A Policy Perspective on the Entry into Practice Issue

Timothy G. Smith, PhD, MPA, BA, LPN

Abstract
It has been forty four years since the American Nurses Association (ANA) published its first position paper on entry into practice advocating that the baccalaureate degree be the minimum degree for entry into registered nurse practice. During that time period, only one state, North Dakota, was successful at getting the entry into practice proposal fully implemented, and even there it was rescinded in 2003. Although there has been much general discussion as to why the proposal initially failed, little has been written on this topic strictly from a policy perspective. This article begins with a brief history of nursing education leading up to the 1965 entry into practice paper (ANA 1965a). This is followed by a look at recent discussions and developments concerning the entry into practice proposal, an examination of the events surrounding the failure of the proposal in the original four focus states identified by the ANA for early implementation, and a discussion identifying possible reasons for the proposal’s initial failures. Encouragement and suggestions for present and future entry into practice supporters are provided.

Citation: Smith, T., (October 5, 2009) "A Policy Perspective on the Entry into Practice Issue" OJIN: The Online Journal of Issues in Nursing Vol. 15 No. 1.
DOI: 10.3912/OJIN.Vol15No01PPT01

Key words: American Nurses Association First Position on Nursing Education; cohesion within nursing; entry into practice; nursing education; agenda setting; nursing practice; interest groups

Over the last 100 years the environment in which healthcare is practiced has changed considerably, as has the need for strengthening nursing education. Several factors, such as an aging population, an increasing awareness of economics, and more complex technologies, have contributed to these changes. In this rapidly changing environment technological competence alone is no longer adequate; rather a broader knowledge base is required (American Association of Colleges of Nursing, 2005; Association of California Nurse Leaders, 2000). This broader knowledge base includes the creative decision-making, critical-thinking, and managerial skills needed for dealing with a diverse and multicultural workforce and patient population. Additionally, today’s nurses should also be familiar with such broad ranging topics as cost-benefit analysis and ethical decision making.

Unfortunately, nursing leaders and educators have had difficulty establishing a national standard for nursing education. Joel (2002, pg. 1) noted that “nursing has been dominated by an external loss of control” and has been “swept along by a host of societal and educational circumstances.” Subsequently, there is no single standard for education required for entry into professional (registered) nursing practice. In most states, basic nursing education is provided at the following levels:

1. Licensed Practical Nurse (LPN) Diploma Program: A technical/vocational nurse training program administered at the Junior College or vocational school level that ranges, by state, from 9 to 18 month
2. Registered Nurse (RN) Diploma Program: These programs are typically a 2-3 year experience leading to professional entry into nursing practice. Before the 1970s there were more than 800 diploma schools in existence; today there are less than 100
3. Associate Degree Nurse (ADN) Program: A two-year educational program administered at the Junior College level leading to professional entry into nursing practice
4. Baccalaureate Degree Program, generally a Bachelor of Science in Nursing (BSN) Program: A four year nurse education program administered at the upper college level leading to professional entry into nursing practice

The requirements for entry into and completion of these programs vary by state and are controlled by forces within each state’s higher education system and healthcare-related interest groups, and the nursing profession itself. Further, each state has its own procedures and laws regulating licensure. A current need is for each of these nursing boards and legislatures to recognize the value of a unified standard for entry into professional nursing.
Currently all state boards of nursing require each nursing graduate to pass the National Council Licensure Examination (NCLEX), developed by the National Council of State Boards of Nursing (NCSBN). The NCLEX is a standardized exam that determines whether or not a candidate is prepared for entry-level nursing practice (NCLEX, 2008). The NCSBN has developed two licensure examinations to test the entry-level nursing competence of candidates for licensure, namely the NCLEX-RN for registered nurses and the NCLEX-PN for licensed practical/vocational nurses. In addition, credentialing programs are offered by the American Nurses Association and a number of specialty organizations.

Given the situation described above, it is vital that the entry into practice dialogue regarding the minimum educational preparation for entry into practice as a registered nurse remains open to a variety of viewpoints. Over the last few years, there have been a number of highly informative discussions concerning the entry into practice issue. However, few discussions have addressed specific reasons as to why the initial effort to require a baccalaureate degree for entry into registered nurse practice failed. The purpose of this article is to examine, from a strictly policy approach, some of the causes of these failures. It is hoped that the information presented in this paper will help those in the forefront of the current entry into practice effort to avoid previous mistakes. Considering the accelerated pace of today’s educational, technological, and social changes, it is imperative that the educational foundation on which our profession is based remains in step with these changes. Now more than ever, we must rededicate ourselves to making the initial entry proposal a reality.

The article will begin with a brief history of nursing education leading up to the 1965 entry into practice proposal (ANA 1965a; 1965b). This will be followed by a look at recent discussions and developments concerning the entry into practice proposal, an examination of the events surrounding the failure of the proposal in the original four focus states identified by the ANA for early implementation, and a discussion identifying possible reasons for the proposal’s initial failures. Encouragement and suggestions for present and future supporters of the baccalaureate degree requirement for entry into practice will be provided.

### Nursing Education: 1896-1965

An important step in the development of nursing education in the United States (US) began with the formation of the Nurses Associated Alumnae of the United States and Canada. This organization was established when it became apparent that training was necessary to protect the sick and injured from nurses who were incompetent and unable to provide adequate care. In 1911 this organization became what we know today as the American Nurses Association (Mason, Leavitt, & Chaffee, 2002).

Soon after, the American Society of Superintendents of Training Schools for Nurses was also established. This Society was later renamed the National League for Nursing Education. This organization sought to establish rules and regulations for the training of nurses. By the early 1900s, several states had passed nurse licensure laws, including New York, North Carolina, Virginia, and New Jersey. These laws established shorter training hours as well as stricter qualifications for getting into nursing school (Mason et al., 2002).

Federal funding for nursing education began in 1935 with provisions in the Social Security Act that provided financial assistance for nurses studying public health (Mason, Leavitt, & Chaffee, 2007). The onset of World War II brought about new programs intended to entice women into nurse training programs. To meet the need for more nurses during the war, the U.S. government enacted the Nurse Training Act of 1943 (Mason et al., 2002; Willever & Parascandola, 1994). This act established the Cadet Nurse Corps, which gave nurses free training, a uniform, and a small stipend for thirty months.

In 1945 State Boards of Nursing Examiners in 25 states adopted a State Board Test Pool of exam questions. Since 1950, all state boards have participated in this test pool (Cherry & Jacob, 2005). The late 1940s and early 1950s saw a major increase in federal intervention in healthcare, including the Hospital Survey and Construction Act of 1946 (Hill-Burton Act). This Hill-Burton Act supplied funding to construct hospitals and to assist states in planning for other healthcare facilities based on the needs of the communities. Nearly 40% of hospitals built in the late 1940s and early 1950s were built with funds from this Act. The boom in hospital construction further contributed to a demand of professional nurses (Cherry & Jacob, 2005; Star, 1982). Other 1950s federal legislation included Title II of the Health Amendment Act of 1956, which set up provisions to enable traineeships for RNs to engage in full time studies in administration and education (Mason et al., 2007).

In 1963, the U.S. Surgeon General’s Consultant Group on Nursing identified that the nation was experiencing a
nursing shortage. Their recommendations led to the enactment of the Comprehensive Nurse Training Act of 1964. This act consolidated a number of nurse education and training programs and supplied funds for construction grants to nursing schools, student loans, education grants, and traineeships. This program markedly enhanced the quality of nursing education while moving it from student-labor training to a professional model (Mason et al., 2007).

The Comprehensive Nurse Training Act was the catalyst for the ANA Committee on Education to study nursing education, practice, and scope of responsibilities (American Nurses Association, 1965b). This study highlighted the ever increasing complexity of healthcare while raising concerns about hospital-based diploma programs. The ANA specifically noted the changes in nursing practice that included “major theoretical formulations, scientific discoveries, technological innovations, and the development of radical new treatments” (p. 107). As a result, the Board of Directors of the ANA adopted the Committee’s statement. This became the 1965 “position paper” containing a recommendation that the minimum preparation for beginning professional nursing practice at the present time should be at the baccalaureate level (ANA, 1965). The position paper recommended the following:

1. That there be a requirement making the baccalaureate degree the minimum standard for a Registered Nurse (RN) license
2. That a new license and title be created for associate degree nurses designating these practitioners as Registered Associate Nurses (RANs)
3. That two types of technical nursing education programs: hospital-based diploma programs and practical nursing programs, be eliminated.

At the time of the ANA position paper, hospital-based nursing education programs provided hospitals with a cheap source of student nurses to staff their wards (Donley & Flaherty, 2002). These hospital-based nursing programs were focused on fulfilling the staffing needs of hospitals. Typically, most nursing students spent 24 to 30 hours a week working in hospital wards. Studying occurred after their hospital work was completed. Their labor was free and lasted three years in exchange for their diplomas. One goal of the 13 authors of the 1965 position paper (ANA 1965a) was that all nursing education should move from the hospital setting to colleges or universities. This goal was fulfilled over the next 20 years (Donley & Flaherty, 2003). This move to the classroom, which coincided with the explosive growth of the associate degree nursing (ADN) programs, furthered an already steep decline in diploma program enrollments. Adding to the movement were extenuating factors which included a nursing shortage, an increase in federal financial assistance for nursing education, and new concerns about equal access to education and healthcare (Haase, 1990).

The rationale underlying the ANA position paper addressing entry to practice considered the changing role of government, especially its investment in nursing education and manpower training; the changing pattern of education in the US; the increasing availability of collegiate education for women; the expansion of science and technology and its impact on health and healthcare; and the new insights into human health problems (ANA, 1965b). It was the general consensus among leaders within the ANA that the profession’s future was dependent on nursing education moving into higher education. In this regard the ANA specifically noted the changes in nursing practice that included “major theoretical formulations, scientific discoveries, technological innovations, and the development of radical new treatments” (ANA, 1965b, p. 107). There was recognition within the organization that nursing was lagging behind other professions in raising educational standards as nurses were the least educated healthcare professionals. It was also recognized that the educational gap between nursing and other health professions was growing. The ANA made it clear that it fully believed that a baccalaureate education was needed if nurses were to maintain equal status with other healthcare professionals.

Recent Entry Discussions and Advancements

More than four decades have passed since the ANA’s position paper on entry into professional nursing was published. During that time, there have been more than a few position statements concerning nursing education standards from various professional organizations. Although the issue continues to spark a number of lively discussions, and the entry proposal has been advanced in a number of states as well as by certain professional organizations, the pace of this advancement has been painfully slow.

Domino (2005) noted that nurses are the least educated of all the major healthcare professionals. While many of these professions require a minimum of a baccalaureate degree for entry into practice, some have moved, or are in the process of moving, to require a master’s degree or higher (Joel, 2002). This includes occupational and physical therapists, speech and language pathologists, audiologists, and genetic counselors (Bureau of Labor Statistics, 2009).
Taylor (2008) noted that there are those who would argue that an associate degree provides ample preparation for entry into nursing practice. Joel (2002), however, noted that nurses educated at the graduate level demonstrate a significant difference in competency compared to nurses with associate degrees. Aiken et al. (2003) completed a study showing a direct correlation between higher levels of nursing education and better patient outcomes. Donley and Flaherty (2002) brought this point home when they noted that under-educated members of the health team rarely sit at policy tables or are invited to participate as members of governing boards. The consequence of this fact is simple; nurses are far less likely to be part of the development of healthcare policy than their better-educated counterparts.

Perhaps the greatest challenge facing the advancement of the entry issue is the lack of cohesion and agreement on how to proceed. Silva and Ludwick (2002) noted that prolonged dissent within the nursing community on the issue has only served to stall its progress; they reiterated the need to resolve it sooner than later. Nelson (2002) examined the course of nursing education over the past three and a half decades and argued that it is time to leave the old debates behind and agree on the importance of developing a better-educated profession. Donley and Flaherty (2008), while supporting the BSN entry requirement, argued that there is a need for more research and dialogue about the amount, type, and measurement of clinical work, adding that these studies are needed in order to make better informed decisions concerning professional legislation, accreditation, certification, education, healthcare outcomes, and future-oriented career ladders.

Although the ANA is still strongly supportive of the BSN entry into practice, it is no longer the sole leader of the movement. The organization is now working in conjunction with a number of other professional groups to promote the BSN as the minimum educational level for entry into professional nursing practice (Huston, 2005; Rose, 2006). These groups include the American Association of Colleges of Nursing (AACN, 2005) and the Association of California Nurse Leaders (2000) among others. ACNL’s stated position is that the baccalaureate degree be the minimum standard of entry into registered nurse practice in California by 2010. The National Black Nurses Association (NBNA, 2003), while not officially supporting the entry issue, does however advocate support of the baccalaureate degree as essential to the delivery of quality nursing. Similarly, other groups and organizations including the National Advisory Council on Nurse Education and Practice, the Pew Health Professions Commission, and the Helene Fuld Health Trust have offered their support in advancing the baccalaureate degree in nursing (Huston). At the state level, California now requires a BSN for certification as a public health nurse, while in New York and New Jersey there have been legislative moves to establish the baccalaureate as the minimum entry level for professional nursing (Huston; Rose). In 2006 the American Association of Colleges of Nursing backed the New Jersey State Nurses Association’s resolution that called for all entry-level nurses to earn a baccalaureate degree within 10 years of entering nursing practice (AACN, 2006). Although the resolution exempts currently licensed RNs, it does apply to future nursing graduates of associate degree and diploma programs.

The educational requirements for participation in nursing certification programs vary. The American Nurses Credentialing Center (ANCC) requires a minimum of a baccalaureate degree or higher for some specialty areas, but not for others (ANCC, 2009). The American Legal Nurse Consultant Certification Board (ALNCC) eliminated the requirement of holding a baccalaureate degree in nursing for eligibility to sit for the Legal Nurse Consultant Certified (LNCC) certification examination which was scheduled to take effect in 2004. This change occurred because the American Board of Nursing Specialties (ABNS) eliminated the need for accredited certification programs to require the BSN degree (ABNS Accreditation Standards, 2004). The ABNS is an advocate for consumer protection by promoting specialty nursing certification. Member organizations of ABNS represent over a half million certified registered nurses around the world (ABNS, 2009).

Focus States

Soon after the release of the 1965 entry into practice position paper (ANA, 1965a), the ANA began working on a proposed timeline for implementing the entry proposal on a nationwide basis. The organization chose four focus states as early implementers, Oregon, Montana, Maine, and North Dakota, and targeted funds to these states to assist with the implementation process (George & Young, 1990; Lambeth, 1992; Rose, 2006). In effect, these states were to act as a testing ground for the proposal. These focus states were chosen carefully with the belief that the policy would be easily adopted in each. However, events did not occur as expected.

These focus states were chosen carefully with the belief that the policy would be easily adopted in each. However, events did not occur as expected.
Oregon

In Oregon, the Oregon State Board of Nursing (OSBN) had the ability to change the nursing educational requirements on its own. As a regulatory board for nursing in the state, it had the power to initiate such a measure. With this ability in mind, discussions within the OSBN concerning the entry issue began in 1977. On March 3, 1982, these discussions resulted in the OSBN adopting two motions relating to the requirements for licensure of RNs and LPNs (Hicks, 1985). These motions called for RNs to hold a minimum of the baccalaureate degree in nursing and LPNs to hold a minimum of the associate degree in nursing. However, in 1985 the Oregon Community College Association (OCCA) successfully sponsored legislation that stripped the OSBN of the power to set educational standards for nursing. This move effectively stalled efforts to adopt the ANA proposal within the state. Key events in this process are described below.

Opposition. One opposition group was the Oregon Federation of Nurses (OFN). This group’s major concern revolved around the possible financial costs of the changes to both the citizens and the healthcare industry in Oregon (Schmidt, 1985). They pointed out that healthcare cost containment was a major concern of the current legislature, and as such, the proposed changes would increase those costs. In addition the Concerned Nurses of Oregon (CNO) was established with the single goal of halting plans to implement the ANA entry proposal. In testimony before the House Education Committee in March 1985, they reported on a national survey done in 1981 showing that 80% of RNs polled were against the changes (Zerzan, 1985). In 1985 the Oregon Community College Association (OCCA) and the Oregon Council of Associate Degree Nursing Programs (OCAP) joined forces to defeat the proposed changes. Both groups had serious objections to the proposed changes based on these concerns: (a) a concern regarding the basic lack of empirical evidence supporting the need for change, (b) a concern that the proposed licensure change would have an adverse effect on nursing supply, especially in rural locales, (c) a concern that a licensure change would adversely affect the cost of education and the cost of healthcare, and (d) a concern about preserving access to a career as an RN for “typical” candidates of community college programs (Ruff, 1985).

Legislative action. In early 1985, in the belief that the proposed changes would deny two-year nursing graduates (Associate Degree Nurses) access to Registered Nursing, the OCCA, with backing from the OCAP, sponsored H.B. 2928 (H.B. 2928, 1985). The main effect of this bill was to remove the authority to change nursing education requirements from the OSNB. In April of 1985, the legislature passed HB 2928, thus halting the entry issue in Oregon.

Montana

In Montana, the Montana Board of Nursing (MBN) presumed it had the ability to change the nursing educational requirements on its own, although it was to later find out that it did not (Munger et al., 1987). As a regulatory board for nursing in the state, it was assumed by the organization that it had the power to initiate such a measure. Discussions within the MNA concerning the entry issue began in 1977 (Munger et al.). These discussions resulted in the introduction and adoption of a position paper endorsing the ANA proposal (MNA, 1984; Munger et al.). The resolution asked that two categories of nursing practice be identified, that the requirement of the baccalaureate degree for entry into registered nurse practice be in place by 1985, and that a plan for implementation of this requirement be developed (Munger et al.). However, due to a number of legal challenges to the proposal brought by opponents, the issue was eventually brought before the state legislature in 1987 and subsequently defeated. Key events in this process are described below.

Opposition. A group called the Concerned Nurses of Montana (CNOM) believed that higher educational standards for nurses weren’t necessary, and would actually contribute to educational discrimination by limiting nursing jobs to those who could afford to obtain a four-year ‘diploma’ (Wilke, 1986; Change in Nurse Rules, 1986). In addition the Montana Hospital Association (MHA) opposed the entry issue due to cost concerns and the perceived difficulty in recruiting baccalaureate-prepared nurses to Montana’s rural hospitals (Munger et al., 1987).

Legislative action. In 1985, CNOM unsuccessfully sponsored H.B. 409 (H.B. 409, 1985). The intent of this bill was to prevent the Montana State Board of Nursing (MSBN) from changing educational requirements for nursing practice through its rules. However, during the 1985 legislative session, the Montana Board of Nursing requested an opinion from the state Attorney General regarding the Board’s rule-making authority over educational requirements. On August 7, 1985, the Office of the Attorney General of the State of Montana issued its opinion on the matter. In its opinion, the Board did not have the authority to change educational requirements for nursing practice through its administrative rules (Munger et al., 1987). On January 5, 1987, H.B. 36 was introduced (H.B. 36, 1987). The purpose of this bill was the full adoption and implementation of the ANA entry proposal. Due to overwhelming opposition from the above mentioned groups, the bill was defeated on January 22, 1987.

Maine

Maine was the only state in which the State Board of Nursing recognized that it did not have the authority to
change the nursing educational requirements on its own. Although it was a regulatory board for nursing in the state, it did not have the power to initiate such measures. Instead all such changes needed to be brought before the legislature. The statewide effort to adopt the new educational standards began in 1984 after the members of the Maine State Nurses Association (MSNA) voted to adopt the ANA proposal. The proposed target date for implementing the new standards was to be January 1, 1985. In 1986, the state legislature adopted the proposal, but due to a number of concerns from various healthcare groups (noted below), full implantation was postponed until certain criteria could be fulfilled. However, those same opposition forces were able to successfully rescind the new educational standards when the issue came before the legislature again in 2003. Key events in this process are described below.

**Opposition.** The major opposition to the proposal came from a group called the Consortium of Maine Nurses. This group specifically identified three areas of concern: the effects of the proposal on the nursing shortage, the cost to the taxpayer and the state of implementing the proposal, and concerns over career mobility and a “grandfather” clause (Incze, 1986). The Maine Health Care Association and Long-Term Care Nursing Council framed their opposition in terms of fairness and safety. Their chief concern revolved around the supply of nurses, the lack of appropriate educational facilities, and the higher educational costs to potential nurses (Hamlin, 1986).

**Legislative action.** During the 1986 legislative session, a BSN entry bill, LD 2061 was introduced (LD 2061, 1986). The bill’s intent was the establishment of two levels of entry into nursing practice. However, to ensure Maine’s readiness for the change and to understand its implications, the legislature mandated the establishment of a Commission to study the law’s impact before full implementation. This Commission was to report its findings to the legislature by January 1, 1990, and every two years thereafter until all concerns were addressed. The targeted implementation date was 1995. During the 1993 legislative session, a new BSN entry bill was introduced (LD 1471, 1992). After much discussion and review, the Commission stated that due the inability of the nursing community to effectively address the legislature’s concerns, further dialogue was needed and recommended an “Ought not to pass” action. At that point the bill died.

**North Dakota**

In North Dakota, the North Dakota Board of Nursing (NDBN) had the ability to change the nursing educational requirements on its own. As a regulatory board for nursing in the state, it had the power to initiate such a measure. In 1984, the Board established the rules that called for the baccalaureate degree as the minimum level of education for registered nurses, and the associate degree as the minimum level of education for practical nurses. The new rules also gave the Board the authority to close any nursing program that did not comply with the new rules (Rose, 2006). After defeating several challenges from a number of opposing healthcare groups, North Dakota became the first and only state to fully implement to ANA proposal. However, in 2003, those same opposing groups successfully sponsored legislation to rescind the new educational requirements. Key events in this process are described below.

**Opposition.** The major professional group opposing the change was a group known as Concerned Nurses. Their framing of the issue was fairly simple indicating that they agreed there needed to be a change in the educational requirements for nurses in North Dakota, but felt they could handle it better than the NDBN could. However, they never clearly spelled out exactly how they would handle things differently (Rose, 2006). The backers of the entry proposal also faced serious opposition from two facilities within the state that sponsored diploma nursing programs, namely the Med-Center One Hospital and School of Nursing and Trinity School of Nursing. In 1984, representatives of these facilities had a legislator request an Attorney General’s opinion on whether the Board of Nursing had the authority to close diploma programs. The Attorney General’s opinion stated that the Board of Nursing, via a 1977 legislative act, did have the power to set educational standards and could close nursing programs that did not meet those standards (Lambeth, 1992; Rose). In 1977, the board of nursing was given legislative authority to set the requirements for nursing education as a function of its regulatory power. In response, the diploma programs introduced legislation that would reverse the 1977 legislative act, thus placing diploma and vocational programs back within the Nurse Practice Act (H.B. 1460, 1985). This would remove the power of the Board of Nursing to set educational standards or close programs (Rose).

**Legislative action.** In January 1985, House Bill 1460 was introduced (H.B. 1460, 1985). The purpose of this bill was to prevent the NDBN from implementing the ANA proposed changes. Proponents of the bill included the Med-Center One Hospital and School of Nursing in Bismarck, the North Dakota Hospital Association, and Trinity School of Nursing in Minot. In January 1985, the combined lobbying efforts of the NDNA and the NDBN resulted in the defeat of H.B.1460. In November 1985, the NDBN adopted the new rules in the Nurse Practice Act, thus implementing two levels of education for nursing.

**The lawsuit.** On March 20, 1986, Med-Center One Hospital in Bismarck and Trinity Hospital in Minot served the NDBN with a restraining order temporarily stopping the Board of Nursing from enacting the new educational standards (Rose, 2006). The lawsuit claimed that law authorizing the NDBN to establish nursing education standards was the result of an unconstitutional delegation of legislative power, which violated the North Dakota Constitution. On April 24, 1986, a motion was filed to stop all further actions by the NDBN. The motion also
Why the Proposal Failed

Nursing education requirements are controlled by forces within each state's higher education system, various healthcare-related interest groups, and the nursing profession itself.

So why did the proposal fail? In theory, it should have been easy: a simple yet logical move to increase nursing education requirements. The major problem with the proposal was that the requirements for this particular change involved a number of complex relationships between key policy players. Nursing education requirements are controlled by forces within each state's higher education system, various healthcare-related interest groups, and the nursing profession itself. Of particular interest in this case is the role played by interest groups outside the nursing profession and also the manner in which the supporters of the proposal failed to overcome the lack of internal cohesion within the nursing community. It is this author's contention that these factors were the major cause of the demise of the ANA proposal in the four focus states identified in this article.

Interest Groups

The needs and demands of various sectors of society must be articulated and pressed upon government. Organized interest groups perform this function by transforming these demands into political influence via their particular area of influence. The role played by certain healthcare-related interest groups involved in the entry issue highlights this fact.

Many groups are fluid in that they only exist for short periods of time to specifically address particular issues (Gray & Lowery, 1996). Accordingly, some groups, rather than being permanent, often enter and exit the lobbying community as issues of direct concern move on and off the state policy agenda. In the four target states identified in this article, nurses who were opposed to the ANA proposal organized into groups formed solely for the purpose of either altering or defeating the proposal. Once the issue was settled one way or another, the groups disbanded and ceased to exist.

According to James Q. Wilson's "Niche Theory" (1976), some groups develop autonomy, i.e., a distinctive area of
This theory offers a very credible explanation of what happened among the interest group players in each of the ANA target states (Oregon, Montana, Maine, and North Dakota). Healthcare policy in the various states is heavily influenced by hospital and nursing home associations, while education policy is heavily influenced by higher education interests, and in some instances (as in the entry issue), by the above-mentioned hospital and nursing home groups. Each of these groups has staked out a claim on their own distinctive area of competence in a clearly demarcated area of policy expertise that exclusively serves a particular clientele or membership, i.e., healthcare and higher education entities.

Thompson and Hrebenar (1996) have identified the established professions of education, law, and medicine as being the most influential interest groups in the various states. In explaining the continuing status of these groups as the strongest interest communities, they point to a common array of strengths: (a) they all have extensive financial resources which they use both to hire full-time political staff members and lobbyists and to contribute to election campaigns, (b) their membership tends to be spread geographically and is fairly politically cohesive, and (c) the services they provide make public officials dependent on them to a high degree (Brace, 1993). This leads directly back to Wilson’s Niche Theory. These very strong organizations have established extremely viable niches in terms of both the resources needed to survive and those needed to project their influence outward to alter decisions of elected and unelected officials.

In reviewing the available documents concerning the entry issue in each of the four focus states, there is little evidence that supporters of the issue fully understood the threat from opposing interests. In each state there were initial efforts to enlist support from some or all of these groups, but no well-formed, consistent enlistment campaigns. The issue ultimately involved a number of interests outside the nursing community, (i.e., strong and influential interests representing hospitals, nursing homes, and two-year-degree institutions). This lack of any concrete, long-term plans to enlist the support of these groups was a major contributing factor to the proposal’s ultimate fate.

**Lack of Internal Cohesion within the Nursing Community**

Another major problem that faced entry backers involved the historical lack of internal cohesion within the nursing community. In all four states, this absence of cohesion was reflected in the presence of well organized nursing groups opposed to the entry issue. Although these groups had varying names in different states (in Oregon, Montana, and North Dakota they called themselves “Concerned Nurses” while in Maine they were known as the “Consortium of Maine Nurses”), they each expressed various concerns with the issue. Although entry supporters in each state worked diligently to bring about unity on the issue, it simply was not to be.

Even the choice of policy entrepreneurs likely added to this lack of cohesion. In each of the three states where the issue was actively addressed, a well placed and influential policy entrepreneur was chosen. A policy entrepreneur is an individual who, from outside the formal positions of government, introduces, translates, and helps implement new ideas into public practice. In this case each nursing policy entrepreneur held a baccalaureate or higher degree and generally came from the upper management levels of their respective state boards of nursing and/or state nurses associations. It is easy to see how those with lesser education could view the process in a less than positive light. However, those selecting the policy entrepreneurs faced a difficult dilemma in that a strong policy entrepreneur is needed to get the issue passed while at the same time core constituents may be alienated by the strong entrepreneur. It is in reality a “damned if you do” and “damned if you don’t” situation. In Montana, for example, Mary Munger was well placed, highly educated, and an experienced policy entrepreneur who acted as the leader of the proposal’s adoption efforts. Ms. Munger was highly respected within the MSBN, the MNA, and the legislature, and was regarded as a knowledgeable and reliable nurse leader. However, it was this same notoriety
that may have alienated her from the “average” nurse within the Montana nursing community; she simply was not viewed as “one of us.” It is this author’s opinion that the social distance of the policy entrepreneur from the mainstream nurses was most likely a major contributor to the issue’s lack of support from many within the nursing community.

Another factor contributing to the lack of cohesion was that the entry issue was not brought about by any type of crisis...

Adding to this lack of cohesion was the top-down decision-making process used by supporting groups. A top-down approach is one in which the decision to make a change is made at the upper levels of an organization, and the proposal is disseminated to the lower levels in the hierarchy, who are, to a greater or lesser extent, bound by them. If reforms are perceived to be imposed “from above,” those at the lower levels may view them with suspicion (Incze, 1986; Lambeth, 1992; Rose, 2006). Having worked as an LPN for over 15 years in a variety of healthcare settings, this author can personally testify to this fact.

Another factor contributing to the lack of cohesion was that the entry issue was not brought about by any type of crisis, but instead by leaders of the nursing community at the national level. There was never any ground swell of support for the issue among the nursing community as a whole or from the general public. Rather the entire process was controlled by the ANA and the various boards of nursing, which did not truly reflect or represent the nursing community as a whole. The feelings and attitudes of nurses who objected to proposal were best summed up during legislative hearings in Maine by one opponent who stated, "The only state having such a law on its books is North Dakota. It was put there NOT by the legislature, NOT by mandate of the people, NOT by mandate of the nurses, but by nine persons, the Board of Nursing of North Dakota” adding, “I ask you that the state of Maine not be made the guinea pig for this legislation which was found to be undesirable in all other states where it was introduced” (Incze, 1986, p 1).

Conclusion

Ask the majority of nurses in this country their opinion of the entry into practice issue, and most will likely reply with a blank stare. Unfortunately, that pretty much sums up where the issue stands today. While some professional organizations and a few state boards of nursing have made some advancement on the issue, the average nurse knows little or nothing about it. For most, it is simply a non issue. Perhaps the most interesting revelation uncovered in the research for this article was, with the exception of North Dakota, the almost complete lack of information available from the other three boards of nursing (Oregon, Montana, and Maine) regarding their attempts to implement the proposal. All information collected came from either state legislative archives, or from state historical societies. And that, quite simply, is the major problem facing proponents of the entry issue today: an almost complete lack of knowledge on the issue by the majority of nurses in this country. How, then, can nursing advance this entry into practice issue when most nurses know little or nothing about it?

The answer is simple: advocates of this issue must become more actively involved in educating the nursing community, the public, and legislators and on this vital issue. Proponents must use their influence and knowledge in any way possible to advance the issue and to develop a unified consensus within the nursing community. Influence can be exerted in several arenas: specifically, in the workplace by affecting the development of institutional policies, in the community through activities on local boards, in professional organizations by participating on committees or serving as an officer, and in government through involvement in campaigns, letter writing, and voting. Most people simply do not understand the power of voting for specific candidates and the influence those office holders have on nursing issues. Yet the active involvement of nursing in the molding of public policy through political involvement is vital. Proponents of the entry into practice issue cannot wait and hope that legislators will act positively on their behalf. If nurses do not become involved in healthcare politics, they will have no power over their own future. Unfortunately, both the nursing community and the public will suffer from their lack of participation.
In summary, what can be learned from the initial attempt by the ANA to get the entry proposal adopted? Of the four focus states examined in this paper, North Dakota stands out for its initial successes. For 15 years it was the only state to fully implement the proposal while warding off challenges from opposing groups. What lessons can be learned from this success?

First and foremost, the initial victory can be placed almost entirely on the unity and vision of the nursing profession in the state. Although a top-down approach was used, every effort was employed by backers of the proposal to achieve unity and cohesion within the nursing community (Rose, 2006). The result was that North Dakota nurses exhibited a clear sense of unity. This unity revealed an acute awareness of the importance of statewide involvement by nurses in the development of social policy, and an understanding of the benefits of higher levels of education. This display of unity and vision, along with policy entrepreneurs who were well placed, brought respect and recognition from legislators and other leaders throughout the state. Testimony before boards, committees, and the legislature along with presentations to a variety of professional and civic organizations, resulted in nursing being considered a reliable healthcare profession and an advocate for the public (H.B. 1460, 1985; Lambeth, 1992; North Dakota Board of Nursing, 1984-2005; Rose; Wakefield-Fisher, Wright, & Kraft, 1986; Wakefield-Fisher & Langemo, 1986).

Clearly then, the early success of North Dakota nurses can serve as a positive example for present and future entry efforts. Though superior in their access to financing and other vital resources, the interest groups representing the healthcare industry were no match for the positive public opinion generated by the unity within the nursing community. This single fact illustrates the vital nature of public opinion in the creation of any public policy (Kingdon, 1995; Lewis, 2005; Weber & Shaffer, 1972). Very often it is the overall perception by the public of the key players in the process that ultimately helps decide an issue’s outcome. If, as in the case of the North Dakota nursing profession, the public perceives a true sense of unity and dedication to a cause (policy), it will most likely be more supportive of that cause. In fact, it was only after the public became aware of a growing sense of disunity within the North Dakota nursing community that the opposition was able to get the policy rescinded. Entry proponents would do well to examine and learn from the lessons of the North Dakota experience.

Author

Timothy G. Smith, PhD, MPA, BA, LPN
E-mail: bhamgrad@gmail.com or smith75@auburn.edu

Timothy G. Smith, PhD, MPA, BA, LPN has over 25 years healthcare experience ranging from Nutrition/Dietary Management to nursing (LPN). He recently completed the PhD program at Auburn University in Public Administration with a concentration on U.S. healthcare policy. He is currently employed as a Lecturer in the Political Science Department at Augusta State University in Georgia and as a nurse in a long-term care setting.

References


AACN supports NJ resolution to require BSN for state’s RNs. (2006). RN Magazine 69(10), 14.


Change in nurse rules called discriminatory. (1986, December 5). *Great Falls Tribune*, p.13A.


Hicks, F. (1985, March 26). *Testimony on HB2928 before the Senate Education Committee*. Available at the Oregon State Archives: Author.


Lewis, D. A. (2005). New deal to no deal: The movement toward less government is shifting social responsibility to


Trinity Medical Center v. ND Board of Nursing, No. 11, 257 (N.D. Supreme Court, August 4, 1986).


Related Articles

Revisiting the American Nurses Association’s First Position on Education For Nurses: A Comparative Analysis of the First and Second Position Statements on the Education of Nurses
Sister Rosemary Donley, SC, PhD, APRN, BC-ANP, FAAN; Sister Mary Jean Flaherty, SC, PhD, RN, FAAN (April 30, 2008)

Education for Entry into Nursing Practice: Revisited for the 21st Century
Lucille A. Joel, EdD, RN, FAAN (May 31, 2002)

Education for Professional Nursing Practice: Looking Backward into the Future
Martha A. Nelson, PhD, RN (May 31, 2002)

The Relevance of Associate Degree Nursing Education: Past, Present, Future
Elizabeth H. Mahaffey, RN, PhD (May 31, 2002)

Revisiting the American Nurses Association’s First Position on Education for Nurses
Sister Rosemary Donley, RN, PhD, C-ANP, FAAN; Sister Mary Jean Flaherty, RN, PhD, FAAN (May 31, 2002)