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BACCALAUREATE NURSING SCHOOL ADMINISTRATOR'S PERCEPTIONS
OF SELECTED ASPECTS OF LONG RANGE PLANNING
FOR
NURSING AND NURSING EDUCATION

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BACCALAUREATE NURSING-SCHOOL ADMINISTRATORS' PERCEPTIONS OF SELECTED ASPECTS OF LONG-RANGE PLANNING FOR NURSING AND NURSING EDUCATION

By

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ABSTRACT

BACCALAUREATE NURSING-SCHOOL ADMINISTRATORS' PERCEPTIONS OF SELECTED ASPECTS OF LONG-RANGE PLANNING FOR NURSING AND NURSING EDUCATION

By

Mary Weisensee

The major problem focus for this study was to ascertain baccalaureate nursing-school administrators' perceptions of selected aspects of long-range planning for nursing and nursing education.

A questionnaire was mailed to 286 nursing school administrators of accredited baccalaureate schools of nursing in the USA during the winter of 1978. There was a response rate of seventy-five percent. All regions of the nation showed similar representation with the midwest having a slightly higher response rate.

The typical respondent was called a dean, was a female between the ages of forty-six and sixty, employed by a public institution having from 100-399 full-time equivalent students, held an earned doctoral degree, reported to a vice president or a dean, and had held the administrative position less than six years. No distinct pattern emerged regarding the ages of the respondents' programs; responses were distributed throughout the age span from less than five years to more than thirty-one years.

The deans perceived long-range planning to be important and they expressed enthusiasm for efforts toward it. They viewed it as being useful, stimulating, and positive; however, they realistically viewed it as expensive and difficult. The majority of respondents indicated that long-range planning in their school extended over a period of five to nine years.

The deans perceived themselves as having the greatest potential influence on facilitation of long-range planning with faculty having the next greatest. The "vested interests" of each profession were cited as the factors most hindering long-range planning.

The deans agreed strongly that the baccalaureate degree should be the initial requirement for professional nursing; however, the route to reach this goal was less clear. They agreed less strongly about advancement from technical to professional education.

Agreement on entry levels and clarification of professional goals were both identified as highly important and urgent issues confronting the profession.

There was strong agreement that the health care delivery system should change its focus from crises care to prevention, but less agreement on the role of the client in initiating an automated device to obtain a physical diagnosis. Clients were perceived to have a positive influence because they facilitated long-range planning.

Interdisciplinary functioning as colleagues was viewed as being more important and urgent than providing for interdisciplinary student education.

Finances and legislation were perceived to be the major factors that will influence long-range planning for nursing and nursing education by 1990, whereas the deans perceived that they (nursing school administrators) and faculty should have the greatest influence on long-range planning.

Technology was perceived as having neutral influence on long-range planning. Several societal changes such as awareness of the need for long-range planning, uncertainty in society, and time available for planning were believed to hinder long-range planning.

It can be concluded that the respondents believed there are major differences between what should and will influence long-range planning. Deans perceived that they and faculty should be highly influential shapers of the future of nursing and nursing education. Meanwhile, high costs and legislation will have major influence.

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INTRODUCTION

> We have arrived at a time in the academic world when real choices are about to be made. They can be forced upon us or we can direct them. And make no mistake about it, they will be forced upon us unless we act with more speed, initiative, intelligence, and ingenuity than we have hitherto displayed.
>
> Samuel B. Gould[1]

A new breed of professional is emerging, the futurist. Coined by a German professor, Ossip Flechtheim, in the 1940's,[2] futurology became a science during the 1960's.[3] Futurology is probably best placed as a division of sociology, opposite historical sociology, because it concerns itself with prospective developments.[4] Yet, futurists penetrate almost every knowledge area and discipline.

For future study to be beneficial to society, it must be wholistic. Therefore, any professional who wants to avoid the fate of the dinosaur must be concerned not only with the relevant knowledge and research of the past and present, but also of the future. The question is, should we plan and create the future or be a victim of it? We face one of our greatest dilemmas: all knowledge is about the past, but all decisions are about the future.

Due to the abstract nature of the futures study, there are differences in the traditional approaches. Amara defines futures research as "any activity that improves understanding about the future consequences of present development and choices."[6] The literature can be somewhat confusing as many futurists differentiate between prediction and forecast while others use the two words synonymously. The difference usually applied in futures literature is that a prediction refers to something that will happen, whereas a forecast is "a probabilistic, reasonable definite statement about the future, based upon an evaluation of alternative possibilities."[7]

In relation to futures research, Harmon maintains that:

> By 1994 the controlled experiment will not be viewed as the only way to revealed truth. The new knowledge paradigm will foster open, participative inquiry. Truth is that which is inescapable.[8]

It is not a completely contemporary innovation to "research" the future, to predict, to speculate, to forecast and use various tools and techniques to determine future roles, fate, or destiny. Many tools of ancient days such as astrology charts, tarot, palmistry, graphology, crystal ball, numerology, and pendulum are still popular today. From time to time the popularity of psychic phenomenon such as extrasensory perception, telepathy, clairvoyance, precognition, and numerous other tangible and intangible

methods and devices become more acceptable as tools for learning what our future will be. Prophets of biblical times had dreams that foretold important future events and the biblical admonishment from Proverbs 29:18 relates to the future and states: "where there is not vision, the people will perish." It can be easy for one to be misled in this mushrooming field. Hack optimistically states: "The new breed of futurist rejects the occult arts of the ancients in favor of more rational and scientific approaches."[9]

With this progressive view in mind, it seems incongruous to read in recent writings comments like Dator's:

> . . . we live by institutions and values which almost totally discount the future. They are hang-overs from the period when powerholders generally could not greatly predetermine the future, and it was not legitimate to question them when they did. . . . [10]

One can ponder whether we as a race, civilization, and profession, are using obsolete methods to cope with our surroundings. Are yesterday's coping patterns and skills leading us to a "dead-end street?" One can speculate about the causes of man's view of the pace of change and his bewilderment about the future. Possibly mankind has become so accustomed to an abundance of material possessions, concrete and tangible, that to ponder and deal with anything so abstract and intangible as the future seems a luxury the majority of today's population cannot fathom. Many persons immediately ask for concrete evidence, facts, proof, and

statistics when confronted with any piece of information or concept that is not within their repertoire of knowledge. This brings to recollection accounts of scoff and severe ridicule that early scientists and explorers encountered when exposing their ideas and theories to the public. Many were hanged. Columbus had difficulty financing his ships because everyone "knew" that the world was flat and that he would fall off the edge. According to Amara: "The crucial difference [now] is the realization that the principle hazards that man faces are largely of his own making and largely within his own control."[11] This is a threat as well as an exciting challenge.

Nursing educators, like members of most other disciplines, tend not to take time to plan far ahead. They are so busy solving today's and yesterday's problems that they neglect to stop and lift their heads and ponder seriously about tomorrow and beyond. Peter Drucker admonishes: "results are obtained by exploiting opportunities, not by solving problems."[12] Nursing educators have continually responded to crisis after crisis by solving problems rather than by ingeniously latching onto opportunities that occur. Barritt, a contemporary dean of nursing, states that: "crisis intervention is one of her main tasks."[13]

Many rationalizations are given by educators for not planning. One of the frequent excuses is: "we do not

know what people will want." Yet it seems that this myopic vision compounds itself when the public does not observe the university taking leadership, it loses confidence in higher education and votes less legislative appropriations. The university cannot do more because it cannot afford adequate staff to meet public demands, and so the vicious cycle evolves. Earl Joseph emphasizes "that systematic reasoning about the future is a prime missing ingredient in all of today's educational systems, and, for that matter, in all of society's institutions."[14] He adds: "So far, only a handful of colleges and universitites include futurology in their curricula; in a sense, we have been teaching and learning 'pastology.'"[15]

Lamson describes the situation so well:

> We tend not to look and plan far enough ahead. We tend to ignore the long range, cumulative and synergistic effects of what we do. These impacts are often not perceived, not understood, not studied, and we do not adequately evaluate, anticipate, control of guide them.
>
> We tend not to consider a wide enough range of alternatives for specific policy problems nor do we consider a wide enough range of values and groups in calculating the costs and benefits of various alternatives.[16]

March and Simon discuss planning and innovation and mention Gresham's Law of planning: "Daily routine drives out planning," and if an individual is given a choice, he will opt for programmed tasks as opposed to the unprogrammed tasks.[17]

McDanield and Mendell, in "What Futurists Can Learn From Creative Problem Solvers," discuss the controversy of soft versus hard research and express their concern:

> Such a split is dangerous and should be of great concern to futurists. The creation of two isolated groups, one overly concerned with probable futures, threatens our capacity to create preferable futures. We cannot afford to lose the benefits of both approaches. We must find a way to combine the approaches.[18]

Toffler suggests that we prevent future shock by describing the alternatives we think are possible, probable, and preferable so that we can make the most rational choices possible with the data currently available.[19]

Acceptance and utilization of knowledge in decision-making are impeded because we are "data bound" in so many ways. We have to have such extensive amounts of data that by the time we obtain "adequate" data to solve the problem, the problem has solved itself, someone else has solved it, or the data are not appropriate for the solution of the problem as it exists at the present time. In 1960, Russell spoke to this:

> . . . The educated person must be skilled in these processes of tentative and precise reasoning about phenomena of inexact measurement. Most human actions must be based on evidence which, though not fully conclusive, is the best available at the time. One of the chief aims of higher education should be to cultivate habits which will prevent human beings from acting blindly with no facts, or procrastinating indefinitely because the last shred of evidence is not in.[20]

By comparison, Mitroff states in a more contemporary vein in 1973:

> they are . . . data bound types who wouldn't be able to save their own ass if a fire was burning next to them because they'd never have enough data to be sure the fire was really there.[21]

If we do not change our ways of thinking and methods of research in relation to accepting new knowledge, we may soon not be able to cope with tomorrow. Bronwell advises:

> . . . If society is to understand itself and deal wisely with its future, while preserving and enhancing its creative dynamism, it will have to break through the philosophy barrier and regard time as a continuum so that researching the future becomes just as acceptable as researching the past and present, even though it may require quite different strategies.[22]

The rules for accepting research conclusions and knowledge also need to be examined. Phillips discusses the criteria and rules for accepting knowledge into the body of sociological knowledge dealing with procedure and quality and asserts: ". . . <u>We do not consult what a proposition proposes, we consult the rules used to decide if what the proposition proposes is warranted</u>."[23] Many people feel that what has been and currently exists is right; they comfort themselves by thinking that if the status quo has been effective in the past, and if some rule will help them to substantiate it, they are satisfied with it. This is not to say that the past is invalid, but that past knowledge as well as new knowledge must be tested and scrutinized.

Planning for nursing education poses many related deep philosophical issues and moot questions. Since nursing education has become a legitimate part of higher education, it inherits the doubts and troubles of overall higher education in addition to being a profession without a commonly accepted single route to the education of the registered nurse.

The fact that there are no easy answers makes life very complex for the administrator of a school of nursing. In addition to the dilemmas mentioned above, the nursing administrator is frequently the only female in a male's world of administration.

If the administrator did not have to spend so much time in crisis intervention, as Barritt[24] mentioned earlier, she/he would have time to plan for the future. If she/he and the faculty could set some priorities for long-range planning, their efforts should be utilized more advantageously for the benefit of the school and the profession.

STATEMENT OF THE PROBLEM

Nursing literature has few articles that focus attention upon future problems, but many recount the past are status quo reports with few recommendations, or reorient only for the short-term future. Even though each study contributed to the profession's knowledge of itself, few

received careful attention and implementation. For example, Brown's 1948 study, Nursing for the Future, discusses many of the identical problems that still face the profession today, especially in academic preparation and professional status concerns.[25]

The profession has no overall, extensive, ongoing, coordinating mechanism for the specified purpose of delineating future goals and directions. A 1975 publication written by a committe of the NLN, Perspectives for Nursing, focused on clients, changing roles of manpower, facilities for health care delivery, and education of health care personnel.[26] This brief report presents a limited discussion on trends and changes needed in relation to the four previously stated areas, but does not elaborate on rationale or implications for long-range planning.

Few planning efforts with other health care disciplines have produced substantial evidence of problem assessment and solution. Indeed, communication between professionals about interdisciplinary health care is infrequent and occurs usually after a crisis has arisen.

At present, to fill the intellectual void, many universities have begun a modest attempt to assess their role and mission for the next decade. Rushmer, for example, notes: "the concept of identifying long-range goals for desirable futures is attracting a great deal of favorable attention among organizations, institutions,

states, and regions."[27] Belatedly, the nursing profession must grapple with the mammoth task of long-range planning as an integral part of higher education.

Significance of the Study

As leaders in higher education, administrators of nursing schools are in a unique and responsible position for giving direction and foresight to the advancement of the profession. They can make an unprecedented contribution by improving planning for the nation's future health care. Torres emphasizes the importance of nursing educators: "Throughout its history, nursing has been most influenced by its educators, who play a key role as change agents."[28] These administrators, by authority of their position, should be of vital importance in initiating changes and shaping a desirable future. The need for a unified effort at long-range planning by nursing and other health professions is analogous to the currently emphasized need for energy planning; both are long overdue. The presentation and analysis of data should extend the knowledge of the profession, provide a rationale for decision making, and stimulate additional research.

To the author's knowledge, no study of this type has ever been conducted. In fact, very little information about these nursing school administrators is evident in the literature on their preparation, activities, roles,

beliefs, or characteristics. The educational literature on academic deans in higher education is also quite meager.

Problem Statement

The major problem focus for this study is to ascertain perceptions of baccalaureate nursing school administrators (deans, chairpersons, directors) in regard to selected aspects of long-range planning for nursing and nursing education.

Areas of Focus in the Study

The organization of the content areas of the study in addition to selected demographics are divided into eight major categories which influence long-range planning as follows (see Figure 1.1):

1. The personal and professional outlooks, values, and priorities of each administrator are important to consider because their views of the world generally and the future specifically, will influence their preparation and imagination for conceptualizing the abstract and uncertain future. The ability to engage in long-range planning requires that certain questions be answered. For example, are nurses socialized as primarily a female profession to act only under conditions of certainty and in a prescribed manner? Does "she" call "him," the physician, if conditions are uncertain?

Categories of Data Which Influence
the Nursing School Administrator
in Long Range Planning

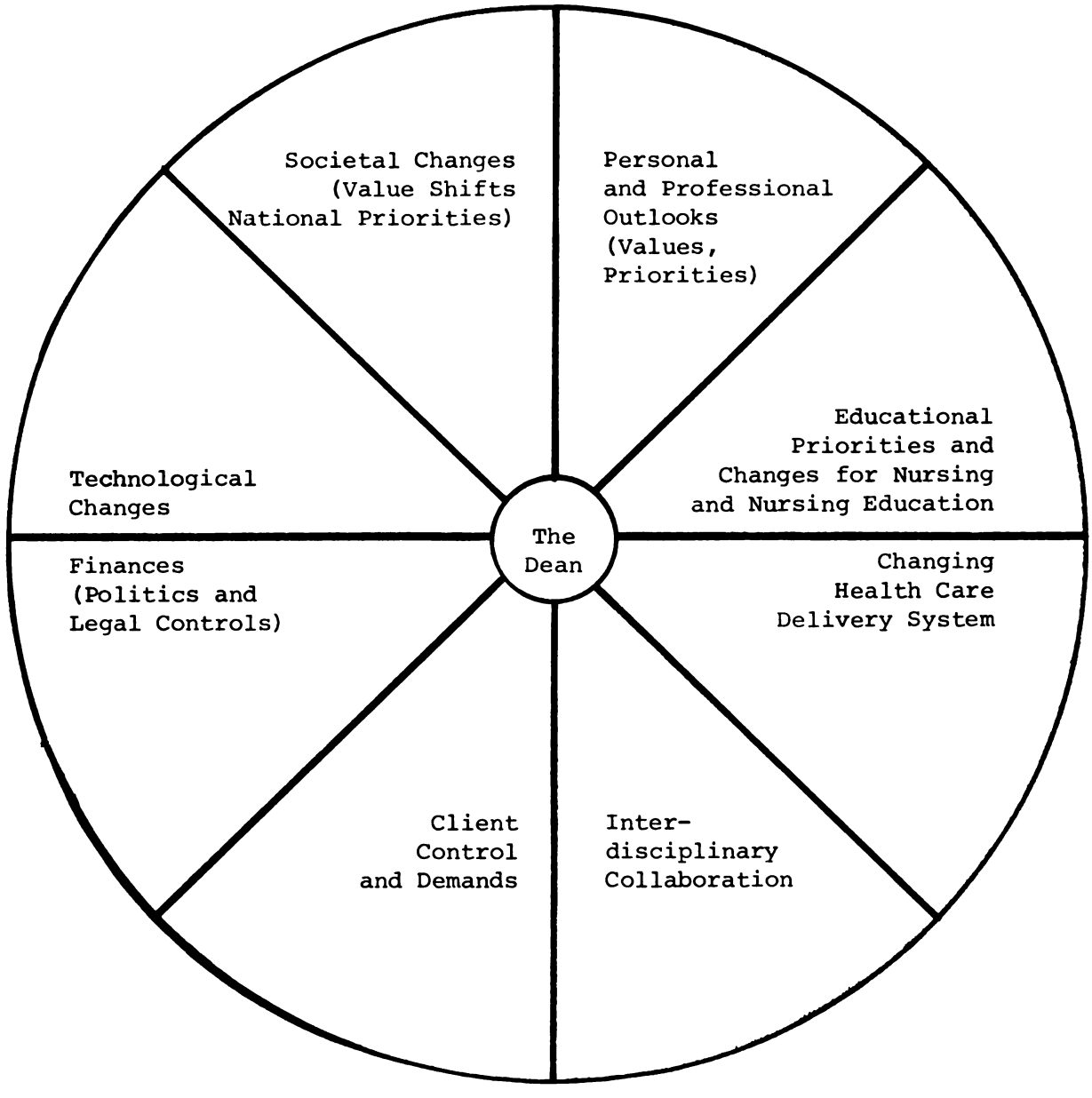

Figure 1.1

Barzun discusses the temper of the administrator and the relationship between the amount of data, the sensing of time, and scholarship in his/her decision-making, and further elaborates:

> As for the academic men who have proved themselves as consultants to industry and government, they tend in their outside dealings to make allowances which they deny to their university. They let business people carry the burden of compromise which they refuse to take on at home.[29]

2. Another category is the <u>educational</u> priorities and projected changes which must occur to prepare the nurse to function in the health care delivery system of tomorrow. A constant conflict exists (as in most professions) between nursing service and nursing education over which group should have greater influence on the educational decisions. The service persons feel that they are the ones who <u>really</u> know what should be taught because they are in actual contact with the patients (clients) and have the practical knowledge. On the other hand, the educators feel that through their past practice and advanced education, they know the theories and principles which will prepare the student for the longer range aspects of learning and problem solving. The service agencies are usually more interested in the short-range immediately applicable skills. Since education is inherently a future-oriented activity, there must be a certain sense of hope for the future apparent in each educator.

3. The changes which should take place in the service areas, or the health care delivery system, are crucial to education as well as to cost consideration and a more humane concern for those seeking health services. The location and variation of services will and should change markedly by the end of the centry. Many of the accepted practices and institutions of today will seem primitive by 2000; i.e., the "modern" hospital of today may be extinct like the tuberculosis sanatorium and "pest-house" of past centuries. With technology the home may again be the locus of care. A home computer may give instructions or a picture phone may aid in diagnosis and treatment.

4. Interdisciplinary collaboration is important for avoiding duplication or omission, but also for providing the client with the best services and knowledge available. Much verbalization takes place about the necessity of working and learning together as students, but the ingrained traditions and vested interests of each discipline seem to defy change. In Maxmen's Post Physician Era, he discusses the 50 percent probability that by 1990 nurse practitioners will provide primary care, and by 2015 MD's will not provide clinical services except for surgery.[30]

5. Changes in societal values and technology in general influence the services that clients of the future expect and demand. Many institutions and agencies

are allowing and encouraging citizen participation in governance and policy determination. The new breed of client is an active participant in his/her health care, not necessarily a sick person (as the word "patient" signifies) or a passive recipient. Will the physician attempt to remain in control of access to the health care delivery system? Or will clients have direct access to the professional and location of their own choice?

6. Finances are receiving increased attention because high costs pose a barrier to many persons who should seek health services. High costs are attributed to lack of efficiency, expensive technology, additional and more highly educated personnel. This increased cost issue has led to the thrust for increased accountability by all health personnel and services. Education also has severe financial problems because of declining enrollments in many disciplines, but costs do not decrease appreciably due to inflation and other costs of maintaining an institution. The ultimatum to accomplish more with less is being issued from all sectors. Political and legal shifts are highly influential in this category.

7. Technological changes have provided for many highly advanced procedures to be performed which seemed impossible a few years ago. Yet though these changes are a blessing on one hand, the dilemmas and the new problems

of "technological success" are oppressive and have wide ethical, moral, and legal implications for health care personnel as well as the recipients and their families. Since the computer never forgets, more accurate health records should be available. This fact, of course, leads to the potential invasion of privacy and other unauthorized utilizations of information.

8. Societal changes, value and national priority shifts, especially the crisis of depleted resources previously accepted and taken for granted, have and will continue to influence travel, costs, acceptability, and practical aspects determining who can afford to seek and provide health care services. The implications of each are extensive and influence education, service, and the client. This category is to be differentiated from category five, the focus of the client on the system. This area includes a broader range of influential national factors.

These eight areas are obviously not mutually exclusive but portray the intense interrelationships and potential consequences of problems that are created when one aspect of a system changes. This is an example of why planning for an uncertain future is such a monumental task in attempting to envision the results of introducing new practices or technology into the system. This brief introduction to these categories will be elaborated upon in Chapter II in the literature review.

PURPOSE OF THE STUDY

It is the intent of this study to serve as an initial assessment of the current perceptions of the nearly 300 administrators of accredited baccalaureate nursing programs in the USA.

The information gained from this survey will be of both practical and heuristic value. It will help the nursing profession focus on some of their most pressing and crucial problems which are amenable to solutions and it will give clearer direction in areas which must receive long-term interdisciplinary discussion. In the author's opinion, the study will stimulate further thinking and research about the future and future planning by merely exposing administrators to the questionnaire.

The potential benefits and need for the study are confirmed by Rushmer:

> The current health-care system evolved with little or no long-range planning or direction. Our main hope for the future lies in our ability to understand our history, assess our current status, and undertake realistic long-range planning that will yield the highest probability for attaining livable or attractive futures. Since we lack historical precedents for these procedures, our learning and accomplishment must be simultaneous.[31]

Therefore, the information gained will be of interest to planners and policy makers of other members of the health disciplines, since the actions of one member are intricately

related to the alterations in functions of other members of the team. Rushmer further states:

> An alternative approach is the concept of creating desirable futures by defining optimal long range goals for a future ten to twenty years hence, identifying the many options for reaching these goals, and evaluating their advantages, disadvantages, and consequences. It is intended that the combination of clearly defined goals and well-evaluated options will be utilized in appropriate decisions at many different decision points during the ensuing years.[32]

DEFINITIONS OF TERMS

The definition of terms as specified in this study are as follows:

1. Associate degree nurse (technical nurse), ADN--a person who has graduated from a technical nursing program at a junior or community college. At the present time this individual is eligible to write licensure exams to become a registered nurse (RN).

2. Diploma nurse--a person who has graduated from a three-year program housed under the auspices of a hospital rather than a university or college. Usually referred to as technical rather than professional. At the present time is eligible to write licensure exams to become a registered nurse (RN).

3. Baccalaureate nurse--a person who has graduated from a four-year college or university program and referred to as a professional nurse. At the present

time this individual writes the same state board exam as the associate degree and diploma graduates and becomes a registered nurse (RN).

4. Position paper--statements published by the American Nurses' Association in 1965 which recommended that the location of nursing education be based in colleges and universities. This would bring about the phasing out of the three-year diploma (hospital-based) schools of nursing.

5. ANA--American Nurses Association (only nurses are members).

6. NLN--National League for Nursing (anyone interested in nursing can become a member).

7. Nursing care--focus on assisting the individual to attain his/her optimum level of physical, social, and psychological state of health in any situation.

8. Medical care--pathology (disease) oriented with the diagnosis of the pathological complaint with prescription of treatment and cure as its goal.

9. Health care--the broader term including medical care and nursing care as well as the intervention of other members of the interdisciplinary team e.g. physical therapist, social worker, etc.

10. Change agent--a person or group that desires to effect an alteration in attitudes, behavior, and/or skills of another individual or group.

11. School of nursing administrator, nursing school administrator--the title of the person in the chief administrative position varies throughout the nation and depends upon the university structure and the relationship of the school of nursing to the total university. The person may be called dean, chairperson, director, department head, coordinator, or in one instance, president.

12. School of Nursing, nursing school--these terms will be used interchangeably and will refer to all units whether they are colleges, schools, divisions, or departments. All are of baccalaureate level and may or may not have a masters or doctoral level program in the same administrative situation.

13. Futurology--the term coined by Ossip Flechtheim referring to attempts to establish the credibility or mathematical probability of prospective developments.[33]

14. Futures research--includes data collection, decision making, planning, forecasting, and prediction.

15. Forecast--"a probabilistic, reasonably definite statement about the future, based upon an evaluation of alternative possibilities."[34]

16. Prediction--refers to an event that <u>will</u> happen, e.g. "it will rain tonight."

17. Perception--outlook, view.

18. Crisis--an event that is unusual and takes priority in one's attention.

19. A Plan--a tool of management.[35]

20. Planning--the prearrangement of policy and guidelines toward objectives. It gives direction, establishes goals, and guides action.[36]

21. Conventional planning--the type of planning which usually results in narrower ranges of alternatives than those provided by the futures-research (long-range) approach.

22. Short-range planning--planning for a span of approximately 1-5 years.

23. Intermediate-range planning--planning for a span of approximately 6-10 years.

24. Long-range planning (LRP)--planning for a span of 11 plus years; many authors use the span of up to 30-40 years.

25. Middle management--the occupants of these positions in an organization usually carry out many decisions made by higher officials, but also must display considerable initiative within their own administrative subunit.

26. Administrator, manager, chief executive, educational administrator, nursing school administrator--all of these terms are interpreted as interchangeable.

LIMITATIONS AND DELIMITATIONS

Limitations

The study was limited to those nursing school administrators who chose to participate by responding to the mailed questionnaire. It has the inherent limitations of reliability and validity which exist in a newly developed tool and especially by the very fact that this type of research data consisting of judgments about the future can only be accepted for the present and verified by the test of time. Planning is a dynamic process, therefore there are only arbitrary points at which to stop and compare the projections made at an earlier date.

Delimitations

The study was delimited to the administrators of accredited baccalaureate schools of nursing in the USA which existed at the time that the questionnaires were mailed to the potential participants.

DESIGN

A questionnaire was mailed to 286 nursing administrators of accredited baccalaureate programs in the USA. The names and addresses of the population were obtained from the annual publication of the NLN, which lists the administrator of each school and certain characteristics about that school.

The questionnaires were confidential but not anonymous, which permitted follow-up reminders to be sent three weeks after the initial mailing through use of a code number which identified the participants.

Regarding anticipated response rates for this study, 50 percent is usually adequate, 60 percent is good, and 70 percent or over is very good.

Since the tool was developed by the author, the validity and reliability were dependent upon consultation and a pilot test of colleagues and previous nursing administrators.

Treatment of data consisted of transfer to computer cards and application of selected tests from the (SPSS) Statistical Package for the Social Sciences.[37]

ASSUMPTIONS

The nursing school administrators (deans, chairpersons, directors, etc.) are an often overlooked, under-utilized group of nursing leaders. Their energies are frequently taken up with clerical tasks that should be delegated to assistants in order that they might utilize their knowledge and expertise in long-range planning for the direction of the profession and in turn for the improvement of the health care delivery system for better client care. These persons are among the most highly educated in the

profession and should have a more forceful impact in regard to long-range planning.

By participating in studies such as this, these nursing school administrators will be engaging in a concerted effort to pioneer in creating a more unified, systematic plan for nursing and nursing education, rather than to remain laggards, followers, and reactors to policies made by others.

The author is assuming that there is a great deal of dissatisfaction with the health care delivery system, of which nursing is the largest professional group. In addition to the extremely high costs of health care, there are other conditions which must be changed for better care now as well as in the future. Some of these conditions have been publicized nationally from the NURSING 77 study in which many nurses did not give favorable ratings to current nursing care.[38]

The author assumes that if more time is spent in planning, less time will be required for implementation of changes and greater satisfaction will result. Therefore, "letting things happen is not the best approach to planning." There will always be those in opposition who argue that long-range planning will deprive them of spontaneous opportunities and serendipitous findings. This, however, is not the intent of long-range planning; it leaves room for constant revision and updating.

It is the author's assumption that merely by being exposed to the questionnaire, nursing administrators will be stimulated to think about the future.

Esfandiary conveys his optimism: "We are daily surging ahead because somewhere, somehow, we believe in the future."[39] This author would tend to agree with the more optimistic opinions about the future of the world in general. As for the turmoil in society, we read of it in Biblical times; the disciples lived through quarrels, murders, and unrest, and from this the church was born. There was maladjusted Moses who wandered in the wilderness for forty years; there are modern prophets today who have important knowledge on computer printouts instead of scrolls. Many famous, currently respected, and honored people seemed out of step with their times in history. Lincoln, Edison, Marconi, Churchill, and Einstein were so intelligent that they appeared to be maladapted in contrast to the majority of society. Obstacles to change are not simply lack of technology, education, or information. In fact, many inventions and technological changes evolve into problems of their own technological success. One example is the use of life maintenance equipment for unresponsive patients; these implications must be explored <u>now</u> to avoid greater problems in the future.

Other sources of obstacles to change and use of education and technology is summarized by Weisskopf:

> There are two powerful elements in human existence: compassion and curiosity. Curiosity without compassion is inhuman; compassion without curiosity is ineffectual.[40]

Much of the controversy, power struggle, and ineffectiveness of the health care system occurs because we have not combined both compassion and curiosity (investigation and research) in nursing education and clinical practice. While no doubt the traditional caring, compassionate aspect is important, the profession must re-consider the present society we are servicing and also prepare for tomorrow. Unless research is included in any system, it will stagnate. It has been mentioned that nursing is a profession in a hurry.[41] This is partially correct, but we have been too eager to be compassionate and present-task oriented; we have procrastinated against preparing for the future and considering theoretical aspects. For too many years nursing educators have been educating nurses for yesterday, using the same content and methods that they learned, creating nurses in their image using the "rearview-mirror" approach.

ORGANIZATION OF CHAPTERS IN STUDY

The study will consist of five chapters.

Chapter One includes the introduction, statement of the problem, significance of the study, purposes of the study, definitions of terms, limitations and delimitations, assumptions and organization of the study.

Chapter Two will be a discussion of related and pertinent literature. The eight categories provide the framework for the items included in the questionnaire. The future-oriented literature will also be explored in relation to each area, and will include arguments for the advantages and disadvantages of long-range planning with special implications for the role of nursing school administrators, nursing education, and its role in higher education and health care.

Chapter Three includes a description of the design of the survey and treatment of the data.

Chapter Four will present analysis of the results with comparisons and contrasts and will utilize the demographic data to point out major areas of agreement and contrast where there are noteworthy findings. Selected statistical tests (SPSS) will be applied where relevant.

Chapter Five will include the summary of the major findings of the study with conclusions and recommendations for long-range planning in nursing.

Chapter 1

FOOTNOTES

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Chapter 2

REVIEW OF LITERATURE

INTRODUCTION

This chapter is presented in four parts. Part I includes a brief description of selected research and relevant literature which relates to the background and purpose of this study.

Part II includes a discussion of plans and planning. Related subtopics are: the concept of plans and planning; the properties; clarification of terminology; the time dimension; the philosophy, values, and attitudes toward planning; the acceptance of planning; and the limitations and benefits of planning.

Part III includes an exploration of the relation of planning to the dean (nursing school administrator), the relaton of planning to universities and business, the responsibilities of academic deans, and future nursing education.

Part IV is an elaboration of the eight categories which have major importance to the administrator in long-range planning. They are: the personal and professional outlooks of the administrator, educational priorities, the health-care delivery system,

interdisciplinary collaboration, changing client roles, finances, technological changes, and broader changes in society which facilitate and/or hinder the planning process.

PART I

PREVIOUS RESEARCH

Research studies which focused on the future in nursing literature were non-existent until the 1970s and those now available are very limited in their scope and sample size. One example is a Canadian study which was conducted by Bramwell and Hykawy. The purpose of this four-round Delphi study was to forecast events which would occur during the next fifty years in nursing education. Consensus was reached on fifteen events that would occur by 2000. A major limitation was the small sample size of thirteen and a very limited geographical area.[1]

Another study focused on nursing research. Lindeman's four-round Delphi study on nursing research identified perceived impact as well as research priorities with data from a nationwide sample of 341 representing nurses in education, practice, administration, and research. It was thought that determination of priorities for nursing research could provide assistance to the profession in seeking funding for important research questions. There was no item on which all respondents were in agreement, however, the study represents an important initial step in establishing some priorities of the highest ranked items for nursing research.[2]

A survey by National Center for Higher Education Management Systems (NCHEMS) has some relevance to this

study. Huckfeldt's five-round Delphi study on long-range directions in higher education included 385 respondents representing a nationwide variety of persons who have major influence on education and its future directions. It is of special interest to note findings regarding areas in which changes are forecasted to occur:

> Considering the impact of changes, the panel felt changes in planning and management would have the highest impact and changes in the educational structure the least impact. . . . The only area in which the panel consistently identified one force (the faculty) as most hindering change.[3]

Keys et. al. conducted a four-round Delphi study (adapted from the Huckfeldt study) which included the perceptions of eighty-eight deans of medical schools for the purpose of forecasting desirability, probability, and impact of changes in medical education and practice over the next twenty years. Of the fifty-four items that were considered by the deans, the highest ranked probability item was the occurrence of a mandatory, comprehensive, national-health insurance program and the lowest probability ranked item was that physicians would pay a special tax on income to support medical education.[4]

RELATED LITERATURE

Speculation as to why more research has not been future-focused in nursing as well as other disciplines

is infrequently addressed in the literature. Bronwell refers to the acceptance issue:

> Scholarly research in universities seldom concerns itself with the future in a philosophically exploratory projective context for this has no acceptability in presentations before learned society forums or publishability in their journals. Indeed, in many academic circles, such research is regarded as tainted and beyond the fringe.[5]

Additional reasons may be related to the traditional curriculum content which does not provide impetus for research on future-oriented topics. When the question of including futures content in various health science curricula is posed to faculty, they usually respond with the comment that their curriculum is already packed, there is no room to insert futures content. In response to this statement, Rich recommends: "One way to prepare for the future is to give futuristic studies a place of equal if not greater importance in the curriculum as historical studies now occupy."[6] He further emphasizes: "The general public needs to learn the art of thinking about the future over a 30 to 40 year span."[7]

Since Brown's 1948 publication, Nursing for the Future,[8] few authors have addressed the long-range concerns of the profession. Authors of nursing literature have only very recently begun to address issues related to the future of nursing. Many articles and texts conclude with a small paragraph or sentence regarding the future, but few have written extensively on the topic.

One prominant nursing leader and administrator who has ventured to elaborate on the topic is Leininger. She emphasizes the need to study, plan, and educate nurses for the future.[9] She is the only author located who describes five requirements for nurse futurists:

> First, a futurist must be a risk taker. . . . Second, a futurist must be an astute analyst of the past and present. Third, a futurist must not only be able to abstract from past and present events and experiences, but must also be able to predict, logically and explicitly goals and directions for the future on the basis of limited or non-verified data. Fourth, a futurist must not be intimidated by popular thinking or by the opinion of the majority. Fifth, a futurist must be able to stand behind his or her hunches or predictions until proven mistaken.[10]

PART II

THE CONCEPT OF PLANNING AND PLANS

This discussion will focus on the concept of planning and plans including the properties; clarification of terminology; the time dimension; the philosophy, values, and attitudes toward planning; the acceptance of planning; and the limitations and benefits of planning.

Since many terms are used interchangeably and have different meanings for various authors, a comparison of selected authors and discussion of their views will follow. George Steiner, one of the foremost writers in the area of planning, conveys the confusion: "Today, there is no generally accepted meaning of planning and plans."[11] Kelly agrees about the difficulty of arriving at a definition.

> The word planning is not so easily dealt with on a definitional basis. There are probably as many different definitions of the term "planning" as there are textbooks and articles on the subject.[12]

Ewing writes:

> I like to define planning as a <u>method of guiding managers so that their decisions and actions affect the future of the organization in a consistent and rational manner, and in a way desired by management</u>.[13]

Newman comments on the lack of clarity in planning.

> Planning is a broad concept; it embraces a wide range of ideas. In fact, much of the confusion concerning planning arises because people use the same words to cover quite different concepts.[14]

Newman concludes that planning is a widespread human behavior and defines it as deciding what is to be done in advance.[15]

PROPERTIES OF A PLAN AND PLANNING

According to Steiner, planning is a mental process differentiated from the plan, which is the tangible evidence of thinking.[16] LeBreton and Henning describe the distinctive properties of a plan as: "futurity, action, and personal or organizational causation."[17] Steiner obviously agrees that futurity and action are properties of planning, as he states: "Planning inherently involves assessing the future and making provisions for it."[18] Also in agreement with Albright, who comments: "Thinking and doing something about the future is planning."[19] He further emphasizes:

> Typically, when people plan for the future (and there is no other kind of planning; no one thinks of planning for the past) they usually extrapolate current trends into the future.[20]

The element of futurity in planning is emphasized by numerous other authors who seem to be in agreement with Longest, who concluded: "The very essence of planning is informed anticipation of the future."[21]

CLARIFICATION OF TERMINOLOGY

Decision-Making and Planning

There are those who define planning as decision-making concerning the future,[22] which is an interesting contrast to LeBreton and Henning's distinction between decision-making and planning: "A decision is the resolution of conflicting alternative choices. A decision need not

involve action or the future."[23] Decisions are used in planning but decisions are not plans. According to Ackoff, "Planning is clearly a decision-making process; but equally clearly not all decision-making is planning."[24] Steiner differentiates: "Planning is not making future decisions. Planning is concerned with making current decisions in light of their futurity."[25]

Comparison of Planning and Forecasting

Because planning is done to help us make today's decisions about tomorrow's world, says Craver, all planning begins with a forecast about the future.[26] Olaf Helmer agrees: "A forecast is not a plan, but all good planning begins with a forecast."[27]

LeBreton and Henning view planning and forecasting as being very closely related.[28] Craver further examines the interrelationship by observing that plans are based on forecasts, but that a forecast in itself does not automatically result in a plan. A forecast must be pertinent, credible, and feasible before it can be used in planning.[29]

Newman stresses the importance of forecasts in administrative planning, but one must recognize that unforseen events may occur; therefore, thinking in terms of probabilities or calculated risks is a necessity.[30]

Drucker approaches the definition of long-range planning by emphasizing what it is not. The first contrast on his list states that forecasting is not long-range

planning and that "Long range planning is necessary precisely because we cannot forecast."[31]

Hussey considers the forecast as having a double use, that of serving as a base for planning and also as an outcome of the planning effort.[32]

THE TIME DIMENSION

Much of the planning literature makes a distinction between short- and long-range planning. Long-range planning is frequently thought of as extending five years or beyond, with some being ten years and a few up to twenty years. A plan may extend for several months or years because of the lead time required for the plan to be implemented.[33]

Administration should be viewing the future and projecting trends not only to help in establishing plans to meet future conditions but also it can be striving to influence and create better conditions.[34]

Time as a dimension in planning has four important aspects which can be differentiated: preparation or development time, lead time, full implementation time, and the length of the planning range.[35] Many factors influence the time dimension which an individual or organization will consider appropriate for accomplishing their mission. Among these are: the type of organization; its goals and commitments; the public and political pressures; its traditions, resources, values, and expertise; and the futurity of the administration.[36]

Ewing discusses semantic labels of long-range, intermediate, and short-range planning which all fall under the same broad definition but differ in the time focus and the amount of change desired.[37]

Steiner concludes that research indicates that the time frame for planning has been increasing recently, though five years is the time frame most frequently mentioned when one surveys business administrators. Of course, there is wide variation on a continuum from no corporate plan to that of approximately one hundred years used by Weyerhaeuser when planting their trees.[38] Kelly differs somewhat with the view that there is nothing sacred about five years. According to Hardy, typical long-range health-care planning will range from five to thirty years.[40]

Drucker's perspective on long-range planning takes yet a different stance than most other authors. He believes that long-range planning is a misnomer.

> To say, "long range" or "short range" planning implies that a given time span defines the planning; . . . But the essence of planning is to make present decisions with knowledge of their futurity. It is futurity that determines the time span, and not vice versa.[41]

PHILOSOPHY, VALUES, AND ATTITUDES TOWARD PLANNING

Philosophy, values, and attitudes about the future tend to influence the type, relevance, time span, and scope of planning which an administrator will pursue. It then

seems relevant to explore four types of planning and the relationship of each to the future.

Ackoff presents four general types of planning: inactive, reactive, preactive, and interactive which determine the individual's approach to planning.

1. Inactivists are described as those who hold a conservative philosophy and are satisfied with the way things are. They focus their energy on keeping changes from being made rather than striving to achieve any change. Their attitude toward the future is one of gloom and doom.[42]

2. Reactivists are those who dislike complexity, are nostalgic, and believe that society is going from bad to worse. Their efforts are focused on recreating the past.[43]

3. Preactivists attempt to prepare for the future and believe that the future will be better than the present or past. Their attitude toward the future is that it is uncontrollable but the effects of the future can be controlled. The time-frame focus for planning by this group is the short-to-medium range future.[44]

4. Interactivists focus on designing a desirable future and inventing ways to implement it. They can be described as idealizers. They not only prepare for the future, they attempt to redirect it. This group gives attention to long-range planning and believes it is necessary to balance short- and long-run consequences.[45]

The issue of long-range planning always raises many moot and philosophical questions. Numerous choices confront planners. Plans must be made which will influence both the immediate and long-term future. Planning carries with it both an optimistic and a pessimistic component. The optimism is apparent in the individual's, group's, or organization's belief that the investment of time and energy in planning will create a more desirable future. The pessimism relates to the belief that unless some actions are taken to change the course of events, an undesirable future will occur.[46]

Ewing elaborates on the importance of feelings and values and their influence on the merit a planner places on the facts available for use in the planning process. "Value judgments are sometimes like a small nagging voice from the corner, and other times like a large overbearing presence."[47]

Ackoff prefers interactivism, believing that our society can be improved because "problems and solutions are in constant flux; hence problems do not stay solved."[48]

THE ACCEPTANCE OF PLANNING

If one term had to be selected to describe the issue of planning, whether it be long-range or not, it would be controversial. Ackoff's quote briefly serves as an example.

> Most of the planning that I have seen in about 250 American and foreign corporations is like a ritual rain dance performed at the end of the dry season to which any rain that follows is attributed. Rain dancing has no effect on the weather even though it may have therapeutic effects on the dancers. Despite this, I find that as a so-called professional planner I'm repeatedly asked to help improve corporate dancing, not to help control the weather.[49]

It is apparent that long range planning is accepted by many types of organizations, individuals, and industries; however, the level of acceptance varies. One of the major variables influencing this acceptance is the elusive or intangible results which are not easily measured and that are attributable specifically to the process of long-range planning.[50] Kelly further elaborates on the wide acceptability of planning to the business world during the last fifteen years, but also recognizes the ambivalence: "Long range planning is being hailed in some quarters as the savior of faltering companies. In other quarters it is being labeled as a waster of time with little payoff."[51]

Pennington mentions two reasons why there has been wide acceptance of planning as a management tool. One being that planning is an important function of the administrator and that it has great logical appeal, being better to control one's future than merely reacting to it.[52]

Steiner's overwhelming acceptance is expressed:

> That a case exists against long-range planning never occurred to me. Being in favor of long-range planning is something like being in favor of motherhood. Who is or can be against it? . . . Any manager who does not plan ahead is clearly not performing one of his major functions.[53]

Weaver, who has conducted futuristic research, comments on the acceptance of statements about the future by saying the future is what one imagines it to be, somewhat analogous to the way one regards a work of art. It can be accepted or rejected by the critic, but cannot be proven false. What the future should be differs markedly with each person and with the assumptions and values they hold about the future.[54]

LIMITATIONS, BARRIERS, AND DIFFICULTIES IN LONG-RANGE PLANNING

Long-range planning may be viewed unrealistically; it may be expected to provide a miraculous cure for the discontent of a profession or an organization.[55] This unrealistic expectation may be an emotional approach lacking intellectual preparation. An administrator may lack the vision and ability to understand what is really meant by planning, to form realistic expectations of what it may accomplish, and to invest adequate resources and timing for it to be of value.[56]

Enarson is concerned that in many institutional settings, planning efforts focus on what is fashionable, whether it be feasible or not.[57] Schaefer identifies this kind of planning as "poor management."[58]

Hilleboe discusses several human characteristics which inhibit planning. Among them is the tendency to

become excited about some unusual threat rather than examining daily practices which may have a greater and more serious potential. The provincialism of individuals is carried through into universities, which exhibit the same vested interests and internal conflicts. Universities allow their past habits to dominate their future thinking rather than include the vast array of variables such as values, economics, social changes, and politics, which influence all of the disciplines somewhat differently.[59]

Fuller writes from an academic perspective with many of the same characteristics.

> . . . The planning of alternative futures is of little apparent concern. The projection of current realities into the future is sufficient.[60]

Few people are terribly concerned about planning in our society of relative comfort, abundance, and complacency until a crisis presents itself which requires an immediate solution for survival.[61] Schaefer further comments regarding another, closely related factor to long-range planning: "Many universities seem largely organized for the work of the past and not of the future."[62]

This past orientation is often promoted in the guise of professionalism, as White calls it, one of the diseases of educators, "hardening of the categories." He further identifies the pitfalls of autonomy: " . . . Each [profession] sees the other's discipline as being out of step with the world, while the real problem may be that neither has an accurate perception of the world."[63]

Kissinger writes in relation to planning limitations in government:

> What passes for planning is frequently the projection of the familiar into the future. . . . Lip service is paid to planning; indeed planning staffs proliferate . . . since planning staffs have a high incentive to try to be "useful," there is a bias against novel conceptions . . . true innovation is bound to run counter to prevailing standards.[64]

Mac Stravic introduces another major barrier to planning, that of the fear of making a mistake. He argues that errors should be not an indication of failure, but realization of the setting and environmental conditions in which planning takes place.[65] This fear is complicated with the uncertainty and abstract nature of having to plan without answers provided by numbers.[66] Ewing adds the crucial roles are played by power and politics[67] along with the personal threat of uncertainty which is emphasized repeatedly by LeBreton and Henning.[68]

Wedley refers to the attitudes of the persons in administration in that many executives have present-oriented personalities. They gravitate toward actions which yield quick feedback and closure, preferring the hustle and bustle of present problems over the agonizing complexities of future events.[69] Newman would also add the psychological reluctance to change a decision, especially after a great deal of hard work and time investment has been made.[70] Planning is expensive and

the advantages may not outweigh the expenditure.[71] It is a constant threat to the administrator who must answer and assume responsibility. Newman concludes:

> No enterprise can exist without some planning. The real question is, how much?--That is, how far ahead and in what detail should planning be carried?[72]

As a basis for planning, the reliability of forecasts is of great concern. The limitations of forecasts and reliability are discussed again by Newman[73] and also by Pennington, who elaborates on three distinct problems of forecasts. They can be summarized thusly, the uncertainty of forecasts, the presentation of unpopular possibilities, and environmental crises which will alter the best of forecasts.[74]

In addition to ambiguities of planning for an uncertain future, also added is the confusion which relates specifically to planning for health care delivery in the decades ahead. This is highly dependent upon the administrators' priorities, values, and definition of health. There are conflicting points of view as to the amount of responsibility which should be assumed by the professionals as well as by the consumers.[75] There is always the fear of who will be in control and to what or whose value or detriment the possession of power will result.[76]

Change merely for the sake of change is not productive but it is the wisdom of the administrator of the nursing school or organization to maintain the sense

of balance between fads and adhering to a tradition, "just because we have always done it this way!" Hussey identifies merit in the restless person who will seek new opportunities and be able to cope with a rapidly changing world, whereas the complacent will rarely conceive of doing anything differently unless it is compulsory.[77]

Aydelotte addresses some of the dilemmas of the health care delivery system and inhibiting factors in relation to planning for nursing education, "our problem is to make up our minds about what we will attend to."[78] She also questions the reality which exists in contemporary educational programs.[79]

Since one of the health professions cannot drastically change its functioning, policies or directions without markedly influencing the other health care providers, it is essential that the universities who educate students begin to provide opportunity for interdisciplinary planning and education for achievement of optimal health care delivery. Several authors speak to this predicament and other barriers to long range planning. Zasowska refers to many of the previously mentioned barriers such as the lack of leadership, preparation, vision, interest, inappropriate reward systems and economic incentives which are highly influential in the planning process.[80] Hussey summarizes much of the underlying rationale which is often observed and expressed by those who wish to avoid or delay

the examination of plans which would obviously have a multiplicity of implications for change.

> Change of any type is anathema to most human beings. There is comfort and a feeling of false security in following the time-worn and well-known rut, often even to the extent that it goes deep enough for the sides to collapse and smother its occupant, killing all drive and initiative. One might almost define a natural law of human inertia which can only be overcome by the restlessness and creative urge possessed by men of vision."[81]

BENEFITS OF LONG RANGE PLANNING

Actual and potential benefits of long range planning are discussed in relation to numerous aspects of business and the military. Karger expresses an extremely optimistic viewpoint:

> When one considers the evidence of results of planning it is hard to understand why more organizations do not take advantage of the procedure. It has long been conceded that well planned military campaigns are necessary to success. Research indicates that similar benefits accrue to the commercial organizations that engage in formal planning."[82]

Ritvo gives illustrations of advantages to planning in health care.

> The benefits of planning are numerous. It affords more time to make a decision. It allows a perspective not given without time. Planning may allow more voices to be heard prior to conclusive actions. It may also define the problems that require solution. Planning also has the additional benefit of allowing the organization the opportunity to accumulate resources, train personnel, and restructure, if mandatory, to accomodate a new technology."[83]

Among others who discuss advantages are Newman, who believes that planning provides opportunity to review the overall purposes of the organization, avoid delays,

anticipate crises, and operate in a more efficient manner.[84] Kelly voices similar agreement: planning forces the organization to think beyond the current crisis and view the scope of their functioning more objectively. He summarizes, "Most managers are forced to agree that planning is a good thing."[85]

Kelly and Newman also agree about the evaluation of planning, even though there are both concrete and intangible factors.[86] Kelly views long-range planning as a tool that will improve performance.[87] Many of the benefits are difficulte to evaluate, not only because of their abstract nature, but also because the time dimension and variables are so enormous that it is often impossible to know which variable influenced the change, or whether time itself has changed the persons who are now the evaluators, or whether the evaluators have changed their values and perceptions. The challenging problems of the 80's and 90's will make the need for long-range planning even greater than at present. Administrators must learn how to more effectively utilize future personnel and tools.[88]

Rushmer, a strong proponent of long-range planning in health care, charges that present methods are incapable of dealing with the contemporary predicament and recommends, "A more effective approach to long-range planning is sorely needed for future health-care delivery."[89] Rushmer is more optimistic about the effectiveness in health care of the

long-range plan over the short-range plan. He recommends:

> An alternative approach is the concept of creating desirable futures by defining optimal long range goals for a future ten to twenty years hence, identifying the many options for reaching these goals, and evaluating their advantages, disadvantages, and consequences. It is intended that the combination of clearly defined goals and well evaluated options will be utilized in appropriate decisions at many different decision points during the ensuing years."[90]

Leininger, one of the few leaders in nursing who writes with a futuristic point of view, states that, "Predicting and planning for nursing's future are very difficult but also very necessary tasks."[91] Both Skovie[92] and Leininger[93] advocate education of all health professionals to deal with the uncertainties of the future. Leininger further emphasizes: " . . . it is timely to emphasize futurology in nursing and in other health fields, and to deal with uncertainties in nursing and health care."[94]

Platt explores the urgent need for solutions to several problems of crisis porportion in the United States and throughout the world and believes that many changes produced by technology are approaching limits.

> . . . We may never have faster communications or more television or larger weapons or a higher level of danger than we have now. This means that if we could learn how to manage these new powers and problems in the next few years without killing ourselves by our obsolete structures and behavior, we might be able to create new and more effective social structures that would last for many generations.[95]

Platt's outlook expresses both optimism and pessimism about society's attempt to deal with the future.

> The future always depends on what we do and can be made worse or better by stupid or intelligent action.[96]

Traditional approaches do not provide contemporary administrators with the skills necessary to deal with the complexities as they currently exist. Mauksch, in The Future is Now, declares that we are totally unprepared to face the consequences of our actions. We have not learned or planned to cope with the current realities, let alone plan beyond them. Regional planning is probably twenty years overdue.[97]

The need for longer-range planning for nursing and health care is discussed from numerous point of view Carmody's concise statement summarizes the intent and urgency for change.

> America's health problems cannot be solved by a patchwork of narrowly based federal programs or further infusions of money alone. A more comprehensive restructuring of the system is needed.[98]

PART III

RELATIONSHIP OF PLANNING TO THE FUNCTIONS OF THE NURSING SCHOOL ADMINISTRATOR

Defining the functions of the manager or administrator of an organization causes much confusion. Longest states that the basic function of the administrator is to manage the inputs of the organization to achieve the desired outputs.[99] For the purposes of this study, the administrator will be defined as one who manages or performs the executive duties for the school of nursing (the dean).

Although there is not universal agreement, most authors support the premise that an administrator in his/her management duties will be engaged in planning. Longest widely surveyed notable authors who agree that management consists of five basic functions: planning, organizing, directing, coordinating, and controlling, and summarizes: "The primary management function is planning. . . . Logically, planning is the first of the management function."[100]

Others support the viewpoint that planning is an important function of the administrator. Karger points out, "Planning is the first and universally recognized function of management."[101] He then mentions two reasons why more executives do not engage in formal planning, one being that many administrators do not know what long-range planning really is, and the other that it is a difficult

complex, and sometimes ego-shattering process. As for the length of planning, Karger believes that, "One cannot have a good short range plan without a long range plan."[102]

LeBreton and Henning also agree that, "One of the most important functions performed by each executive is that of planning."[103] Newman also concludes that planning is an essential duty of every executive.[104]

Comments from a university president indicate that much planning is inadequate, being too narrow, too broad, focused on tangible, "countable" items, or obsessed with tools; nonetheless, it is inseparable from academic management.[105]

RELATIONSHIP OF PLANNING TO UNIVERSITIES AND BUSINESS

Planning as a major function of management has received considerable attention in the business sector. There are important similarities and differences in administrative functions and expectations in the academic world. Riley and Baldridge explain:

> Colleges and universities are different from most other kinds of complex organizations. Their goals are more ambiguous and contested, they serve clients instead of seeking to make a profit, their technologies are unclear and problematic, and professionals dominate the work force and decision-making process. Thus colleges and universities are not standard bureaucracies, but can best be described as "organized anarchies."[106]

The differences are further elaborated on by Riley and Baldridge:

> The collegial leader presents a stark contrast to the heroic bureaucratic leader. The collegial leader is above all the "first among equals" in an organization run by professional experts. . . . The basic role of the collegial leader is not so much to command as to listen, not so much to lead as to gather expert judgments, not so much to manage as to facilitate, not so much to order but to persuade and negotiate."[107]

Barber also compares the roles of the university and business:

> Higher education has evolved into a big business and has cultivated close working partnerships with both the corporate and governmental sectors. . . . Today's university resembles a widely diversified nonprofit conglomerate more closely than any other organism on the contemporary scene.[108]

The changing conditions and needs of government and the general missions of universities; teaching, research and service have changed the university so that it resembles a business and acts as a force of change in the corporate world.[109]

Even though much of the management literature is focused on settings other than those related to education or health care, there seems to be much transfer of principles for the academic dean in his/her administrative duties.

Longest points out the dilemma for many professionals:

> One thing is absolutely certain -- being a good physician, nurse or technologist does not make one an effective manager. Two areas of knowledge (professional and managerial) are simply not the same.[110]

Albright reiterates with the question:

> And what of the educational administrators, most of whom have had little, if any, preparation related to the performance of functions they are called upon to carry out.[111]

Roaden explains how the selection process conflicts with expectations:

> Deans usually have been selected on the basis of their scholarly achievements. Since knowledge is the unique domain of the scholar, the growth of knowledge has made "knowledge planners" of college deans.[112]

RESPONSIBILITIES OF ACADEMIC DEANS

The responsibilities of the dean will vary in each situation and in every discipline. The duties of the dean in one setting may be similar to those of the department chairperson in another. In baccalaureate schools of nursing in the United States, the administrators have the following titles:

Dean in 152 programs
Chairperson in 129 programs
Director in 45 programs
Head in 15 programs
Coordinator in 3 programs
President in 1 program[113]

It is evident there is no uniform title for administrators in the baccalaureate nursing programs in this nation. The unit within which the nursing program functions may be called "college," "school," "department," or "division."[114] In this study the term "school" will be used.

For any new administrator there are prodigious amounts of new responsibilities and relationships which are acquired and must be mastered. The administrator of a school of nursing is usually a woman and may be the only female in the predominantly male world of administration in the academic setting.

In this middle-management, administrative role, at best, there are numerous difficulties and conflicts even for the male in the more traditional academic subject areas. Dressel et al. only speak of the male and outline duties which may fall within the realm of department chairperson or dean. His overbearing list is as follows:

> Tradition and faculty demand require the chairman to be a scholar, but the demands placed upon the chairman include many functions; chairmen initiate action on budget formulation; selection, promotion, and retention of academic staff; faculty salaries; sabbatical leaves; interdepartmental relationships; research grants; educational development and innovation; university committee membership; discipline representation; professional growth; advise to dean on departmental matters; administration to faculty relationship; new faculty orientation; departmental meetings; adequate nonacademic help; student administration, student advising; class scheduling; student personnel records; faculty load; graduate student application approval; grading standards and practices; and curriculum changes. Also they have knowledge of the administrative routine of the college; institutional legislative organization; government grants procedures; policies relating to graduate students; and scholarly productivity of department faculty.
>
> Most new deans lack familiarity with many of these activities, and there is usually no ready way to acquire familiarity. They attain familiarity at the expense of their scholarly effort.[115]

Baldridge studied roles and conflict in New York University. In relation to these middle management administrative positions, he recapitulates:

> The dean is caught between the expectations of the central administration and the local departments; the department head is caught between the dean and professors in the department; the central administration jockeys among the various schools; the individual professor struggles between the expectations of the university on one hand and his students on the other. There is great role strain in the university for each level exerts strong--and often contradictory--pressures on the role occupants. The dean is often described as the "man in the middle," but it seems more accurate to say that literally dozens of "men in the middle" are scattered throughout the formal system. George Pollach, former vice president of NYU, called this the "sandwich theory" of administration because the behavior of individuals is often related to the levels between which they are sandwiched.[116]

The dean's position, as described by Gould, is indeed multifacted. He/she is:

> . . . prophet, prime mover, keeper of the status quo, skull collector, servant of the faculty, trail blazer, weather vane, builder, housekeeper, maverick, and lackey.[117]

Schlotfeldt, a former dean of nursing, recalls:

> A former dean colleague of mine subsequently was appointed to an academic vice president's post. While holding the latter appointment, he shared with me his opinion that the dean's role is the most difficult and demanding of any in the university. He justified his position by observing that a dean, to be successful, must steadfastly support his faculty associates, although sometimes he receives very little, perceptible sustained support himself from the persons holding central university administration posts. . . . The challenge to deans is to turn those dilemmas into delights by taking advantage of all the opportunities that can be found in executing the leadership role.[118]

Articles by nursing school administrators describing their experiences in the literature are rather sparse, but it seems that they would echo the same or at least similar reactions of Gould and Baldridge. Samples of comments from nursing administrators follow.

Barritt, Dean of Nursing at the University of Iowa, states that "crisis intervention is probably one of the main tasks in a deanship."[119]

Anna Gallagher, a former chairperson of nursing in Louisiana, believes that the greatest administrative responsibility is "leadership in the development of curriculum."[120] The broader view of the administrator with knowledge of educational trends must be used to guide faculty in a contemporary curriculum plan.[121]

Palmer, Dean of Boston University School of Nursing, emphasizes that one of the major capabilities of the dean must be in selection of first-rate faculty.[122]

Isabelle Payne of Michigan State University stated that much of her time is spent in recruiting faculty.[123]

It is evident that the dean has many masters to serve and publics to please. This dilemma is described quite aptly by Buchen: "If he is not a swinger, the students won't listen to him; if he is, the faculty will not."[124]

Hanzeli discusses the middleman position of the dean and bemoans the fate that "very few conscientious

deans are able to continue active scholarship in their former disciplines."[125] He further remarks that they can be no more than an enlightened reader in the discipline. In the academic deanship they become students in higher education.[126]

In conclusion, Roaden, Vice Provost and Dean, Graduate School of The Ohio State University, describes the deanship as the "uneasy role of middle managers" and lists three primary functions of the dean of today: "(1) giving academic leadership, (2) managing the control of activities, and (3) functioning as a member of a university policy making body."[127]

FUTURE NURSING EDUCATION

Generally there is agreement that deans cannot abdicate their role as shapers of the future in their interaction with students whether they are in nursing or any other discipline. What remains unclear is how involved deans or other administrative officers should be in curriculum decisions. It is curious to speculate how much innovation is not ventured into because of ambiguity of who should be making and implementing curriculum decisions. Higgs concludes from her study that there is a trend for these decisions to be made by faculty.[128]

Ashley and LaBelle offer compelling suggestions for change and improvement of nursing education stating:

"New ideas, exploration, innovation, and experimentation must be the focus of nursing education."[129] They emphasize a new focus is necessary to advance nursing from its primitive status. To accomplish this, "We need rebels, that is, teachers who are not afraid to ask questions without having preconceived answers, questions that will not perpetuate the existing order. We need students who can do the same."[130]

It seems ironical that educators, those who purport to assist in preparing individuals for the future, have become so tradition-bound. Dror reiterates: "education has no other important activity to perform, but to shape the future through the process of educating society's future members for their future roles and styles of life."[131]

PART IV

PERSONAL AND PROFESSIONAL OUTLOOKS OF DEANS

The personal and professional outlooks of deans of schools of nursing are obviously influenced by multiple factors. The abundance of references to values in the literature review has convinced the writer that there are numerous variables other than facts which influence an individual administrator or group assisting the administrator in planning priorities, the planning process, and finally in the credence given to the ultimate plan itself.

The importance of values and their role on the impact of long-range planning is repeatedly emphasized. Hussey is emphatic that their existence will influence the success or failure of long-range planning:

> Unless a chief executive has a personal belief in the ability of long-range planning to help improve his results, he should not attempt to introduce it into his organization.[132]

Albright poses the challenge to those in the decanal role: "A most difficult yet essential problem in dealing with alternative futures is to estimate changes in values."[133] When the administrator must set priorities for the uncertain decades ahead, as Albright explains it, "To get from here to there, when 'there' is different from 'here' means that policies must be formulated to effect that desired transition, to govern the future not the past."[134]

The priority of technology on planning is presented by Ackoff:

> The problems we select for solution and the way we formulate them depends more on our philosophy and world view than on our science and technology.[135]

Not all planners and/or administrators are aware or want to accept the importance and value-laden perspective which influences the acceptance or rejection of a plan. They feel much more comfortable and secure with the objective data of figures, charts and graphs.[136] Drucker points out:

> . . . it is not the 'facts that decide;' people have to choose between imperfect alternatives on the basis of uncertain knowledge and fragmentary understanding.[137]

Albright presents the options to the academic administrator:

> Thus, the way, or how, we view the future--whether we want to plan for a future, choose one, invent one, or simply let one happen--will have a great deal to do with the kind of college and university we have to administer.[138]

Nursing, as a major profession in health care, must be more aware of the consequences of action or inaction for planning within the profession and in interdisciplinary functioning.[139] The various levels of education and varying values of health providers are also a source of confusion. Tannen and Liebman discuss the impact of values on planning for health care.

> Health planning is not a neutral force; it serves some parties to the neglect of others. Health planning methods are value-laden instruments used to determine which services should be offered, to whom, and to what degree. The values of both planners and those who implement the final plan are reflected in various parts of the planning process, such as problems definition, priority selection, and the range of alternatives considered feasible.[140]

As has been mentioned in an earlier section, the roles and expectations of the person in the administrative role vary considerably; therefore, the question of who should identify areas for specific planning and how much time should be spent on this activity must be adduced. Albright, in addressing a conference on the decanal role, offers:

> Administration can rightly be expected to spearhead the identification of issues and problems, alternative solutions to them and current or foreseeable institutional shortcomings that are indicated by careful analyses and reviews.[141]

Fuller proposes that the most important and moot question facing administrators and planners is: ". . . Do large academic organizations, characterized by an enormous diffusion of power and decision making, have the ability to direct their destiny?"[142] Weaver points out the extremely long time lag between the initial plan in education and the observation of its impact, adding to the dean's problem of setting time, energy, and resource priorities. The dean must carefully budget all items and justify them to superiors in the university, the legislature, and the

public, as well as to the faculty and students who must live and work with them.[143]

EDUCATIONAL PRIORITIES

As a billion-dollar industry, education has functioned without a great deal of attention to planning, cost analysis, and comprehensive evaluation in past decades.[144] Administrators have weighed the benefits and relevance of programs with "judgment, perception, experience and sometimes luck"[145] as their aid. These traditions no longer are adequate for the increasing cost, declining enrollments, intense competition, and changing environments which are testing the adaptive capacity of administrators and the educational institutions.[146]

Dill cautions that organizational environment is vital to survival. "Some organizations are set up in a way that permits them to respond effectively to new opportunities and challenges, but many are not."[147] The roles and functions of deans will no doubt become more complex in years ahead, Abrell projects, as we move toward the 21st century. It seems certain that dedicated, intelligent, and sensitive educational leaders are destined to experience increased anxiety and stress.[148]

Thompson and McEwen point out that to avoid extinction, one must learn quickly and accurately in order to permit organizational adjustments.[149] Drifting from

one budget-planning period to the next will not suffice. Albright advises: "The formulation of explicit goals and planning will become increasingly important in educational leadership."[150]

Weaver, who has conducted future research, apprises us, "educational thinking must take into account more of the future. . . ."[151] The current priorities may be much more significant for dealing with the crisis of today than the shaping of plans for the decade ahead.[152] Rapidity of change and obsolescence of knowledge and persons will probably increase at an accelerating rate.[153] The knowledge explosion of scientific information and technology has great impact for those who are planning for the education of nurses and their relationship of meeting the societal demands and needs for health care. Schlotfeldt calls attention to the critical need for nursing research for the university schools of nursing:

> The opportunities and challenges facing nursing school deans demand their giving leadership that will be effective in enhancing research efforts in nursing. . . . There is no social agency, other than university nursing schools, charged with responsibility for nursing's future and thus for the conduct of inquiry through which to make advances in knowledge and to verify and restructure the science of nursing.[154]

Nursing and higher education share many similar planning problems, traditions, dilemmas, and shortcomings, as are discussed by Reller and Corbally in Designing Education for the Future:

> Higher education has developed with less coordinated planning than has been the case in elementary and secondary education. Even in elementary and secondary education, however, there has been remarkably little comprehensive research and planned development. The educational system has grown substantially through experience and as a result of pressures to meet growing needs rather than through careful analysis and planning. The resources that have been devoted to planning have been regretably small--and have too frequently been available only for short intensive studies. Thus resources and expertness in planning have been extremely limited.[155]

Insufficient Leadership in Nursing

An eternal cry in nursing is that there is a paucity of leadership--in both nursing service and nursing education. Schaefer emphasizes that it is "nursing's foremost internal problem."[156] As one reviews the literature in higher education, specifically the literature describing how nursing administrators are prepared, one finds few master's programs in nursing administration and no doctoral programs in nursing that explicitly purport to prepare a nursing school administrator. The focus of the few doctoral programs in nursing is research, teaching, and clinical practice. Therefore, the administrative gap is real and not soon to be ameliorated by existing professional doctoral programs.

Preparation of Nursing School Administrators

The earliest documentation of a program to prepare a person for an administrative role in nursing schools is of a course called "Hospital Economics" offered by Teachers College of Columbia in 1899. This course began as a one-year course; a certificate was awarded upon completion. In 1905, the course was extended to two years with a diploma awarded.[157] It is difficult to trace the final stages of the course through the various historical accounts, but since Teachers College later developed a Department of Nursing Education, it was probably included in their curriculum under a different title. During World War I, some departments closed. Christy indicates the influence of the Columbia course: "graduates of the department were occupying positions of leadership in all fields of nursing in most parts of the world."[158]

In 1976 the NLN assisted administrators of nursing schools in better preparation for fulfilling the responsibilities of their role.[159] Schaefer stressed:

> . . . the importance of deans anticipating the impact of future developments, suggested that a pool of managerial talent be created and that special attention be focused on interdisciplinary relations.[160]

Anti-Intellectualism in Nursing

Nursing administrators and educators have to work doubly hard at being accepted in the professional community of practicing nurses. The practicing nurses in service often feel that the faculty is far-off, isolated in an ivory tower above the "real" world, dreaming up far-fetched and unworkable theories. Practicing nurses often feel that caring for patients is what is <u>really</u> important.

This anti-intellectualism is not unique to nursing, but does not make the problem any easier to deal with; in fact it compounds it, according to Sizer, former Dean of Education at Harvard.[161] The conflicting relationship between nursing education and nursing service exists in almost every setting. Some of this conflict is an inherent, antitheoretical, anticonceptual trait that also exists in other disciplines of the so-called, innovators. Even though the university faculty may consider itself avant-garde in curriculum and many of its practices, there are those areas of "vested interest" that are supremely resistant to change even though there is no theoretical rationale for adhering to the past traditional practice.

Sizer expounds on his disappointment in those who "prefer to fiddle with things we understand and can manipulate."[162] This is frequently seen as a method of procrastination, due to inability or fear of proceeding

into the abstract and making a mistake or statement that others may question and/or criticize. It is easier to deal with concrete, overt data than to plan for an abstract and uncertain future of nursing education.

Sizer's comment that "we worship experience," certainly finds a corollary in nursing and nursing education. The hospitals and schools of nursing advertise for those who are "experienced." They must assume that quality is analogous with the quantity of years of work. The status of experience is almost as absurd as the opposite of the requirement of a certain degree to qualify for a position. This relates to Sizer's second frustration, that "education is more than schooling."[163] Because an individual has had ten years of experience, it may not mean that they have learned and grown with this experience each year. It is possible that the individual has had one year of experience ten times. That is to say that they always do things the same way they did them last year.

Sizer's third frustration, "the relative inability of the education profession to connect the ideas of those working on curriculum matters with those involved with policy,"[164] is frequently evident in schools of nursing. This is a recurrent dilemma and exemplifies the administrative-faculty schism caused by inadequate understanding of the pressures upon and expectations of each other for planning.

Barriers to the Advancement of Nursing Education

The advancement of nursing education in status, though still chaotic and multifocused, has historically survived some monumental obstacles. In addition to the distinct disadvantage of being primarily a profession composed of females, nursing has struggled against the physicians (predominantly male) who have vigorously protested the education of nurses in the university setting.[165]

The influential Dr. Charles Mayo of the famous Mayo Clinic believed that nurses spent too much time being educated and not enouth time alleviating the pain and suffering of humankind.[166]

Another barrier is pointed out in a recent article on the status of nursing. The socialization process of nurses (nursing education) "has served to stifle the initiative, creativity, and academic potential of the human resources of the profession."[167]

THE HEALTH CARE DELIVERY SYSTEM, INTERDISCIPLINARY COLLABORATION, CLIENTS, AND FINANCES

In the interest of not boring the reader with repetition, this section will include the next four categories of the health care delivery system, interdisciplinary collaboration, clients changing needs and demands, and finances. Although each possesses some unique

characteristics to be addressed, they will be discussed as a group because they are so intricately inter-related. Most references contain comments which include at least three of the categories in each of their articles. Since the provision of health care requires a complex array of professionals and clients functioning, ideally, collaboratively in what is commonly referred to as the health care delivery system, and because this system is highly dependent on financial incentives, it seems artificial at this point to treat these categories separately. They were separated on the questionnaire for the purpose of insuring that all were included but consideration of them as a group is most feasible here because none exist in isolation.

Claiborne reviews some of the weaknesses of health insurance presently mislabeled because in the majority of cases it is only "sickness insurance," covering no preventive health services. Once again, the choices that must be made are in the hands for the most part of the politicians and those who have power to influence them in enacting the legislation which will allocate the financial resources for health and sickness care programs. The choices are based upon values and priorities of these persons in power since there are not adequate resources to accomplish all projects and potential programs. The ultimate choices must be based upon the realization that:

> No system for meeting people's health needs, indeed no economic system, can do everything for everybody. There isn't that much money in the world. And by choosing to spend the available money in one way rather than another, we are choosing--whether we care to recognize it or not--who shall be sick and who shall not; on the bottom line, who shall live and who shall die.[168]

Matek analyzes American health policy and practices.

> The greatest problems facing us in the proximate future in health or in other fields--are not problems of specific technology. They are matters of allocation and organization--that is, matters ultimately of value, policy and social technique.[169]

Even though modern science and technology have made some of the most impressive accomplishments noted in history, Rogers notes an increasingly evident dilemma of the current system is that:

> . . . we are confronted with a wholly inadequate fit between our fine medical technology and the health requirements of many of our citizens.[170]

Finances are given priority, according to Richie. He opens his article with this statement: "One of the major concerns facing health care providers today is holding down costs."[171]

Finances for illness care receive further attention from Bulger as being a major part of the nation's budget. The control of the purse strings continues to speak:

> . . . it is through the budgetary process that our government gives final expression to significant parts of our philosophy and ethics regarding health care.[172]

The role of clients/patients/consumers in the health care system is changing from that of passive

recipient to active consumer as has been mandated by legislation for planning.[173] Ramey examines some of the causes of the health care crisis, which includes greater demands by consumers and inadequacies of the health care system, in themselves additional expenses, frequently discussed under the name "fragmentation."[174] Again, values are readily apparent in that the areas for which funds are appropriated for research are determined by the value orientations of politicians.[175]

Factors Contributing to Confusion

Confusion exists for numerous reasons. New books and articles are published daily on various aspects of the "health care crisis" focusing on the uses and abuses of the system by both providers and consumers of services. Basically, there is no agreement about the roles and interrelated goals of each professional provider in the system. Many vested interests and power struggles exist in the struggle to decide which profession has control over what piece of the activity. Dachelet presents the nursing point of view in planning:

> It would clearly be folly for planners, administrators, physicians, or government to proceed to restructure elements of the health care system without regard for the internal changes in nursing.[176]

This, however, is not the accepted point of view in all disciplines, especially physicians,[177] and therein lies

much of the conflict undermining the ideal of a collaborative relationship between health care professionals.[178]

The ideals and strengths of the health-care team are frequently dissipated in energy-draining controversies when theoretically the diversity should enhance the quality of planning. Enarson emphasizes that diversity is usually ignored and the trouble with planning is that the problem is too narrowly defined.[179] Hardy also supports the belief that the complexity of the health-care planning process is best implemented by the skills of a team. "For major planning, at least eight to ten disciplines should be readily available to make their special and unique contributions."[180]

Another closely related factor is the lack of a clear definition of health. This is also closely associated with the incorrect, synonomous use of the terms "health care" and "medical care" by many.[181] Conflict continues when medical (illness) care is provided by the physician and the primary focus of nursing is the provision of care to enhance the health or adaptive potential of the individual.[182]

The Dean's Role

Armiger presents an optimistic view of the dean's role in education and as a leader in future nursing practice.

> The Dean of the future will exert leadership in health care delivery as well as in education per se. This will often be achieved indirectly. It will be possible because deans and faculty will have worked through old anxieties about the nursing service--nursing education dichotomy and will be able to begin to identify meaningful interrelations for the clinical practice of faculty.[183]

Armiger's optimism is again obvious in her view that a system of cooperation will exist; the future dean will "administer her school in a new health care delivery system."[184]

Roaden speaks to the dean's role:

> As higher education is being called on to deliver know-how for solving social problems, interdisciplinary efforts outside traditional academic departments are required. These efforts, if they are to be productive, require skillful and insightful leadership from the dean.[185]

Christman, a dean of nursing, refers to the need for planning with other disciplines:

> The future of nursing does not exist in a vacuum but is closely keyed to the developments in the health field in general.[186]

Poulin would also be in agreement with this view:

> The future cannot be considered only within the framework of developments in nursing. The future of our health system will neither be determined by, nor depend on, nurses and the nursing profession alone. It is contingent on a multidisciplinary, provider-consumer approach and will be as sound and progressive as we wish to make it.[187]

Changing Priorities

Margaret Walsh, NLN Executive Director, speaks out:

> It's time to rethink some of your premises when life-saving services are talked about in terms of cost-benefit ratios. . . . We're in the midst of a health care crisis of the greatest magnitude. None of our old ways are working.
>
> I believe nursing holds the solution to all the difficulties we face.
>
> To meet this challenge, we must show through research that nursing care is not only indispensable but also cost-effective. . . . We must impress our theories and values on the system. . . . We must have more nurses in decision making positions. We need nurses in congress.
>
> Our work is cut out for us. But we have a rare opportunity to shape our future roles into whatever professional configurations we deem necessary to meet the nation's health care needs.[188]

The American Nurses Association statement stresses that:

> . . . it will not be possible to deliver quality health services to people [until] the potential for nursing's contribution to the health and well being of people is fully integrated . . . into the U.S. health care system.[189]

The mandates for the health providers to cut costs and provide necessary services has involved the public as potential clients who have an interest in the quality of services as well as the costs. Donabedian points out this is the strength of public input in "that clients and providers do not view that process or the product in the same way."[190]

Such reorganizations in the health care delivery system as the HMO (Health Maintenance Organization) which are a recent change of the past decade in an attempt to provide a more health-focused, economical option for many clients. A major potential threat to their success may be

due to physicians being reluctant to give up their fee-for-service system of functioning autonomously.[191] From the vantage point of nursing, it may provide an increase in the use of nurses to engage in health teaching and preventive care.[192]

As Zasowska points out, technology, humanism, and the health care delivery system are intricately related.

> The emerging priorities of this era--health maintenance, comprehensive health care, and prevention--must be the focus of planning for health care delivery. Technology must serve to improve health conditions and increase options. The educational process must be used to inform people where the quality of life is dependent upon not only personal growth and material possessions, but also on what is done with available resources. Decisions must be made within the range of possible choices. Health education and health services must assume an equally important role in health care delivery.[193]

In summary, one must consider the numerous personalities, values, traditions, and emotions which provide incentives for the provision of cost effective health care for the nation. The evaluation of the HMO will continue but vested interests can impede progress.

> Although it is unlikely that HMO's will replace the current method of health care delivery in the near future, they constitute an important recognition of the deficiencies in the current system and a major attempt to rectify the inadequacies that prevail in the fee for service model.[194]

TECHNOLOGY

Technology in nursing and health care can be a bane or a blessing. Zasowska relates the dilemma:

> A viable future society will have to be humanistically rather than technologically oriented. It is not a question whether we need technology, but rather how and in whose interests it is being used.[195]

Enarson skillfully articulates the complex relationship of technology and personal values.

> . . .tools tend not to be the neutral servants we describe them to be. Techniques and tools are used, always, by persons operating in time, place, circumstance, culture, and power relationships. The tools and techniques are, of course, neutral. But the persons who use them are never neutral, for, as human beings, we have as our burden and our pride the legacy of a congested bundle of ideas, faiths, opinions, preconceptions, goals, and aspirations.[196]
>
> Our tools have special allure for some of us, becoming part of our very identity. (Horse and man combine to make the man different, more powerful.) . . . The computer, brilliant achievement and marvelous toy, has the same capacity to enthrall, captivate, and finally to imprison. And so it is that we witness an excess of faith in the tool and the technique.[197]

Technology has changed much of the day-to-day functioning in many aspects of our lives. There are those who cannot accept the benefits of technology and live in awe and fear that robots will replace them. Malone attempts to allay this fear by examining the potential capabilities and stresses the fact that we still have control over machines.[198]

Values and fears certainly influence the acceptance or rejection of technology as does the way in which one defines technology. It would seem that the broad definition offered by Ferkiss would be more acceptable than a more specific "machine" oriented one.

> Technology includes both methods and machines. . . . a self-conscious organized means of affecting the physical and social environment, capable of being objectified and transmitted to others, and effective largely independently of the subjective dispositions or personal talents of those involved.[199]

Technology in Education and Practice

Schlotfeldt speaks to the multiple uses of technology and gives emphasis to its extreme importance in research which will have profound impact in the future.

> It is important to point out that technology is an important aspect of all professional practice and that professional practitioners are expected to be highly competent, technically. They are also expected, however, to be highly knowledgeable, to be able to use knowledge creatively, to exercise exquisite judgment, and to be visionary with regard to practice and research.[200]

Zasowska views technology as a tool which will assist in improving the health status and also increase our options in education.[201] Technology in education can be viewed as a threat or as much of a benefit as attitudes and values will allow deans and faculty to accept and utilize it in their teaching methodologies. Meadows examines the use of computers in nursing education. To

achieve acceptance of computer-assisted instruction, it is absolutely essential to have administrative support. "In order to achieve this goal the administration must be visionary, willing to take risks and supportive of faculty efforts."[202] Computers have made a definite impact upon many areas in our society. A nurse may find that orientation to her job will in part, be provided by way of a computer terminal . . . as will inservice education, and client education.[203]

Ritvo relates the benefits of planning and notes throughout his acticle that without adequate advance planning beneficial technology may not be appropriately utilized.[204]

Bulger summarizes the situation:

> . . . Afterall, the challenge to the health care system is really the challenge to twentieth century America and perhaps all of modern western civilization, i.e., how to humanize a technocracy in a technocratic society. If we cannot succeed in the serving, caring professions, what hope can there be for the rest?[205]

SOCIETAL CHANGES

In order to cope with or effectively change the directions of societal trends, we need to become a population of planners. Mauksch, in The Future is Now, states:

> Up until now we have not been a planning society. We have been infinitely more prone to put our heads into our hands or into the sand. We have not faced those realities which were indeed foreseeable, let alone cope with those which were perhaps a little more obscure.[206]

Sovie identifies four social factors which she believes have great impact on the way in which nursing will shape its future. They are, "the Women's Movement, consumerism, health planning and policy making, and the knowledge explosion and the learning society."[207]

Closely related to social changes for the roles of women are changes in legislation and politics which are influencing the dynamic impact that women are beginning to have today. In this respect nursing is a very young profession; in addition to coping with the uncertainties and confusion of the profession, the dean of the school of nursing must assist the faculty and students to prepare for an uncertain future.[208]

Politics--A Barrier to Long-Range Planning

The political system contributes to the lack of involvement in long-range planning as indicated by Ramey in that most politicians' actions are focused on re-election rather than on long-range planning and comprehensive implementation of programs with adequate evaluation of the actual goals.[209]

Leininger emphasizes the crucial role of politics and economics in determining health care at all levels: federal, state, and local.[210]

Changing Roles of Politics in Contemporary Society

Anderson discusses political health relationships:

> . . . health care issues are no longer resolved exclusively in the arena of the health care worker. Rather, health care issues are increasingly decided upon in the political arena in competition with other demands related to defense, transportation, commerce, environment, recreation, space, international relations, and the like.[211]

Politics, values, and economics and their influence are discussed by Mac Stravic:

> . . . Ultimately, health needs are determined by an intellectual, and political process which sets and modifies the goals and standards for health services; those goals and standards are then used to guide the development of the health system.[212]

Ashley and LaBelle trace the changing social mission of nursing through the century and question the beneficial influence that specialization has caused for nursing and its influence on health care.[213]

Unrest within the profession and discontent with the role status have prompted some nurses to offer client services through private or independent practice. Dachelet notes the influence of this social change: "Whether or not independent nursing practice spreads is not the significant issue; what is more important to note is the new mood found among nursing professionals."[214] Other educational changes which will influence and be influenced by society are the efforts to establish a common

entry level for the profession and mandatory continuing education.[215]

Social Priorities

Zasowska aptly summarizes lifestyle changes:

> Standards of what is important are changing. Even upper-middle class Americans find that attainment of status and material goals is so relatively easy that the quest for them no longer offers a challenge. People at every level of life are seeking different goals with which are associated higher values. Society is experiencing a change from competitive care to sophisticated concern for self-growth and self actualization. The quality of life is as much a concern as life itself. All sectors of society seek and demand good health care. In the last analysis, this shift in fundamental values is hammering out the social policy regulating health service.[216]

Difficulties and challenges for health professionals are pointed out by Anderson:

> . . . health no longer holds a favored position it enjoyed in the past. There is a need for strong health advocates and organizations who can rekindle the public's interest in human life. The health professional's participation in political activities is an essential extension of his professional life if he hopes to see his values operationalized through the formation of public health policies which foster access to health care and upgrade the quality of health care services for all American citizens.[217]

Vested interests of professionals is referred to by Mac Stravic:

> Health professionals have also raised some valid objections to using need as a basis for planning, the most serious of which concerns its theoretical nature. Professionals are likely to specify needs for health services in excess of what people will ever seek.[218]

The political lobbyists can have a profound influence as related by Anderson.

> The discipline of medicine has had strong legislative advocates, whereas the fields of nursing, social work, and pharmacy, only recently have had strong and organized professional advocates of their causes and concerns.[219]

Social Changes Influencing Nursing Education

> Social changes have had profound effect on higher education. Those of us whose academic careers began in the 1940's and 1950's, for instance, lived in a world where only one-fourth of 18-year olds entered college--a different world from today, where over 40 percent do so. Universities are now mass education systems and fast becoming universal ones.[220]

The changing role of student outlook and involvement in the educational process as well as legal requirements have influenced revision of some traditions and created new tensions for administrators. Fuller relates these changes to planning. Economic, social, and demographic changes have created situations which have promoted the relevance of academic planning.

> Academic planning is indeed gaining currency. However, the meaning of academic planning remains conceptually ambiguous. . . .[221]

Not only nursing is faced with the dilemma of lack of leadership and visionary planning for the future. Reif discusses the need for colleges and universities to anticipate problems rather than responding to them and suggests they might emulate progressive industries who

allocate great sums to advancement through research focused specifically on the future.[222] DeTornyay comments on the dean's role: "The dean's job is to create an effective climate."[223] Albright,[224] deTornyay,[225] and Leininger view the rapid and radical social changes as an indication to the dean for the importance of planning within the profession as well as with other disciplines. Leininger reiterates, "Societal realities are forcing us to be futurists. . . . When sudden changes occur within a planned framework, there tends to be less anxiety than when sudden changes occur within an unplanned framework."[226]

Drucker elaborates on the risk factors which merit consideration in planning for the social uncertainty of the long-range future. He identifies four kinds which would seem to have relevance for the nursing school administrator. They are:

1. The risk one must accept.
2. The risk one cannot afford to take.
3. The risk one can afford to take.
4. The risk one cannot afford not to take.[227]

The mission, values, and priorities of the dean and the school of nursing may vary markedly when using Drucker's four-risk screening criteria. If a planning group used these criteria, possibly they could arrive at agreement and know why they were making one choice over another.

Hesburgh et al. point out some of the dilemmas of education in escaping past traditions and viewing future opportunities for lifelong education. Some view it as a threat but a more positive outlook can be that of seeking knowledge to contribute to both personal growth and to the welfare of society.[228]

A major social factor which has had an impact on the nursing profession is that of the changing role of women in society. Until recently women have not been viewed as being capable of creating new knowledge through research and intellectual exploration.[229] The educational socialization process is vital in that "The quality of our thinking and the quality of our actions are shaped by educational systems."[230]

Educators must learn and teach students to conceptualize the future, as is recommended by a prominent nursing dean:

> Although it is difficult to conceptualize the world of nursing in the year 2000 and beyond, nevertheless it is essential to think about how we believe nursing to be in light of societal changes.[231]

Dubos summarizes the challenge and fascination for the future.

> As long as mankind is made up of independent individuals with free will, there cannot be any social status quo. Men will develop new urges, and these will require ever new solutions. Human life implies adventure, and there is no adventure without struggles and dangers.[232]

SUMMARY

There is a paucity of research directly related to this study. Some of the reasons for this dearth are explored, such as the slow acceptance of futures-oriented research and studies in academia. The issue of long-range planning in relation to the nursing profession and its role in the decades ahead is beginning to receive attention from only a few authors.

Much ambiguity and confusion is associated with the definition and acceptance of planning and plans. The added dimension of time also is open to criticism. Various levels of acceptance, understanding, and ability exist among administrators who use and participate in the planning process. Most authors who discuss management and/or administrative functions seem to agree that planning is the one universal function of the person assuming this role. There are controversies as to the degree of involvement of the administrator as well as the time dimension about how far projections are realistic and economically feasible. The controversial nature of any type of planning is not soon to be resolved as there will always be the traditionalists who will adhere to the nostalgic past and the futurists and restless individuals who are discontent with the status quo. Proponents of long-range planning believe it is an idea whose time has come, whereas the opposition claims it is merely a fad that will pass by.

The roles and functions of the dean of the school of nursing are varied, numerous, and extremely demanding. The nursing school administrator must be a scholar in nursing as well as in administration and higher education to be able to most advantageously cope with the politics of the university system as well as being a leader of the nursing profession, as the largest group of the health care delivery team.

Values are an extremely important factor which influence the planning process, whether it be short- or long-range, or for education, business, or health care delivery. The values and outlook an individual possesses will determine how optimistic or pessimistic he/she is and will thereby influence the degree of futurity evident in the content of the plan.

Planning at any level and any time dimension is an extremely complex process. The interesting paradox exists that while promoting long-range planning on the one hand, it is frequently resisted on the other. Numerous factors influence this resistance. Among them are: personal and professional inertia, vested interests and power struggles, individual insecurity, fear of making mistakes, societal uncertainty, fear of control and/or being controlled, financial emergencies, attitudes, habits, values, attachment to traditions, inability to conceptualize the abstract, philosophical myopia, being accustomed to the

"hustle and bustle" activities (Gresham's Law), enthrallment with technology and tools, fascination with an abundance of facts and an "analysis paralysis," lack of facts and evidence, inappropriate use of data, complex political processes, sexism, changing social priorities, professional parochialism, present-oriented time perspectives, and action-oriented persons versus knowledge-oriented persons.

When examining the consequences of a plan, it is frequently difficult to determine whether a given factor, event, or condition was the primary or secondary factor which hindered or facilitated an occurrence, since the variables are intricately interrelated. The persons evaluating the change are also entering the environment from a different perspective than the planners may have intended initially.

In the past, the health care delivery system was not planned with the client's/patient's best interests always in central focus. A plethora of professional and lay articles on the current health care crisis are available. Most frequent criticisms of the health care delivery system concern the extremely high costs for inadequate or impersonal services. The present system is not effective; it is even more complex to determine which professions should change or expand their roles and functions. A societal change that has recently influenced

planning is the changing role of consumers/clients who are now represented on numerous planning boards and committees.

Another major societal change that cannot be overlooked, especially in relation to the nursing profession, is the changing role of women. The sexism that has been a hindrance to much of the progress within the profession has influenced how nurses view their longevity and commitment to the profession. The position of being a female dean in the primarily male world of academia is extremely challenging. The dean's role requires an enormous amount of fortitude to maintain a balance of priorities between superiors who make demands and subordinates who look to the dean for leadership, scholarship, and support. Rapid changes in knowledge, technology, and society demand a discerning ability to plan for both a school and a profession which will not be obsolete tomorrow.

Chapter 2

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[222]F. Reif, "Where are the Leaders in Higher Education?" Chronicle of Higher Education, Vol. 14, No. 24 (February 28, 1977), p. 32.

[223]de Tornyay, p. 193.

[224]Albright, p. 37.

[225]de Tornyay, p. 193.

[226]Leininger in Chaska, p. 382.

[227]Peter F. Drucker, Managing for Results (New York: Harper & Row, 1964), p. 206.

[228]Theodore Hesburgh, Paul A. Miller and Clifton Wharton Jr., Patterns for Lifelong Learning (San Francisco: Jossey Bass, 1973), p. 59.

[229]Ashley and LaBelle, p. 51.

[230]Ibid., p. 55.

[231]Leininger in Chaska, p. 380.

[232]Rene Dubos, Mirage of Health (Garden City, New York: Anchor Books, 1959), pp. 227-228.

Chapter 3

DESIGN OF THE STUDY

Problem Statement

The major problem focus for this study was to ascertain baccalaureate nursing-school administrators' perceptions of selected aspects of long-range planning for nursing and nursing education.

Design

To collect the appropriate data as defined by the problem statement of this study, that of obtaining nursing-school administrators' perceptions of long-range planning, it was determined that survey research was the most suitable design. Kerlinger agrees that survey research is appropriate to collection of data pertaining to "personal and social facts, beliefs and attitudes."[1]

Kerlinger further discusses the relation of various functions of research to the purposes of this investigation, namely, practical and heuristic values, and formation of a basis for further research.[2]

Warwick and Lininger compare various methods and conditions for accomplishing research goals. The purpose and conditions of this study qualify for the method of choice for survey research in that the type of data, the

familiarity of the respondents with the information requested, and the researcher's knowledge of the problem are all appropriate and met.[3]

It was explained in the cover letter to the administrators that the study was intended to have both practical and heuristic value. As to the purpose of providing practical information for long-range planning, it was explained that the data collected would provide deans with some degree of insight into how their perceptions compared with those of other respondents in the study and would highlight areas where further research efforts might be directed in the future. Warwick and Lininger discuss the survey design and state that it can:

> . . . Lay the ground work for the pursuit of other objectives, including explanation and hypothesis testing, evaluation, prediction, and the development of indicators.[4]

Because this was a descriptive study, no hypotheses were posed or tested. Instead, this investigation attempted to ferret out topics or questions for further research with data which challenge or verify previous trends or projections. It was intended that the heuristic aspect be realized in delineation of more specific, researchable problems for subsequent studies which would contribute to more, sophisticated, theoretical formulation focusing on long-range, futuristic issues in nursing and nursing education.

Population

The target population for this investigation was the deans and directors of the accredited baccalaureate nursing programs in the United States. It was assumed that members of this group, although very busy people, would reply at a high rate as demonstrated by the leadership, scholarship, and research responsibilities inherent in their positions.

It was decided that to eliminate sampling error and to have a potentially more meaningful and useful study, the entire population of deans and directors should be included in the study. Since the group of deans was assumed to be a rather homogenous group having small differences in perceptions in many areas, it was advisable to survey as large a group of respondents as possible.[5] Because a mailed questionnaire was used as the data collection instrument, the expense of including all 286 potential respondents was not prohibitive.

The Instrument

The mailed questionnaire was an obvious choice of data collection instrument for this group of individuals located throughout the United States. (See Appendix A.)

The cover letter encouraged the participation of the deans and directors and indicated the purposes and potential benefits of the study for the improvement of the

nursing profession. (See Appendix A.) Also, the respondents were offered a summary of the study results upon request. The cover letter requested that the nursing school administrator complete the questionnaire rather than delegate the task to another administrator or faculty member. This was done to provide for more meaningful results that would be of greater usefulness to the profession.

The conceptual content areas of the study, in addition to selected demographic data, were divided into eight major categories and included at various points in six major sets of questions. The eight major categories of content included were:

1. personal and professional outlooks of deans, including values and priorities
2. educational priorities and changes for nursing and nursing education
3. the changing health-care delivery system
4. interdisciplinary collaboration
5. client control and demands
6. finances, including politics and legal controls
7. technological changes
8. sociological changes, value shifts, and national priorities

These categories of content were explored in the literature and found to be intricately related to the

planning process in which the nursing school administrator participates. Further, the content of these categories was found to have great impact on decisions influencing both short- and long-range planning in nursing and nursing education.

A brief description of the instrument follows:

Question Set A consisted of ten items of demographic data, included as a basis for determining the generalizability of the results and for identifying a profile of the respondents.

Question Set B was composed of eight statements regarding long-range planning to which the respondent was requested to reply according to his/her extent of agreement from very strong agreement to strong disagreement.

Question Set C included nine selected statements representing current issues and dilemmas confronting the nursing profession. The responses were requested to be made according to the nursing school administrator's perception of their importance, urgency, and degree of progress by 1990.

Question Set D attempted to ascertain the respondent's agreement or disagreement with twelve trends and/or potential changes in nursing education and health care delivery by 1990.

Question Set E consisted of a series of twelve adjective pairs on a seven-point scale in the Semantic

Differential format to elicit attitudes toward the stimulus phrase, "long range planning."

Question Set F was intended to elicit responses to a twenty-one item list of persons, groups, and factors that may influence nursing education and practice. It was requested that responses be made according to the dean's perception of the degree of influence that the persons, groups, or factors should have on nursing by 1990; and secondly, perceptions according to the influence these persons, groups, and factors will probably have on nursing by 1990.

Question Set G requested the dean's perceptions of twenty-two items consisting of persons, events, conditions, and policies that hinder or facilitate long-range planning and that are presently taking place in his/her school of nursing. The responses were constructed on a seven-point scale from one, hindrance, through four, neutral, to the highest point of facilitation, seven.

Question Set H consisted of one open-response question asking the length of time for which the school plans. This question provided a quantified, practical definition of planning for that school.

Pilot Test

The pilot test of the instrument was administered to a group of nurses who were similar to the target population and others with special expertise in the

research process. The purposes of the pilot test were to determine the clarity of instructions and questions, content validity, face validity, appropriateness of length, and to provide an estimate of the amount of time required for completion of the questionnaire.

Data Collection

The questionnaires were mailed to 286 deans (nursing school administrators) of accredited baccalaureate schools of nursing in the United States during the winter of 1978. Names and addresses of these persons were obtained from the National League for Nursing's publication, Baccalaureate Education In Nursing.[6]

The instrument was reproduced on green, standard-size paper. The cover letter was typed on white paper and attached to the front of the questionnaire. These items were enclosed with a hand-stamped, self-addressed envelope.

The questionnaires were coded to determine who had responded and after three weeks a postcard reminder was sent to the non-respondents. (See Appendix B.) After two additional weeks, another questionnaire packet was mailed to the non-respondents.

Analysis of Data

Returned questionnaires were edited for usefulness and notations were made regarding those who had sent requests for a summary of the results. There were 214

(74.8%) useable questionnaires returned in time for analysis. These questionnaires were sent to key-punch facilities where the data were transferred to computer cards and verified prior to computer analysis.

Descriptive statistics and selected procedures were performed through use of the Statistical Package for the Social Sciences (SPSS).[7]

Summary

In summary, the design of this investigation, to be accomplished through a mailed questionnaire, was considered a realistic and economically feasible approach for accomplishing the established purposes of this descriptive study. The research was designed to establish a basis for development of further inquiry and to provide practical information to members of the profession about the perceptions these deans had of long-range planning for nursing and nursing education.

Chapter 3

FOOTNOTES

[1]Fred N. Kerlinger, Foundations of Behavioral Research (New York: Holt, Rinehart and Winston, Inc., 1973), p. 422.

[2]Ibid., p. 7.

[3]Donald P. Warwick and Charles A. Lininger, The Sample Survey: Theory and Practice (New York: McGraw Hill, 1975), p. 9.

[4]Ibid., p. 49.

[5]Walter R. Borg and Meredith D. Gall, Educational Research (New York: David McKay Company, Inc., 1971), p. 123.

[6]Division of Baccalaureate and Higher Degree Programs, Baccalaureate Education in Nursing: Key to a Professional Career in Nursing 1977-78 (New York: National League for Nursing, 1977).

[7]Norman Nie et al., Statistical Package for the Social Sciences, 2nd ed. (New York: McGraw Hill, 1975).

Chapter 4

ANALYSIS OF DATA

The purpose of this chapter is to present results of the survey of baccalaureate nursing school administrators who responded to a mailed questionnaire regarding their perceptions of long-range planning for nursing and nursing education.

Part I of this chapter contains a demographic profile of the respondents and related background data from Question Set A of the questionnaire.

Part II contains a presentation of each set of the questions, pointing out major notable findings, and is followed by tables displaying a summary of the responses to items with means and standard deviations. In explanation of tables "term" and "statement" are used interchangeably. The raw data for each question set will be found in Appendix C.

Response Rate to the Questionnaire

In Table 1 a summary of the response rate to the questionnaire can be found. The total usable number of questionnaires was 214 (74.8%). Three questionnaires (1.9%) were received too late for analysis and three were presumed to have been lost in the mail. Eighteen (6.3%) were returned unanswered with various notes of apology,

most mentioning the lack of time available as reason for not participating in the study. Only 48 (16.78%) of the target population did not respond.

Table 1

Summary of Response Rate to Questionnaire

Status of Questionnaire	Frequency	Percent
Usable questionnaires returned	214	74.82
Returned too late for analysis	3	1.04
Returned unanswered	18	6.29
Lost in mail	3	1.04
No reply	48	16.78
Total sent	286	99.97

PART I

RESPONSES TO QUESTION SET A

Types of Institutions Represented by Respondents

Table 2 shows the number of respondents from public or private institutions and subdivides them into colleges and universities. By far the largest group, 99 of the respondents (46.3%), were from public universities. The next most frequently represented group was private colleges with 56 (26.2%) responding. They were followed by the private universities represented by 42 respondents (19.6%). The smallest group of respondents was from public colleges. Their numbers totalled 17 (7.9%). As could be expected, because of a larger potential target population, the public institutions were represented 8.5 percent more frequently than private institutions.

Full Time Equivalent (FTE) Enrollment

The FTE enrollment of the schools represented is presented in Table 3. The majority, 121 (61.3%) of the schools, were indicated to possess a FTE enrollment of 100-399 students. There were 50 (23.4%) with 500 or more FTE students. The largest sub-category was composed of 49 schools (22.9%) with 200-299 students. Only 6 administrators were from schools which (2.8%) had fewer than 100 FTE students.

Table 2

Total Responses to the Question: Which is the Type of Institution in Which You Are Currently a Nursing School Administrator?

Type of Institution	University		College		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Public	99	46.3	17	7.9	116	54.2
Private	42	19.6	56	26.2	98	45.7
Total	141	65.9	73	34.1	214	99.9

Table 3

Total Responses to the Question:
What is the FTE Enrollment in
your Baccalaureate Program?

FTE Enrollment in Baccalaureate Program	Frequency	Percent
1 - 99	6	2.8
100 - 199	44	20.6
200 - 299	49	22.9
300 - 399	38	17.8
400 - 499	23	10.7
500 or more	50	23.4
No Response	4	1.9
Total	214	100.0

Regional Locations of Respondents

The frequency and percentage of total respondents found in nursing regional locations are presented in Table 4. The largest group of respondents was from the Midwest Alliance, 66 (30.8%); followed by the Southern Region (SREB) with 58 (27.1%); the New England Region (NERB) with 46 (21.5%); lastly the Western Region (WICHEN) with 31 (14.5%) and no response from 13 (6.1%).

Since it was apparent that not all of the states were included in the original nursing regions as presented in the questionnaire in Question A-3, the code numbers of the respondents were compared with the geographical locations of the target population, which included all states. This percentage of respondents by region compared with the target population is presented in Table 5. To preserve the anonymity of the respondents a more specific classification (such as individual states) is not revealed, but the percentages of the respondents were compared with the target population for generalizability by geographical location. Utilizing a regional breakdown of Midwest (80%), North Atlantic (73.3%), South (73.2%), and West (71.1%), all of the states were included. The percentages show a very close rate of return by region with the Midwest being slightly higher than the other three regions.

Table 4

Total Responses to the Question:
Which is Your Regional Location?

Regional Location	Frequency	Percent
SREB	58	27.1
NERB	46	21.5
Midwest Alliance	66	30.8
WICHEN	31	14.5
No Response	13	6.1
Total	214	100.0

Table 5

Return of Questionnaires from Respondents by Region Compared with the Target Population

Regions	Number Questionnaires Sent	Number Questionnaires Returned	Percent Questionnaires Returned
Midwest	80	64	80.0
North Atlantic	75	55	73.3
South	86	63	73.2
West	45	32	71.1
Total	286	214	

Title of Administrative Position Held

Table 6 readily demonstrates that the majority of the nursing school administrators, 109 (50.9%), held the title "dean." A smaller number, 80 (37.4%), were called "chairperson." Twenty (9.3%) had the title "director." Two other titles, "head" and "coordinator" were used by one respondent each (0.5%), and two respondents (0.9%) possessed the title "president" in their position.

Length of Time Respondents Have Held Their Position

The length of time the respondents have held their positions is displayed in Table 7. The majority was six years or less by 156 (72.9%). The two largest subgroups were the "less than one year" group and the "1-3 years" group, represented by 53 (24.8%) and 54 (25.2%) respondents respectively. A close third was the "4-6 years" subgroup represented by 49 respondents (22.9%). The next largest subgroup, 26 (12.1%) have held their positions for "7-9 years." Twenty respondents (9.3%) had been in their positions for "10-12 years." Only eleven respondents (5.1%) had been in the administrative position for thirteen or more years.

Ages of Respondents' Programs

The ages of the respondents' programs are displayed in Table 8. The ages did not cluster, but covered a wide

Table 6

Total Responses to the Question: What is the Primary Title of the Administrative Position you Hold at Present?

Title of Administrative Position Held	Frequency	Percent
Dean	109	50.9
Chairperson	80	37.4
Director	20	9.3
Head	1	.5
Coordinator	1	.5
President	2	.9
No Response	1	.5
Total	214	100.0

Table 7

Total Responses to the Question:
How Long Have you Held
this Position?

Length of Time in Position	Frequency	Percent
Less than 1 year	53	24.8
1 - 3 years	54	25.2
4 - 6 years	49	22.9
7 - 9 years	26	12.1
10 - 12 years	20	9.3
13 or more years	11	5.1
No Response	1	.5
Total	214	100.0

Table 8

Total Responses to the Question:
What is the Age of the
Baccalaureate Program
Where you are Currently
Employed?

Age of Program	Frequency	Percent
5 years or less	15	7.0
6 - 10 years	58	27.1
11 - 15 years	25	11.7
16 - 20 years	15	7.0
21 - 25 years	34	15.9
26 - 30 years	23	10.7
31 or more years	41	19.2
No Response	3	1.4
Total	214	100.0

span; however, the youth of the profession is evident in that 73 programs (34.1%) were less than ten years old.

The second largest grouping of respondents' programs in the twenty-one to thirty years combination received 57 responses (26.6%). There were 41 programs (19.2%) which were thirty-one or more years old. The next grouping, eleven to twenty years, was composed of 40 (18.7%) of the respondents' programs.

Title of the Person (Superior) to Whom the Nursing School Administrators Report

The title of the person to whom the nursing school administrators report is presented in Table 9. The person (superior) to whom the nursing school administrators report was most frequently a vice-president for 80 respondents (37.4%), followed closely by a certain type of dean which was identified by 73 respondents (34.1%). Twenty-one respondents (9.8%) reported to various superiors in the "Other" category, followed by 16 (7.5%) who reported to a provost and 10 (4.7%) who reported to a president. Only 8 respondents (3.7%) reported to a chancellor.

Ages of Nursing School Administrators

The ages of the nursing school administrators are displayed in Table 10. The age range "51-55" included the largest subgroup of respondents, 54 (25.2%). The majority, 128 (59.8%), were between the ages of 46 and 60 years.

Table 9

Total Responses to the Question:
What is the Title of the Person to Whom you Report?

Title of Person (Superior)	Frequency	Percent
President	10	4.7
Vice-president	80	37.4
Provost	16	7.5
Dean of	73	34.1
Chancellor	8	3.7
Other	21	9.8
No Response	6	2.8
TOTAL	214	100.0

The second largest subgroup of 55 respondents (25.7%) was composed of the age range 36-45, followed by equal-sized groups (12 respondents or 5.6%) of the youngest in the 30-35 age range, and the oldest in the 61-65 age range. Only one person indicated that they were in the "66 or over" age group.

Sex

Table 11 illustrates the obvious fact that the group was overwhelmingly female 207 (96.7%) with only 4 of the respondents (1.9%) identified as male.

Highest Earned Degree

The highest earned degree of the respondents is shown in Table 12. It was clear that the majority, 146 (68.2%), have earned a doctoral degree. All held degrees above the baccalaureate level, 64 (29.9%) indicated that they held a masters degree followed by 2 (0.9%) in the "other" category.

Summary

A typical respondent; was a female, from a public university, held a doctoral degree, was in the age range 46-50, from a school of 100-399 FTE students, reported to a vice-president, and had held the administrative position less than 6 years.

Table 10

Total Responses to the Question:
What is your age as of Your Last Birthday?

Age of Administrator	Frequency	Percent
25 - 30 years	2	.9
31 - 35	12	5.6
36 - 40	30	14.0
41 - 45	25	11.7
46 - 50	36	16.8
51 - 55	54	25.2
56 - 60	38	17.8
61 - 65	12	5.6
66 or over	1	.5
No Response	4	1.9
TOTAL	214	100.0

Table 11

Total Responses to the Question:
Which is your sex?

Sex	Frequency	Percent
Male	4	1.9
Female	207	96.7
No Response	3	1.4
TOTAL	214	100.0

Table 12

Total Responses to the Question:
What is your Highest Earned Degree?

Highest Earned Degree	Frequency	Percent
Baccalaureate	0	0
Masters	64	29.9
Doctorate	146	68.2
Other	2	.9
No Response	2	.9
TOTAL	214	100.0

PART II

PRESENTATION OF FINDINGS

Responses According to Extent of Agreement About Long-Range Planning

Question Set B included the deans' personal and professional outlooks for nursing and nursing education as well as interdisciplinary collaboration.

The responses to Question Set B are ranked from highest to lowest according to their mean scores as shown in Table 13.

It was evident that the deans strongly agreed with the majority of the eight statements and most of all with "Long-range planning is becoming crucial to the nursing profession." The statement received the highest mean score of (4.64) out of the highest possible score of (5.00).

The statement which received the lowest mean score (2.50) was: "Long-range planning is adequate in my school at present," placing it between the "somewhat agree" and "strongly agree" categories.

For the most part, the future-focused statements (those with "should") were ranked higher (second, third, fourth and sixth) than the present-focused statements (those with "is"), receiving ranks by mean scores in first, fifth, seventh, and eighth places.

In summary, the deans have indicated that they believe very strongly in the importance of long-range

Table 13

Rank, Standard Deviation, and Means* of Responses According to Extent of Agreement About Long-Range Planning

Statement	Rank	Means*	S.D.
Long range planning is becoming crucial to the nursing profession	1	4.64	0.55
Nursing school administrators should participate in long range planning with other nursing schools in my region	2	4.46	0.68
Nursing school administrators should participate with other health care faculty in the region for long range planning	3	4.44	0.66
Long range planning should be one of the primary activities of the nursing school administrator	4	4.20	0.86
Long range planning is high on my personal list of activities for the school	5	4.01	0.92
Long range planning should be more actively pursued in my school	6	3.90	1.13
Long range planning is high on my institution's list of priorities for all programs	7	3.56	1.05
Long range planning is adequate in my school at present	8	2.50	1.19

*Means are based on scale of one being most disagreement, to five being the most agreement.

N = 214

planning also realizing that it is not as adequate as they would desire in their schools.

Issues Confronting the Nursing Profession According to Importance, Urgency, and Degree of Progress by 1990

Table 14 introduces the responses made to statements in Question Set C. The format is presented according to ranked means and standard deviations for the nine statements on issues confronting the nursing profession according to importance, urgency, and degree of progress by 1990.

The ranking of the means according to importance and urgency agreed closely; however there were greater differences in ranking according to the degree of progress by 1990. There were two items which received the same ranking of eight and nine in each of the three areas of importance, urgency, and degree of progress. These were: "Interdisciplinary student education with nursing, medicine, and pharmacy" with mean scores of (3.48), (3.30), and (3.71) respectively, and "Educational preparation for independent nursing practice at baccalaureate levels" at (3.09) importance, (3.00) urgency, and (3.45) for degree of progress by 1990.

One item, "Agreement on levels of preparation for entry to professional nursing practice," received the same or first ranking, (4.76), for importance and (4.28) for

degree of progress by 1990, and second ranking, (4.67), on urgency.

Two items received equal rankings for importance and urgency. Receiving third rank, (4.47) and (4.17) respectively in these two areas, was the statement, "Nurses and physicians functioning as colleagues," and receiving sixth rank (3.85) for degree of progress by 1990.

The seventh ranked item, "Continuing education credits for relicensure," received (3.81) for importance and (3.66) for urgency. This item ranked second (4.19) for the degree of progress by 1990.

The item, "Direct payment to nurses for services rendered," was fourth ranked equally for both urgency (4.16) and for degree of progress by 1990 (4.10). This item received fifth rank (4.27) in importance.

The item which received the most variation in ranking in the three categories of importance, urgency, and degree of progress by 1990, was "Clarification and agreement on the goals and direction of professional nursing by the majority of the profession," being ranked second (4.75), first (4.70), and seventh (3.72), respectively.

The remaining two statements fluctuated at midpoint rankings. The fourth ranked statement (4.31) on importance: "Colleague relationship with health professionals other than physicians" was sixth (4.03) on urgency and fifth (4.09) for degree of progress by 1990.

The sixth rank statement on importance (4.21), "Separate state board exams for the designated levels of education," was fifth (4.14) on urgency and third (4.11) on degree of progress.

Summary

The issue of agreement on levels of preparation for entry to professional practice was perceived as being of high importance, urgency and that there was optimism that progress will be made toward resolution of the problem by 1990. Clarification and agreement on goals of the profession was perceived with highest priority on urgency, but the possibility of progress being made by 1990 was not nearly in as high agreement.

Other issues of interdisciplinary functioning and educational change, fee structure are all perceived with lesser importance, urgency, and lesser degrees of optimism for change.

Amount of Agreement With Trends/Potential Changes in Education and Health Care Delivery by 1990

Responses to Question Set D are included in Table 15 which is a presentation of the ranks by mean scores and standard deviations of responses to twelve trends/potential changes in nursing education and health care delivery. For ease of comparison the two areas are ranked and discussed separately.

Table 14

Rank, Standard Deviation, and Mean Score on Statements of Issues Confronting the Nursing Profession According to Importance, Urgency and Degree of Progress by 1990

Statement	Importance			Urgency			Degree of Progress		
	Rank	Means*	S.D.	Rank	Means**	S.D.	Rank	Means***	S.D.
Agreement on levels of preparation for entry to professional nursing practice.	1	4.76	0.56	2	4.67	0.63	1	4.28	0.71
Clarification and agreement on the goals and direction of professional nursing by the majority of the profession.	2	4.75	0.50	1	4.70	0.57	7	3.72	0.90
Nurses and physicians functioning as colleagues	3	4.47	0.66	3	4.17	0.85	6	3.85	0.76
Colleague relationship with health professionals other than physicians	4	4.31	0.77	6	4.03	0.90	5	4.09	0.61
Direct payment to nurses for services rendered	5	4.27	0.88	4	4.16	0.89	4	4.10	0.74
Separate state board exams for the designated levels of education	6	4.21	1.09	5	4.14	1.05	3	4.11	0.83
Continuing education credits for relicensure	7	3.81	1.03	7	3.66	1.07	2	4.19	0.91
Interdisciplinary student education with nursing, medicine, pharmacy	8	3.48	1.04	8	3.30	1.04	8	3.71	0.65
Educational preparation for independent nursing practice at Baccalaureate levels	9	3.09	1.33	9	3.00	1.28	9	3.45	0.98

N = 214

*Mean based on scale of one being least important to five being most important.

**Mean based on scale of one being no urgency to five being extremely urgent.

***Mean based on scale of one = Became a greater problem
two = Became obsolete
three = No change from 1978
four = Progress being made
five = Resolved satisfactorily

Nursing Education

There was strong agreement on four of the five items with the highest ranked item (4.76), "Baccalaureate degree as the initial requirement for all professional nurses," indicated by 179 (83.6%) of the respondents. Items ranked second, third, and fourth deal with trends in baccalaureate, masters, and doctorate level education. The second and third items, "Baccalaureate education with a generalist focus" and "Specialization at the masters level," are almost identical in their mean scores, (4.55) and (4.54) respectively, while there is less agreement (4.06) with "Specialization at the doctoral level," although still qualifying for "strongly agree."

The lowest or fifth ranked item in this section (3.65) falls at midpoint between "somewhat agree" and "strongly agree" being: "Educational mobility allowing more orderly advancement from technical to professional education."

Summary

Strong agreement exists for the initial preparation of the professional nurse. However, the focus of higher educational programs has slightly less agreement, but the route to obtain this education is perceived with much less agreement.

Health Care Delivery

Seven statements focused on health care delivery. The highest ranked statement (4.70) "Focus on preventive rather than crises care" was in "very strong agreement" by the deans.

The second highest ranked item (4.59) related to "More health care taking place in the home under the guidance of nurses."

It is of interest to compare items ranked third (4.46) and the lowest of the seven statements (3.36) which focused on use of technology. The deans were in much more agreement with, "More effective utilization of technology which will make the cost of health care affordable to all" as contrasted to "Automated physical diagnosis that is client initiated and operated."

"Strong agreement" was indicated (4.38) for "Baccalaureate nurses providing the majority of care in ambulatory centers with referral to other health care workers as needed."

"Provision of mobile care vans for those unable to travel" was ranked as fifth of the seven statements by its mean score of (4.20) placing it in "strong agreement."

The sixth ranked statement received a mean score of (3.87) which pertained to "Consolidation of current hospitals into regional centers" qualifying it in the "somewhat agree" category.

Table 15

Rank, Standard Deviation and Means* of Responses To Amount of Agreement with Trends/Potential Changes in Education and Health Care

Statement	Rank	Means*	S.D.
Nursing Education			
Baccalaureate degree as the initial requirement for all professional nurses	1	4.76	0.66
Baccalaureate education with a generalist focus	2	4.55	0.79
Specialization at the masters level	3	4.54	0.80
Specialization at the doctoral level	4	4.06	1.21
Educational mobility allowing more orderly advancement from technical to professional education	5	3.65	1.21
Health Care Delivery			
Focus on preventive rather than crises care	1	4.70	0.54
More health care taking place in the home under the guidance of nurses	2	4.59	0.54
More effective utilization of technology which will make the cost of health care affordable to all	3	4.46	0.78
Baccalaureate nurses providing the majority of care in ambulatory centers with referral to other health care workers as needed	4	4.38	0.82

Table 15 (continued)

Statement	Rank	Means*	S.D.
Health Care Delivery (Continued)			
Provision of mobile care vans for those unable to travel	5	4.20	0.79
Consolidation of current hospitals into regional centers	6	3.87	0.97
Automated physical diagnosis that is client initiated and operated	7	3.36	1.02

*Means are based on the scale of one being the most disagreement, to five being the most agreement.

N = 214

Summary

There was strong agreement on the change of health care delivery to a preventive focus but much less agreement on the role of the client in initiating an automated device to obtain a physical diagnosis.

Responses to the Stimulus Phrase, "Long-range Planning"

Responses to Question Set E are displayed in Table 16. This question set consisted of twelve adjective pairs to which the deans were asked to respond according to their perceptions toward the stimulus phrase, "Long-range Planning." The scale for this question extended from a low of one (Negative) to the highest possible of seven (positive) with four being considered neutral.

The adjective pairs primarily focused on financial, personal, and professional perceptions of the respondents.

Only two adjective pairs received mean scores in the negative range (below four). These were given for "Difficult" (2.53) and "Expensive" (3.23).

Only one mean score (4.79) was classified in the neutral area in response to "Constrained" versus "Free."

The remaining nine adjectives received responses on the positive side of neutral ranging from the lowest (5.05) for "Successful" to the highest (6.37) for "Useful." Therefore, the respondents perceive long-range planning to be: "Useful" (6.37); "Stimulating" (6.12); "Positive" (5.99); "Rewarding" (5.84); "Meaningful" (5.75);

Table 16

Ranks, Standard Deviations, and Means* of Responses to Phrase "Long Range Planning"

Negative	Positive	Rank	Means*	S.D.
Worthless	Useful	1	6.37	1.09
Boring	Stimulating	2	6.12	1.03
Negative	Positive	3	5.99	1.56
Unrewarding	Rewarding	4	5.84	1.19
Meaningless	Meaningful	5	5.75	1.54
Not Enthusiastic	Enthusiastic	6	5.61	1.46
Incompetent	Competent	7	5.51	1.17
Inexperienced	Experienced	8	5.23	1.53
Unsuccessful	Successful	9	5.05	1.18
Constrained	Free	10	4.79	1.55
Expensive	Inexpensive	11	3.23	1.51
Difficult	Easy	12	2.53	1.43

*Means are based on a negative to positive scale (one being negative, four being neutral, and seven being the most positive).

N = 214

"Enthusiastic" (5.61); "Competent" (5.51); "Experienced" (5.23); and "Successful" (5.05).

Summary

The deans showed enthusiasm toward long-range planning in that they perceived it to be highly useful but were also realistic as to its difficulty and expense entailed. Neutrality was expressed on the issue of its constraints as compared to freedom.

Persons/Groups/Factors That May Influence Long-range Planning for Nursing and Nursing Education

Table 17 displays twenty-one statements in order of mean scores with standard deviations according to the degree of influence the persons/groups/factors should have contrasted with the ranks of the amount of influence they will have on nursing and nursing education by 1990. Question Set F was based on a five point scale, the highest degree of influence being five.

The most readily apparent observation that no agreement was expressed in the ranking by means for any of the statements in relation to the degree of influence they should have and will have by 1990.

The deans perceived that they should have extremely high influence (4.59) whereas the mean score rank for the degree of influence they will have was ranked fifth or (4.00).

Second, to the deans, "Teaching faculty in graduate programs" should have next highest influence (4.54) but ranked fourth (4.13) in amount of influence they will have.

"Faculty teaching in baccalaureate programs" received the third highest mean score (4.36) in regard to influence it should have while being ranked seventh (3.76) in degree of influence it will have.

The "ANA" was fourth ranked (4.28) for influence it should have versus fourteenth (3.48) for influence it will have.

"Nursing research" ranked fifth (4.25) for influence it should have while eighteenth (3.34) in degree of influence it will have.

Sixth ranked (3.96) in influence they should have were "Clients (the general public)" while being ranked nineteenth (3.19) in degree of influence they will have.

The "NLN" ranked seventh (3.95) in degree of influence it should have and tenth (3.61) in degree of influence it will have.

"Directors of nursing service in community health agencies" received eighth rank (3.89) for degree of influence they should have and seventeenth (3.43) for degree of influence they will have.

Ninth ranked by mean (3.84) for the degree of influence they should have were "Directors of nursing service in hospitals" while ranking eleventh (3.56) in degree of influence they will have.

"Interdisciplinary teams" ranked tenth (3.71) for degree of influence they should have and ranked twentieth (3.14) for the degree of influence they will have.

The eleventh ranked item (3.55) for degree of influence it should have was "The high cost of health care" while being ranked first (4.39) in degree of influence it will have.

"Nursing students in baccalaureate programs" were ranked twelfth (3.54) for degree of influence they should have while being twenty-first (3.07) in degree of influence they will have.

"State higher education coordinating boards" were ranked thirteenth (3.53) in degree of influence they should have whereas they received ninth rank (3.64) in degree of influence they will have.

The statement which received the closest rankings for both should and will was "State boards of nursing" which ranked fourteenth (3.52) in degree of influence they should have contrasted to being ranked fifteenth (3.45) in degree of influence they will have.

"National legislation" ranked fifteenth (3.30) in degree of influence it should have and third in degree of influence (4.22) it will have.

"The high cost of education" ranked sixteenth (3.25) in degree of influence it should have and second (4.28) in degree of influence it will have.

"State manpower planning agencies" ranked seventeenth (3.21) for degree of influence they should have while being ranked eighth (3.67) for degree of influence they will have.

"State legislation" ranked eighteenth (3.19) for degree of influence it should have and sixth (3.97) for degree of influence it will have.

"Foundation and grant sources" ranked nineteenth (3.03) in degree of influence they should have and twelfth (3.54) in degree of influence they will have.

The twentieth ranked item was "Non-nurse professional planners" (2.71) for the degree of influence they should have in contrast with being ranked sixteenth (3.45) for the degree of influence they will have.

Ranked twenty-first were "Hospital administrators" (2.51) for the degree of influence they should have and thirteenth (3.48) for the degree of influence they will have.

Summary

The persons/groups/factors which should have and will have influence on long-range planning were indeed a contrast. Persons (deans and faculty) and professional nursing organizations should have influence but costs and legislation will have the greatest influence on long-range planning.

Table 17

Ranks, Standard Deviation, and Means* to Statements According to Degree of Influence Persons/Groups/Factors Should Have and Will Have by 1990

Statement	Degree Influence Should Have			Degree Influence Will Have		
	Rank	Means*	S.D.	Rank	Means*	S.D.
Administrators (deans) of baccalaureate schools of nursing	1	4.59	0.57	5	4.00	0.83
Teaching faculty in graduate programs (MS and PhD)	2	4.54	0.59	4	4.13	0.78
Faculty teaching in baccalaureate programs	3	4.36	0.67	7	3.76	0.88
ANA	4	4.28	0.84	14	3.48	0.84
Nursing research	5	4.25	0.86	18	3.34	0.90
Clients (the general public)	6	3.96	0.86	19	3.19	0.99
NLN	7	3.95	1.03	10	3.61	0.91
Directors of nursing service in community health agencies	8	3.89	0.84	17	3.43	0.80
Directors of nursing service in hospitals	9	3.84	0.86	11	3.56	0.78
Interdisciplinary team composed of nurses, MD, social workers, etc.	10	3.71	0.97	20	3.14	0.88
The high cost of health care	11	3.55	1.21	1	4.39	0.79
Nursing students in baccalaureate programs	12	3.54	0.79	21	3.07	0.89
State Higher Ed. Coordinating Boards	13	3.53	0.92	9	3.64	0.91

Table 17 (continued)

Statement	Degree Influence Should Have			Degree Influence Will Have		
	Rank	Means*	S.D.	Rank	Means*	S.D.
State boards of nursing	14	3.52	1.02	15	3.45	0.92
National legislation	15	3.30	1.05	3	4.22	0.87
The high cost of education	16	3.25	1.18	2	4.28	0.84
State manpower planning agencies	17	3.21	0.88	8	3.67	0.89
State legislation	18	3.19	0.97	6	3.97	0.92
Foundation and grant sources	19	3.03	1.08	12	3.54	1.04
Non-nurse professional planners	20	2.71	0.98	16	3.45	0.99
Hospital administrators	21	2.51	0.99	13	3.48	0.99

N = 214

*Means are based on a scale of, one being no influence to five being extremely high influence.

Persons/Events/Conditions/and Policies which Hinder or Facilitate Long-range Planning in the Respondents' Schools

Question Set G is presented in Table 18 and represents twenty-two items to which the deans were requested to respond in regard to the tendency of the persons/conditions/events/policies to hinder or facilitate long-range planning in the deans' schools. If the item was equally hindering or facilitating, the appropriate response was four or the mid-point on the seven point scale with one being the greatest hindrance to seven being the greatest facilitator.

The placement of the items into rank order by mean scores seemed to rather naturally divide the twenty-two statements into thirds.

The eight items which received the highest mean scores in descending order were:

the first ranked item: "Myself" (5.88),

the second ranked item: "The present curriculum" (5.26),

the third ranked item: "Students in baccaluareate programs" (5.06),

the fourth ranked item: "Nursing faculty at the baccalaureate level" (5.05),

the fifth ranked item: "Central administration in my institution" (4.98),

the sixth ranked item: "Accreditation agencies, (NLN, State Board)" (4.94),

the seventh ranked item: "Rules and regulations in my institution" (4.91), and

the eighth ranked item: "Clients, (consumers' demands)" (4.71).

The middle group of items clustered in the range of four which indicated that they equally hindered and/or facilitated long-range planning in the respondents' institutions. These six statements are presented in descending order by their ranked mean scores:

the ninth ranked item: "Rules and regulations in my institution" (4.42),

the tenth ranked item: "Value changes in society" (4.46),

the eleventh ranked item: "Other administrators, (peers in other disciplines)" (4.36),

the twelfth ranked item: "Rapid changes in technology" (4.31),

the thirteenth ranked item: "Other health related faculty" (4.10), and

the fourteenth ranked item: "Hospital and agency administrators" (3.91).

The remaining eight items had mean scores which indicated they tended to hinder long-range planning in the respondents' schools.

These items are listed in order of descending mean scores:

the fifteenth ranked item: "Awareness for the need for long-range planning by society in general" (3.79),

the sixteenth ranked item: "Uncertainty in society" (3.45),

the seventeenth ranked item: "Financial conditions in my institution" (3.21),

the eighteenth ranked item: "Work load of faculty" (3.09),

the nineteenth ranked item: "National financial conditions" (3.01),

the twentieth ranked item: "Statewide financial conditions" (2.95),

the twenty-first ranked item: "Time available for planning" (2.71), and

the twenty-second item: "Each profession protecting his/her own 'vested interests'" (2.52).

Summary

The items which were perceived to facilitate long-range planning tended to be primarily related to people (deans, faculty, students, and clients). The items perceived to be neutral tended to be related to policies, values, changes, and other administrators. The items which clearly were perceived to hinder long-range planning were finances, time available for planning and most of all "vested interests" of each profession.

Table 18

Rank, Standard Deviation, and Means* of Persons, Events, Conditions, and Policies According to Hindrance or Facilitation of Long-Range Planning

Statement	Rank	Means*	S.D.
Myself.	1	5.88	0.98
The present curriculum.	2	5.26	1.26
Students in baccalaureate programs.	3	5.06	1.02
Nursing faculty at baccalaureate level.	4	5.05	1.22
Central administration in institution.	5	4.98	1.68
Accreditation agencies, (NLN, St. Bd.).	6	4.94	1.35
Rules and regulations in my school.	7	4.91	1.27
Clients, (consumers' demands).	8	4.71	1.05
Rules and regulations in institution.	9	4.42	1.36
Value changes in society.	10	4.46	1.17
Other administrators, (peers in other disciplines).	11	4.36	1.04
Rapid changes in technology.	12	4.31	1.10
Other health related faculty.	13	4.10	1.14
Hospital and agency administrators.	14	3.91	1.26
Awareness for the need for long range planning by society in general.	15	3.79	1.52
Uncertainty in society.	16	3.45	1.10
Financial conditions in my institution.	17	3.21	1.57
Work load of faculty.	18	3.09	1.39

Table 18 (continued)

Statement	Rank	Means*	S.D.
National financial conditions	19	3.01	1.51
Statewide financial conditions	20	2.95	1.43
Time available for planning	21	2.71	1.36
Each profession protecting his/her own "vested interests"	22	2.52	1.21

*Means are based on one, being the greatest hindrance, to four being neutral, to seven being the greatest facilitation.

N = 214

Long-range Planning in Each Respondents' School

Question set H is presented in Table 19 and represents the length of time that each respondent perceived long-range planning to take place in their school. This was an open-response type of question to which the largest number 108 (50.4%) responded that they planned for a time span of "5-7" years. The second highest grouping of responses by time span was in the "8-10" years category which was indicated by 44 (20.5%) responses. Thirty, (14%) indicated that their school planned for "2-4" years followed by seven respondents (3.3%) who planned for less than two years. Five, (2.3%) respondents stated that their school planned for "14-16" years. Only one respondent indicated planning for twenty or more years. The number of blank spaces or non responses to this question was present on 15 (7.0%) of the questionnaires.

Summary

The majority of respondents indicated that long-range planning in their school extended over a period of 5 to 10 years. The large number of non-responses for this question was greater than some other categories of response.

Table 19

Total Responses to the Question:
Long range planning in my school means
planning ahead for __ months or __ years

Years	Frequency	Percent
Less than 2 years	7	3.3
2-4	30	14.0
5-7	108	50.4
8-10	44	20.5
11-13	4	1.8
14-16	5	2.3
17-19	0	0
20 and over	1	0.4
No response	15	7.0
	214	99.7

Chapter 5

SUMMARY, IMPLICATIONS, CONCLUSIONS, AND RECOMMENDATIONS

SUMMARY

Problem Statement

The major problem focus for this study was to ascertain baccalaureate nursing-school administrators' perceptions of selected aspects of long-range planning for nursing and nursing education.

Design

A questionnaire was mailed to 286 nursing school administrators of accredited baccalaureate schools of nursing in the USA during the winter of 1978. There was a response rate of seventy-five percent. All regions of the nation showed similar representation with the midwest having a slightly higher response rate.

Demographic and Background Profile of Respondents

The typical respondent was called a dean, was a female between the ages of forty-six and sixty, employed by a public institution having from 100-399 full-time equivalent students, held an earned doctoral degree, reported to a vice president or a dean, and had held

the administrative position less than six years. No distinct response pattern emerged regarding the ages of the respondents' programs; responses were distributed throughout the age span from less than five years to more than thirty-one years.

Extent of Agreement About Long-range Planning

The deans agreed to some degree about all of the eight statements which included their personal and professional outlooks for nursing and nursing education and interdisciplinary collaboration. The future-focused, "should" statements tended to receive higher mean scores than the present-oriented, "is" statements.

Issues Confronting the Nursing Profession According to Importance, Urgency and Degree of Progress by 1990

This question related to various phases of nursing and nursing education in addition to inter-disciplinary collaboration. The respondents answered according to three aspects of the statement: its importance, urgency, and degree of progress (or resolution) by 1990. Comparison of the three sets of responses generally indicated closer agreement about importance and urgency than about the degree of progress by 1990. The deans identified agreement on entry levels and

clarification of professional goals as the two most important and urgent issues confronting the profession.

Trends, Potential Changes in Nursing Education and Health Care

Nursing Education. In response to the first five statements focusing on education, the deans agreed very strongly that the baccalaureate degree should be the initial requirement for all professional nurses. However, they agreed less strongly on the educational route that should be taken to reach this goal.

Health Care Delivery. Responses to the seven statements relating to health care delivery issues tended to cluster into the two areas of highest agreement. The deans agreed strongly that the health care delivery focus should change from crises care to preventive care, but agreed less strongly on the role of the client in initiating an automated device (use of technology) to obtain a physical diagnosis.

Perceptions of Long-range Planning

The deans generally held positive perceptions of long-range planning as indicated by their characterizations of it as useful, stimulating, positive, rewarding, meaningful, enthusiastic, competent, experienced, and successful.

The negative perceptions indicated that long-range planning was expensive and difficult.

Persons, Groups, Factors That May Influence Long-range Planning Nursing Education and Practice

There was a marked contrast between the two sets of ranked means showing which persons, groups, factors "should" have influence on long-range planning and which "will" have influence on long-range planning. There was no statement for which there was agreement for the two sets of ranked means. The deans perceived that persons (deans and faculty) and professional nursing organizations "should" have the greatest influence but that costs and legislation "will" have the greatest influence on long-range planning.

Persons, Events, Conditions, and Policies Which Hinder or Facilitate Long-range Planning

The statements, when ranked according to means, clustered almost equally into thirds. The highest ranked items which were perceived to facilitate long-range planning tended to relate primarily to people: deans, faculty, students, and clients.

The middle set of statements, perceived to be neutral, were related to policies, values, technology, change, and other administrators.

The lowest scored items that were clearly perceived to hinder long-range planning were finances, time available for planning, and, most of all, "vested interests" of each profession.

Long-range Planning in Each Respondent's School

The majority of respondents indicated that long-range planning in their schools extended over a period of five to ten years.

IMPLICATIONS

A most outstanding contradiction was apparent between the findings of this study and the results of the Huckfeldt study. In this study, the nursing school administrators perceived that the faculty had a highly positive influence on facilitating long-range planning. The Huckfeldt study in contrast, identified the faculty as the force most hindering change.[1] Some caution is advised against directly comparing the two studies since nurses were not the subject of the Huckfeldt study and since the panel of participants in the Huckfeldt study was composed of persons other than administrators (although administrators composed the largest number of participants).

Several questions with implications for nursing and nursing education are raised. Are nursing faculty different than other types of faculty? Are nursing

school administrators different than other types of administrators? Is the working relationship between the nursing school administrator and the nursing faculty different from other types of working relationships?

A curious discrepancy can be noted between the deans' belief in the importance of interdisciplinary collaboration and their less strong support of interdisciplinary education. One could ask how this relates to the perception that "vested interests" inhibit change most. How is one supposed to know how the other members of the professions function unless there is some sharing of common ideas in the basic student experience?

Another observation which points out a major dilemma in the profession and which could be viewed as a note of pessimism, is that the deans perceived clarification and agreement on goals and direction of the profession to be highly important and urgent but much lower in the degree of progress which will be made by 1990. Are the deans realistic or pessimistic in their perception? What actions by the profession are indicated?

What will be the consequences to the profession if the factors which "should" influence and those which "will" influence long-range planning are not perceived to be the same? Is this an indication that nurses must influence legislation, increase their awareness and sophistication in politics and economics to have any

significant voice in long-range planning for the profession?

CONCLUSIONS

The following conclusions were reached as a result of this study and are discussed according to the eight content areas of focus included in the study.

1. Personal and Professional Outlooks

(a) Long-range planning was a topic of strong personal and professional concern to the deans. They perceived themselves as being highly influential in facilitating long-range planning.

(b) The deans were positive and realistic in their perceptions of long-range planning. They expressed enthusiasm toward it while perceiving it as expensive and difficult.

(c) Clarification of and agreement on professional goals was perceived to be an urgent and important issue.

2. Educational Priorities

(a) The deans seemed to agree strongly with the generalist focus at the baccalaureate level and with specialization at the master's level. They agreed slightly less about specialization at the doctoral level.

(b) The controversial nature of the issue of career mobility was confirmed in that there was some agreement

on proceeding from technical to professional education. This issue was also evident in that agreement on entry levels was high in importance and in urgency for the profession.

(c) Educational preparation at the baccalaureate level for independent nursing practice was of least priority to the deans, possibly because many respondents believe that master's level preparation is preferable and necessary for independent practice.

(d) Interdisciplinary education was perceived to be moderately important and urgent.

3. Changing Health Care Delivery System

(a) The respondents agreed strongly that the focus should be changed from crises to preventive care and that more nurses should be providing health care in the home and in ambulatory care centers.

4. Interdisciplinary Collaboration

(a) The respondents agreed moderately that interdisciplinary collaboration was important.

(b) The deans agreed very strongly that baccalaureate nurses should provide care in ambulatory centers with referral to other health-care workers as needed.

5. Clients

(a) The respondents indicated that clients "should" have much more influence than they "will" have.

(b) Clients were perceived to have a positive influence because they facilitate long-range planning.

(c) Allowing clients to initiate and operate an automated device for physical diagnosis received a low mean score indicating ambiguous attitudes about the extent of client control.

6. Finances

(a) The deans perceived that legislation and finances "will" have an extremely high influence on long-range planning, considerably more influence than they "should" have.

(b) This finding also relates to the fact that the deans believed state and national legislation and financial conditions in the dean's institution would hinder long-range planning.

7. Technological Changes

(a) Technological changes were perceived to have a neutral effect on long-range planning.

(b) The deans agreed strongly that technology should be utilized effectively to make health care more affordable.

(c) Deans agreed only somewhat that technology should be available and initiated by clients for physical diagnosis.

8. Societal Changes

(a) Several factors were perceived to hinder long-range planning in society: awareness of the need for long-range planning, uncertainty in society, and time available for planning. The factor perceived to be the greatest hindrance to long-range planning was "vested interests" protected by each profession.

9. The Instrument

(a) A limiting factor of the study could have been the instrument and constraints imposed by the response options given to the nursing school administrators. If further studies are conducted with open-ended responses, other important and urgent items might possibly emerge.

RECOMMENDATIONS

Recommendations based on the findings of this research are presented to encourage more productive efforts toward long-range planning for the benefit of nursing and nursing education.

1. Deans and individual schools of nursing should examine their goals and purposes and the length of time needed and desired for engaging in long-range planning.

2. The profession must give educational priorities attention and must reach some consensus on

levels of preparation and long-term employment goals of graduates. Deans must examine their mission and obligation to the current student and future graduate. Career mobility must be studied and some consensus about it reached by educators and employers of persons identified as "nurses."

3. Factors that have been identified as hindrances to long-range planning should be examined and strategies designed to decrease or eliminate their negative influence.

Efforts to decrease "vested interests" and increase trust levels within and between professions should be given high priority. Solutions should be explored and discussed openly so the profession can achieve the professional goals they espouse to hold and practice.

4. Methods to enhance those factors identified as facilitators of long-range planning should be studied further.

5. More interdisciplinary educational programs and courses should be promoted to improve learning and collaboration between the disciplines and to arrive at the purported goals of providing high-quality care for clients/patients.

6. Major efforts in all facets of the profession (nursing and nursing education) must be made to enhance the positive factors, persons, and groups that the

profession believes should have high influence on nursing education and practice.

7. Further study of other populations perceived to be influential on the education and employment of nurses should take place with regard to their perceptions of long-range planning.

8. Further study of a practical definition of long-range planning for the profession should be pursued.

9. Based on the findings of this study and recognizing the factors which have been identified as having influence on future long-range planning, deans and faculty should become more knowledgable about and aware of economics and the political process so that they may acquire greater influence in these areas. These areas should also receive greater emphasis in undergraduate and graduate curricula.

Chapter 5

FOOTNOTES

[1]Vaughn E. Huckfeldt, A Forecast of Changes in Post Secondary Education (Boulder, Colorado: National Center for Higher Education Management Systems at Western Interstate Commission for Higher Education, 1972), p. 38.

APPENDIX A

COVER LETTER

Michigan State University
College of Education
Department of Administration and
Higher Education

Dear Nursing School Administrator:

With the growing recognition that the nursing profession needs to plan more systematically for the future, the focus of this study deals with the perceptions of Deans and Directors regarding long range planning. This subject was selected because of my own committment to the significance of establishing this knowledge base. This nationwide descriptive study includes all Deans and Directors of accredited baccalaureate schools of nursing. Little literature is available about the activities and perceptions of this group of influential nursing leaders in our nation relating to long range planning. Many of us recognize the lack of long range planning, (eleven or more years ahead, as defined in this study) in nursing education. Attempts to reach any concensus for future directions on either short or long range perspectives have produced a sporadic disarray of reports by commissions and study groups. Therefore, I believe this study will provide practical information for long range planning as well as providing heuristic value to the nursing profession.

All responses will remain confidential and the code numbers will be used only to facilitate follow up communication. The data will be reported in group form. I will offer to present the results to the Deans and Directors Conference as soon as possible following completion of the study. If you personally desire a summary of the results you may send your request to me at: 444 So. Lexington Pky., St. Paul, MN 55105.

Even though there may be a designated person who is responsible for the baccalaureate program in your school of nursing, I am requesting the chief administrative person in nursing to complete the questionnaire. As I'm sure you understand, this will increase the meaningfulness of the data. The questionnaire should take about 30 minutes to complete.

I would appreciate your response within the next three weeks. Thank you for your time and contribution to nursing research.

Sincerely,

Mary Weisensee

Mary Weisensee, RN, MS
PhD Candidate

QUESTIONNAIRE ON LONG RANGE PLANNING FOR NURSING #_____

A. Demographic and background data

Please check the one most appropriate response which pertains to you or your institution.

1. Which is the type of institution in which you are currently a nursing school administrator?

_____1. Public University
_____2. Public College
_____3. Private University
_____4. Private College

2. What is the FTE enrollment in your Baccalaureate program?

_____1. 1 - 99
_____2. 100 - 199
_____3. 200 - 299
_____4. 300 - 399
_____5. 400 - 499
_____6. 500 or more

3. Which is your regional location?

_____1. SREB
_____2. NERB
_____3. Midwest Alliance
_____4. WICHEN

4. What is the primary title of the administrative position you hold at present?

_____1. Dean
_____2. Chairperson
_____3. Director
_____4. Head
_____5. Coordinator
_____6. President
_____7. Other, please specify _____

5. How long have you held this position?

_____1. Less than 1 year
_____2. 1 - 3 years
_____3. 4 - 6 years
_____4. 7 - 9 years
_____5. 10 - 12 years
_____6. 13 or more years

6. What is the age of the Baccalaureate program where you are currently employed?

_____1. 5 years or less
_____2. 6 - 10 years
_____3. 11 - 15 years
_____4. 16 - 20 years
_____5. 21 - 25 years
_____6. 26 - 30 years
_____7. 31 or more years

7. What is the title of the person to whom you report?

_____1. President
_____2. Vice-president
_____3. Provost
_____4. Dean of _____
_____5. Chancellor
_____6. Other, please specify _____

8. What is your age as of your last birthday?

_____1. 25 - 30 years
_____2. 31 - 35 years
_____3. 36 - 40 years
_____4. 41 - 45 years
_____5. 46 - 50 years
_____6. 51 - 55 years
_____7. 56 - 60 years
_____8. 61 - 65 years
_____9. 66 or over

9. Which is your sex?

_____1. male
_____2. female

10. What is your highest earned degree?

_____1. Baccalaureate
_____2. Masters
_____3. Doctorate
_____4. Other, please specify _____

Note on definitions specific to this study.

NURSING SCHOOL ADMINISTRATOR is used to include all participants in the study whether they are a Dean, Director, Chairperson or Department Head, as long as they are the Chief Administrator.

LONG RANGE PLANNING refers to planning for the future 11 or more years ahead.

Although the primary focus of this study is on baccalaureate education, other areas of nursing education and practice are included as they are related to long range planning which influence the basic preparation of professional nurses.

B. Using the above definition of long range planning, to what extent do you agree with the following statements about long range planning?

Please respond to each of the following statements by circling one number for each statement.	Very Strongly Agree	Strongly Agree	Somewhat Agree	Slightly Disagree	Strongly Disagree
1. Long range planning is adequate in my school at present.	5	4	3	2	1
2. Long range planning should be more actively pursued in my school.	5	4	3	2	1
3. Nursing School Administrators should participate with other health care faculty in the region for long range planning.	5	4	3	2	1
4. Nursing School Administrators should participate in long range planning with other nursing schools in my region.	5	4	3	2	1
5. Long range planning is becoming crucial to the nursing profession.	5	4	3	2	1
6. Long range planning should be one of the primary activities of the Nursing School Administrator.	5	4	3	2	1
7. Long range planning is high on my personal list of activities for the school.	5	4	3	2	1
8. Long range planning is high on my institution's list of priorities for all programs.	5	4	3	2	1

C. The following is a list of current issues and dilemmas confronting the nursing profession. Please respond to the nine statements in three ways:

1. According to the magnitude or importance of the statement.
2. The degree of urgency that solutions be found by 1990.
3. Where you forecast the progress will be by 1990.

Circle one number in each of the three sections which most nearly reflects your perception at the present time.	1. Importance					2. Urgency					3. Degree of progress by 1990				
	Extremely Important	Very Important	Moderately Important	Slightly Important	Of No Importance	Extremely Urgent	Very Urgent	Moderately Urgent	Little Urgency	No Urgency	Resolved Satisfactorily	Progress Being Made	No Change From 1978	Became Obsolete	Became a Greater Problem
1. Agreement on levels of preparation for entry to professional nursing practice.	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
2. Separate state board exams for the designated levels of education.	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
3. Continuing education credits for relicensure.	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
4. Nurses and physicians functioning as colleagues.	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
5. Colleague relationship with health professionals other than physicians.	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
6. Educational preparation for independent nursing practice at Baccalaureate levels.	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
7. Interdisciplinary student education with nursing, medicine, pharmacy, etc.	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
8. Direct payment to nurses for services rendered.	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
9. Clarification and agreement on the goals and direction of professional nursing by the majority of the profession.	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1

D. How much do you agree with the following trends and/or potential changes in nursing education and health care delivery by 1990?

Circle one number on the right which corresponds to the statement on the left.	Very Strongly Agree	Strongly Agree	Somewhat Agree	Slightly Disagree	Strongly Disagree
Nursing education					
1. Baccalaureate degree as the initial requirement for all professional nurses.	5	4	3	2	1
2. Baccalaureate education with a generalist focus.	5	4	3	2	1
3. Specialization at the masters level.	5	4	3	2	1
4. Specialization at doctoral level.	5	4	3	2	1
5. Educational mobility allowing more orderly advancement from technical to professional education.	5	4	3	2	1
Health care delivery					
6. Baccalaureate nurses providing the majority of care in ambulatory centers with referral to other health care workers as needed.	5	4	3	2	1
7. More health care taking place in the home under the guidance of nurses.	5	4	3	2	1
8. Automated physical diagnosis that is client initiated and operated.	5	4	3	2	1
9. Focus on preventive rather than crises care.	5	4	3	2	1
10. More effective utilization of technology which will make the cost of health care affordable to all.	5	4	3	2	1
11. Consolidation of current hospitals into regional centers.	5	4	3	2	1
12. Provision of mobile care vans for those unable to travel.	5	4	3	2	1

E. As you think about long range planning and your personal feelings toward the process, mark your response on the following adjective scale. For each item, place a check mark on the line corresponding to the scale which most nearly describes your feelings. Place check (✓) on a line, NOT BETWEEN. If you are neutral, use the middle or fourth space.

Long Range Planning

		1	2	3	4	5	6	7	
1.	Constrained	___	___	___	___	___	___	___	Free
2.	Easy	___	___	___	___	___	___	___	Difficult
3.	Boring	___	___	___	___	___	___	___	Stimulating
4.	Enthusiastic	___	___	___	___	___	___	___	Not Enthusiastic
5.	Unsuccessful	___	___	___	___	___	___	___	Successful
6.	Meaningful	___	___	___	___	___	___	___	Meaningless
7.	Unrewarding	___	___	___	___	___	___	___	Rewarding
8.	Positive	___	___	___	___	___	___	___	Negative
9.	Incompetent	___	___	___	___	___	___	___	Competent
10.	Experienced	___	___	___	___	___	___	___	Inexperienced
11.	Expensive	___	___	___	___	___	___	___	Inexpensive
12.	Useful	___	___	___	___	___	___	___	Worthless

F. The following is a list of persons/groups/factors that may influence long range planning for nursing education and practice.

Please respond to the following items in <u>two</u> ways.

1. According to your perception of the influence that the persons/groups/factors SHOULD HAVE ON NURSING by 1990.
2. According to your perception of the influence that the persons/groups/factors WILL PROBABLY HAVE ON NURSING by 1990.

Circle <u>one</u> number in each of the <u>two</u> sections.

	1. Degree Influence SHOULD HAVE					2. Degree Influence WILL HAVE				
	Extremely High Influence	High Influence	Moderate Influence	Low Influence	No Influence	Extremely High Influence	High Influence	Moderate Influence	Low Influence	No Influence
1. Administrators (deans, etc.) of bacc. sch. of nsg.	5	4	3	2	1	5	4	3	2	1
2. Faculty teaching in baccalaureate programs.	5	4	3	2	1	5	4	3	2	1
3. Teaching faculty in graduate programs (MS and PhD).	5	4	3	2	1	5	4	3	2	1
4. Nursing students in baccalaureate programs.	5	4	3	2	1	5	4	3	2	1
5. Non-nurse professional planners.	5	4	3	2	1	5	4	3	2	1
6. Hospital administrators.	5	4	3	2	1	5	4	3	2	1
7. Directors of nursing service in hospitals.	5	4	3	2	1	5	4	3	2	1
8. Directors of nursing service in Community Health agencies.	5	4	3	2	1	5	4	3	2	1
9. State boards of nursing	5	4	3	2	1	5	4	3	2	1
10. State manpower planning agencies.	5	4	3	2	1	5	4	3	2	1
11. Interdisciplinary teams composed of nurses, MD, soc. workers, etc.	5	4	3	2	1	5	4	3	2	1
12. Clients, (the general public).	5	4	3	2	1	5	4	3	2	1
13. Nursing research.	5	4	3	2	1	5	4	3	2	1
14. ANA.	5	4	3	2	1	5	4	3	2	1
15. NLN.	5	4	3	2	1	5	4	3	2	1
16. The state Higher Education Coordinating Boards.	5	4	3	2	1	5	4	3	2	1
17. State legislation.	5	4	3	2	1	5	4	3	2	1
18. National legislation.	5	4	3	2	1	5	4	3	2	1
19. Foundations and grant sources.	5	4	3	2	1	5	4	3	2	1
20. The high cost of education.	5	4	3	2	1	5	4	3	2	1
21. The high cost of health care.	5	4	3	2	1	5	4	3	2	1

G. How do you perceive the influence of the following persons, events, conditions, and policies on the future planning that takes place in your school of nursing at the present time? Please indicate whether the items listed tend more to hinder or facilitate long range planning by circling one number which represents the majority of your experiences. If the items are equally hindering and facilitating circle the middle or number four.

	< ----Hinder----------Facilitate---->						
1. Central administration in my institution.	1	2	3	4	5	6	7
2. Myself.	1	2	3	4	5	6	7
3. Nursing faculty at the baccalaureate level.	1	2	3	4	5	6	7
4. Other administrators, (peers in other disciplines).	1	2	3	4	5	6	7
5. Other health related faculty, (MD, pharmacy, soc. workers, etc.).	1	2	3	4	5	6	7
6. Accreditation agencies, (NLN, State BD.).	1	2	3	4	5	6	7
7. Rules and regulations in my institution.	1	2	3	4	5	6	7
8. Rules and regulations in my college, school, department, or division.	1	2	3	4	5	6	7
9. Uncertainty in society.	1	2	3	4	5	6	7
10. Clients, (consumers' demands).	1	2	3	4	5	6	7
11. Statewide financial conditions.	1	2	3	4	5	6	7
12. National financial conditions.	1	2	3	4	5	6	7
13. Financial conditions in my institution.	1	2	3	4	5	6	7
14. Rapid changes in technology.	1	2	3	4	5	6	7
15. Value changes in society.	1	2	3	4	5	6	7
16. Students in baccalaureate programs.	1	2	3	4	5	6	7
17. The present curriculum.	1	2	3	4	5	6	7
18. Hospital and agency administrators.	1	2	3	4	5	6	7
19. Work load of faculty.	1	2	3	4	5	6	7
20. Time available for planning.	1	2	3	4	5	6	7
21. Awareness for the need for long range planning by society in general.	1	2	3	4	5	6	7
22. Each profession protecting his/her own "vested interests".	1	2	3	4	5	6	7

H. Long range planning in my school means planning ahead for _____ months
or
_____ years.

End of questionnaire
Thank you

APPENDIX B

POST CARD REMINDER

Dear Nursing School Administrator;

In early February, I mailed a questionnaire to you which focuses on long range planning for nursing and nursing education. If you have not returned the questionnaire, I would appreciate your response within the next two weeks. If you have recently mailed it, please disregard this card and accept my thanks for participating in the study.

Sincerely,

Mary G. Weisensee
444 South Lexington Parkway
St. Paul, Minnesota 55105

APPENDIX C

RAW DATA

Table C-1

Total Responses to the Question: To What Extent Do You Agree With the Following Statements About Long Range Planning?

Statement	Very Strongly Agree (5)		Strongly Agree (4)		Somewhat Agree (3)		Slightly Disagree (2)		Strongly Disagree (1)		No Response	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Long range planning is adequate in my school at present.	12	5.6	29	13.6	70	32.7	44	20.6	58	27.1	1	(.5)
Long range planning <u>should</u> be more actively pursued in my school.	75	35.0	80	37.4	31	14.5	14	6.5	12	5.6	2	(.9)
Nursing School Administrators <u>should</u> participate with other health care faculty in the region for long range planning.	114	53.3	78	36.4	20	9.3	0	0	0	0	2	(.9)
Nursing School Administrators <u>should</u> participate in long range planning with other nursing schools in my region.	118	55.1	73	34.1	19	8.9	1	.5	0	0	3	(1.4)
Long range planning is becoming crucial to the nursing profession.	145	67.8	60	28.0	8	3.7	0	0	0	0	1	(.5)
Long range planning <u>should</u> be one of the primary activities of the Nursing School Administrator.	92	43.0	83	38.8	29	13.6	7	3.3	2	.9	1	(.5)
Long range planning is high on my <u>personal</u> list of activities for the school.	70	32.7	93	43.5	38	17.8	7	3.3	5	2.3	1	(.5)
Long range planning is high on my <u>institution's</u> list of priorities for all programs.	42	19.6	76	35.5	63	29.4	24	11.2	8	3.7	1	(.5)

N = 214

Table C-2

Total Responses to Statements According to Importance of Issues Confronting the Nursing Profession

Statement	Extremely Important		Very Important		Moderately Important		Slightly Important		Of No Importance		No Response	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Agreement on levels of preparation for entry to professional nursing practice.	170	79.4	34	15.9	7	3.3	0	0	1	.5	2	.9
Separate state board exams for the designated levels of education.	112	52.3	54	25.2	23	10.7	9	4.2	9	4.2	7	3.3
Continuing education credits for relicensure.	58	27.1	78	36.4	51	23.8	11	5.1	8	3.7	8	3.7
Nurses and physicians functioning as colleagues.	118	55.1	76	35.5	16	7.5	1	.5	0	0	3	1.4
Colleague relationship with health professionals other than physicians.	98	45.8	85	39.7	24	11.2	3	1.4	1	.5	3	1.4
Educational preparation for independent nursing practice at Baccalaureate levels.	35	16.4	50	23.4	50	23.4	33	15.4	34	15.9	12	5.6
Interdisciplinary student education with nursing, medicine, pharmacy.	38	17.8	66	30.8	70	32.7	30	14.0	6	2.8	4	1.9
Direct payment to nurses for services rendered.	103	48.1	75	35.0	22	10.3	9	4.2	2	.9	3	1.4
Clarification and agreement on the goals and direction of professional nursing by the majority of the profession.	165	77.1	38	17.8	7	3.3	0	0	0	0	4	1.9

Total N = 214

Table C-2 (Continued)

Total Responses to Statements According to Urgency of Issues Confronting the Nursing Profession

Statement	Extremely Urgent		Very Urgent		Moderately Urgent		Little Urgency		No Urgency		No Response	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Agreement on levels of preparation for entry to professional nursing practice.	156	72.9	43	20.1	12	5.6	0	0	1	.5	2	.9
Separate state board exams for the designated levels of education.	101	47.2	53	24.8	42	19.6	2	.9	9	4.2	7	3.3
Continuing education credits for relicensure.	55	25.7	57	26.6	70	32.7	15	7.0	8	3.7	9	4.2
Nurses and physicians functioning as colleagues.	88	41.1	76	35.5	39	18.2	5	2.3	1	.5	5	2.3
Colleague relationship with health professionals other than physicians.	75	35.0	76	35.5	50	23.4	6	2.8	2	.9	5	2.3
Educational preparation for independent nursing practice at Baccalaureate levels.	28	13.1	44	20.6	62	29.0	30	14.0	35	16.4	15	7.0
Interdisciplinary student education with nursing, medicine, pharmacy.	30	14.0	55	25.7	83	38.8	31	14.5	10	4.7	5	2.3
Direct payment to nurses for services rendered.	91	42.5	70	32.7	42	19.6	5	2.3	2	.9	4	1.9
Clarification and agreement on the goals and direction of professional nursing by the majority of the profession.	158	73.8	39	18.2	12	5.6	0	0	0	0	5	2.3

Total N = 214

Table G-2 (Continued)

Total Responses to Statements According to Degree of Progress by 1990 on Issues Confronting the Nursing Profession

Statement	Resolved Satisfactorily		Progress Being Made		No Change From 1978		Became Obsolete		Became a Greater Problem		No Response	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Agreement on levels of preparation for entry to professional nursing practice.	81	37.9	109	50.9	13	6.1	2	.9	2	.9	7	3.3
Separate state board exams for the designated levels of education.	72	33.6	92	43.0	32	15.0	7	3.3	1	.5	10	4.7
Continuing education credits for relicensure.	83	38.8	94	43.9	14	6.5	6	2.8	6	2.8	11	5.1
Nurses and physicians functioning as colleagues.	23	10.7	150	70.1	26	12.1	3	1.4	7	3.3	5	2.3
Colleague relationship with health professionals other than physicians.	46	21.5	139	65.0	21	9.8	3	1.4	0	0	5	2.3
Educational preparation for independent nursing practice at Baccalaureate levels.	16	7.5	101	47.2	47	22.0	24	11.2	10	4.7	16	7.5
Interdisciplinary student education with nursing, medicine, pharmacy.	12	5.6	135	63.1	51	23.8	10	4.7	0	0	6	2.8
Direct payment to nurses for services rendered.	54	25.2	130	60.7	18	8.4	2	.9	4	1.9	6	2.8
Clarification and agreement on the goals and direction of professional nursing by the majority of the profession.	23	10.7	130	60.7	40	18.7	3	1.4	12	5.6	6	2.8

N = 214

Table C-3

Total Responses to Statements According to Agreement With Trends/Changes in Nursing Education and Health Care Delivery By 1990

Statement	Very Strongly Agree		Strongly Agree		Somewhat Agree		Slightly Disagree		Strongly Disagree		No Response	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Nursing Education												
Baccalaureate degree as the initial requirement for all professional nurses.	179	83.6	24	11.2	6	2.8	1	.5	3	1.4	1	.5
Baccalaureate education with a generalist focus.	145	67.8	47	22.0	16	7.5	2	.9	3	1.4	1	.5
Specialization at the masters level.	143	66.8	50	23.4	14	6.5	3	1.4	3	1.4	1	.5
Specialization at doctoral level.	110	51.4	37	17.3	35	16.4	15	7.0	11	5.1	6	2.8
Educational mobility allowing more orderly advancement from technical to professional education.	62	29.0	64	29.9	51	23.8	17	7.9	17	7.9	3	1.4
Health care delivery												
Baccalaureate nurses providing the majority of care in ambulatory centers with referral to other health care workers as needed.	115	53.7	71	33.2	16	7.5	8	3.7	1	.5	3	1.4
More health care taking place in the home under the guidance of nurses.	130	60.7	77	36.0	5	2.3	0	0	0	0	2	.9
Automated physical diagnosis that is client initiated and operated.	29	13.6	64	29.9	84	39.3	24	11.2	11	5.1	2	.9

Table C-3 (continued)

Statement	Very Strongly Agree		Strongly Agree		Somewhat Agree		Slightly Disagree		Strongly Disagree		No Response	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Focus on preventive rather than crises care.	158	73.8	47	22.0	8	3.7	0	0	0	0	1	.5
More effective utilization of technology which will make the cost of health care affordable to all.	128	59.8	59	27.6	20	9.3	2	.9	2	.9	3	1.4
Consolidation of current hospitals into regional centers.	70	32.7	62	29.0	65	30.4	14	6.5	1	.5	2	.9
Provision of mobile care vans for those unable to travel.	87	40.7	85	39.7	37	17.3	2	.9	1	.5	2	.9

N = 214

TABLE C-4

Total Responses to Stimulus Phrase "Long-Range Planning"

Categories	Scale																Categories
	1		2		3		4		5		6		7				
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	No Response		
Constrained	2	(0.9)	16	(7.5)	33	(15.4)	32	(15.0)	41	(19.2)	56	(26.2)	27	(12.6)	7	(3.3)	Free
Difficult	54	(25.2)	71	(33.2)	44	(20.6)	22	(10.3)	10	(4.7)	7	(3.3)	4	(1.9)	2	(0.9)	Easy
Boring	0	0	0	0	4	(1.9)	16	(7.5)	29	(13.6)	64	(29.9)	99	(46.3)	2	(0.9)	Stimulating
Not Enthusiastic	3	(1.4)	8	(3.7)	11	(5.1)	20	(9.3)	33	(15.4)	67	(31.3)	70	(32.7)	2	(0.9)	Enthusiastic
Unsuccessful	0	0	8	(3.7)	15	(7.0)	32	(15.0)	74	(34.6)	67	(31.3)	15	(7.0)	3	(1.4)	Successful
Meaningless	5	(2.3)	7	(3.3)	14	(6.5)	10	(4.7)	24	(11.2)	67	(31.3)	86	(40.2)	1	(0.5)	Meaningful
Unrewarding	1	(0.5)	1	(0.5)	9	(4.2)	18	(8.4)	38	(17.8)	71	(33.2)	75	(35.0)	1	(0.5)	Rewarding
Negative	1	(0.5)	2	(0.9)	7	(3.3)	12	(5.6)	30	(14.0)	76	(35.5)	85	(39.7)	1	(0.5)	Positive
Incompetent	1	(0.5)	6	(2.8)	5	(2.3)	24	(11.2)	44	(20.6)	98	(45.8)	33	(15.4)	3	(1.4)	Competent
Inexperienced	4	(1.9)	12	(5.6)	20	(9.3)	16	(7.5)	47	(22.0)	72	(33.6)	42	(19.6)	1	(0.5)	Experienced
Expensive	27	(12.6)	50	(23.4)	45	(21.0)	48	(22.4)	21	(9.8)	17	(7.9)	3	(1.4)	3	(1.4)	Inexpensive
Worthless	2	(0.9)	1	(0.5)	5	(2.3)	5	(2.3)	15	(7.0)	52	(24.3)	133	(62.1)	1	(0.5)	Useful

N = 214

TABLE C-5

Total Responses to Statements Influencing Long Range Planning for Nursing Education and Practice According to Degree of Influence They Should Have and Will Have by 1990

Statements		Degree Influence SHOULD HAVE						Degree Influence WILL HAVE					
		Extremely High Influence 5	High Influence 4	Moderate Influence 3	Low Influence 2	No Influence 1	No Response	Extremely High Influence 5	High Influence 4	Moderate Influence 3	Low Influence 2	No Influence 1	No Response
Administrators (deans, etc.) of bacc. sch. of nursing	F*	132.0	67.0	9.0	0	0	6.0	66.0	79.0	59.0	4.0	0	6.0
	%*	61.7	31.3	4.2	0	0	2.8	30.8	36.9	27.6	1.9	0	2.8
Faculty teaching in baccalaureate programs.	F*	94.0	97.0	14.0	3.0	0	6.0	46.0	79.0	66.0	15.0	0	8.0
	%*	43.9	45.3	6.5	1.4	0	2.8	21.5	36.9	30.8	7.0	0	3.7
Teaching faculty in graduate programs (MS and PhD).	F*	123.0	75.0	10.0	0	0	6.0	75.0	86.0	42.0	3.0	0	8.0
	%*	57.5	35.0	4.7	0	0	2.8	35.0	40.2	19.6	1.4	0	3.7
Nursing students in baccalaureate programs.	F*	25.0	73.0	99.0	8.0	2.0	7.0	13.0	44.0	97.0	45.0	5.0	10.0
	%*	11.7	34.1	46.3	3.7	.9	3.3	6.1	20.6	45.3	21.0	2.3	4.7
Non-nurse professional planners.	F*	13.0	18.0	92.0	64.0	20.0	7.0	29.0	68.0	72.0	25.0	6.0	14.0
	%*	6.1	8.4	43.0	29.9	9.3	3.3	13.6	31.8	33.6	11.7	2.8	6.5
Hospital Administrators.	F*	7.0	23.0	69.0	76.0	31.0	8.0	29.0	77.0	67.0	23.0	7.0	11.0
	%*	3.3	10.7	32.2	35.5	14.5	3.7	13.6	36.0	31.3	10.7	3.3	5.1
Directors of nursing service in hospitals.	F*	46.0	93.0	57.0	7.0	3.0	8.0	15.0	64.0	103.0	20.0	1.0	11.0
	%*	21.5	43.5	26.6	3.3	1.4	3.7	7.0	29.9	48.1	9.3	.5	5.1
Directors of nursing service in Community Health agencies.	F*	48.0	98.0	49.0	8.0	2.0	9.0	19.0	68.0	94.0	20.0	0	13.0
	%*	22.4	45.8	22.9	3.7	.9	4.2	8.9	31.8	43.9	9.3	0	6.1

TABLE C-5 (Continued)

Statements		Degree Influence SHOULD HAVE						Degree Influence WILL HAVE					
		Extremely High Influence 5	High Influence 4	Moderate Influence 3	Low Influence 2	No Influence 1	No Response	Extremely High Influence 5	High Influence 4	Moderate Influence 3	Low Influence 2	No Influence 1	No Response
State boards of nursing	F*	40.0	64.0	75.0	23.0	6.0	6.0	29.0	63.0	86.0	23.0	3.0	10.0
	%*	18.7	29.9	35.0	10.7	2.8	2.8	13.6	29.4	40.2	10.7	1.4	4.7
State manpower planning agencies.	F*	13.0	62.0	91.0	35.0	5.0	8.0	38.0	79.0	68.0	17.0	1.0	11.0
	%*	6.1	29.0	42.5	16.4	2.3	3.7	17.8	36.9	31.8	7.9	.5	5.1
Interdisciplinary teams composed of nurses, MD, Soc. workers, etc.	F*	49.0	69.0	68.0	16.0	3.0	9.0	12.0	52.0	98.0	35.0	6.0	11.0
	%*	22.9	32.2	31.8	7.5	1.4	4.2	5.6	24.3	45.8	16.4	2.8	5.1
Clients, (the general public).	F*	60.0	89.0	48.0	9.0	1.0	7.0	21.0	55.0	79.0	45.0	6.0	8.0
	%*	28.0	41.6	22.4	4.2	.5	3.3	9.8	25.7	36.9	21.0	2.8	3.7
Nursing research.	F*	101.0	63.0	35.0	7.0	0	8.0	25.0	51.0	99.0	28.0	2.0	9.0
	%*	47.2	29.4	16.4	3.3	0	3.7	11.7	23.8	46.3	13.1	.9	4.2
ANA.	F*	100.0	73.0	31.0	1.0	3.0	6.0	23.0	75.0	85.0	21.0	1.0	9.0
	%*	46.7	34.1	14.5	.5	1.4	2.8	10.7	35.0	39.7	9.8	.5	4.2
NLN.	F*	75.0	68.0	48.0	10.0	6.0	7.0	34.0	77.0	72.0	16.0	3.0	12.0
	%*	35.0	31.8	22.4	4.7	2.8	3.3	15.9	36.0	33.6	7.5	1.4	5.6
The state Higher Educational Coordinating Boards.	F*	37.0	59.0	90.0	19.0	2.0	7.0	40.0	70.0	80.0	12.0	3.0	9.0
	%*	17.3	27.6	42.1	8.9	.9	3.3	18.7	32.7	37.4	5.6	1.4	4.2

TABLE C-6

Total Responses to Statements According to Degree Factors Hinder or Facilitate Long Range Planning

Statement	Hinder						Neutral						Facilitate			
	1		2		3		4		5		6		7		No Response	
	F*	%*	F*	%*	F*	%*	F*	%*	F*	%*	F*	%*	F*	%*		
Central administration in my institution.	6	2.8	17	7.9	20	9.3	29	13.6	32	15.0	61	28.5	39	18.2	10	4.7
Myself.	1	.5	0	0	4	1.9	12	5.6	36	16.8	97	45.3	53	24.8	11	5.1
Nursing faculty at the baccalaureate level.	2	.9	4	1.9	13	6.1	43	20.1	61	28.5	60	28.0	19	8.9	12	5.6
Other administrators, (peers in other disciplines).	0	0	10	4.7	23	10.7	85	39.7	58	27.1	24	11.2	3	1.4	11	5.1
Other health related faculty, (MD, pharmacy, soc. workers, etc.)	6	2.8	11	5.1	36	16.8	84	39.3	46	21.5	10	4.7	4	1.9	17	7.9
Accreditation agencies, (NLN, State BD.).	2	.9	10	4.7	19	8.9	31	14.5	65	30.4	53	24.8	21	9.8	13	6.1
Rules and regulations in my institution.	5	2.3	10	4.7	32	15.0	58	27.1	52	24.3	32	15.0	12	5.6	13	6.1
Rules and regulations in my college, school, department, or division.	2	.9	5	2.3	15	7.0	57	26.6	51	23.8	51	23.8	20	9.3	13	6.1
Uncertainty in society.	7	3.3	32	15.0	63	29.4	72	33.6	23	10.7	5	2.3	1	.5	11	5.1
Clients, (consumers' demands).	1	.5	5	2.3	13	6.1	60	28.0	79	36.9	34	15.9	7	3.3	15	7.0

TABLE C-6 (Continued)

Statement	Hinder 1		2		3		Neutral 4		5		6		Facilitate 7		No Response	
	F*	%*	F*	%*	F*	%*	F*	%*	F*	%*	F*	%*	F*	%*		
Statewide financial conditions.	35	16.4	44	20.6	62	29.0	32	15.0	16	7.5	9	4.2	3	1.4	13	6.1
National financial conditions.	28	13.1	60	28.0	50	23.4	30	14.0	17	7.9	10	4.7	6	2.8	13	6.1
Financial conditions in my institution.	29	13.6	44	20.6	53	24.8	34	15.9	21	9.8	16	7.5	5	2.3	12	5.6
Rapid changes in technology.	2	.9	5	2.3	36	16.8	74	34.6	55	25.7	22	10.3	5	2.3	15	7.0
Value changes in society.	1	.5	7	3.3	32	15.0	65	30.4	57	26.6	32	15.0	7	3.3	13	6.1
Students in baccalaureate programs.	0	0	1	.5	11	5.1	48	22.4	68	31.8	62	29.0	11	5.1	13	6.1
The present curriculum.	1	.5	4	1.9	18	8.4	22	10.3	58	27.1	69	32.2	28	13.1	14	6.5
Hospital and agency administrators.	8	3.7	21	9.8	36	16.8	65	30.4	51	23.8	15	7.0	1	.5	17	7.9
Work load of faculty.	26	12.1	48	22.4	55	25.7	37	17.3	25	11.7	9	4.2	1	.5	13	6.1
Time available for planning.	41	19.2	57	26.6	55	25.7	25	11.7	16	7.5	5	2.3	2	.9	13	6.1
Awareness for the need for long range planning by society in general.	13	6.1	31	14.5	38	17.8	53	24.8	36	16.8	19	8.9	8	3.7	16	7.5
Each profession protecting his/her own "vested interests."	44	20.6	65	30.4	49	23.9	33	15.4	5	2.3	3	1.4	1	.5	14	6.5

N = 214

F = Frequency; % = Percent

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