Entry into Practice and the Continuing Debate over Doctoral Degrees

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"Great leaders are almost always great simplifiers, who can cut through argument, debate, and doubt to offer a solution everybody can understand."

Colin Powell

The educational entry level into nursing practice has been debated for decades. The old debate about entry into professional nursing at the prelicensure level and the latest debate about doctoral education and entry into advanced nursing practice inspire strong opinions from leaders in nursing education and practice. The early debate focused on entry at the prelicensure level, and more specifically, the movement of professional nursing practice into the academic setting. The current debate moves the dialogue to consideration of doctoral education, calling for acceptance of both the traditional research-focused doctorate and the rapidly increasing doctorate of nursing practice (DNP) as the profession's terminal degree. Both debates concern the transformation of nursing practice in the midst of changing health care systems and practice demands.

The belief that a nurse's educational entry point impacts the quality and competence of the nurse's work has fueled both debates. This notion, that entry affects practice, has resulted in numerous position statements from professional organizations describing the nature of education needed for the future. The first of these statements, the American Nurses Association (ANA) 1965, First Position on Education for Nursing (American Nurses Association [ANA], 1965) sought to change the trajectory of nursing education and move education out of the service sector and into academic settings. The paper's authors saw a future with two levels of nursing, technical and professional; two-year colleges would provide "minimum preparation for beginning technical nursing practice" (Committee on Nursing Education, 1965, p. 108) and four-year programs would prepare graduates for beginning professional practice. This document also called for practical nursing programs to eventually be replaced by technical programs. Its publication created controversy and debate in the nursing education and practice communities. Following the 1965 ANA position paper, colleges and university nursing programs created specialized master's programs (MSNs) that became the norm for credentialing and licensing of advanced practice roles. The 2004 position paper of the American Association of Colleges of Nursing (AACN), which called for the establishment of the DNP, proposed that study for the four advanced practice roles (midwives, nurse anesthetists, clinical nurse specialists, and nurse practitioners) should be elevated from the MSN to the DNP level by 2015. The DNP is viewed as the clinical path into specialized advanced practice (Donley & Flaherty, 2002). This was a radical departure from specialized master's programs and represented a new form of entry into advanced practice nursing.

THE ENTRY INTO PRACTICE DEBATE

HISTORICAL PERSPECTIVE

Following World War II, a shortage of nurses occurred because many nurses returning from military service did not re-enter the workforce. Also, changes in health care including hospital-based births, surgical procedures, and anesthesia necessitated more nurses working in hospitals (Haase, 1990). In 1948 the Carnegie Foundation commissioned a sociologist, Dr. Esther Lucille Brown, to study nursing education and to address the critical nursing shortage in the United States caused by a decreased supply of nurses and an increased demand following World War II. Brown's report, *Nursing for the Future*, called for nurses to be educated in colleges and universities instead of hospital-based programs (Brown, 1948). The ANA and the National League for Nursing (NLN) supported the Brown report and urged the profession to move nursing education into the college environment (Orsolini-Hahn & Waters, 2009). Simultaneously, President Harry Truman convened a National Commission on Higher Education which called for the expansion of community colleges. In response to both documents, the NLN representatives arranged a meeting with the Association of Community Junior Colleges (AAJC) (now known as the American Association of Community Colleges [AACC]), to explore teaching nursing in two-year community college programs (Haase, 1990).

While these events transpired on a national level, faculty at Teachers College, Columbia University, were engaged in the exploration of new models of nursing education. A doctoral student, Mildred Montag, proposed in her dissertation that nurses be educated at community colleges as nursing technicians (Montag & Gotkin, 1959). Based on Dr. Montag's dissertation, entitled *Education for Nursing Technicians*, she received funding to conduct research on this new model and in 1952, under her leadership, faculty from seven original associate degree programs created the 2-year technical program. Although the course of study was referred to as technical and terminal, a term used at the time to signify that the entire course of study could be accomplished in a set time-frame, faculty in the new programs viewed their mandate as more than the development of a shortened traditional program; they envisioned a program of learning that would revolutionize nursing education. The curriculum was no longer based on a "map of the hospital" (Waters, 2007). By 1980, associate degree programs were educating approximately 20% of new graduate nurses (Orsolini-Hahn & Waters, 2009). At the same time, professional nursing programs developed in baccalaureate programs, although not at the same pace as occurred in community college programs (Haase, 1990). The extraordinary growth of associate degree programs from the midpoint of the last century is compelling: in 2011 associate degree nursing graduates accounted for 60% of new Registered Nurse (RN) graduates from more than 900 associate nursing degree programs nationally (Human Resources Services Administration [HRSA], 2013).

UPHEAVAL WITHIN THE PROFESSION

Controversy followed the associate degree programs from their inception. The main reason for this was that the educational model was not consistent with the way associate degree graduates were used in practice. Dr. Montag had proposed this new model based on a two-level system of nursing care delivery. She intended that associate degree graduates would function in teams led by baccalaureate-prepared nurses due to the significant difference in technical and professional education. The practice environments, however, used the associate degree graduate in management and leadership positions where they performed satisfactorily (Orsolini-Hahn & Waters, 2009). For almost 50 years, nursing attempted to define the differences between graduates of the two types of nursing programs. Because these debates focused on practice in acute care both at the bedside and in management, where roles of both graduates were blurred and overlapped, they failed to clearly define the differences (Haase, 1990). In both education and practice, no clear distinctions between the two levels emerged and most employers never distinguished ADN and BSN nurses with regard to pay, function, or task.

As early as 1965, organized nursing attempted to bring clarity to the differentiation debate. Due to the increasing complexity of health care and changes in practice, the ANA convened the Committee on Education to study nursing education, practice, and scope of responsibilities. The study group recommended that the minimum preparation for professional nursing practice should be the baccalaureate degree. The Committee on Education's statement became the ANA's position paper and contained a description of three levels of nursing education: baccalaureate education for beginning professional nursing practice, associate degree education for beginning technical nursing practice, and vocational education for assistants in the health service occupations (ANA, 1965). The authors of the position statement also recommended that associate degree programs replace practical nursing programs, further alienating vocational and practical nurses and faculty. That same year, the NLN published a document, Resolution 5, calling for examination of the differentiated functions of the two levels of nursing education (Haase, 1990). Subsequently, the 1965 ANA position paper was later reaffirmed by a 1978 ANA House of Delegates resolution which resulted in the recommendation that, by 1985, the minimum preparation for entry into professional practice would be the baccalaureate degree.

These actions divided the health and nursing community (Donley & Flaherty, 2002). Many associate degree nurse educators became disillusioned with the ANA and NLN, leaving both organizations to start a new organization in 1986, the National Organization for the Advancement of Associate Degree Nursing, which later became the National Organization for Associate Degree Nursing (NOADN). The NLN established separate councils for associate degree and baccalaureate educators; the councils rarely interacted. And strained relationships developed between faculty in both types of programs, resulting in little constructive dialogue on ways to differentiate between programs and build a more educated workforce, which had been the primary intent of the Brown report, the ANA 1965 position statement, and the NLN early documents. The central focus of the early debate had been to improve educational preparation, elevate the status of nurses, and ultimately improve the quality and safety of patient care. Yet nursing had become mired in differentiation debates that served only to sidetrack the discussion. As a result, more than 50 years later, the need for a more educated workforce remained at the core of the entry into practice debate.

CURRENT CLIMATE: COLLABORATION WITH COMMON GOALS

The release of the Robert Wood Johnson Foundation (RWJF) and Institute of Medicine Report *The Future of Nursing: Leading Change, Advancing Health* (2011) was a pivotal event in the entry to practice debate. The report's wide dissemination and the positive response from the nursing community changed the national focus from differentiation debates to collaborative calls for an "action-oriented blueprint for the future of nursing" to advance the nation's health. Two of its recommendations related specifically to academic progression within nursing: (1) to support an increase in the proportion of nurses with a baccalaureate degree in nursing by 2020 from 50% to 80% and (2) to double the number of nurses with doctorates to add to the cadre of nurse faculty and researchers, with attention to diversity (Institute of Medicine [IOM], 2011). The report noted that nurses who enter the profession with either an associate or baccalaureate degree on average seek one more degree over the course of their careers and that approximately 60% of new nurses are associate degree graduates. Thus, having sufficient qualified faculty and advanced practice nurses to manage emerging models of care in a variety of settings would be unattainable with current articulation agreements. The report affirmed that in order to respond to increasing demands, nurses must achieve higher levels of education and training through an innovative education system that promotes seamless academic progression.

What factors influenced this change in thinking? What turned the dialogue away from differentiation to how academic progression could be accomplished to benefit the profession and advance the nation's health?

Nursing Schools of Yesterday. Numerous trends converged to coalesce around the need for a more educated workforce in the context of multiple entry points into the profession. The complexity of care and the predicted shortage of RNs in the mid-1990s to provide that care drove home the need for those RNs in the workforce to be better prepared to provide new models of care delivery, to manage the care of individuals with complex chronic care needs who require intervention in both institutional and home settings, and to teach future nurses in schools of nursing. Additionally, the calls for health care reform, which preceded the adoption of the Patient Protection and Affordable Care Act (2012), called for new approaches to delivering care to chronically ill individuals and a greater focus on health promotion and disease prevention. These approaches require nurses who are knowledgeable about research, care coordination, outcomes management, risk assessment, and quality improvement, skills that are core to the practices of professional nurses. New methods of care delivery required a systems approach to address the consequences of disparities in access to health care services that preclude quality care for all individuals. They also required that nurses have advanced study and practice experience.

Over time, the nursing community embraced the idea that the need for a highly educated workforce was the key issue, not the nurse's educational entry point. Academic progression would be the critical factor for the nursing profession to fully impact the quality and competence of a nurse's work, and the movement to embrace academic progression as essential to nursing's future gained new energy and momentum.

Factors Inside of Nursing. In 2011, the National League for Nursing released a statement promoting academic progression in nursing education. The statement made clear the NLN's conviction that transformation of nursing education is vital to the preparation of a nursing workforce prepared to tackle the demands of our ever-changing, dynamic 21st century health care system, with its advanced technologies, culturally diverse and aging patient population, and the shrinking of global borders. The NLN reaffirmed its support of multiple entry points to the nursing profession and advocated for creating new opportunities for life-long learning and academic progression to advance the nation's health. Additionally, The Future of Nursing: Campaign for Action, was launched shortly after the release of the IOM report in 2010. The campaign, a national initiative to guide implementation of the report's recommendations, envisions a health care system where all Americans have access to high-quality care, with nurses practicing to the full extent of their capabilities. It is coordinated through the Center to Champion Nursing in America (CCNA), an initiative of the AARP (formerly the American Association of Retired Persons), the AARP Foundation, and the RWJF. As of 2014, the campaign included 51 state Action Coalitions and a wide range of health care providers, consumer advocates, and other leaders.

Internal Cohesion Comes to Nursing. In the wake of the IOM report's release, groups and organizations that were once viewed as adversarial developed joint position statements and programs. In 2012, The Joint Statement on Academic Progression for Nursing Students and Graduates brought together the NLN, AACN, American Association of Community Colleges, Association of Community College Trustees, and NOADN to declare that every nursing student and nurse needs to have access to additional nursing education (NLN, 2012).

The momentum generated by this report and the Campaign for Action resulted in dramatic changes in academic progression in nursing. The number of students enrolled in RN to BSN programs increased by 22% from 2011 to 2012 (American Association of Colleges of Nursing [AACN], 2012). By 2014, AACN data revealed a strong enrollment surge in baccalaureate nursing programs designed for practicing nurses looking to expand their education in response to employer demands and patient expectations. The number of students enrolled in RN to Bachelor of Science in Nursing (BSN) programs increased by 12.4% in 2013, the 11th year of enrollment increases in these programs (AACN, 2014a). These data reflect a trend in

hospital employment that favors BSN graduates, and 59% of new BSN graduates had job offers at the time of graduation, which is substantially higher than the national average across all professions (29.3%) (AACN, 2013b). As employer demand has increased, more nurses from ADN and diploma programs recognize the need to advance their education to remain competitive in today's workforce.

Additionally, enrollment in master's and doctoral degree nursing programs also increased significantly. Nursing schools with master's programs reported an 8% jump in enrollments. In doctoral nursing programs, the greatest growth was seen in DNP programs where enrollment increased by 20% between 2011 and 2012. Enrollment in research-focused doctoral programs increased slightly by 1% (AACN, 2012).

At this time nursing students from minority backgrounds represented 28.3% of students in entry-level baccalaureate programs, 29.3% of master's students, and 27.7% of students in research-focused doctoral programs (AACN, 2014). RN-to-BSN programs exhibited the largest upturn, with minority enrollment gaining four percentage points to reach 26%. Although community college nursing programs are often the access point for entrance into nursing for individuals from minority backgrounds, there is much work to be done in nursing to have adequate representation reflective of the U.S. population.

The history of nursing progression in education includes years of debates about entry into practice at the prelicensure level, an exercise that proved to be divisive and counterproductive. For more than 50 years, from the time of the 1965 ANA position statement, the nursing community became sidetracked about how to achieve differentiation, and the ensuing debates diverted nursing's productive energy away from its fundamental vision to meet the needs of patients in changing practice environments. With the release of the IOM *Future of Nursing* report (2011) that energy is now channeled into productive dialogue about academic progression and creation of innovative programs to move new RN graduates more efficiently and effectively into advanced degrees. The next 50 years are poised to witness the transformation of nursing practice in the midst of changing health care systems and practice demands.

THE ENTRY INTO ADVANCED PRACTICE DEBATE

HISTORICAL PERSPECTIVE

Advanced practice nursing emerged as a response to the physician shortage in the late 1950s (Joelle, 2002). By the mid-1960s, nurse practitioner programs existed throughout the United States as post-baccalaureate certificate programs of varying length (O'Sullivan et al., 2005). In 1990 the National Organization of Nurse Practitioner Faculties (NONPF) published *Advanced Nursing Practice: Nurse Practitioner Curriculum Guidelines* and called for nurse practitioner education to be grounded in graduate level programs (National Organization of Nurse Practitioner Facilities [NONPF], 1990). Within the next decade, the shift away from certificated nurse practitioner (NP) programs was complete, with less than 1% of all NP programs representing non-master's education tracks (O'Sullivan et al., 2005).

Over time a growing movement evolved within nursing to reconsider nurse practitioner educational preparation in earnest. The practice doctorate was discussed as a means to meet the demand for increased knowledge and skills. The following societal changes and emerging health care trends sparked this movement:

- In the late 1990s, nurse-managed health centers emerged as safety net providers for underserved populations, extending the range of primary care services offered by nurse practitioners in autonomous practice settings (Hansen-Turton & Kinsey, 2001; O'Sullivan et al., 2005).
- The nursing community recognized that the demand for new models of care to manage complex chronic comorbidities, specifically of an aging population, required movement away from illness management to nontraditional approaches to case management involving multiple intersecting systems of care. Nurse faculty teaching in NP programs called for parity with other allied health professions. These disciplines,

for example, pharmacy, audiology, and physical therapy, had expanded their master's degree programs and created practice doctorates in response to the need for advanced practice professionals to work within complex systems, advocating for evidence-based quality care in an interdisciplinary environment. Nursing leaders argued that parity for nursing was not simply a matter of status but a necessary credential for credibility in leadership and policy positions (Lenz, 2005).

- The Institute of Medicine (2003) proposed changes in practice to reduce medical errors and increase the competencies needed to deliver quality care, including use of informatics, understanding of quality improvement, a focus on patient-centered care, wide acceptance of evidence-based practice, and movement to interdisciplinary care models. Changes in practice would require new approaches to the education of advanced practice health care professionals, including courses in health care finance and policy, process and outcomes measurement, and analysis and use of evidence-based methods to plan and implement care (O'Sullivan et al., 2005). These new educational demands resulted in increased clinical and classroom hours in NP programs; however, the credit allotment had not increased commensurately. It became apparent to faculty in NP programs that nursing may be under-credentialing its advanced practice graduates (Lenz, 2005).

EMERGENCE OF THE DNP: THE EARLY DEBATE

In 2004, AACN members endorsed a position statement on the Practice Doctorate in Nursing (AACN, 2004). This document was a response to calls for change in master's-level advanced practice nursing programs and advocated for moving entry from the master's to doctorate level by the year 2015. The DNP, as the new entry level would be termed, was viewed as a viable alternative to the research-focused doctorate in nursing for those nurses who desired to pursue excellence in nursing practice.

A collaboration between NONPF and the AACN created the publication of the AACN documents (AACN, 2004, 2006). This generated considerable debate within the nursing community (Donley & Flaherty, 2002; Meleis & Dracup, 2005; NLN, 2007):

- What to do about schools in colleges or universities that are not authorized to offer doctorates or interested in offering a DNP?
- Was the AACN document released too soon, before adequate analysis and support from the nursing community could be garnered?
- Did the apparent separation of practice and research in the DNP program's curriculum lead to greater fragmentation in advanced nursing education?
- With the research-intensive environment of higher education, would the DNP undermine the scholarly productivity and funding advantage that schools of nursing receive from research grants?
- What was the impact on the need for well-qualified nursing faculty?

EXPONENTIAL GROWTH OF THE DNP: LESS DEBATE AND MORE DIALOGUE

Despite the initial concerns about the DNP, the growth of DNP programs across the United States has been unprecedented. From 2005 to 2011, DNP programs increased by 85%, with a 66% increase between 2009 and 2011 (Udlis & Mancuso, 2012). By 2014, almost 250 DNP programs existed and an additional 59 DNP programs were in the planning stages. From 2012 to 2013, the number of students enrolled in DNP programs increased from 11,575 to 14,699. During that same period, the number of DNP graduates doubled (AACN, 2014c).

Clearly the DNP program has addressed an unmet need for doctoral preparation in nursing as schools nationwide reported sizable and competitive student enrollment (AACN, 2013a). Although all DNP programs must adhere to the Essentials of Doctoral Education for Advanced Nursing Practice (AACN, 2006), numerous ways in which to organize and deliver programs currently exist (Udlis & Mancuso, 2012). The Essentials document called for moving the level of preparation necessary for advanced nursing practice from the master's degree to doctorate level by the year 2015, a deadline which has proved to be unrealistic. This variability

in both intent and implementation of programs has led to a continuing debate about the purpose and value of the DNP. Three of the issues at the heart of the debate are: lack of standardization of the DNP program, uncertainty over nurse practitioner versus DNP practice, and lack of preparation of graduates for the faculty role.

Lack of Standardization. The DNP was viewed by proponents as a benefit to advanced practice nurses because it leveled the playing field in terms of status and authority between nursing and other health professions who have practice doctorates. Burns-Bolton and Mason (2012) argued that the DNP would distinguish advanced practice nurses as professionals that compare to other clinical doctorate health professionals but "has been undermined by the development, and now domination, of DNP programs that prepare administrators and educators" (p. 248). The DNP degree does not clearly represent the four roles of advanced clinical practice, and role definitions have been imprecise and unclear.

Lack of Preparation of Graduates for the Faculty Role. As more and more graduates of DNP programs begin or return to faculty roles in schools of nursing, the concern is that graduates will lack the complex and specialized knowledge intrinsic to the role of the nurse educator. In 2013, the NLN called for doctoral programs in nursing, including both research and practice doctorates, to prepare graduates with the knowledge and skills to teach, provide leadership for transforming education and health care systems, and conduct or translate research in nursing education. In practice disciplines such as nursing, it is especially important that educators and practitioners alike be able to evaluate and demonstrate links between educational outcomes and patient care quality, a particularly challenging task in a health system that is undergoing rapid change.

Calling for the doubling of the number of nurses with doctorates by 2020 to add to the number of nurse faculty, the IOM *Future of Nursing* report (2011) notes that at no time has there been a greater need for research on nursing education. Consideration needs to be given to the urgent need to not only double the number of nurses with doctorates, whether DNP or PhD, but to prepare them to develop and incorporate evidence-based approaches to coordinated care within programs of learning and to expand graduates' views of patient-centered care, population-based care, and team-centered coordination during care transitions.

LESSONS LEARNED FROM NURSING'S JOURNEY

There are at least five major areas of learning from the profession's protracted journey in nursing education: vision, inclusion, diversity, the practice and education bridge, and the politics of connection: allies, partners, and champions (Box 70-1). To achieve transformation of a system, the nursing community must continually prioritize the essential components of the nursing education agenda and be sure they are consistently implemented across the country.

CONCLUSION

Donley and Flaherty (2002) have raised the question regarding the long-term achievements of the 1965 ANA position paper. The document called for all nursing education to take place in colleges and universities; today over 90% of prelicensure nursing programs exist in community colleges and bachelor's degree–granting institutions. In that sense, the position paper had a profound effect on changing the trajectory of nursing education. However if you consider the document to be a call for a more educated workforce, then the mandate has not yet been fully achieved. Similarly, if you consider that the major outcome of the DNP is parity for advanced practice nursing with other allied health disciplines, then the nursing profession is well on its way to establishing leadership and greater policy credibility. Moreover, if the intent is to advance excellence in nursing practice and nursing education to address the vision of a transformed health care system that is patient centered and community responsive, the outcome is, at present, unknown.

BOX 70-1 Lessons Learned from Nursing's Journey

There are at least five major areas of learning from the profession's protracted journey in nursing education: vision, inclusion, diversity, the practice and education bridge, and the politics of connection: allies, partners, and champions. These are not unknown areas of learning for nursing; however, they are frequently the forgotten and discounted priorities as change is pursued. As time moves us forward, to achieve not only change but transformation of a system, these priorities must be acknowledged and consistently implemented as essential components of the nursing education agenda.

Vision. By refusing to become distracted by old and new arguments related to entry, rather than focus on being responsive to a new vision for the nation's health care system, nursing/education today has the opportunity for leadership into a new era of lifelong learning and progression, claiming a stake in the vision without the perception of exclusive professional self-enhancement, sometimes referred to as tribalism. The vision is the overarching umbrella that allows space for dialogue, reflection, and debate that can exceed our individual or professional differences leading to creative pathways of collaboration and transformation. It is a vision that provides space for cocreation in alignment with the NLN definition of excellence: cocreating and implementing transformative strategies with daring ingenuity.

Inclusion. Nursing's history is replete with vivid examples describing the exclusion of nursing as a legitimate profession. It would seem that having been the recipient of a model of exclusion, we would be especially sensitive and proactive to dispel it within our ranks. Even at this time, however, the nursing profession still clearly disallows space for the licensed practical nurse (LPN) and the health care assistant (HCA). For nursing not to claim our relationship to our colleagues and exclude nurses from a variety of entry points for both prelicensure and postlicensure programs is shortsighted of the patient-centered, community-responsive care vision that a reformed health care system can offer.

Diversity. To focus on the vision for nursing, diversity has to be broader than race and ethnicity (NLN, 2012). Yet to be true to the vision for this nation with its multicultural people, race and ethnicity must also be a focus. Although the nursing workforce is still predominantly white, over time the proportion of racial/ethnic minorities has been increasing. Black/African Americans, Asians, and Hispanics/Latinos currently make up 25% of the RN population. Although this growth is notable, the RN workforce has a smaller percentage of Hispanics/Latinos and black/African Americans when compared with the total working-age population in the United States. The percentage difference for Hispanics/Latinos is particularly troubling: they compose 14% of the working-age population but only 5% percent of the RN workforce (HRSA, 2013). The old and new debates infrequently discuss these issues. Strategic efforts are still lacking in terms of making a difference in diversity. For a culture of diversity within the nursing/education workforce and workplace there must be the desire; the will to envision, create, plan, and implement; and to move to a culture of inclusiveness.

The Practice and Education Bridge. It would seem that the more recent debate on the DNP has learned from the earlier debate on entry for education and practice. This new learning involves an ongoing relationship between practice and education, and means a redesigning of both our nursing education and clinical organizations to be more inclusive of one another. The resounding question is "How can one think about a nursing education or clinical issue without practice and education playing primary roles in understanding the question and helping to determine the answer?"

The Politics of Connection: Allies, Partners, and Champions. From these nursing education debates of old and today, there is the message that nursing cannot stand alone or that even sectors of nursing cannot stand alone. Without allies, partners, and champions, we become so internally focused that we repeatedly lose sight of the vision. The vision of a transformed health care system that is patient centered and community responsive is the life line for the nursing profession. Nursing education with all of its twists and turns has consciously and unconsciously worked to create a strong diverse nursing workforce to heal the world.

UNIT 4

DISCUSSION QUESTIONS

1. Is the current movement to produce a more educated workforce consistent with multiple entry points into the profession? Can these two realities exist in harmony?
2. How will the profession provide leadership to address the vision of a transformed health care system that is patient centered and community responsive? How will nurses with doctorates, whether DNP or PhD, lead the development and use of evidenced-based approaches to nursing

education? Will these two challenges be the next debate for the nursing profession?

3. How will the lessons learned from nursing's protracted journey in nursing education influence future debates about nursing's role in health care reform?

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ONLINE RESOURCES

AACN Position Paper: The Baccalaureate Degree in Nursing as Minimal Preparation for Professional Practice
www.aacn.nche.edu/Publications/positions/baccmin.htm

Future of Nursing Campaign for Action
www.nln.org/aboutnln/livingdocuments/nln_vision.htm

NLN Vision Series
www.nln.org/aboutnln/livingdocuments/nln_vision.htm