The discussion of nursing continuing education in the United States is approached by a consideration of the following aspects:
Definition and Background Evolution of the Concept Administration of the Process Teaching Techniques Range of Subjects Evaluation of the Program Issues and Problems: Mandatory vs. Voluntary Participation Control of the Accreditation Process Responsibility for Participation Program Cost/Availability

Definition and Background
Most of us would probably agree that the term continuing education includes some form of learning activity after a basic educational program but because it has been subject to various interpretations a definition from the organization most broadly associated with nursing continuing education in the U.S. would be appropriate.* During 1974, the American Nurses’ Association (ANA), in its statement on Continuing Education in Nursing said:

Continuing education in nursing consists of systematic learning experiences designed to enlarge the knowledge and skills of nurses. As distinct from education toward an academic degree or preparing as a beginning professional practitioner, continuing professional educational activities have more specific content applicable to the individual’s immediate goals; are generally of shorter duration; are sponsored by colleges, universities, health agencies and professional organizations; and may be conducted in a variety of settings.1

This statement resulted from a resolution passed in 1974 by the ANA House of Delegates which resolved to establish a system of accreditation of continuing education programs in nursing. This was further supported in the same year by a statement by the National League for Nursing (NLN), in effect the accreditor of college and university programs, which established guidelines for the development of continuing education programs in nursing. The League’s position statement, which outlined its role in continuing education, included a comment to the effect that continuing education is a personal evaluative educational experience, objectively planned for individual growth and enrichment of and attitudes and skills beyond the basic preparation for a profession or occupation. The manner in which continuing education is obtained and the method of documenting it, while important, are secondary to the goal, which is to assure the continued development of competence of nursing personnel at all levels of practice and education.2

Based on the full role statement, the League went on to establish guidelines which focused on four factors for program development: assessment, planning, implementation and evaluation. The detailed subheadings are available from the League’s statement and the guidelines are probably most notable for reference to use of the continuing education unit (CEU) within the Implementation section. The CEU, developed by a national task force made up of representatives of 34 organizations and agencies, is defined as Ten contact hours of participation in an organized continuing education experience under responsible leadership, capable direction and qualified instruction.3 CEU’s are not used for programs carrying academic credit or diplomas, in-service learning, orientation programs or short-term programs casually related to upgrading.
It’s principal benefit stems from it’s general acceptance as a standard unit for organized educational offerings, and the emphasis is on the word organized.

**EVOLUTION OF THE CONCEPT**

Actually, continuing education for nurses in the United States had its early beginnings around the turn of the century, mainly to make up for the poor quality of education in many programs, where students were used almost entirely to meet service needs... Institutes and workshops by the professional organization gained some momentum in the 1920’s and are still a major source of continuing education. Refresher courses for inactive nurses were most prevalent in times of major nursing shortages, such as during World War II and the 1950’s and 1960’s. Federal funding under the Nursing Training Act in 1964 provided funding for short term courses, and institutions of higher education took a renewed interest in providing continuing education, an interest that had dwindled through lack of funds and prepared faculty. Other federal funding for Regional Medical Programs also resulted in nursing workshops. When these funds began to vanish during the Nixon administration, many colleges found it impossible to continue full programs. Others, seeing both the need and the trend, established institution-funded continuing education programs. This led to greater emphasis on inservice education.

By the turn of the decade, momentum had picked up to the point where Prof. Malcolm Knowles of the University of NC, well known for his writings in the field, said: I believe that in the ’70’s continuing education will become an integral element of all the professions in general, but of nursing in particular. The creation of a new role, that of Continuing Education Specialist, will assure that every professional practitioner is engaging in a process of continuing self-development. While the role of the continuing education specialist has most certainly evolved, the author believes that the best most practitioners — together with Prof. Knowles — would say about assurance of continuing self-develop-

**How the Model Works**

The model encompasses local, state, regional, and national levels and functions in two ways. First, it identifies criteria for accrediting other agencies and associations as approval bodies of CE offerings. For example, if a state nurses’ association applies for and is granted accreditation as an approval body, it may in turn approve an individual provider within the state. This provider can then offer programs that are “ANA-approved”.

Secondly, the model also identifies criteria for the approval of individual continuing education offerings and programs. This is the usual route for independent or commercial providers who present programs in more than one state. Obtaining ANA approval of their programs often, though not always, eliminates the need to apply to each individual state.

The mechanism emphasizes self-regulation and collaboration between all levels of the ANA, other national nursing organizations, health agencies and organizations, and providers who sponsor continuing education activities for nurses.
DIAGRAM 1
ACCREDITATION OF CONTINUING EDUCATION IN NURSING

A monitoring group will be established to evaluate the effectiveness of the National Accreditation Board for Continuing Education for a minimum of five years.
Overall authority and responsibility for reviewing and revising the accreditation and approval criteria reside in the National Accreditation Board for Continuing Education.

The three RACs grant accreditation to universities and colleges, national nursing organizations, state boards of nursing, state nurses associations, national specialty nursing organizations, and federal nursing services. The committees also approve offerings of independent providers and commercial organizations.

A separate National Review Committee, which is also governed by NAB, reviews applications and accredits the non-degree programs for the expanded role.

Only state boards of nursing, state nurses' associations, national specialty organizations and federal nursing services are eligible to apply for accreditation and as approvers of the offerings of their constituents. Universities and colleges, and national nursing organizations receive only accreditation. Commercial companies may apply for approval of their programs/offerings but not for offerings of their constituents. All the organizations who approve CE offerings must have an approval mechanism which meets the criteria set forth by NAB.

Purposes of Accreditation
The essential purpose of the accreditation process is to provide a professional nursing judgement regarding the quality of the CE offerings and/or programs. Through the national accreditation process, the professional association seeks to promote the standards for CE in nursing at the national, state, and local levels. The process also encourages sponsors to consistently improve the quality of their offerings.

As can be readily seen, the accreditation process is complex; it is also awkward, time-consuming and expensive. On the other hand, it works, and will probably improve with time, experience and improved computer techniques. The ANA is found to be tough but fair.

TEACHING TECHNIQUES
Another aspect of nursing continuing education in the United States which is interesting stems from several well established trends — the segmentation of specialty groups within nursing resulting in an increased number of nursing specialty organizations; the knowledge/communications explosion — which makes more knowledge more available to the expanded specialties; the shift in teaching concepts from pedagogy to adragogy which gears continuing education to adults as learners; — all of which have truly produced new considerations.

For the most part the same trends have been exercised the use of expanded teaching techniques and vehicles which have also stimulated a very broad range of subject offerings. The real extent of this range cannot be conveyed but a quick sight is provided into the scope offered by the University of Pennsylvania School of Nursing Center for Continuing Education during the academic year Fall 1980 - Spring 1981:

- 1.0 CEUs "Pain Management: The role of the Health Professional"
- 2.0 CEUs "Basic Physical Assessment of the Adult. A Non-Traditional Course: Combining Self-Study and a Practice Workshop"
- 3.0 CEUs "Interpretation and Implications of Diagnostic Studies: Update Series III"
- 4.0 CEUs "Changing Life Styles: Yours and Your Patients"
- 5.0 CEUs "Brief Treatment: Policies and Practice"

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- 5.0 CEUs "Brief Treatment: Policies and Practice"
This collection of twenty-two offerings over a period of nine months, averaging better than two per month, is pretty broad and diverse and the University of Pennsylvania is by no means unique. This can be multiplied by a factor of several thousand approved providers and you would probably be in the range of the CE offerings available nationwide. Unfortunately, despite the marvels of computer high technology, the figure cannot really be corroborated because there is no program clearing house mechanism. However, it is a good sized number, and now the reader can begin to understand why continuing education programs must become highly competitive for both nursing time and money; why continuing education has become a big business and why nurses are becoming increasingly selective.

**ISSUES AND PROBLEMS**

Based on what has been said about nursing continuing education administration, teaching techniques, range of subjects and evaluation of programs, it is not surprising, since it is a subject very close to the hearts, minds and pocketbooks of a comparatively large number of Americans, that it may have stimulated a few issues and problems. Most of the issues, all of which represent problems, are inextricably interrelated and revolve around a central concern for professionalism and competency. The principal issues include (not necessarily in order of importance): mandatory versus voluntary participation; control of the accreditation process; responsibility for participation and program cost/availability.

**Mandatory versus voluntary participation**

The concept of special knowledge, expertise and competency is inherent in the definition of professionalism and while health care professionals in general, and nursing in particular, has held self-regulatory accountability and competency inherent in a license to practice, the public has doubted the responsiveness of some professionals in voluntarily meeting their public trust obligations. Proof demanded of the medical profession became federally mandated through the passage of legislation which required peer review through Professional Standards Review Organization (PSRO). Despite efforts by the ANA, nurses were not included in the PSRO legislation and in an effort to demonstrate accountability in 1974 the ANA House of Delegates publicly went on record in favor of mandatory continuing education as a condition of relicensure. The intent was to demonstrate competency in nursing practice. Mandatory as opposed to voluntary continuing education has become one of the more controversial issues in nursing.
social need . . . It is only through mandatory relicensure and a commitment to excellence that the nursing profession will realise the true dimensions of professional practice.  

Interestingly, Prof. Levine is far from a voice in the wilderness. A relatively recent survey conducted by Nursing '78 among a random sample of 900 subscribers had a 61 percent response in favour of mandatory continuing education, 30 percent were opposed and 9 percent were undecided.

However, the decade of the 80's may show us the other side of the coin, with a reversal of the trend toward mandatory continuing education. One reason is the lack of definitive research findings correlating continuing education with nursing practice . . . if there is no proof of improved practice, through mandatory CE to demonstrate competence in practice it becomes irrational. Writing in AORN Journal, Gwen Dodge, AORN's Assistant Director of Education points out another reason, stating 'One of the facts of political life is the subtle and not so subtle influence exercised by vested interests. At least one of these groups, the hospital industry, is likely to contribute to the decline of mandatory CE for relicensure . . . State hospital associations generally oppose the requirement because, among other reasons, they believe mandatory CE has increased hospital operating expenses without proven cost savings'. Ms. Dodge continues, 'The final blow for the movement will come when the first license is denied for failure to meet CE requirements. The ensuing legal action will be precedent setting and, if as likely, the judgement goes in favor of the licensee, every state mandating CE will abolish the requirement with all due haste'.

Actually, a voluntary program has been set up which does allow maximum freedom for nurses to set their individual education goals and recognises their achievement of them. Called CEARP (Continuing Education Approval and Recognition Program), the system works like this: the National Accreditation Board of the American Nurses' Association certifies state nursing associations as continuing education providers and approval bodies. This ANA certification provides national recognition of contact hours earned by registered nurses who attend continuing education activities approved or offered by the state nursing associations.

Nurses who attain a designated number of contact hours within a specified time are awarded certificates of recognition by the state associations. Their achievement is recorded and publicized, and in many cases their employers are notified. Also, most states with mandatory continuing education permit nurses moving into the state to transfer credits earned elsewhere under CEARP to meet their licensure requirements.

Some states with mandatory programs have voluntary ones as well. One such state is Colorado, which recognizes under CEARP those nurses who accumulate 60 contact hours in two years, three times the mandatory requirement. Thus, the state board is attempting to assure competency under its mandatory program; the state association is attempting to encourage excellence under CEARP.

However, regardless of the outcome of the controversy for mandatory versus voluntary continuing education, what is not controversial is the responsibility of the nurse, as a professional practitioner, to maintain competence in whatever area of practice is being engaged in: clinical, administrative or other.

Control of the accreditation process

Another major issue involves control of the accreditation process. As has already been discussed, the ANA has set up a working process for accreditation. We also noted that the National League for Nursing (NLN) issued statements of support. Implicit in those statements was the fact that NLN would continue to accredit continuing education nursing programs in university or college settings. The original concerns about the duplicative accreditation role of each organization have not been resolved.

A further complicating factor is that a number of the nursing specialty organizations have their own accreditation procedures which do not fall within the ANA framework, and other specialities control both credentialing and the content of continuing education programs for their respective members. An example of the former is the organization of Pediatric Nurse Practitioners (NAPNAP); an example of the latter is the Nurses' Association of the American College of Obstetrics and Gynecology (NAACOG). The ANA accreditation structure was discussed previously; Diagram 2 shows how NAACOG ties into it.

NAACOG sought and was granted initial accreditation from the ANA/NAB in 1976. It is currently accredited as both approver and provider of continuing education through to 1983, at which point it will submit for re-accreditation approval for another four year period. The NAACOG Fact Sheet on Accreditation points out: Two NAACOG national committees are responsible for review of NAACOG Programs and determining the quality of content as well as designating the contact hour credit to be given. The Committee on Education reviews all continuing education programming which is subsequently offered on a national level. This includes NAACOG continuing education courses and national meetings. The Program Review Committee is responsible for reviewing and approving or denying contact hour credit to programs developed by NAACOG districts.

What has just been discussed only deals with the tip of the complexity iceberg. However, it should indicate that there is something less than a standardized approach to handling continuing education. This situation could probably be vastly alleviated if the nursing profession could agree on the establishment of a proposed centre for credentialing, the study for which has recently been completed. This study addresses all aspects of credentialing of institutions and individuals in the occupation of nursing, including accreditation, certification, licensing, degree designation and other forms. The study proposal is currently under serious consideration by most of the organizations within the nursing profession in the United States. If it can do what it proposes to do for the credentialing structure in the United States — the current structure is illustrated in Diagram 3 and the proposed structure in Diagram 4 — just think what that magnitude of change might do for the structure of continuing education, and it could start with centralized record keeping for CEU credits.
Responsibility for Participation

The next major issue involves responsibility for participation in continuing education programs. When all is said and done, this probably centers primarily on the individual. It could be argued that responsibility for providing and assuring continuing education for members resides in the professional organization, which makes continuing education a condition of membership. This is actually the case, and has worked well, for some state medical societies in the United States. However, given past positions and current trends, it seems more likely that it will continue to be incumbent on the individual nurse, regardless of membership in professional organizations, to assume individual responsibility for participation in continuing education. After completion of the basic program it is up to the individual to maintain a level of current competency commensurate with her professional commitment and public expectations. In the recent climate of malpractice suits, such a demonstrable commitment to competency can also serve as an insurance policy.

Program Cost and Availability

The final major issue under consideration is program cost and availability. Who should bear the cost of the nurse's continuing education has been the subject of some heated discussion. Formalized programs in continuing education are offered as in-service education in places of employment, through conferences, workshops, institutes and other program meetings of professional or other health organizations, or in continuing education programs offered by colleges and universities. Only inservice education is always free. The other programs frequently charge at least a token fee of some kind, even for members because the cost of providing quality programs is high. Some courses, which may extend over a period of days or months, could run into hundreds of dollars; however, the average fee appears to be closer to $25.00.

The professional nurse should expect to bear part of the cost. There are some who feel that because the employers ultimately benefit from the employee's improved performance they should provide some support as partial or full tuition payments, sabbaticals or short-term leaves. On the other hand, hospitals and like institutions often maintain that these additional costs must be passed on unfairly to the patient and that they have the right to expect competent practitioners. Both hospitals and universities point out that qualifying for ANA approval is an expensive, time-consuming process.

Another cost/availability factor is that while there is almost a plethora of offerings, they are concentrated in urban areas which makes participation by rural nurses more time-consuming and expensive. It also raises the question of formal/classroom versus informal home-study and programmed learning. Coupled with these are the considerations of quality versus accessibility.

The cost impact cuts two ways and more recently it has been felt as much by the universities and big association providers as by participants. Government and grant funding has done much to facilitate big organization providers has recently been less available, which has had the impact of cutting back on both the quality and availability of offerings. To some extent, this gap has been filled by commercial providers of which there are two varieties. The first is represented by manufacturers of health care products whose offerings are largely oriented to mutual interest — this might be called industry continuing education. The other might be called the continuing education industry — commercial companies who have capitalized on mandatory continuing education with program offerings for profit. This is a logical development in a free enterprise society and, because theirs have to be quality offerings which qualify for CEUs in order to survive, they have provided serious competition for the academic and association programs.

With so many programs from which to choose sophisticated nurses have become increasingly selective with regard to cost, quality and accessibility. Gloria Hochman in an article titled Continuing Education: How Can You Make the Most Of It? in Nursing '78 comments: How to pick the best program for you? Whether continuing education is voluntary or mandatory in your state, you have the burden of selecting the quality programs most appropriate to you. Doing so effectively requires skill, sophistication and aggressive consumerism that many nurses are just beginning to cultivate. And I suspect the realistic nurse may ask herself: “and what are my deficiencies?”

NURSE-MIDWIFERY AND NURSING CONTINUING EDUCATION IN THE UNITED STATES

As a final consideration in our review of continuing education in nursing in the United States a brief insight into how continuing education affects American nurse-midwives is given, through the kindness of Ms. Fay Lebowitz, Administrative Direc-
Categories of organizations, such as general nursing organizations, speciality nursing organizations, federal government nursing services, state credentialing agencies, nursing student organizations, related health organizations, and consumer groups.

** Departments of shared support services, such as research and development, tests and measurements, records, library and resources, administration, fiscal affairs.
In the United States a nurse-midwife has to be registered as a nurse in at least one state, presumably the state in which she starts her practice. If she moves her practice to another state, it is necessary to transfer her registration. Since there is reciprocity among all the states for the transfer of registration, this transfer can be accomplished through the payment of a fee to the State Board of Nursing. However, the same reciprocity does not necessarily apply to the transfer of continuing education credit. Although for the present nurses and nurse midwives participate in continuing education, programs, for the most part, on a voluntary basis, there are eleven states where continuing education is mandatory — i.e. where it is essential to have a certain number of continuing education contact hours each year for license renewal.

There are two broad types of continuing education agencies: those which are not for profit — represented generally by academic institutions, hospitals and professional organizations; and those which are for profit such as commercial companies like NURSECO and ASPEN, or like such state agencies as those which exist in Florida and California. In connection with the latter, for example, continuing education credit obtained in California is not necessarily transferable to Florida. While the nurse-midwife moving from California to Florida can transfer her license because of nationwide reciprocity, she cannot qualify for her license in Florida because of the catch-22 situation which prevails in states where there is mandatory continuing education.

CONCLUSION

This concludes the observations about nursing continuing education in the United States. If the impression has been given that a lot is happening, that is correct; if it has been implied that a lot still needs to happen that, too, is correct. And, if you in South Africa are planning to expand your program for nursing continuing education, it might be said — somewhat brashly — that you are commended to further study of the United States process, just as long as you do it with an eye to simplification.

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3. Ibid.
10. Ibid.
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14. Ibid.

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27. Salmond, Susan W. Inservice and Patient Education. AORN Journal. Vol II. (Interim Executive Committee on Accreditation of Continuing Education) American College of Nurse Midwives. Chairperson for the College's Committee on Continuing Education. It is both interesting and frustrating to contemplate the Catch-22 situation which prevails in states where there is mandatory continuing education.