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THE INTEGRATED CURRICULUM IN
ACCREDITED BACCALAUREATE NURSING
PROGRAMS IN THE UNITED STATES

By

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THE INTEGRATED CURRICULUM IN NURSING EDUCATION

DEGREE PROGRAMS IN THE UNITED STATES

Evaleen Johnson Essiet, Ph.D.

University of Pittsburgh, 1983

The use of the integrated curriculum in nursing education continues to be questioned. This study was designed to answer the following concerns: (1) The extent of integration in nursing programs. (2) The advantages and disadvantages of the integrated curriculum as identified by the study population. (3) Activities which nursing educators see as contributing to the success of the integrated program. (4) The attitudes of the study population toward integrated baccalaureate nursing programs. (5) Student and faculty satisfactions with the integrated curriculum and the study population. (6) The extent to which nursing educators favor curriculum revisions either towards or away from integration. (7) What tools/activities are being employed to assess the effectiveness of the integrated curriculum.

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The study sample consisted of 177 of the 287 nursing programs in existence.

Content validity of the total questionnaire was established by a panel of experts. The reliability of the Likert scale was .80.

The findings indicated that (1) The term "integrated" was not used consistently. (2) The study population did not have the same view of the advantages and disadvantages of integration in baccalaureate nursing programs. (3) The study population did not have the same view of the advantages and disadvantages of integration in nursing, but there were also many disadvantages. (4) Research needs to be conducted to better understand the curriculum of baccalaureate nursing education and to determine the extent to which nursing educators favor curriculum revisions either towards or away from integration.

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The findings indicated that: (1) The term "integrated curriculum" does not have the same meaning for all educators. (2) There are definite advantages to the utilization of integration in baccalaureate programs in nursing, but there are also major disadvantages. (3) Research needs to be conducted to solve problems related to curriculum models in baccalaureate nursing education.

Recommendations included: (1) A replication of this study be carried out with a larger number of faculty from a smaller number of randomly selected schools. (2) A delphi study be conducted to obtain a consensus on the terminology and definitions essential for nursing curriculum development practices. (3) A needs assessment tool be developed to obtain faculty perceptions of their curriculum development inservice needs. (4) Evaluation research be conducted to give direction to future curriculum development in baccalaureate programs in nursing.

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A special note of thanks is expressed to Ms. Ruthie Scott and Dr. Dorothy Richey for their technical assistance and encouragement during the preparation of this study.

Special recognition is paid to friends, coworkers and respondents who participated actively in the study.

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CHAPTER I

BACKGROUND OF THE PROBLEM

Nursing educators have always found curriculum development to be a challenging task. In the early history of education, curriculum was often interpreted as a course of study whether it was written or not. The first courses or curricula in nursing education programs emphasized the art of nursing. These curricula evolved from the philosophy of each program focusing on the development of hands on manual skills that were implemented to care for patients in the service oriented, hospital educational programs and were commonly referred to as the medical model.

The shift of the nursing curriculum from the medical model to an integrated approach was described by Torres in 1974 to be the "most dynamic change in nursing education" which had occurred since the early 1960s (p. 2). This dramatic increase in the use of the integrated curriculum in nursing was accompanied by literature which emphasized the lack of an agreed upon definition of integrated curriculum. However, the most often cited definition of integrated curriculum was offered by Torres in 1974 who stated:

unifying the nursing curriculum by means of the integrated approach means blending the nursing content in such a way that the parts of specialities are no longer distinguishable. This involves concentrating on the generalizations relating to nursing rather than specifics. (p. 2)

Later this definition was refined to state that an integrated curriculum "uses a process orientation as its approach to theoretical

nursing knowledge which encourages nursing generalization"(1982, p.76). The move from the medical model to the integrated model came into vogue when the rapid increase in knowledge made it impossible to teach all the pertinent information about every disease. Efforts were made to organize instruction in nursing around two basic approaches: (1) patients care settings, e.g. all patients with the same disease and medical conditions were grouped together; and (2) the body systems approach, e.g. the gastro-intestinal system and the cardio-vascular system (Schoen, 1975 pp. 383-387).

Both approaches made the organization of the nursing content a bit more manageable. However, problems soon became apparent with the body systems approach since a fragmented biological view ignored the totality of man. Attempts were made to rectify this problem by adding "communication-system, self-system, behavioral system, social system and the like" (Longway, 1972, p. 119).

The incorporation of the behavioral content placed the patient/person as the pivot of all nursing. A variety of approaches to nursing emerged as a result of attempts to consider the whole person. One of these approaches, the person-centered approach, facilitated the integration of natural, behavioral and health sciences. According to Longway:

Several terms are used to identify the person-centered approach: the integrated curriculum, the commonalities approach. All have in common the use of concepts and principles from many knowledge fields to promote the movement of the person toward optimum health. All require the learner to synthesize, analyze, and transfer learnings from one situation to another. (1972, p. 120)

A definitive definition of integrated curriculum is lacking in the literature. In spite of this lack of consensus, the term integrated curriculum has become very much a part of the vocabulary related to curriculum in American baccalaureate schools of nursing. But what remains in question is how integration is being utilized, and to what extent the integrated curriculum is employed in baccalaureate nursing programs.

Statement of the problem:

The problem of this study was to survey the status of the integrated curriculum programs in nursing education accredited by the National League for Nursing.

Sub-Problems:

1. To what extent are baccalaureate nursing programs integrated?
2. What are the advantages and disadvantages of the integrated curriculum as identified by the study population?
3. What activities do nursing educators see as contributing to the success of the integrated programs?
4. What are the attitudes of the study population toward integrated baccalaureate nursing programs?
5. What are the student and faculty satisfactions with the integrated baccalaureate nursing curriculum as perceived by the study population?
6. To what extent are nursing programs planning revisions of their curriculums either towards integration or away from integration?

7. What activities have been employed to assess the effectiveness of the integrated curriculum?

Limitations:

1. This study is limited to generic baccalaureate nursing programs which are accredited by the National League for Nursing.
2. The study is also limited to the data that can be obtained via a mailed questionnaire.
3. This study is limited due to the lack of agreement on definitions and terminology in the literature.

Definitions:

1. Content element: concepts and theories that convey subject matter ideation.
2. Approaches to content: the specified modalities and methods utilized to structure and convey subject matter.
3. Integration: a mental mechanism/process whereby subconcepts are reconstructed into a unified conceptual whole.
4. Integrated content: content arrived at by reformulating entities of subject matter into a conceptual whole.
5. Conceptual framework: a group of interrelated concepts utilized as a model for organizing essential knowledge into a curricular design.
6. Medical model: curriculum in which the structure utilized as the organizational focus for the nursing content is disease-oriented.

7. Nursing model: a conceptualization of the theories and concepts which constitute the discipline of nursing as delineated by the essentials of the practice of nursing.
8. Blocked content curriculum: here, the subject matter related to the medical specialities is organized to be taught and learned within a specified time period.
9. Integrated nursing curriculum: a format for teaching and learning the discipline of nursing whereby problem solving, and various other processes, methods and modalities are utilized which encourage and accomplish the reformulation of theories and concepts into a conceptual whole (as prescribed by a specified conceptual framework).
10. Traditional nursing program: a plan of instruction that utilizes the medical model or the blocked content structured curricular approach as the format for the teaching and learning of knowledge essential to the practice of nursing.
11. Integrated nursing program: a plan of instruction which conceptualizes the discipline of nursing as the curricular approach and format for teaching and learning of knowledge essential to the practice of nursing.
12. Process: "A series of progressive stages in which interdependent activities have a specific purpose. It has the characteristics of being systematic, dynamic, and spiraled" (Torres & Stanton, 1982, p. 173).

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

For this research, computer searches were conducted on the integrated baccalaureate nursing curriculum. The Educational Research Information Center (ERIC) and the Medical Literature Analysis and Retrieval Service (MEDLAR II) of the University of Pittsburgh, both provided some information. Initially, available sources revealed an apparent limited amount of research and documentation on the integrated baccalaureate nursing education curriculum.

The review of the literature encompassed a brief profile of historical perspectives of curriculum development in nursing education, the historical development of curricula in baccalaureate nursing education as well as the development of the integrated curriculum in baccalaureate nursing education in the United States.

A Brief History of Curriculum Development in Nursing Education in the United States

There are a number of opinions as to when to date the beginning of formal nursing education or training in the United States. The early curriculum referred to as a plan of study, which in many instances was an unwritten one, tended to be more unique than similar.

In the United States, one of the earliest organized structures for the preparation of nurses during the first half of the nineteenth

century was in Catholic sisterhoods. Initially, the preparation of nurses was strictly an apprenticeship and restricted to members of the order. Subsequently, the nuns opened schools for the training of secular nurses (Nutting & Dock, 1912, p. 187).

By the third decade of the nineteenth century another type of educational system for nursing appeared in the United States. These schools of nursing were planned under the direction of physicians who gave lectures, supervised demonstrations and care which was primarily for obstetrical patients and infants. The physician-supervised form of instruction became known as the "training of nurses" (Putnan, 1947, p. 918).

One such program was started in Boston in 1872 by Dr. Susan Dimach. The one year program consisted of medical, surgical, obstetrical and pediatric lectures given by physicians (Richards, 1901; Richards, 1911). The first diploma graduate of this program was Linda Richards, in 1873.

Also in 1873, the Nightingale System of nursing education spread to the United States. The Nightingale system advocated that nursing schools be a "self-supporting educational institution to train nurses" (Stewart, 1921, pp. 3). Nightingale's mission was that the school should prepare nurses "to go into other hospitals and there, in turn, organize, teach, and train" (Dock & Stewart, 1900, p. 126).

Florence Nightingale wanted the school matron to have final authority over the curriculum which would include theoretical as well as practical experience. Records would be kept on students who would be required to attend lectures given by teachers who were paid for their instruction. These nursing students were required to take quizzes, write papers, and keep diaries (Ellis and Hartley, 1980, p. 23).

Three schools were established in 1873. Bellevue in New York City was followed by the Connecticut Training School of New Haven and the Boston training school (Dock & Stewart, 1920, pp. 152-155). While each of these three schools was purported to be patterned after the Nightingale Plan, all three differed significantly from that model (Dolan, 1975, p.989). The amount of information available on each of these schools' curriculum varies accordingly.

Bellevue's school, which began in 1873, gave the following account of their curriculum in 1875:

Eight lectures upon circulation, respiration, digestion, diseases of women, and care of children, four lectures on obstetrics; ten on anatomy, physiology, and digestion; two on symptoms of disease and temperature; three on digestion; two on obstetrics, one on walking; one on hemorrhages; one on bedside manipulations.

Add to these a regular and most valuable course of lectures from the assistant superintendent on the various duties of a nurse, on urine, wounds, and eruptive and typhoid fevers. (Hobson, 1901, p. 96)

There is duplication on these sequentially listed courses. This illogical sequence of content may have been due to the availability of the lecturer of the content. Much of the student learning was still by the apprenticeship method and by trial and error.

Connecticut Training School began in October of 1873, at the request of the medical school of New Haven Hospital. A one year program was established with the students spending a second year in service. Little is known about the early curriculum, but by 1874, the doctors and nurses at the Connecticut Training School collaborated to write the New Haven Manual of Nursing as a comprehensive nursing textbook. This text was used by nearly all of the nursing schools being organized at the time throughout the United States (Dock & Stewart, 1935, p. 155).

The Boston Training School at Massachusetts General began in November 1873 with six students (Stewart, 1920, p. 155). The Boston Training School was one of the pioneering schools which introduced a formalized instructional program. The responsibility for administration of the educational program was often given to the Director of Nursing Service who also functioned as the Director of Nursing Education. Student exploitation was common; very long hours of duty on the hospital wards were required. Very few schools had classrooms which were suitable, while most of them had neither laboratories nor other teaching materials. Anything that could be considered as a library was only available to less than one-third of the schools (Nutting, 1912, p. 45; Nutting, 1926, p. 267).

In the schools most of the instruction which was provided consisted of lectures which were given by different physicians of the staff who rendered their services gratuitously.

The school had little power to choose or control the quality of its curriculum offerings. With neither means to pay for suitable teaching, nor freedom to choose the teacher, it must accept whatever is within reach. (Nutting, 1926, p. 18)

As the number of nursing schools increased, the curriculum of these programs utilized the medical model and continued to be expanded to coincide with the nurses' need to keep up with the changes in medicine which occurred when ether anesthesia was introduced in the United States. A rapid expansion of the whole system of hospital care occurred (Dock & Stewart, 1920. pp. 159-160). The training courses continued to be lengthened in an effort to better prepare the students. Isabell Hampton Robb, a nursing leader, "amplified and graded the course of instruction up to and through two years, "then in 1894 she advocated and

prepared the way for the three year course (Nutting & Dock, 1920, p. 125). In 1896, a report of the American Society of Superintendents of Nursing Schools urged that medical, surgical and gynecological nursing with examinations be included in the curriculum, that nurses teach classes in the first year and doctors in the second year (Watson, 1977, p. 35).

Traditionally, nursing program content has its origin in the medical profession. Earlier, medicine had evolved into basically five areas of practice which were surgery, medicine, obstetrics, pediatrics and psychiatry. Doctors began to confine their practices to one of the specialities. Patients, likewise, were grouped in like conditions in the early hospital systems. Hence when doctors taught student nurses, they utilized a "medical model" framework to organize and impart their information. Gradually, as nurse-lectures replaced physicians-lectures, they also continued the same format of organizing lectures around diseases and body processes (Anderson, 1981, p. 24). The nurse-educators developed their curriculum by focusing on the content and learning activities on the five medical clinical speciality areas, for example, medical-surgical nursing, maternal and infant nursing, pediatric nursing, psychiatric nursing and community health nursing.

Basically, the traditional nursing program content was taught as separate subjects as outlined in the Standard Curriculum Guide of 1917. These courses were constructed following the medical or logistic method, the oldest surviving nursing curriculum was disease centered or was taught by the "body systems" approach (Stevens, 1971, p. 389). Theory was taught in two different settings. The segment that is referred to as

the clinical experience component was taught in the hospital unit specified on the actual patient; whereas, a limited amount of theory was also taught in the lecture format in the classroom setting. As can be seen in this structure, it was necessary for students to apply information gained from two learning modalities in two different settings, from the classroom over to the clinical ward and vice versa.

Weiner indicated that the students were rotated to these five different locations in the hospital during pre-designated sequential blocks of time (1969, p. 2505). Clinical experiences occurred at different times of the academic calendar year for student who were members of the same class. Unfortunately, there was no logical placement of the clinical experience. Due to the limited number of speciality teachers, students had to be taught and accommodated at the convenience of the specialized staff members of the institution. Since these institutions were not under the influence or control of the nursing schools, nurse-educators did not have very much control over their nursing content. The logistics of getting each student to receive the same amount of time and quality of clinical experience in each of the speciality areas was difficult.

During the expansion years in the early 1900's M. Adelaide Nutting, a nursing leader from Teachers College, conducted the first comprehensive and critical survey of nursing schools in the United States. The survey was published by the U. S. Bureau of Education, in 1912, under the title "The Educational Status of Nursing." The survey investigated what students were being taught, what techniques were being employed, as well as under what conditions the students were living. They found excessively long work hours and poor sanitary living conditions. This

study set a precedent for later nursing studies and has been credited with having established nursing as a profession. It further showed a need for continued investigation of educational practices and the need for schools of nursing to be independent from hospitals.

One year after the Nutting publication, in 1913, the committee on nursing of the National League of Nursing Education developed a three part plan to improve curricula (Proceedings of the Nineteenth Annual Convention of the National League of Nursing Education, 1913). Subsequently, The Standard Curriculum for Schools of Nursing was published in 1917. This book contained concrete suggestions on how to improve standards in the schools of nursing as well as guidelines on how to set up actual courses.

The structure of the courses followed the previously mentioned medical model. The length of the course was specified as "three calendar years." The general schedule of hours suggested that the first four months, or preliminary term, was somewhat different from the rest of the course. The number of hours per day for practical work doubled from four hours to eight hours. The three hours devoted daily to lecture and class during the preliminary period was reduced to about one hour for the rest of the course. The three hours for study and practice was reduced to one hour daily for study. "This means ten hours of actual required work daily throughout the academic year with the exception of Sundays..." (1927, p. 36)

The general time schedule of practical instruction included medical and surgical nursing (eight months each), obstetrical nursing (three

months), special diseases (two months) and electives (four months), (1927, pp. 37-38). The theoretical courses were given in two terms of sixteen weeks each year (1927, pp. 39-40).

Many schools lifted and used content directly from the book even though the Committee on Education (1927) suggested that their work not be used as a standard:

It is recommended, however, that each school work out its own list of practical objectives, using this outline perhaps as a basis and amplifying it to that particular type of school.... The committee accepts the principle of the basic course in the sense that the training offered in the undergraduate nursing schools should be as general as opposed to a specialized training and that it must supply the foundations on which all additional training and experience should be built. (p. 9)

The 1927 revision of this book appeared under the title A Curriculum for Schools of Nursing. The change of title, it was hoped, would discourage programs from just lifting the content from the book rather than using the information as a guide for the development of their curricula. The third revision, in 1937 was entitled the Curriculum Guide for Schools of Nursing. It established guidelines for curriculum planning and discussed the need for clinical instruction to augment the theoretical courses. (National League of Nursing Education, Committee on Education, 1917, 1927, 1937).

Studies Related to the History of Curriculum Development in Baccalaureate Nursing Education in the United States

During this time of rapid increase in the number of nursing schools and the expansion of the curriculum, nursing leaders were cognizant of the multiple problems existing in nursing education. It was apparent to the leaders that the only way to upgrade nursing was to upgrade the leaders and teachers of nursing who, in turn, would elevate the

standards of nursing. Linda Richards and Isabel Robb, two nursing leaders, emphasized the need for improving the preparation of leaders and teachers. Mrs Robb, suggested that Teachers College, Columbia University, which was established in 1888 to "train teachers for normal schools" develop educational programs for nurses (Dock & Nutting, 1912, pp. 131-132; Dock & Stewart, 1920, pp. 176-177). The idea became a reality in 1899, when a program for graduate nurses in Hospital Economics began to be offered at the school. The course was one year in length and included psychology, chemistry, biology, bacteriology, food and nutrition, and involved cookery and household sanitation (Nutting, 1920, pp. 323-326). Upon completion of the course the nurses were given a certificate, not a degree. This was a real milestone in that it was the first step toward the realization of the nurses' dream for better education offered in schools of higher education.

While Teachers College launched the new program for nurses, Mrs. Fenwich, (1901) the President of the International Council for Nurses, summed up a speech with a "plea for higher education for trained nurses." She said that there was:

need for a more thorough and better organized educational curriculum for trained nurses, and the foundation and endowment of colleges in which such education should be centered. (p. 4)

Such thinking led to the development of the college preparatory courses and affiliations of nursing schools with university systems (Grippando, 1977, p. 117). Once again Teachers College became a pioneer when in 1909, the department that offered the home economics course at Teachers College was reorganized into the Department of Nursing and Health. It offered four programs: teaching and supervision

in training schools; general administration in training schools and hospitals; public service-teacher nurse, visiting nurse service, board of health assistants and teachers of hygiene; and preparatory courses for nurses (Nutting, 1920, pp. 323-326). Again nurses received a certificate, not a degree.

In that same year the University of Minnesota established a nursing school at the hospital controlled by the University. Although the nursing school was established under the umbrella of the University, the school in actuality was a diploma school. The graduates of this early university-based program received a certificate not a degree (Dock & Stewart, 1920, p. 179). The program was elevated to full university status in 1919 by expanding its program to five years, incorporating liberal arts, nursing education and one year of public health or teaching (Petry, 1937, p. 288). The graduates received a diploma as well as a Bachelor of Science degree (Petry, 1937, p. 288). Two universities lay claim to the first nursing programs that led to a nursing degree.

The first basic programs in nursing education leading to a degree were offered in 1916, one by the University of Cincinnati and the other by Teachers College in cooperation with the Presbyterian Hospital School of Nursing, New York (Dock & Stewart, 1920, p. 179). These inaugural programs leading to a baccalaureate degree added two years of liberal arts to the basic three year diploma schools which followed the medical model curriculum (Logan 1921 ,p. 620).

During the second and third decades of the Twentieth Century, more university and collegiate programs were begun. Many of the early university schools were organized under schools of medicine. The establishment of a baccalaureate nursing program apparently made little

impact on the direction and standard of hospital schools. Minimal written evidence regarding the professional component of the nursing curricula in hospital or collegiate programs was available (Mc Donald, 1965, p. 65). "There was considerable variation in different universities" regarding the courses offered in the first two years. The preparatory subjects required as soon as the student entered the hospital usually included: nutrition, cookery, elementary materia medica, elementary nursing, hospital housekeeping and history of nursing (Logan, 1921, p. 714).

While these early schools were gaining a foothold in university settings, the Rockefeller Foundation appointed a committee to study Public Health Nursing in the United States. It soon became apparent that the survey, under the directorship of sociologist Josephine Goldmark and committee chairman, Dr. C.E.A. Winslow, Professor of Public Health at Yale University, had a limited focus and, therefore, their committee was requested to expand to encompass the trends in nursing education. The report published in 1923 as Nursing and Nursing Education in the United States, (also known as the Winslow-Goldmark Report) surveyed twenty-three schools of nursing and forty-nine public health agencies. They sought answers to questions relating to the preparation of teachers, administrators, public health nurses, clinical and laboratory experiences for students, licensure for nurses, financing schools of nursing and the development of university schools. Goldmark reported that there were 16 universities and colleges offering combined academic and professional programs leading to a baccalaureate degree. The three major findings were that (1) there was wide spread neglect in nursing education in the field of public health; (2) many

many schools had inadequate facilities and deficient clinical facilities for teaching students and (3) the same person was responsible for nursing service and nursing education.

The report made the following recommendations for nursing education and the reorientation of the field of nursing towards meeting the needs of society. High school graduation was proposed as the minimum preparation. The curriculum was to be planned for theory and clinical experience so the repetition of content would be eliminated. An eight hour day was proposed. Schools of nursing were to be separated and autonomous from hospitals and be adequately funded. More university schools utilizing the five year program were recommended.

An important result of the study was the establishment of the Yale University School of Nursing which was financed by the Rockefeller Foundation (Dock & Stewart, 1930, p. 181). Yale University replaced the Connecticut Training School in 1924 (Notter & Spalding, 1976, p. 20). Students were given a baccalaureate degree in nursing from 1926 through 1936. In 1936, Yale changed their program to the first basic Master in Nursing program (Dolan, Fitzpatrick and Herrmann, 1983, pp. 298-299). Students with a baccalaureate degree in any other area could be admitted and upon completion of the program received a Masters in Public Health (M.P.H.).

Within two years of the (1925) Winslow-Goldmark report, the Committee on Grading of Nursing Schools was organized (Committee on the Grading of Nursing Schools, 1934, p. 8). The findings of this study ultimately led to the elimination of inferior schools of nursing and a temporary reduction in the number of nursing schools. During the Committee on Grading Schools' tenure, a group of nursing educators

concerned about the disorganization evidenced in the collegiate educational programs held a meeting at Teachers College in 1928. At that time there were at least five different types of arrangements being classified as collegiate schools of nursing. The predominating arrangement seemed to be spending the first, second, and fifth year in the college, with the third and fourth years being spent in the hospital. It was the opinion of that committee that two years of academic work should precede the professional nursing preparation.

Nursing made few gains during the 1930's and 1940's. The depression was hard on nursing education. College programs which were financially dependent upon hospitals found it difficult to control the development of the curriculum and small schools closed. Almost every collegiate program depended upon hospital nursing service personnel to teach the specialized courses because there was a scarcity of prepared faculty. This resulted in the curriculum being fragmented, since students had to be sent for courses and experiences at the convenience of the agency (Dock & Steward, 1920, p. 181).

In 1936, Petry published a study, Basic Professional Curriculum in Nursing Leading to Degrees. The data for the study was obtained from a questionnaire sent to those schools of nursing designated on the List of Accredited Schools as compiled in January 1935 by the National League of Nursing Education. There were 245 schools, of which only seventy offered nursing degrees. More than half of these programs were established since 1930. The rate of growth of the programs as reported in five year intervals was 9 between 1916 - 1919; another 9 up to 1924; an additional 14 by 1929 and 23 from 1929 to 1934; however, for 1935 alone 15 new programs were reported.

Following World War II members of the National Nursing Council for War Services believed that a comprehensive study of nursing was needed. The council persuaded the Carnegie Corporation of New York to fund a study. Their study was published in 1948, and is known as the, "Brown Report" entitled Nursing for the Future. The Brown Committee Report differentiated between the professional nurse and the graduate bedside (non-professional) nurse, and emphasized that professional nursing education belonged "squarely within the institutions of higher learning" (p. 138).

The Brown Report also criticized all professional schools, including nursing, for the separation of academic and professional education rather than integrating the two. The rationale was that such integration would reduce the time required in the educational program and would "enhance student motivation and understanding" (1948, p. 141). Two major changes suggested were that schools of nursing should have affiliations with universities and have separate school budgets. This was especially pertinent because the majority of nursing schools, at the time, were still the hospital diploma programs.

A study, published in 1950, was one attempt to implement the previously discussed Brown Report. The National Committee for the Improvement of Nursing Services (a committee of the joint board of the six national nursing associations active at that time) was responsible for the study. Some of the areas studied were the organization of the schools, the cost of nursing education, curriculum content, clinical resources and student health. Their findings were based on the

practices of over 1,000 schools of nursing in 1949. Their report contained statistical tables and graphs that schools could use to compare their own performance with that of others. The report is now out of date and out of print (Kelly, 1975, p. 898).

Also, in 1950, the post graduate Board of Review in Nursing, responsible for accreditation for the National League for Nursing Education, established the purpose of the baccalaureate education in nursing as the preparation of the generalist (National League of Nursing, No. 15-1758, 1979, p. 1). The importance of the preparation of nursing education on the college level continued to be emphasized. However, information on what was necessary to include in the basic baccalaureate curricula was not yet available. To rectify this, in 1949 the Russell Sage Foundation made available to colleges and universities a temporary nursing education counseling service. Dr. Bridgeman was the consultant who would study the diversity of current teaching programs in existing schools for nursing. Her report published in 1953, based on the findings of eighty senior colleges led to an over-all strengthening of the programs. This was accomplished by development of criteria to assist in evaluating the purposes and objectives of existing programs, in establishing and developing new programs that would maintain a consistent standard in course design and content so as to preserve the integrity of the degree.

After a fifteen year study, the American Nurses Association (ANA) published a position paper on nursing education in 1965. The ANA had decided to promote the baccalaureate degree program as the basic education for professional nurses (pp. 104-111). In the same year, the National League for Nursing adopted a resolution which supported the

trends towards college-based programs in nursing. However, they committed their organization to the task of defining the different programs for personnel to be prepared to perform complementary but different functions. The resolution stressed the need for local planning and recruitment into all programs in order to ensure that community nursing needs would continue to be met.

In June of 1970, the National Commission for the Study of Nursing and Nursing Education completed three years of study and published its report, An Abstract for Action. This report described the findings, reported the conclusions, and proposed a series of recommendations intended to "improve the delivery of health care to American people, particularly through the analysis and improvement of nursing and nursing education" (Lysaught, p.1). In keeping with the Brown and Bridgeman studies, Lysaught saw a need for changes in the basic organization in the educational institutions of nursing. The number of hospital schools of nursing had been sharply reduced since the sixties. Further, the study revealed that there had been corresponding increases in the number of collegiate programs especially the community and junior colleges. Lysaught believed that the shift reflected the realities of the economy as well as the expectations of society (p. 156).

The Commission's recommendations for nursing education centered on the proposals for moving all institutions into the collegiate mainstream. Reactions from organizations which represented the hospital schools of nursing were geared for non-support. Feelings were still high in June of 1973, when the commission published their implementation report, From Abstract into Action, (1973, p. 1). In September of 1970, the Commission formally moved from "investigation to

implementation" (1973, p. 20). The first of their three stages of implementation was aimed at clarifying the real underlying problems of the manpower shortage. In the second stage, a National Joint Practice Commission between medicine and nursing would be established to re-examine the practice roles. Most pertinent to curriculum, the third stage would emphasize the planning and change process necessary for reconstructing the patterns of education and practice in nursing (1973, p. 20).

The historical review of curriculum development in nursing education has revealed a progression of efforts to improve the education of professional nurses. It is evident that the greatest move toward placing nursing within the framework of schools of higher education occurred after World War II. Although the impetus was there to improve nursing education, most of the curriculum was unimaginative and followed the medical model which had originally evolved. The early nursing curriculum design was a series of separate courses. Both physician and nurse-teachers utilized a body system or disease-centered framework to structure the knowledge being taught. Either of these formats had been a logical frame of reference from the medical model point of view.

However, due to societal influences, nurses recognized and responded to the need to integrate while still using the medical model. They began early in the 1930s', simply by combining social and other related health concepts into the medical speciality areas they were previously using. Mental health nurses were another group of the speciality nursing areas, to become involved early, in providing suggestions and proposed curricular changes and plans for unifying content (integration). The interaction of mental health concepts had fit neatly within

the medical model. It was fairly easy to conceptualize that the mind and body were connected as had been advocated by Essentials of a Good School Manual (1936, p. 26).

Much was written on the suggestions that nursing committees give attention to the societal influences and health related concepts upon the physical aspects of nursing care. These groups were actively encouraging the educators to incorporate this content into the basic nursing curriculum. Another evidence of these trends being advanced appeared in the 1937 Curriculum Guide, which is credited with having integrated the social and health factors throughout all courses. The guide advocated that what was considered the essentials of a professional curriculum were "the same in good nursing schools under all types of organization" (p. 654). It was beginning to become apparent that the nursing discipline utilized and needed to incorporate a lot more than medicine and disease as its core of knowledge. The integrated curriculum, which emerged later was but one approach to achieving this goal.

A valid presentation of the historical development of the integrated nursing curriculum necessitates an unbiased presentation of what has been documented. Therefore, the next segment of the review consists of three important parts: first, literature that helps to clarify the concept of integration is provided as a frame of reference; next, the four major studies which are related to this present study are covered; and last, other related studies which represent the major themes of concerns that continue to be raised about integration, concludes the review.

Since there has not been an agreed upon definition of integration, an attempt has been made to clarify the concept from a historical perspective. The history of the integrated baccalaureate nursing curriculum, which is covered next, begins with the issues and concerns which are pertinent to the understanding of curriculum practices utilized to accomplish integration.

The History Of The Integrated Curriculum in Baccalaureate
Nursing Education in the United States

Clarifying the Concept

Nursing education began limited first attempts at integration in the early 1940's. Unfortunately, however, the 1940 endeavors are not always acknowledged as being integration attempts. This is not surprising since even currently there is a running controversy over what constitutes integration.

Much of the literature related to the use of integration in nursing laments the lack of an agreed upon definition of the term "integration", also modalities employed for the purpose of "integrating the curriculum" are questioned, and according to Torres and Stanton (1982):

There is no consensus among educators on the characteristics of an integrated curriculum. And, for that reason, confusion persists as to whether or not it truly exists and to what extent within any given program it is implemented. (p. 75)

Due to the lack of documentation in the nursing literature of the specific practices which were being employed for integration purposes, it was necessary to review the broader area of general education. In general education, it appears that some schools were claiming to be integrating, while in reality they were using correlations. The idea of

correlation usually applies to the finding of threads connecting separately taught subjects, but the word "correlation" has been used in a number of different ways (Dressel, 1958, p.14).

Dressel proposed the following three methods whereby attempts at integration can be accomplished:

Contrasted somewhat with the concept of correlation of independent subjects is that of fusion which involves the actual joining together of what were previously separate subjects.... Other attempts at integration have functioned through setting up activity units around a central, nonsubject theme involving perhaps the act of thought itself, general concepts or principals, great ideas or values. Still others have attempted to organize the curriculum around some central core of subject matter or experience.... In general ...attempts at integration have been of three types: (a) those developing interrelationships among existing courses, (b) those involving reorganization of content into more general courses, and (c) those involving the centering of content about vital problems of society or of the student. It is also possible to develop a curriculum using all three types (Dressel, 1958, p. 15).

In the late 1930's and early 1940's attempts in nursing education to integrate the program of study would best fit into Dressel's "b" category. The increasing use of integration in nursing during the sixties and seventies has undoubtedly encompassed the use of all three. An assessment of the exact amount of integration that is occurring will remain difficult until there is a disclosure of, and subsequent documentation of, the integrative practices that are occurring. Unfortunately, the documentation process has been hampered by the lack of an accepted and/or an agreed upon definition of integration. Thus, this elusive definition perpetuates the cycle of confusion evidenced in the literature on nursing integration.

Motivated to get beyond these impediments, this researcher decided to attempt to assess the integrative practices in current usage to

determine the extent of integration that is actually being utilized. While it would be an over-simplification to consider the practice of combining concepts and content as being equivalent to the integrating process; it is assumed, that in order to achieve integration, the components which comprise the "integrated product/entity" must somehow unite together. Consequently, the term "combining", has been examined and employed in this study to define as simply as possible the process that content or other component parts must undergo in order to be considered integrated. This examination of the combining of concepts and content is only one of several methods used to solicit a composite picture of integrative practices which are being employed in baccalaureate nursing programs.

One of the earliest citations located which speaks to the combining of subjects in nursing was written in the March issue of the American Journal of Nursing. It related that:

We segregate for ease of administration and better care as well as for ease in teaching clinical practice to both nursing and medical students...Actually patients in home and most hospital situations usually require both medical and surgical nursing resulting in consecutive or simultaneous experiences in both fields for the nurse....(Amberson, 1936, p. 267)

Amberson (1936) suggested in this article a "new approach to teaching surgery, medicine and communicable disease," by combining the three subjects which would reduce repetition and duplication. The main purpose of planning such a course would be to "direct the students' thinking to the interweaving of medical and surgical nursing throughout the period of care of the patient" (pp. 267-268).

While Amberson did not use the term integration, she speaks of interweaving content, which is consistent with the terminology Torres

to view the interweaving process as a preliminary step towards integration. Ambersons' goal was to reduce repetition and duplication, which are also reasons for employing integration.

Other early suggestions on the need for integration in nursing were published in 1938, in the January issue of the Public Health Nursing Journal. This article by the subcommittee on student affiliations of the Education Committee of the National Organization for Public Health Nursing offered recommendations on "ways in which the affiliations could carry out the spirit and purposes expressed in the New Curriculum Guide." It was pointed out that the purpose of the affiliation was not to introduce the field of public health, but rather a unified approach was intended to be offered to schools which had definite plans to incorporate the social and health aspects of nursing throughout the entire curriculum (Subcommittee on student affiliation of the Education Committee of the National Organization for Public health Nursing, 1938, pp. 15-19).

There is a series of three articles on the reports of the joint committee of the Leagues' Curriculum Committee and the state organization for Public Health Nursing formed in 1940 for the purpose of studying the social and health aspects of the curriculum (p.228). These articles appeared under the title, "Social and Health Aspects of Nursing-Suggestions for Their Integration in the Basic Course," and were published in the American Journal of Nursing Vol. XLIII for March, April and May of 1943. In the March article it was said that:

To study the curriculum, to accelerate or telescope courses is the order of today. ...that the social and health factors in nursing pervade the entire curriculum and cannot be confined to any one special branch of nursing but is the obligation of those who care for anyone sick or well. (Joint Committee of the Leagues' Curriculum Committee and the State Public Health Organization, A.J.N., 1943, p. 228)

Suggestions were made to include some of the social and health aspects of the courses in psychology, sociology, social problems in nursing service, introduction to medical science, pharmacology, introduction to nursing arts, nutrition, foods, and cookery plus others. The committee concluded their recommendations by citing the fact that "This content is included in the Curriculum Guide, but, instead of being isolated into a single course, it is integrated throughout all courses" as their rationale for advocating this practice (A.J.N., Mar. 1943, p. 228). The second article in April was related to medical and surgical nursing (A. J. N., 1943, p. 386). And in the final May issue, suggestions were offered for the inclusion of social and health aspects into courses in obstetrics, pediatrics, and psychiatric nursing. They also covered nursing and health service in the family (A. J. N., 1943, (5), p. 484).

Dunn (1944) wrote an article regarding the "Social and Health Aspects of Nursing" in the March issue of the American Journal of Nursing, indicating that the "societal influences upon nursing had many implications for nursing education" which required a revision of content and changes in familiar curriculum patterns and teaching methods (p. 265). She described the need for a new emphasis on the inclusion of the social and health aspects of nursing as one of the most effective means of improving the quality of nursing (A.J.N., (3), 1944, p. 265). The following statements leave no doubt that Dunn is referring to the type of integration which programs are attempting to achieve currently:

It is obvious that integration of this type involves much more than mere knowledge of subject matter, but rather (of) an attitude, an understanding and a mastery of caring for the whole patient in various environmental situations, including the hospital and the home...Such a program presupposes:

(1) knowledge and utilization of all appropriate community facilities; (2) a faculty well prepared to recognize and capitalize on learning situations for the students; (3) students with ability to learn. Integration is a reality only when every opportunity or situation is seized by every instructor to emphasize the preventive health, and social aspects from the time the student enters the school of nursing until the completion of her nursing program. (A.J.N., (3) 1944, pp. 265-268)

In 1945, other concerns are written on the need for "correlation or integration" in nursing. Bunge explains clearly how she recommends integration should be implemented:

Clinical experience is a part of the whole curriculum pattern and, therefore, cannot be lifted out and discussed alone...certainly planned clinical experience is one of the indispensable means of reaching the goals of basic nursing education (1945, p. 137). One of the most coveted methods in Nursing Education is that of teaching students in actual nursing situations... Much of the teaching goes on at the bedside in the form of planned conferences or incidental, informal ward teaching. This is an example of the most perfect correlation and often integration of theory and practice... On certain services the importance of close correlation or integration is more apparent than on others, i.e. operating room special skills theory needs to precede--sometimes students cannot be prevented from having the related theory some time before or even after they encounter the situation in their care of patients. The ward teaching program acts as a buffer. (Bunge, 1945, p. 137)

Bunge gives three common patterns which were used for clinical rotations: 1) The self contained block with theory and practice occurring at the same time; 2) The alternating block; here, several weeks or months of theory are followed by a period of ward experience and 3) The individual rotation consisted of less rigid and less formal structure. There was no well-developed regular pattern of rotating students in groups, and theory was given at the same time or before hand (1945).

It should be noted, that Bunge wrote about the use of both correlation and integration which tends to validate that Dressle's previously discussed definitions on how correlation can be used to achieve

integration was occurring in nursing during the early 1940s. Today the use of the patterns of block rotations continue. This is one factor which could be acting as a catalyst which is clarifying for the educators the need to move toward more integration of their content.

The continuing concern with the integration of "Social and Health Aspects" is also demonstrated in two other articles. The first article on faculty preparation appeared in the July, 1945 issues of both the Public Health Nursing and the American Journal of Nursing. Then, in August of 1947 both journals published "Action Program for the Community...", which was a report of the Joint Committee on Integration of the Social and Health Aspects in the Basic Curriculum. In the 1945 article, "Faculty Preparation in Health and Social Components of Nursing," which appeared in the Public Health Nursing the following argument was made: Since the basic concept of nursing includes prevention of illness, promotion of health, and care and rehabilitation of the sick, the present graduate of nursing should be able to provide this type of nursing care. Hence, it is the responsibility of nursing educators to "prepare students to function in this broad capacity" (P.H.N., 1945, pp. 348-355).

The 1947 article prepared by the joint committee of the National Organization for Public Health Nursing and The National League of Nursing Education which appeared in American Journal of Nursing conveyed grave concern about the increasing difficulty they were encountering in securing experience in public health agencies for students in basic nursing programs (1947, pp. 555-556).

Over time, the concept of integration changed and eventually "nurses with public health experience" were brought into the schools "to

assist the faculty with the integration of health and social aspects into the total curriculum" (Heidgerken, 1955, p.128). The concept of integration of public health aspects has continued to change as evidenced by the Yaksich et al, (1979) study under the APHA auspices.

They found that:

slightly more than half of the schools of nursing (59%) reported that community health nursing was provided in an integrated program with the clinical experience at a specific time through a block rotation in a community agency. (p. 105)

Heidgerken was one of the first nursing educators to write on integration issues. She pointed out that integration which was first used in connection with health, and social aspects of nursing could be accomplished through a period of student experiences in public health agencies. There is some disagreement currently on whether or not Heidgerken is really discussing integration as it is used today. Her works have been included because they are of historical significance in that they substantiate that nursing initially utilized the same types of devices and terminology as general education. The information which follows is consistent with three methods that Dressler has mentioned that could be used to effect integration.

In 1949 and again in 1955, Heidgerken attempted to clarify the issues on integration. In the first instance she discussed the increased usage and expanded meaning that the term "integration" had undergone. Thus "integration is used to describe, the entire school curriculum, how learning takes place and in many ways too numerous to mention." She examines the term integration as found in general education, as well as its use in nursing education.

In her 1955 article, Heidgerken makes a distinction between the two terms "correlation" and "integration". "Correlation may be considered as one of the first steps toward integration, the word is defined as the act of establishing a mutual relationship, or of connecting systematically. When applied to curriculum practice, it means relating two or more subjects through cross reference from one subject to another, or through assignments which draw upon both subjects, however, fusing the subjects into one", (pp. 128-130).

Integration for her, "means the process of uniting so as to form a complete or perfect whole" (Heidgerken, 1955, p. 129). Heidgerken believed that educators were using integration in describing both the learning process and the organization of the curriculum content:

While the educational psychologist argues that integration can take place only within the individual it is an internal unification and, therefore, the word is used incorrectly when it is applied to teaching procedures and curriculum plans. On the other hand, the educator says that curricular material (content and experiences) can be arranged to facilitate internal integration and the word is correctly used here since it is intended to denote unification. (Heidgerken, 1955, pp. 128-130)

It is acknowledged that Heidgerken may not be employing the concept of integration which is thought to be in use today. The review shows evidence that there is not a clear indication of what types of practices are actually being used, therefore it is necessary to acknowledge that fusion and correlation are possibly being used instead of integration. According to the literature, nursing utilized and borrowed information and practices on integration from sources outside of nursing. Johansen was one of these particular sources.

Johansen, a professor of history, also wrote about the use of correlation and integration in nursing during the late 1940's. Her

speech on integration given at the Education Section of Oregon State Nurses' Association in 1949 seems to be more in line with the current usage of integration in nursing. This paper, published in the February American Journal of Nursing, was entitled "The Integrative Method of Teaching" (1950, pp. 117-119). Her second paper entitled, "Integration or Correlation" appeared in the February 1951 issue of the American Journal of Nursing, (pp. 405-406).

Johansen suggested that if the nursing profession wanted a "vitalized approach as a process...integration is worth trying" (1950, p. 119). Also she expressed a concern with integration in its pedagogical aspect, the method "of relating varieties of subject matter to units of study or to problem solving situations." She felt that "a number of methods have been advanced by which integration of subject matter might be achieved, and all of these have been called integrative." Correlation was one such device (Johansen, 1950. p.117).

The fusion of two courses of study does not lead automatically to integration in the learning process or in content and method. Difficulties encountered in working out integrated studies may be related to subject matter, students and faculty. (Johansen, 1950, 117)

Currently, educators of nursing are experiencing problems with all three components. In Johansen's experience not all students are capable of developing the ability to abstract. And yet this is needed in integrative learning. She made the distinction that the difference between integration and correlation as teaching methods is chiefly in the way in which the subject matter is organized and presented.

Integration, as a teaching device, is the process of unifying both the approach to and the end results of learning. Subjects are related to one another about a common core of interest, or in a problem-solving situation. (Johansen, 1951, p. 405)

Johansen also pointed out that:

Some correlation is always made in teaching but, to be effective as a teaching method, correlation must be directed not just to relationships between subject area but to the understanding of the whole, whether this is the whole body, the whole man, the whole society, or simply a whole situation (1951, p. 406)...Correlation must also have been a common focus of interest and a unity of theme: this is why it is a step toward integration...In both integration and correlation, there is an attempt to unify the student's learning experience. (1951, p. 406)

The concept of unity is consistent with Weitzel's philosophical view of the intent of integration. According to this nursing educator, "it can be inferred that the intent of the integrated nursing curriculum is to promote an awareness of unity or wholeness of the field of nursing in the student" (Weitzel, 1980, p. 17). Weitzel (1980) relates that "Heidgerken and Johansen both refer to integration as a type of 'unification' which applies to learning methods and content"(p. 18).

Long before integration became popular in nursing, most educators supported the need for an underlying philosophy for developing curricula. With the increased use of concepts, there is even more of a crucial need for the use of and the guidance of a philosophy in the curriculum development process today. Concepts are abstract images used to convey one's thoughts.

According to Torres:

The use and meaning of the terms concept and theory within nursing...are often conflicting. This confusion can be caused by differences of opinion. However, such confusion is more likely to be caused by the frequent use of these terms in a broad nondefined sense, leaving the listeners or readers uncertain as to the purpose of the presentation and encouraging them to focus on details or specifics rather than on concepts. (1980, p. 1)...In Nursing, the most significant concepts that influence and determine its practice are man, society, health and nursing. Among the four concepts, the core of the practice of nursing is man. It is from the client or patient that other nursing concepts arise....(1980, p. 2)

Therefore, the educator's philosophy regarding man, needs to be clarified because the meanings attributed to the client or patient and any of the three other concepts can only be clearly understood if the definitions are congruent with the stated philosophy. Some nursing programs utilize the conceptual framework, which would further define and clarify the concepts which are being employed. It is clear that there has been continual rethinking of the terms correlation and integration over the years which necessitates an ongoing periodic reassessment of these concepts and their meanings within the individual practice setting.

Amidst the discussion on correlation of content, some integration began to occur. Nurse-educators continued their examination of the courses in medical and surgical nursing. They planned the lectures to be given concurrently with the clinical practice in the medical and surgical wards, and eventually the two courses were combined into medical-surgical nursing (Daley, 1963, p. 413). This was a beginning effort in integration. Sister Daley's historical development of the medical-surgical nursing course provides a good summary for review of the literature at this point.

Daley believed that in order to accomplish basically sound educational planning, it was essential to understand historical developments and trends of clinical courses which constitute the professional major in nursing programs. Her history of the developments in the medical-surgical nursing course in the United States from 1873 to 1950 is presented in four periods of about twenty years each. This history covers four major developments in the course.

Each stage of development may be briefly described as follows: (1) From 1873 to 1893 medical nursing and surgical nursing courses were supervised and experiences were provided for the students at the patient's bedside in the wards; (2) from 1893 to 1913 doctors gave lectures according to the five medical specialities but they were not correlated with the work on the wards; (3) from 1913 to 1933 related nursing procedures were incorporated with lectures on diseases for formal classroom instruction, but continued to be separated from ward practice, and (4) finally, the medical and surgical nursing course was combined into one medical-surgical course in which the formal classes were scheduled to concur with nursing practice on the respective ward (Daley, 1963).

The medical and surgical courses have continued to change. In 1963 when this history was written, Daley related that there was an "unsettled state" of concern about the purpose and scope of medical-surgical nursing. There had been a continuing trend toward new approaches to teaching which would emphasize the patient rather than the disease. In order to accomplish this aim, material from related courses had been incorporated. Daley (1963) offered the following rationale on the need to change the curriculum.

A conscious awareness of the origins and purposes of medical-surgical nursing, the forces shaping its features, and the changes and adjustment that have been made within it have led to a realization that the clinical area of nursing is not necessarily the natural unit around which instruction in nursing is best organized. The difficulties in teaching nursing and the constantly changing methods and types of instructors seemed to be inherent in the structure; trying to keep emphasis on broad aspects on nursing functions based on total needs of patients while disease classifications remained the center of organization for learning experiences created many of the difficulties. (p. 413)

As Torres (1980, p. 2) has previously pointed out, the focus was on the specifics and details of caring for the patients' disease conditions, and not on the concepts of nursing which would allow for the development of a unified plan of care for the total patient as a unique person. The use of medical science was being questioned as the only area of knowledge upon which all nursing action was centered. It was apparent that actions in nursing were also based upon the social sciences, humanities, biological and physical sciences. Therefore, while clinical areas of nursing practice remained the basis of curriculum development it would continue to be difficult to incorporate all the other areas of knowledge into a core of generic nursing principles. "A complete reorganization of learning experiences into a new curriculum structure with the commonalities of health needs as the core" was recommended (Daley, 1963, p. 413).

This review has indicated that nursing educators have attempted to implement Daley's recommendations. There has been an increase in the use of nursing models, process and core concepts to integrate the curriculum in the early 70's. It is acknowledged, however, that integration is but one term used to identify the patient-centered approach. The present study is intended to assess how much integration has really occurred. Ill-defined concepts and practices have continued to be problems which impede this process.

In the mid-seventies, Torres (1974) wrote that a "review of over fifty baccalaureate nursing programs showed:

that the shift of focus in the nursing curriculum from the medical model to an integrated approach is the most dynamic change in nursing education in the last ten years. (p. 2)

Other written sources reveal that a number of nursing educators were not describing the trend toward the integrated curriculum in the same positive view espoused by Torres. Their writings strongly questioned the trend, and expressed concern for its popularity. Chief among these dissenting authors were Hipps (1981), Styles (1976), and Veith (1978).

Styles (1976) discussed various concerns on integration in the nursing curriculum, its effects on performance of students and faculty, and its application to clinical experience, team teaching, and curriculum structure. She related that:

On the whole, we seem to have focused upon the curriculum as the object of the unifying process. We hear and read much more, for instance, about the "integrated curriculum" than we do about the "integrated learner" or "integrated patient." (The people we seem to want most to integrate are the faculty whom we have organized into homogenized teams to teach the "integrated curriculum."). (pp.738-39)

...This construction of integration has led us to engage in a cluster of educational practices (and perhaps even some malpractices) such as team teaching, giant size courses, non-departmentalization and the like, which we have seen as mandated by and corollary to the integration goal. (Styles, 1976, p. 739)

Veith, (1978) a nursing professor at the University of Kansas, concurred with Styles. She voiced reservations about the use of integration and suggested that perhaps integration needed re-thinking on the grounds that the term "integrated" still conveys many different things. Veith restated Styles' claim that some nursing schools were heading back to old curricular models. Veith (1978) shared how their school of nursing correlated its curriculum to include both the integrated and logistic approaches.

One author indicated that correlation may be more meaningful than integration. Hipps (1981) contends that she knows of no evidence that

the integrated curriculum organized according to concepts does a better job educating creative and critical thinkers than a nonintegrated one. Furthermore, she felt that "correlation is a curricular goal that in the long run may prove more desirable and durable than integration" (Hipps, 1981, p. 978). In her opinion correlation "is certainly more attainable" (p. 978). According to Hipps "no one has demonstrated...how the integrated model structures the discipline of nursing beyond a few general concepts" (1981, p. 976).

The literature review on the integrated nursing curriculum has revealed that most of the studies have been designed to deal with curriculum engineering rather than design issues. Curriculum engineering issues include the processes and activities which are necessary to maintain and improve a curriculum system. Curricular design issues are confined to specific types of curriculum, the sequencing of the content or a comparison of curricular approaches (Bleauchamp, 1975, p. 196). No studies were found on the current status of the use of the integrated curriculum in baccalaureate nursing programs. It can be inferred that the types of studies which have been conducted are reflective of the types of concerns that nursing educators have had in regard to maintaining and improving the integrated curriculum. Consequently, the following four studies are quite relevant to the present study.

Most Relevant Studies

National League for nursing accredited baccalaureate nursing programs were surveyed by Ketefian (1970) to identify trends in curricular innovations in nursing education. She reported that 29% of those she studied claimed to be using the integrated curriculum design.

However, after closely examining a few selected "integrated curricula", she found that most frequently this content was really correlated or summated. The content was tied together without eliminating the subject matter content (Ketefian, 1970, p. 142). She states that although "team teaching" was adapted to "integrate different subjects" in actual practice, each teacher taught blocks of a course that had to do with her own clinical speciality (Ketefian, 1970, p. 142).

According to Ketefian (1970) it was not clear from the data just how these blocks of content were "integrated" (p. 141). In regards to the 226 innovations, she reported the following findings: (1) 49 innovations were in teaching methods; (2) 28 innovations dealt with new materials, facilities and equipment for teaching; (3) 81 innovations involved changes in subject matter, content, and organization of the curriculum; and (4) 26 innovations were still in the planning stage and were still evolving at the time they were reported (Ketefian, 1970, p. 139). Katefian concluded that: 1) The data suggested that nurse educators were aware of the need to teach nursing in different ways; 2) new and more relevant content needs to be introduced into nursing curricula; 3) different ways of organizing the curriculum are needed to make material more meaningful; and 4) different experiences are needed to be provided to achieve new goals.

Examination of the underlying curricular structure revealed that in most other cases changes were minor. Overall, there appeared to be a strong sense that the educational experiences in the nursing curriculum should give the student a unified view of the "whole" as well as help the student to exhibit unity of behavior. To this end, 67 innovations (29%) claimed to be "integrated" (Ketefian, 1970, p. 141).

Unfortunately, these efforts to employ integration were ill-defined and confusing as reflected in her previously stated findings and conclusions. Ketefian attempted to help clarify the trends in curricular innovations in nursing education and did shed some light on how integration was being utilized at the time.

In an attempt to identify problems with teaching in integrated programs, Maloney (1978) conducted an opinion survey of the baccalaureate curriculum. There were thirty-six deans and 140 faculty respondents (a 52% return rate) upon whom the conclusions of the study were based. She also hoped to obtain data on the possible effect integration might have on graduate nursing education. Maloney used Torres' 1974 definition of integration with the participants of her study. She concluded that although teaching in the integrated curriculum presents some problems for faculty who were prepared as clinical specialist, these problems are not insurmountable. Maloney also reported that solutions to the problems were dependent upon changes in content in graduate nursing education.

Strandell conducted a study that examined the effect of nursing faculty perceptions upon the actual implementation of the curriculum. The problem investigated was to examine baccalaureate nursing faculty perceptions of the integrated curriculum in terms of (a) what their perceptions are of the concept of the integrated curriculum, (b) what they perceive their current integrated curriculum should be. Strandell also utilized Torres' first definition of integration and selected twelve study participant schools which had a fully integrated curriculum to study.

Based on the findings of the study, Strandell (1980) concluded that there were significant differences in faculty perceptions of the integrated curriculum both by geographical areas and schools. Strandell recommended that: (1) a nursing educator's understanding of the integrated curriculum should be assessed when being interviewed to teach in these programs; (2) graduate programs should teach curriculum development including the integrated curriculum; (3) time should be allocated for faculty development and discussion of problems related to implementation of the integrated curriculum; and (4) qualitative studies might aid in describing problems that continue to exist in implementing the integrated curriculum.

The last of the four relevant studies deals with curricular design. Quiring and Gray (1982) conducted a study to identify the models being employed to organize curricula in order to estimate the frequency of their use. They assumed that most schools utilized some scheme for organizing the curriculum whether they advertised their program as integrated or not. They also asked that the respondents indicate the number of courses which used each organizing approach selected. The respondents indicated that most programs used the same organizational pattern for all courses. Few programs used different organizational approaches for different blocks of courses.

The last item revealed the main difference in curriculum design. This item asked respondents to "give one or more examples to further describe the method (s) of curriculum organization..." (Quiring et al., 1982, p. 41). The responses to this item indicated that the major differences in curriculum design were related to complexity of organization and the selection of specific organizing features.

Of these programs which indicated a complete curriculum scheme; the use of four curriculum components was common. From these data it is evident that concepts are a major choice for a curricular organizational approach. These authors suggest that the choice of concepts is critical since each should be considered pertinent and applicable only if it serves to assist the student to more effectively develop and implement nursing care.

The results of this Quiring study indicated that the overwhelming majority of schools attempted to integrate curriculum components through the use of some combination of concepts, threads, and nursing process orientation. Most indicated that their schools used more than one method of integrating content. The data was obtained from 91 of 144 forms (a 61% return). From their study, they conclude that, "concepts apparently have served to assist a number of faculties in achieving this since the majority have indicated they are using this approach" (Quiring et al., 1982, p. 43).

Basically, the Quiring survey makes it apparent that no one approach to curriculum organization seems universally satisfactory. However, the trend is to identify concepts as a major approach. The reason typically offered for the use of concepts is that they serve to unify or interrelate details. It is felt that this popularity of the use of concepts in the organizational design is a logical way to link up the broad nursing content and its related sciences (Quiring et al, 1982). Quiring and Gray determined that the majority of schools were attempting to integrate.

Related Issues and Concerns Pertinent to the Understanding of Integration

In the survey of the literature on past and more current integration efforts in baccalaureate nursing education, some common themes appear quite often as impacting on the understanding and/or implementation of an integrated curriculum. These are leadership, group process and, particularly, team teaching. Others are faculty and student satisfaction, creativity, problem solving, and critical thinking.

Higgs (1978) studied the expectations and perceptions of the curricular leadership role of administration of nursing education units. The faculty agreed that deans should be involved in curricular design and evaluation questions; however, there was no agreement within either group in regard to curriculum implementation questions. The results were based upon the responses of 52 deans and 451 faculty.

Eisenhauer (1976) focused on the group processes involved when nursing faculty from various speciality backgrounds form teams in order to plan and implement an integrated baccalaureate nursing curriculum. It is important that anxiety be channeled toward positive action so members can progress from frustration to collaboration. Also Tschudin and Morgan (1953) indicated that it is difficult for all faculty members to work together to improve the curriculum because interests of members are divergent, time is difficult to arrange, and there are many complexities inherent in any group process. Two questions are frequently asked: (1) how can faculty members with different and often highly specialized interest be brought together for curriculum study? (2) How can a faculty group get started on this process of more extensive participation? (Tschudin et al., 1953.

Stone and Green (1975) conducted a five year investigation at the University of San Francisco of the impact, as measured by the students' perception of their collegiate experience, of an innovative four year curriculum leading to a bachelor's degree and professional preparation in nursing. The team teaching aspects were summarized. It was found that the team teaching features of the program seemed to command approximately an equal share of commendation and criticism. Complete reliance on team teaching probably should be reconsidered.

Kramer (1968) concluded that converting to a team teaching approach is not a simple task, nor one which should be contemplated without adequate preparation and planning. With planning, preparation and continuing inservice education, team teaching has proved to be a rewarding and satisfying experience for both student and faculty. Team teaching had proved to be a very agonizing problem for faculty prior to the integration trend. When utilized with a new integrated program, it has in many cases helped add to the problems that the faculty must learn to deal with. Stone and Green (1975) suggested that team teaching can be more effective if planned and managed correctly.

Another concern with the integrated curriculum is centered around nurse educators having been prepared to function as specialists, but finding that they may be required to function as generalists in an integrated curriculum setting. Bach (1979) discusses the positive and negative aspects of assigning faculty in nursing specialties to teach foundations of basic nursing skills courses. Students' reaction to nursing specialist's as instructors are also examined. Recommendations are made for duplicating the positive outcomes of a multi-disciplinary faculty.

Murdock (1978) described a new integrated nursing curriculum at the University of Connecticut School of Nursing as representative of a change from a traditional to an integrated nursing program. The integrated program required teachers to become generalist in nursing theory and practice. She described the new curriculum framework which redefined faculty teams, and clinical experience.

Pagel (1972) examined the process of curriculum change in three baccalaureate schools of nursing. Data from tape recorded interviews which were quantified in order to identify the curriculum change at each school revealed that: 1) all schools were searching for a new approach to content organization utilizing basic ideas and integrating threads; 2) subject matter was the focus of change most frequently cited. 3) the cultural context of the curriculum changes was limited in perspectives; 4) the faculties fully accepted the responsibility for curriculum change; 5) there was widespread dissatisfaction with methods used by leaders; 6) faculty worked more effectively in small groups; and 7) problem-solving skills were not used for effective decision-making in curriculum matters.

Pardue (1979) evaluated the differences between blocked and integrated content baccalaureate nursing programs related to faculty satisfaction, senior students' critical thinking ability, and students' state board examination performance. Faculty satisfaction had ten factor scores, seven directly teacher related factors and three indirectly teacher related factors. Analysis of 85 faculty members revealed that faculty satisfaction was not a function of the type of content program. (Pardue, 1979).

Researchers have reported contradictory findings on the ability of students in integrated nursing curriculum programs to solve problems and to be more creative. Hipps (1981) had suggested that correlation not integration was a much more attainable goal. Pardue conducted an analysis of 104 senior students which revealed no significant difference in critical thinking ability between the two types of content programs. When 320 students' State Board Examination (SBE) scores were examined, it was found that students enrolled in a blocked-content program scored significantly higher than those in an integrated-content program (Pardue, 1979).

Zaweckis and Westfall (1976) reported that they were able to strengthen student knowledge of the nursing process by integrating elements of teaching-learning and community assessment and diagnosis throughout a course. Their definition for integration was simply:

a way of organizing content to assist students in analyzing and applying relationships of content, concepts and principles to the utilization of the nursing process as the methodology of nursing practice in various settings. (1976, p. 13)

They concluded that the students could determine relationships of core content in any nursing situation (Zaweckis et al., 1976).

This survey was structured to obtain information on some of the areas of concern which have been presented in this review such as: student and faculty satisfaction with the use of an integrated curriculum; attitudes towards integration; advantages and disadvantages of the integrated curriculum and the extent to which the integrated curriculum was in use in baccalaureate nursing programs nationally. The next chapter on the methodology includes the development of the questionnaire to examine some of the issues mentioned in the review of the literature.

CHAPTER III

METHODOLOGY

Introduction

The descriptive method of research, specifically the status survey type, was utilized for this study. Best (1977) stated that:

A descriptive study describes and interprets what is. It is concerned with conditions or relationships that exist, opinions that are held, processes that are going on, effects that are evident, or trends that are developing. It is primarily concerned with the present, although it often considers past events and influences as they relate to current conditions. (p. 116)

Whitney (1950) defined the survey as an organized attempt to analyze, interpret and report the present status of a social institution, group or area. Its purpose is to get groups of classified, generalized, and interpreted data for the guidance of practice in the immediate future (p. 155).

Both definitions explain why the survey method was selected to achieve the essential purpose of this study. A survey and analysis of the current status of integration in baccalaureate nursing programs nationally was warranted. The Literature review suggest a need for data with which nursing educators could plan and conduct further research which was needed to guide practice.

A two part questionnaire was developed to achieve the purposes of the study. Part I consists of 26 items which solicited demographic data on the background characteristics of the survey respondents, as well specific information on the integrated curriculum/program. In Part I,

twenty items were addressed to all respondents and the last six were addressed to respondents of substantially integrated programs. Part II of the questionnaire consists of 55 attitudinal items placed in the Likert Scale format. All respondents were requested to respond to the 55 items in Part II.

The data were collected from selected faculty by means of a questionnaire developed for the purpose of the study. The purposes for which questionnaires are used, and the type of information sought vary from study to study. Berdie (1974) pointed out that it is important that the respondent realizes whether you wish a factual answer or an opinion answer (pp. 61-62). According to Batholomew, (1963) "A difference is likely to exist between what is and what should be and unless you are precise about which information is wanted, the respondent can easily confuse the two" (p. 12). An opinion is defined as "an expression of attitude in words, either written or spoken" (Childs, 1940, pp. 66-67).

Best (1977) stated:

The information form that attempts to measure the attitude or belief of an individual is known as an opinionnaire or attitude scale. Since the terms opinion and attitude are not synonymous, a clarification is necessary.

How an individual feels, or what he believes, is his attitude. But it is difficult, if not impossible, to describe and measure attitude. The researcher must depend upon what the individual says are his beliefs and feelings. This is the area of opinion. Through the use of questions, or by getting an individual's expressed reaction to statements, a sample of his opinion is obtained. From this statement of opinion may be inferred or estimated his attitude--what he really believes. (p. 169)

In general, eighty percent of the population respond to the social demand that they have an opinion; while the other twenty percent of the

people are either undecided about their opinion or refuse to give an opinion (Dollard, 1948-49, p. 636). Opinions are usually favorable or unfavorable, for or against an issue or object (Childs, 1940, pp. 66-67).

During the 1930's attitude scales were developed to ascertain shades of opinion and degrees of favor or disfavor (Childs, 1965, p. 13). Attitude scales are techniques for placing individuals on a continuing relation to one another, in relative not in absolute terms (Oppenheim, 1966, p. 121).

The evaluation of opinions has been refined over the years. Childs (1934) wrote that it was possible to differentiate between various shades of opinion and different degrees of intensity of opinions (p. 81). The most widely used attitude scale among survey researchers is called the Likert Scale (Orlich, Clark, Fagan, and Rust, 1975, p. 40). According to Oppenheim (1966) if we wish to study attitude patterning, the Likert procedure will be most relevant (p. 123).

Questions which require rating of opinions usually utilize Likert Scales. Such scales when used primarily for assessing opinions, are usually composed of five or more response categories, e.g., strongly agree, agree, undecided, disagree, strongly disagree, or some such continuum (Orlich et. al., 1975, p. 40). Part II of the survey instrument utilized in this study contains fifty-five attitudinal statements. These attitudinal items are placed in a five point Likert Scale format. Further questionnaire construction details are covered under the development of questionnaire heading which follows the study population section of this chapter.

Study Population

Four National League for Nursing (N.L.N.) publications were reviewed to obtain a current list of all N.L.N. accredited baccalaureate nursing education programs in the United States. These publications are: 1. The Nursing Data Book, 1980;

2. Nursing and Health Care, (Vol. I, No. 2, Sept. 1980)

3. Baccalaureate Education in Nursing, Key to a Professional Career in Nursing, 1980-1981;

4. State-Approved Schools of Nursing R.N., 1981

Although each of these publications provided a list of programs, State-Approved Schools of Nursing R.N., 1981, contained the most current data as well as the names of program directors and complete addresses of the schools. Thus the decision was made to use this source for the study. In order to query programs which meet the same set of criteria, only National League for Nursing accredited baccalaureate programs were included in this study.

There are three types of baccalaureate nursing programs: (1) those which admit only students with no prior nursing education (basic generic programs); (2) programs which admit students with no previous nursing education and also admit registered nurses (R.N.s) to the same curriculum; and (3) programs which admit R.N.s only.

This study was confined to the first two types of programs which number 287 in the nation. Schools which educate R.N.s only were excluded since they would differ from the other two types of programs which were selected to be studied. Since registered nurses working for a baccalaureate degree need not take all of the content required of an applicant with no previous nursing education, it would be impossible to

Table 1
Distribution of Baccalaureate Programs

Designated Region	Geographic Area	Number of Programs
1	North Atlantic	78
2	Mid West	82
3	South	88
4	West	<u>39</u>
	Total	287

offer a totally integrated curriculum in this type of program. The distribution of the first two types of baccalaureate nursing programs across the United States is tabulated in Table 1.

Examination of these figures indicates that there were less than half as many of these programs in region 4 as there were in each of the other regions. There was no source available which indicated how many of the 287 programs were utilizing integration. One of the major purposes of this survey was to establish the actual number of programs which were integrated, out of the total number of programs surveyed.

Development of the Questionnaire

A questionnaire was developed for the specific purpose of gathering selective faculty perceptions of the integrated baccalaureate nursing curriculum and the degree of integration currently being utilized, as well as faculty and student satisfaction with its use.

The literature review of the integrated nursing curriculum concept initially yielded a set of 124 questions and statements pertaining

to the increasing use of the integrated nursing curriculums. The questions and statements identified basically four areas of concern: (1) the curriculum process and practices that were being employed and questioned, (2) issues related to faculty preparation, responsibilities and practices in an integrated nursing program, (3) matters pertaining to the classroom and clinical instruction in an integrated curriculum, and (4) those of a general nature, most of which were attitudes regarding the advantages and disadvantages of nursing education's use of integration. Review of these concerns served to identify issues and clarify aspects of the problem which should be studied.

In the initial stages of the development of the questionnaire, the 124 questions and attitudinal statements regarding the integrated curriculum were typed on five-by-five cards. A set of these cards was given to each of five nursing educators experienced in working with the integrated curriculum approach. They were requested to read, respond and to critique the 124 items. These nurses also separated the items into the previously mentioned four areas of concern which needed to be studied. Their efforts and an analysis of their findings and recommendations helped to establish content validity for the questionnaire.

Several revisions of the questionnaire length and item format were made in order to obtain a manageable and meaningful survey tool (see Appendix A). Studies have shown that questionnaire length itself need not interfere with response rates (Berdie, 1973; Champion and Sear, 1969). Seemingly more important is the questionnaire content.

Berdie and Anderson (1974) wrote that:

questionnaire items should be interesting to the respondent, obviously relevant to the purpose of the study, and limited to absolutely essential items. All these factors will make the questionnaire more meaningful to the respondent and his view of how meaningful the questionnaire is, more than how long it is, will determine whether or not he chooses to respond. (pp. 61-62)

The final questionnaire was composed of two parts. Part I included twenty-six items that were geared to gather demographic data about the institutions in the survey population, the extent of faculty involvement in the planning and monitoring of the curriculum, the degree to which integration was utilized and the advantages and disadvantages of the integrated nursing curriculum. One item sought to identify the curriculum model of preference, if the respondent were given a choice. Another item queried why the program became integrated.

Included also were items on how the types of courses were constructed, what major theories were used, and what major concepts were included in the conceptual framework. Only respondents whose programs were integrated were asked to answer items 21-26. These questions sought to elicit information on the degree of satisfaction of both faculty and students in integrated programs. These respondents were also asked to list procedures which they felt assured the success of their integrated curriculum. Part II contained 55 items in a Likert Scale format. All respondents were requested to respond to the 55 items.

Pretest Of The Questionnaire

Borg and Gall (1979, pp.301-2) emphasized pretesting as being an important step in developing survey instruments while Parten agreed and indicated that testing, revising and retesting questionnaires tends to

yield higher dividends (1950, p. 390). Efforts were made to assure that the final questionnaire possess both content validity and internal reliability (see Appendix C).

Content validity was established by a panel of three judges who critiqued each item to detect if it solicited an attitude toward integration. Three items were somewhat ambiguous in their wording. These three (3) items were revised as suggested by the panel of experts. The following items were suggested for revision: items 3, 37, and 54. Agreement was obtained on the final wording and these items are located in Appendix B. The reader is referred to the chart on the Percentage of Agreement of Experts in Relationship to Content Validity of Likert Scale items given in Appendix B.

Cronbach's coefficient alpha test was used to establish internal consistency reliability of the pretest questionnaire data. The "internal-consistency reliability is estimated using only one test administration and thus avoids the problems associated with repeated testings" (Allen and Yen, 1979, p. 78). After content validity was established, the questionnaire was pretested using nine (9) respondents. The coefficient alpha test was used to determine the reliability of the results of the data obtained from the pretest questionnaires. The reliability of the items on the instrument was 0.8. A coefficient of reliability of above 0.7 is considered good for this type of instrument.

Data Collection

The questionnaire was developed specifically to be administered to selected faculty of the previously described accredited baccalaureate nursing programs. Since the number of those utilizing an integrated

curriculum is unknown, every possible effort was made to follow up and obtain, as close to as possible, a 100 percent return of the survey tool so that the findings of the survey would be accurate. Data were collected via the mailed questionnaire. A copy of the questionnaire is placed in the Appendix A.

In the cover letter, (see Appendix A) a request was made to each administrator to direct the accompanying questionnaire to the person most knowledgeable and/or responsible for the baccalaureate nursing program. In order to assure respondents' anonymity and also do the necessary follow-up, the following procedure was utilized. It was explained in the cover letter that the same identification number would be used on the questionnaire and the postcard for follow-up purposes only. Neither institutions nor individuals would be identified in any manner in the study. The respondents were requested to grant permission for the use of their information by submitting their signature on an enclosed postcard (see Appendix D) which accompanied the questionnaire.

The questionnaire was sent out by first class mail to each program administrator. A cover letter, a postcard and a return self-addressed envelope accompanied each questionnaire. The cover letter stated the purpose of the study and explained the need for their participation. The respondents were requested to mail back the questionnaire and the postcard at the same time but separately, and follow-up was done only on respondents who did not return their cards. Three follow-up mailings of both questionnaires and cards were conducted at an interval of one month between postings.

Measurement and Interpretation of Opinion

Opinions on each item of Part II of the questionnaire were measured on a Likert scale. Some statements on the questionnaire expressed negative views toward integration. This was done in order to prevent a mind set, and it also served the purpose of providing a method to cross check some items against other items elsewhere in the questionnaire. Opinions which are most favorable to integration earned the highest score which is five, while those which are most unfavorable to integration earned the lowest score which is one. Disagreement with negative views would earn the same number of points as agreement with statements favorable to integration.

Opinions in the questionnaire were phrased either to support or to disapprove of the idea of integrating the baccalaureate nursing curriculum. There were, of course, a few opinions which were not so clear cut but, all the same, precise enough to be categorized. Primary purposes of the opinion survey were to establish how many baccalaureate nursing schools did support the idea of integration of their programs.

Item 18 is an example of an opinion held by someone who does not support the idea of an integrated nursing curriculum. On the other hand, item 19 is an example of an opinion held by someone who supports an integrated curriculum. Therefore while item 19 is coded positively (from strongly disagree (1) to strongly agree (5)), item 18 is coded in reverse order in the computer input.

Treatment Of The Data

Information from the questionnaire from closed-ended items was transferred to computer sheets to allow for processing at the University of Pittsburg Computer Center. The Statistical Package for the Social Sciences (SPSS) was used to compute appropriate descriptive statistics. The data were reported by frequencies, percents, means, standard deviations, modes, ranges and coefficients of variation of opinion scores of respondents.

Information obtained from the questionnaires on the open-ended items was transferred from the questionnaires to cards. These responses were grouped and tabulated according to their frequency of occurrence. Analysis and interpretation of the data followed the grouping of these responses in relation to the respective questions. Demographic information was summarized and used to describe the programs and the characteristics of the sample surveyed. Other information was summarized and analyzed in order to answer the research questions.

In the analysis of the results of the questionnaire, the following statistical terms are used:

- a. The frequency, mean, mode and standard deviations are given.
- b. On Likert scale items, the range is also used to measure the variability of opinion. It will be calculated as the difference between the maximum and the minimum value of a group of scores.
- c. Where a comparison of opinions over multiple items is needed, the coefficient of variation (c.v.) is used as a decisive measure of variability of opinion.

Mathematically expressed, the coefficient of variation gives what percentage of the Mean the Standard Deviation is. It is the ratio of

the latter to the former. Therefore the larger the c.v. is, the more varied the opinion is from the central tendency. The reverse is also true.

As an illustration, a comparison of the variability of opinions over items A, B, and C may be made. If the respective item c.v.'s are 30%, 20% and 40%, it means that whatever opinion was indicated by the mode for item B was most homogeneous and that for item C was the least homogeneous of the three.

CHAPTER IV

FINDINGS

In this chapter background information about the educational institutions and findings in relation to the research questions are presented. The chapter has been organized so that the presentation of the findings will follow the numerical sequence of the subproblems. A discussion of the meaning of the findings completes the chapter.

Background Information

Questionnaires were mailed to all 287 baccalaureate programs in the United States accredited by the National League for Nursing. A total of 226 individuals responded. A total of 39 letters were received which expressed regrets that they could not participate due to lack of time, personnel, or policies. Therefore, only 187 questionnaires were returned. Of the 177 respondents whose responses were usable, 35 were teachers, 127 were administrators, and 15 had dual roles. Table 2 contains background information about the educational programs which were used in this study. These data were provided through answers to items 1-6 of the questionnaire.

Types of Institution

The first question asked the respondent to indicate the type of institution in which the baccalaureate program was offered. The directions stated that there could be multiple choices. The respondents

made a total of 322 choices to describe the type of institution in which they worked. Eighty-four of the 177 respondents characterized their institutions as public, while 74 stated that they worked in private institutions. Fifty-six institutions were state related and 40 were church related. Only 66 institutions were coeducational.

Location of Programs

Most of the institutions were located in the North Atlantic (50), Midwest (56) and South (55) regions of the country. These three areas had 91% of the programs in the study. The other 16 programs (9%) were located in the West.

Generic Enrollment

The number of generic students enrolled in each program varied from 25 to 1080 students. More than half of the programs (51.4%) enrolled between 101 and 300 students. Only three institutions (1.7%) enrolled more than 700 students. Enrollment was not given for 14 programs (7.9%).

Registered Nurse Enrollment

Ninety-three programs (52.5%) had from 0 to 49 registered nurses enrolled for a baccalaureate degree; 38(21.5%) had between 50 and 99 enrolled; 18 (10.2%) had between 100 and 149 enrolled. Only twelve programs (6.9%) enrolled 150 or more registered nurses. One program (.6%) reported an enrollment of 1300 registered nurses. Sixteen programs (9%) did not provide enrollment statistics for registered nurses.

Table 2

Characteristics of Educational Programs

Variable	Number	Percent
Types of Institutions		
Private	74	41.8
Public	84	47.5
Church Related	40	22.6
State Related	56	31.6
Co-Educational	66	37.3
Other	<u>2</u>	1.1
Location of Program		
North Atlantic	50	28.3
Midwest	56	31.6
South	55	31.1
West	<u>16</u>	<u>9.0</u>
	177	100.0
Generic Enrollment		
1 - 100	15	8.5
101 - 200	48	27.1
201 - 300	43	24.3
301 - 400	25	14.1
401 - 500	12	6.7
501 - 600	10	5.6
601 - 700	7	4.0
701 - 800	1	0.6

Table 2 (Continued)

Variable	Number	Percent
801 - 900	1	0.6
901 - 1000	0	0.0
1001 - 1100	1	0.6
No Answer	<u>14</u>	<u>7.9</u>
	177	100.0
Registered Nurse Enrollment		
0 - 49	93	52.5
50 - 99	38	21.5
100 - 149	18	10.2
150 - 199	3	1.7
200 - 249	4	2.3
250 - 299	1	0.5
300 - 349	3	1.7
Over 349	1	0.6
No Answer	<u>16</u>	<u>9.0</u>
	177	100.0
Full-Time Undergraduate Faculty		
1 - 10	17	9.6
11 - 20	78	44.1
21 - 30	31	17.5
31 - 40	24	13.6
41 - 50	10	5.6
51 - 60	4	2.2

Table 2 (Continued)

Variable	Number	Percent
61 - 70	2	1.1
71 - 80	2	1.1
No Answer	<u>9</u>	<u>5.1</u>
	177	100.0
Part-Time Undergraduate Faculty		
0 - 4	85	48.0
5 - 9	44	24.8
10 - 14	19	10.7
15 - 19	6	3.4
20 - 24	1	0.6
25 - 29	1	0.6
30 - 34	1	0.6
35 - 39	1	0.6
No Answer	<u>19</u>	<u>10.7</u>
	177	100.0
Current Faculty Who Planned The Curriculum		
0 - 4	78	44.1
5 - 9	35	19.8
10 - 14	10	5.6
15 - 19	6	3.4
20 - 24	7	4.0
25 - 29	2	1.1
30 - 34	2	1.1

TABLE 2 (Continued)

Variable	Number	Percent
No Answer	<u>37</u>	<u>20.9</u>
	177	100.0
Years School/Department in Existence		
0 - 2	0	0.0
2 - 5	3	1.7
6 - 10	34	19.2
11 - 15	43	24.3
16 - 20	16	9.0
Over 20	79	44.7
No Answer	<u>2</u>	<u>1.1</u>
	177	100.0

Full-Time Faculty

The smallest number of full-time faculty reported for any program was 5. Seventeen programs (9.6%) had 10 or fewer full-time faculty members; 133 programs (75%) had 11 to 40; and 10 (5.6%) employed 41 to 59 nursing faculty members on a full-time basis. Only eight programs (4.4%) employed more than 50 full-time faculty members. Nine programs (5.1%) did not respond to this item.

Part-Time Faculty

Eighty-five programs reported that they employed four or fewer part-time faculty members. An additional 44 (24.8%) stated that they employed five to nine part-time faculty members. Nineteen others (10.7%) employed 10 to 14 part-time faculty members. Ten programs (5.8%) employed 15 or more faculty members on a part time basis. Nineteen (10.7%) did not respond to this item.

Planners of Curriculum

Item 6 asked how many of the group who planned the original curriculum still remained on the faculty. Seventy-eight programs (44.1%) still employed four or fewer faculty members who had participated in the planning of the current curriculum; 45 (25.4%) had five to fourteen members of the original group. The remaining 17 programs (9.6%) had 15 to 34 remaining planners. Thirty-seven respondents (20.9%) did not respond to this item.

Program Existence

Item 5 asked how long the institution had offered a baccalaureate program in nursing. No program had been in existence for less than two years, while 79 (44.6%) had begun more than 20 years ago. Three programs (1.7%) had been in existence two to five years; and 34 (19.2%) six to ten years. Exactly one third, 59 (33.3%), had begun 11 to 20 years previously. One respondent checked over twenty and wrote in "Oldest in the country". Only two programs (1 %) did not respond to the question. The baccalaureate nursing programs that participated in the study were stable as shown by the longevity of over twenty years for 45% of them

and eleven to twenty years for another 59 programs (33.3%). The number of years in operation will be examined with reference to their use of integration later in the findings.

Findings in Relation to Research Questions

The main purpose of this study was to survey the status of the integrated curriculum in National League for Nursing accredited baccalaureate nursing programs in the United States. In order to accomplish this purpose, seven sub-problems were identified. The questionnaire items were related to the subproblems in the following manner:

1. To what extent are baccalaureate nursing programs integrated? Part I-items 8, 9, 10, 11a-11c, 19 and 20.
2. What are the advantages and disadvantages of an integrated curriculum as identified by the study population? Part I-items 17 and 18.
3. What activities contribute to the success of integrated programs? Part I-items 22, 25.
4. What are the attitudes of the study population toward integrated programs? Part II-all (55) items.
5. What are the perceptions of student and faculty satisfactions? Part I-items 12, 23, 24.
6. To what extent are nursing programs planning revisions of their curriculums either towards integration or away from integration? Part I items 13, 14, 15, 16 and 21.
7. What are the activities that have been employed to assess the effectiveness of the integrated curriculum? Part I-item 26.

All respondents were requested to respond to Part I items 1 through 20 and the 55 Likert Scale items in Part II. Only respondents who were employed in substantially integrated programs were requested to respond to items 21 to 26 of Part I. Data provided by responses to the questionnaire items will be presented according to the subproblems to which they relate.

Extent of Integration in Baccalaureate Nursing Programs

The first subproblem asked to what extent baccalaureate nursing programs in the United States are integrated. Three devices were developed to help establish some estimate of the extent of the integration. First, respondents were asked how they would describe the structure of their present nursing program. They were given four options to use in describing their curriculum model: the medical model, the integrated model, the partially integrated model and an open-ended "other". Second, they were asked to indicate an estimate of the degree of integration they were employing in their program. Third, a self-report of the types of courses that their individual programs were developing was solicited. Items 8, 10, and 11 were structured to solicit these data.

Curriculum Model

Item 8 asked how the respondents would describe the structure of their present nursing curriculum. The types of curriculum models which were reported by the respondents to describe their program structure are presented in Table 3. All 177 survey participants responded to item 8 on the structure of their curriculum model. A tally of the reported responses were as follows. The medical model was checked by 17

Table 3
Responses of Respondents Regarding Their Curriculum Models

Types of Models	Single Model N(%)	More Than One Model N(%)	Totals N(%)
Medical	8 (4.5)	9 (5.1)	17 (9.6)
Integrated	74 (41.8)	5 (2.8)	79 (44.6)
Partially Integrated	<u>65 (36.7)</u>	<u>16 (9.0)</u>	<u>81 (45.8)</u>
Totals	147 (83.0)	30 (16.9)	177 (100.0)

respondents, eight of these responses represented single (unmixed curriculum) models. The integrated model was reported 79 times, with 74 of these responses representing single models. Partially integrated models were reported a total of 81 times with single responses totaling 65. By far the greater number of respondents (83%) reported single models; only 30 (16.9%) indicated two or more models as the basis for the organization of their curriculum. Some of the respondents who said that their curriculums were organized around two or more models identified "conceptual" as the basis for the organization of content.

Percentage of Integration of Nursing Content

Item 10 asked for an estimate of the percentage of nursing content which was integrated. Table 4 presents the respondents' description of the degree to which their programs were integrated.

Total integration was reported by 32 (18.1%) of the 177 programs. Forty-five respondents (25.4%) stated that 75 to 99% of their nursing

content was integrated. Thirty respondents (16.9%) estimated that 50-74% of their nursing content was integrated. If 50% of integration of nursing content or a higher percentage is used as a criterion for describing a program as substantially integrated, then 107 of the 177 programs (60.7%) were substantially integrated.

Integration was utilized to a greater or lesser extent in all types of nursing programs reported by respondents. In fact, all 8 medical model programs reported some degree of integration. Only 7 programs of the total 177 surveyed in this study reported that no nursing content was integrated. These 7 programs had been described by respondents as being organized around more than one model.

When the percentage of integration within models is looked at, respondents from programs which were categorized as integrated, indeed, reported the highest estimates of nursing content integration: 29 respondents (16.4%) reported 100% of integration of nursing content and 33 (18.6%) estimated integration to be within the 75-99% range. The percentage of integration for partially integrated programs ranged from 75-99% in 10 programs (5.6%), from 50-74% in 20 Programs (11.3%), 25-49% in 25 programs (14.1%) and only 1-24% in 8 programs (4.5%).

Seven of the 8 medical model programs (87.5%) reported 25-49% of integration with the eighth program reporting 1-24% integration. Among the multiple model programs the highest estimate of integration was 100% for 3 programs (10.0%); 7 programs (23.3%) reported no integration. The highest number of multiple model programs (26.7%) reported 1 to 24% integration of nursing content.

Table 4

Identified Curriculum Models by Estimate of Percentage of
Integration of Nursing Content

Estimate of Percent of Integration of Nursing Content	Curriculum Models				
	Medical N(%)	Integrated N(%)	Partially Integrated N(%)	Multiple Model N(%)	Total N(%)
100	0	29 (39.2)	0	3 (1.7)	32 (18.1)
75 - 99	0	33 (44.6)	10 (15.4)	2 (6.7)	45 (25.4)
50 - 74	0	6 (8.1)	20 (30.8)	4 (13.3)	30 (16.9)
25 - 49	1 (12.5)	2 (2.7)	25 (38.5)	6 (20.0)	34 (19.2)
1 - 24	7 (87.5)	1 (1.4)	8 (12.3)	8 (26.7)	24 (13.6)
None	0	0	0	7 (3.9)	7 (4.0)
Unknown	0	3 (4.1)	2 (3.1)	0	5 (2.8)
Totals	8 (100.0)	74 (100.0)	65 (100.0)	30 (100.0)	177 (100.0)

Years Models Were in Operation

Item 9 asked for the number of years the current curriculum model had been in operation. This information has been placed in Table 5 according to the model said by the respondents to be in use. The grouping of data is also based on the degree of integration of nursing content reported by respondents. Seventy-seven of the 177 respondents (43.5%) reported that their models had been in use between 6 and 10 years. Seventy-one programs (40%) had been in operation 5 years or less. Twenty-five (14.1%) had utilized their model for 11-15 years. Only 4 programs (2.3%) stated that their current model had been in operation 16 or more years.

A careful review of Table 5 reveals that between 1967 and 1980 the percentage of integration within programs apparently received greater emphasis. In fact, 65 (88%) of the 74 integrated programs implemented their models within that time frame.

Course Structure Within the Curriculum

Because the term "integration" means different things to different people, respondents were asked which courses were taught as separate subjects (see item 11 in Part I of the Questionnaire in Appendix A). Item 11 has three parts. Part A contains two lists of content areas: nursing and non-nursing. Respondents were requested to indicate which areas of this content they taught as separate courses. Part B asked which courses from the 11 A lists were combined together to form one course. Part C asked that respondents indicate their primary reasons for combining content.

Table 5

Number of Years in Operation According to the Percent of
Integration of Nursing Content for Each Type of Curriculum Model

Estimate of percent of integration of nursing content	Years in operation						Totals	
	Unknown	Under 2	2 - 5	6 - 10	11 - 15	16 - 20		Over 20
Medical models (N=8)								
25 - 49	0	0	0	1	0	0	0	1
1 - 24	0	0	1	3	1	0	2	7
Totals	0	0	1	4	1	0	2	8
Integrated models (N=74)								
100	0	3	7	15	4	0	0	29
75 - 99	0	1	11	15	5	1	0	33
50 - 74	0	0	4	1	1	0	0	6
25 - 49	0	0	1	1	0	0	0	2

Table 5 (Continued)

Estimate of percent of integration of nursing content	Years in operation							Totals
	Unknown	Under 2	2 - 5	6 - 10	11 - 15	16 - 20	Over 20	
1 - 24	0	1	0	0	0	0	0	1
None	0	0	0	0	0	0	0	0
Unknown	0	0	2	1	0	0	0	3
Totals	0	5	25	33	10	1	0	74

Partially integrated models (N=65)

100	0	0	0	0	0	0	0	0
75 - 99	0	2	2	5	1	0	0	10
50 - 74	0	1	5	12	2	0	0	20
25 - 49	1	0	9	11	4	0	0	25
1 - 24	0	0	3	3	2	0	0	8
None	0	0	0	0	0	0	0	0

Table 5 (Continued)

Estimate of percent of integration of nursing content	Years in operation						Totals	
	Unknown	Under 2	2 - 5	6 - 10	11 - 15	16 - 20		Over 20
Unknown	0	0	2	0	0	0	0	2
Totals	1	3	21	31	9	0	0	65
Conceptual models (N=12)								
100	0	0	1	0	0	0	0	1
75 - 99	0	1	0	0	0	0	0	1
50 - 74	0	0	0	0	0	0	0	0
25 - 49	1	0	0	0	0	0	0	1
1 - 24	0	0	2	1	0	0	0	3
None	0	1	3	1	1	0	0	6
Unknown	0	0	0	0	0	0	0	0
Totals	1	2	6	2	1	0	0	12

Table 5 (Continued)

Estimate of percent of integration of nursing content	Years in operation						Totals	
	Unknown	Under 2	2 - 5	6 - 10	11 - 15	16 - 20		Over 20
Multiple response models (N=18)								
100	0	0	0	2	0	0	0	2
75 - 99	0	0	0	1	0	0	0	1
50 - 74	1	0	1	0	2	0	0	4
25 - 49	0	1	1	2	1	0	0	5
1 - 24	0	0	2	1	1	0	1	5
None	0	0	0	1	0	0	0	1
Unknown	0	0	0	0	0	0	0	0
Totals	1	1	4	7	4	0	1	18

Separate subject courses. Table 6 presents the number and percent of courses taught separately. Within the nursing courses, community nursing was the course taught as a separate subject most frequently. Seventy-one programs (40.1%) used this approach. Next in frequency were maternity nursing and nursing of children. The former subject was taught as a separate subject by 48 programs (27.1%) whereas the latter subject was taught separately by 46 programs (25.9%). Nursing courses taught less frequently as separate subjects were physical assessment and and health care of the young adult. Only 6 institutions (3.3%) taught one or both of these subjects as separate courses.

Table 6
Content Taught As Separate Courses

Content Areas	Number of Programs	Percent
Nursing		
Medical Nursing	17	9.6
Surgical Nursing	18	10.1
Maternity Nursing	48	27.1
Nursing of Children	46	25.9
Psychiatric Nursing	38	21.4
Mental Health Nursing	20	11.2
Community Health Nursing	71	40.1
History of Nursing	22	12.4
Nursing Ethics	20	11.2

Table 6 (Continued)

Content Areas	Number of Programs ^a	Percent
Legal Aspects	14	7.9
Nursing Research	30	16.9
Leadership	15	8.4
Trends/Issues	10	5.6
Nursing Care Management	9	5.0
Physical Assessment	6	3.3
Health Care of the Young Adult	6	3.3
Non-Nursing		
Nutrition	127	71.7
Pharmacology	79	44.6
Microbiology	170	96.0
Chemistry	169	95.4
Sociology	167	94.3
Anatomy	156	88.7
Physiology	149	84.1
Research	105	59.3
Growth and Development	16	9.0
Pharmacology	12	6.7
Statistics	10	5.6
Philosophy	9	5.0

^aBecause the choice of courses by individual programs overlapped, the total number of programs is greater than 177.

Of the non-nursing courses, microbiology was most frequently taught as a separate subject. This was the case in 170 institutions (96%). Following closely behind were chemistry and sociology with 169 programs (95.4%) and 167 programs (94.3%) respectively, utilizing the separate subject format for these courses. Least frequently taught as a separate subject was philosophy. This course was written in by nine respondents (5.0%). A low percentage here does not mean that it is very frequently integrated. It probably means that formal content in philosophy is infrequently included in nursing programs.

Combinations of subjects. Item 11 B asked the respondents to list courses which were combined in their curriculums. Table 7 provides a summary of the number of different combinations reported according to

Table 7
Combination of Content Areas

Number of content Areas Combined Together	Number of Different Combinations	Number of Times Reported
13	1	1
12	3	1
11	4	4
10	7	7
9	7	9
8	5	15
7	11	16
6	13	13

Table 7 (Continued)

Number of content Areas Combined Together	Number of Different Combinations ^a	Number of Times Reported
5	26	29
4	25	48
3	29	68
2	<u>28</u>	64
Total	155	

^aAn Additional 56 other combinations were written in by respondents.

the number of subjects from the list of content provided in 11 A and the number of times the combinations were reported. As many as 13 content areas were said to be combined in one curriculum. Most frequently reported were 3 content areas. In relation to different kinds of combinations, the 3-course combinations showed the greatest variety. A total of 155 different combinations was reported for the content areas listed in 11 A. In addition, 56 other combinations of course content were written in.

Table 8 presents the frequency with which courses listed in item 11 were combined. A total of 50 programs (28.2%) combined medical-surgical nursing content and 33 programs (18.6%) combined maternal and child nursing content. These subjects accounted for the first and second highest

Table 8

Number and Percentage of Programs Which Combine Courses

Types of Combination of Content Area	Number	Percent
Most Frequent of Two-Area Combinations		
Medical and Surgical	50	28.2
Maternal and Children	33	18.6
Psychiatry and Mental Health	21	11.8
Anatomy and Physiology	17	9.6
Most Frequently Used in Multi-Course Combinations		
Medical	50	28.2
Surgical	3	1.7
Maternity	22	12.4
Children	11	6.2
Psychiatric	9	5.1
Mental Health	10	5.6
Community Health	5	2.8
History of Nursing	9	5.1
Nursing Ethics	5	2.8
Legal Aspects	1	0.6
Most frequently Used in Non-Nursing Multi-Course Combinations		
Nutrition	3	1.7
Pharmacology	1	0.6
Microbiology	1	0.6

Table 8 (Continued)

Types of Combination of Content Area	Number	Percent
Chemistry	1	0.6
Sociology	1	0.6
Psychology	1	0.6
Anatomy plus	17	9.6
Physiology	1	0.6
Research	1	0.6
Other	3	1.7

frequencies of two area combinations. Two other frequently combined content areas reported were psychiatry and mental health by 21 programs (11.8%) and anatomy and physiology by 17 programs (9.6%).

Other combinations involved 11 nursing courses that combined three or more content areas together. Among these combinations medical nursing was reported by 50 programs; 22 programs reported that maternity nursing was combined with two or more areas. Reported third was pediatric content; mental health content was fourth combined with two or more areas by 10 programs; psychiatric nursing and history of nursing tied for fifth place with 9 respondents each. The remaining courses were reported by 5 or less programs.

Anatomy, reported by 17 programs, was the only significant course in the non-nursing content list which was combined with two or more content areas. Nutrition was reported by 3 programs and the rest of the non-nursing courses had only one listing each.

Primary Reason For Combining Content

Item 11 C requested the respondents to give their primary reason for combining content areas. Table 9 presents these primary reasons and the frequency with which they were given.

The single reason given by the largest group of respondents (67), which comprised 37.8% of the 177 programs, was that they were developing courses based upon the conceptual model. The next most popular response selected was a combination of the following two reasons: for the purpose of developing a conceptual model as well as for the purpose of developing an integrated model. This selection was made by 16% of the survey population, which accounts for an additional 28 programs. The reason for combining content reported by the third highest number of respondents was to develop an integrated model; this was stated by 23 programs.

A large number of respondents listed more than one primary reason. If the 28 programs that reported that they were developing a combined integrated and conceptually based model are added to the 23 who were developing integrated models, the total for the integrated model becomes 51 programs. However, if the same 28 programs are added to the 67 programs which reported the development of a conceptually based model as their primary or only reason for combining courses, the new group, would then

Table 9

Primary Reason Given by Respondents for Combining Content

Reason Given	Number	Percent
A. They have traditionally been taught together	5	3.0
B. They logically fit together	15	8.0
C. There was a planned effort to develop courses based upon a conceptual model	67	37.0
D. There was a planned effort to develop integrative courses	23	13.0
E. Other:		
A plus B	3	2.0
B plus C	7	4.0
B plus D	3	2.0
C plus D	28	16.0
B plus C plus D	9	5.0
F. Write-ins	4	2.0
No response	10	6.0
Totals	177	100.0

account for 95 programs. This then would have indicated that a majority of programs (53%) reported that their partial or primary reason for combining content was to develop conceptually based curriculum models.

Until very recently curriculum organization based on a conceptual framework was a criterion for accreditation of baccalaureate programs by the National League for Nursing.

Four respondents wrote in their primary reasons. The reasons were:

1. Provides less redundancy and boredom for instruction and learning.
2. Scheduling in clinical areas and within the college is easier.
3. Model calls for integration of concepts.
4. Focus was on developing a nursing framework.

Item 19 and 20 asked the respondents to list the concepts and theories utilized in their curriculums. These are found in Table 27 in Appendix H.

Advantages and Disadvantages of Integration

In items 17 and 18, respondents were requested to list five advantages and five disadvantageous of the integrated curriculum in the order of their importance, starting with the most important as number 1. These data were sorted and categorized.

Advantages

Table 10 lists categories of advantages and the ranks given to them by the 177 persons in the total sample. The key word (s) that were used by the respondents to describe the merits of an integrated curriculum, were retained as much as possible. Since some advantages which were listed could be placed in more than one category they were classified as to major emphasis. Six major classifications occurred and were placed in Table 10. A total of 33 respondents reported that the greatest advantage of using the integrated curriculum centered on the use of the nursing process and that with integration the goals associated with individualizing nursing care could be achieved.

Table 10

Rankings Given to the Advantages of an Integrated Curriculum

Advantages	Rankings given by respondents					Total Rankings N(%)
	1	2	3	4	5	
	N(%)	N(%)	N(%)	N(%)	N(%)	
Promotion/enhancement use of concepts/ conceptual framework	32(18)	29(16)	27(15)	11(6)	4(2)	103(22)
Nursing process/ individualization	33(19)	14(8)	22(12)	9(5)	8(5)	86(19)
Opportunities for faculty development	14(8)	13(7)	19(11)	25(14)	18(10)	89(19)
Student learning	6(3)	5(3)	7(4)	11(6)	7(4)	36(8)
Wholism/preparation of generalist	32(8)	18(10)	15(8)	9(5)	4(2)	78(17)
Flexibility and creativity	14(8)	13(7)	14(8)	21(12)	9(5)	71(15)
No response	46(26)	84(48)	87(49)	91(51)	127(72)	
Total	177(100)	177(100)	177(100)	177(100)	177(100)	463(100)

Although, the promotion/enhancement of the use of concept/conceptual framework category received one less first ranking than did the nursing process/individualization category, it was given more weight by the 177 respondents. Of the total 449 rankings made by the respondents 103 (23%) were related to the promotion/enhancement of the use of concepts/conceptual frameworks. Only 86 (19%) of the rankings pertained to the nursing process/individualization category. Lowest in overall rankings were advantages related to student learning. This category was ranked only 36 times (8% of the rankings) by the respondents. Closer together were categories related to opportunities for faculty development, wholism/preparation of a generalist and flexibility/creativity. The number of times these three categories were listed as advantages by the respondents were 89 (20%), 78 (17.4%) and 71 (16%) respectively. However, when weighting is applied to the order of the rankings, wholism/preparation of a generalist can be said to have been described by the respondents as a greater advantage than opportunities for faculty advancement and flexibility/creativity.

Disadvantages

Table 11 lists rankings of disadvantages of an integrated program. A total of 562 rankings of disadvantages are included in 11 categories. Overall the greatest weighted disadvantage ranked by the group was related to increased faculty development needs and problems. These were mentioned by 137 persons. The next greatest disadvantage according to level of rankings and the number of respondents listing the disadvantage related to the statement that clinical settings are not integrated.

Table 11

Rankings Given to the Disadvantages of An Integrated Curriculum

Disadvantages Related to:	Rankings given to disadvantages of an integrated curriculum					
	1 N(%)	2 N(%)	3 N(%)	4 N(%)	5 N(%)	N(%)
More expense	13(7)	6(3)	2(1.1)	0	2(1.1)	23(4.1)
Loss of content	28(16)	8(5)	6(3)	2(1.1)	1(5)	45(8.0)
Not used in the clinical setting	39(22)	40(23)	15(8)	8(5)	4(2)	106(18.8)
Increased faculty development needs and problems	23(13)	27(15)	46(26)	22(12)	19(11)	137(24.2)
Increased planning difficulties	28(16)	19(11)	7(4)	5(3)	0	59(10.4)
Increased faculty time in preparation and participation	14(8)	16(9)	12(7)	9(5)	3(2)	54(9.6)
Reduction of student learning	14(8)	16(9)	14(8)	16(9)	7(4)	67(11.9)
Development/organization of concepts/content/ curriculum difficulty	12(7)	8(5)	5(3)	7(4)	5(3)	37(6.5)

Table 11 (Continued)

Disadvantages Related to:	Rankings given to disadvantages of an integrated curriculum					
	1 N(%)	2 N(%)	3 N(%)	4 N(%)	5 N(%)	N(%)
Confusion	4(2)	11(6)	6(3)	2(1.1)	0	23(4.1)
Reduction in state board scores	0	0	0	1(0.5)	1(0.5)	2(0.3)
Lack of textbooks	1(0.5)	2(1.1)	2(1.1)	4(2)	0	9(1.6)
None	1(0.5)	2(1.1)	0	0	0	3(0.5)
No response	0	22(12)	62(35)	101(57)	135(76)	
Totals	177(100)	177(100)	177(100)	177(100)	177(100)	565(100)

Next in order of weighted ranks (and the number of respondents listing the disadvantages) were reduction in student learning (67), increased planning difficulties (59), loss of content (45), and increased faculty time in preparation and participation (54). Three respondents (1.6%) of total sample said that there were no difficulties.

Activities That Contribute to the Success of the Integrated Curriculum

Subproblem 3 asked what activities contribute to the success of an integrated program. There was only one item (number 22) which had been specifically structured to solicit information on activities and procedures which were being employed by integrated nursing curriculums to ensure their success. Item 22 was one of 6 which only respondents from substantially integrated programs were asked to answer. Responses to one or more of the restricted items were provided by 103 respondents. A total of 93 different types of activities were reported by 101 individuals who responded to item 22. These have been categorized as internal resources, external resources and a combination of internal and external resources. Internal resources were mentioned by 27(27%) of the respondents. They included:

1. Curriculum development process/faculty development measures
2. Task forces/self studies/workshops
3. Input from faculty members with previous experiences with integration
4. Use of existing literature
5. Administrative support/curriculum development expertise
6. Faculty commitment and determination to make the program succeed, good leadership and teamwork

Twenty-three (23%) of the individuals responding to this item described external resources such as:

1. Consultation with experts and authors of books on curriculum
2. Consultation with faculty members of older integrated programs
3. Consultation with National League for Nursing experts
4. Federal grants and studies

A combination of internal and external resources was listed by 37 (37%) of the respondents.

Attitudes Toward Integration

Subproblem 4 asked about the attitudes of the 177 persons in the sample toward integrated curriculums in baccalaureate nursing programs. A 55-item Likert scale in Part II of the questionnaire elicited information to answer this question (see Appendix B). Response options varied from "strongly agree" to "strongly disagree". Five points, were given for strong agreement with a statement favorable to integration and five points for strong disagreement with a statement unfavorable to integration.

Statistical Explanations

Table 12 contains the responses of the sample on items 18 and 19 in the Likert scale. The table is presented in order to explain how responses are interpreted. Item 18 is an example of an opinion held by someone who does not support the idea of an integrated nursing curriculum. On the other hand, item 19 is an example of an opinion held by someone who supports an integrated curriculum. Therefore, while strong

Table 12

Response of Sample on Items 18 and 19

Item: Faculty believes that there is a decrease in the students' ability
18 to apply theoretical concepts to the clinical practice setting
in the integrated program.

Opinion	Points	Number of Respondents	Frequency Percent
Strongly Agree	1	4	2.4
Agree	2	25	14.8
Neutral	3	32	18.9
Disagree	4	81	47.9
Strongly Disagree	5	27	16.0
Total		168	100.0

Item: The majority of faculty of integrated programs are satisfied
19 with their students' achievement in meeting their program
objectives.

Opinion	Points	Number of Respondents	Frequency Percent
Strongly Disagree	1	2	1.2
Disagree	2	25	15.0
Neutral	3	49	29.3
Agree	4	77	46.1
Strongly Agree	5	14	8.4
Total		177	100.0

Table 13 presents measures of central tendency and variability for items 18 and 19.

Table 13

Measures of Central Tendency and Variability for Items 18 and 19

Item	Mean	Standard Deviation	Mode	C.V. Percent
18	3.604	1.001	4.0 (Disagree)	27.8
19	3.455	0.890	4.0 (Agree)	25.8

agreement with item 19 results in five points and strong disagreement merits only one point, the opposite is true for item 18.

For responses to both items 18 and 19, the output shows a mode of 4.0 on the Likert scale. Now, a score of 4.0 in item 18 indicates disagreement while it indicates agreement in item 19. Logically, a disagreement with an opinion which does not support integration (item 18) should be voiced by a supporter of integration

In the analysis of the results of these two items as well as 53 others, the following statistics were used:

1. The frequencies, means, modes, and standard deviations were computed.
2. On Likert scale items, the range was also used to measure the variability of opinion. It was calculated as the difference between the maximum and the minimum values of a group of scores.
3. When a comparison of opinion over multiple items was needed, the coefficient of variation (c.v.) was used as a measure of variability of opinion.

Mathematically expressed, the coefficient of variation gives what percentage of the mean the standard deviation is. It is the ratio of the latter to the former. Therefore the larger the c.v. is, the more varied the opinion. The reverse is also true. A c.v. is examined in relationship to another c.v., thus the interpretation as to which one of the two is more or less varied becomes a simple task.

As an illustration, a comparison of the variability of opinions over items 1, 3 and 14 may be made (see Table 14). The respective item c.v.'s are 36%, 15.6% and 44%. This means that there was much less variation in opinion regarding items 1 and 3; on the other hand there was much less consistency among the respondents' opinions on item 14. Item 1 was more like item 14 in relation to the variability of opinion of the sample on this item.

Item 3, which stated that true integration takes place only when the student is able to assimilate the integrated data and then use these data in his or her clinical experience, was poorly worded in relation to determining the attitude of respondents toward integration. This is evidenced by the fact that 79 respondents agreed with the statement and 84 strongly agreed with it (see Appendix B) even though the overall mean for the attitude of the total did not indicate strong agreement with the concept of integration. Five points were assigned for strong agreement with this item, even though agreement with it could indicate the belief that an integrated curriculum was not necessary because integration actually could be effected only by the student in his/her clinical practice. It is interesting to note that only one-third of the experts used to establish the content validity of the Likert scale approved the original item 3. However, there was 100% agreement on the revised item 3 (see Appendix B).

Table 14

Measures of Central Tendency and Variability for Items 1, 3 and 14

Item	Mean	SD	Mode	C.V.(%)	Prevailing Opinion ^a
1. Students more frequently express their satisfaction with the teaching/learning strategies utilized in the integrated curriculum than any other model.	2.94	1.059	3.0	36.0	Neutral
3. True integration takes place only when the student is able to assimilate the integrated data and then utilize these data in his or her clinical experience.	4.40	0.69	5.0	15.7	Strongly Agree
14. Faculty must be well prepared in all disciplines to guide students effectively in the clinical setting in the integrated curriculum.	2.708	1.192	2.0	44.0	Agree

^aPrevailing Opinion = Most frequently occurring opinion

Attitude Scores of Participants

Since there were 55 items on the Likert scale, the highest possible score indicating a very favorable opinion toward integration would be 275. The lowest possible score would be 55. Table 15 presents total scores for the 130 respondents who answered all 55 items.

Table 15

Total Likert Scores for 130 Respondents
Who Answered All 55 Opinion Items

Score	Number	Score	Number	Score	Number
106	1	149	5	180	1
108	1	150	1	181	1
109	1	151	2	182	2
110	1	152	2	183	2
114	1	153	1	184	1
116	1	154	3	185	2
122	1	155	2	186	1
124	2	156	3	187	2
125	1	157	1	188	5
127	1	158	1	189	1
128	2	159	2	190	3
129	1	160	2	192	2
130	3	162	3	193	2
131	4	164	1	195	1
132	2	165	1	199	1
133	1	166	1	200	1
134	1	169	3	204	1
135	1	170	2	206	1
137	3	172	1	211	1
139	2	173	2	212	1
140	3	174	3	218	1
141	1	175	2	224	1
142	1	176	1	237	1
143	2	177	4	254	1
146	2	178	2		
148	2	179	1		

Table 16 presents measures of central tendency and variability for total attitude scores of the 130 respondents by curriculum model. The mean scores of respondents from all three model groups—medical, partially integrated, and integrated—were in the neutral range. Standard deviations varied from 19.10 to 27.73. The highest range was in the scores of the integrated model group—108 to 254 points. The lowest range—130 to 189—was found in the scores of the medical model group.

Table 16
Means, Standard Deviations, and Ranges of Attitude Scores
by Curriculum Model

Type of Model	Number	Mean	Standard Deviation	Range
Medical	15	157.20	19.10	130-189
Partially Integrated	59	153.28	25.47	106-237
Integrated	56	174.13	26.24	108-254
Total	130	161.80	27.73	106-254

When scores on individual Likert scale scores are looked at, there is much greater variation (see Appendix E). Table 17 presents measures of central tendency and variability for the individual score means.

The mean for the average individual scores of 130 participants was only 2.94 on a scale of 1 to 5 with 1 indicating a very unfavorable attitude toward integration and 5 suggesting a very favorable attitude toward the concept of integration in baccalaureate nursing education. The

Table 17

Means, Standard Deviations and Ranges
of Average Item Scores of Respondents

Group	Mean	Standard Deviation	Range
130 respondents	2.942	0.504	1.927-4.618
174 respondents	2.985	0.676	1.929-4.618

standard deviation was 0.50 and the range 1.93 to 4.62. It is interesting to note that when the average individual score mean for the 174 individuals (who answered either all of the items or only part of the scale) is compared with the average individual score mean for the 130 respondents (who answered all items) there is practically no difference.

Although the overall average response to the 55 Likert scale items was only 2.94, there was considerable variation among the items in relation to the favorableness of attitudes toward integration indicated by responses to individual items. The lowest coefficient of variation was 15.7% on item 3 and the highest was 44.3 on item 15.

It has already been hypothesized that the high agreement on item 3 may have been due to agreement with a general learning principle rather than with a preference for or against integration of content in baccalaureate nursing programs. An additional item presented problems. This was item 22 which stated that faculty understanding of group dynamics is necessary in making curriculum decisions in an integrated program. This statement was scored as being favorable to the concept of integration.

It could be interpreted as an unfavorable statement. If responses to items 3 and 22 were eliminated, the mean average opinion of respondent' would be less favorable.

Student-related items. Items 1-13 relate directly to students. Others relate indirectly to them. The first suggested that students in integrated programs express more satisfaction with teaching/learning strategies. Respondents to item 1 were almost equally divided (55 Agree, 52 Neutral and 63 Disagree). Item 2 suggested that integration helps student to have a better understanding of rationales and expected results. Here the diversity was greater (104 Agree, 22 Neutral and 47 Disagree). The same type of response was found to item 4 which stated that integration makes it easier for students to provide wholistic care (111 Agree, 24 Neutral and 38 Disagree). Responses to item 5 (76 Agree, 50 Neutral and 44 Disagree) favored the opinion that students in the integrated program more readily achieve the terminal objectives of the program. Similarly, responses to item 19 (91 Agree, 49 Neutral and 27 Disagree) suggest that more respondents believe that faculty are satisfied with their students' achievement of program objectives. The same favorable view toward integration is provided by responses to item 18 (29 Agree, 32 Neutral and 108 Disagree) which suggests that integration decreases students' ability to apply theory in the clinical setting. In the responses to item 6 (95 Agree, 43 Neutral and 33 Disagree) a preference for integration is expressed. The item indicates that clinical evaluations show that students in integrated programs perform as well or better than those in other curriculum designs.

Overall response to items 7 (98 Agree, 28 Neutral and 41 Disagree) and to item 8 (48 Agree, 57 Neutral and 65 Disagree) indicate less

favorable attitude toward integration. The first states that students in integrated programs express fear at graduation that they have obtained too little knowledge and experience. More respondents to item 8 disagreed with the statement that graduates of integrated programs are apt to have less difficulty meeting their employers' expectations. More respondents agreed with item 9 (116 Agree, 33 Neutral and 21 Disagree) that said that integration provides greater continuity of learning and with item 10 (70 Agree, 62 Neutral and 37 Disagree) that indicated that students from integrated programs are more apt to seek out their own learning experience, although 62 respondents to item 10 neither agreed nor disagree. There was an expression of a less favorable attitude toward integration in responses to item 12 (32 Agree, 56 Neutral and 80 Disagree) which stated that students in integrated program have less difficulty with learning experiences. Almost the same number of respondents agreed as disagreed with item 13 (76 Agree, 21 Neutral and 72 Disagree) which said that it was not difficult to evaluate students in relation to blended content.

Faculty-related items. Items 14 to 33 focused on faculty-related concerns. Items 14, 15, 17 and 21 related to faculty preparation. Most prevalent opinion in relation to item 14 (92 Agree, 17 Neutral and 62 Disagree) and item 21 (47 Agree, 21 Neutral and 102 Disagree) indicated respondents' belief that faculty must be prepared in all disciplines in integrated programs and that the majority of faculty are not adequately prepared to function in integrated programs upon employment. Responses to item 26 (159 Agree, 7 Neutral and 2 Disagree) would seem to show that there is a general feeling that faculty initially are often apprehensive

about functioning in a setting different from their clinical speciality. On the other hand, responses to item 29 (73 Agree, 26 Neutral and 71 Disagree) suggest that the respondents were very divided on whether the majority of faculty teach integrated concepts in the clinical setting without difficulty. However, opinions expressed in relation to item 30 indicate that many respondents believed that there is sometimes the problem of poor teaching of classroom theory because of the faculty's difficulty with adjustment to the integrated model (86 Agree, 36 Neutral and 46 Disagree).

Responses to item 54 (106 Agree, 42 Neutral and 22 Disagree) indicated that a large percentage of respondents believed that some of the major teaching problems in integrated programs might be resolved if there were changes in graduate education. Almost equal numbers of respondents either agreed or disagreed with item 15 (77 Agree, 12 Neutral and 80 Disagree) which stated that students may be denied the expertise of specialists in integrated programs, and with item 17 (70 Agree, 25 Neutral and 74 Disagree) which stated that the integrated curriculum requires the employment of faculty with a generalist background. However, responses to item 25, (129 Agree 26 Neutral and 12 Disagree) indicated the belief that specialists could maintain their expertise in integrated programs. Responses to item 31 (31 Agreed, 39 Neutral and 99 Disagree) showed that the largest number of respondents did not consider it "not difficult" to change the attitudes and behaviors of specialists to those of generalist. On the other hand a large number of respondents to item 20 (80 Agree, 39 Neutral and 48 Disagree) indicated that most faculty are supportive of integrated programs.

Items 16, 28, 32, 33 and 43 all referred to the greater amount of time, effort or commitment demanded of faculty in integrated curriculums. The greater number of respondents agree that greater demands are placed on faculty in integrated programs: item 16 (85 Agree, 34 Neutral and 51 Disagree), item 28 (95 Agree, 38 Neutral and 38 Disagree), item 32 (104 Agree, 26 Neutral and 37 Disagree), item 33 (116 Agree, 18 Neutral and 37 Disagree) and item 43 (118 Agree, 21 Neutral and 32 Disagree).

Curriculum-related items. Rather surprisingly, a number of quite unfavorable views about integrated curriculums were supported by relatively large numbers of respondents. Item 11 (53 Agree, 40 Neutral and 74 Disagree) stated that integrated curriculums were necessary because few students could integrate separate units of study. As can be seen, only 31.7 % of the persons who responded to the item agreed. Item 27 (81 Agree, 42 Neutral and 47 Disagree) said that faculty relate that the integrated curriculum looks great as a model, but does not work in practice; 48% agreed; only 28% disagreed. Item 37 (145 Agree, 20 Neutral and 7 Disagree) stated that more research is needed to document the effectiveness of the integrated curriculum. Only 4% of those who answered disagreed. Item 38 (117 Agree, 28 Neutral and 27 Disagree) indicated that respondents believed that confusion regarding terminology made efforts to use the integrative approach difficult. Item 46 (24 Agree, 22 Neutral and 124 Disagree) said that there was no risk of omitting important factual learning in an integrated program. It can be seen that 73% of the respondents thought that there was such a risk; only 14% thought there was not such a risk. However, responses to item 45 (52 Agree, 30

Neutral and 89 Disagree) indicated that only 30 % of the persons answering the item thought that there was a tendency toward superficiality in handling content in an integrated program. Responses to item 52 (55 Agree, 59 Neutral and 58 Disagree) and item 53 (47 Agree, 75 Neutral and 47 Disagree) indicate that there was considerable doubt about the future of the integrated curriculum in baccalaureate nursing education.

Items which elicited a favorable response toward integration from the greatest number in the sample include item 35 (101 Agree, 37 Neutral and 33 Disagree) which stated that essential concepts from all the traditional specialities can be meaningfully integrated; item 44 (30 Agree, 35 Neutral and 105 Disagree) which said that the integrated curriculum deemphasizes the teaching of technical skills; item 48 (88 Agree, 39 Neutral and 41 Disagree) which said that nursing integration is logical even though there is a trend toward more specialization in other professions; and item 51 (132 Agree, 20 Neutral and 18 Disagree) which indicated that it is easier to teach total care concepts in an integrated curriculum.

Other areas where large numbers of respondents saw problems were in relation to faculty load (item 55: 90 Agree, 36 Neutral and 36 Disagree), lack of suitable textbooks (item 50: 92 Agree, 36 Neutral and 42 Disagree), difficulty in constructing integrated curriculums (item 34: 126 Agree, 14 Neutral and 31 Disagree) and problems with team teaching (item 24: 98 Agree, 32 Neutral and 39 Disagree).

Answers to item 40 (69 Agree, 47 Neutral and 55 Disagree) and item 41 (47 Agree, 61 Neutral and 63 Disagree) show that respondents were more evenly divided in their responses to the statements that the integrated curriculum is necessary because of the knowledge explosion

and technological advances respectively. They were almost equally divided on item 47 (65 Agree, 46 Neutral and 59 Disagree) which stated that it is easier to provide greater consistency in clinical expectations in integrated programs; item 39 (66 Agree, 34 Neutral and 70 Disagree) which stated that the integrated nursing curriculum was adopted without specifying a rationale for doing so; item 42 (61 Agree, 46 Neutral and 65 Disagree) which claimed that the integrated curriculum was more apt to require constant revisions; and item 49 (73 Agree, 22 Neutral and 75 Disagree) which said that selecting clinical activities that are consistent with the conceptual framework is not a problem in the integrated program.

Faculty and Student Satisfactions with Integrated Curriculums

Subproblem 5 asked for a description of the perception of the respondents regarding the satisfactions of faculty and students with integrated programs. First, all respondents were asked in item 12 how satisfied they were with their current model. Then in items 22 and 23, respondents who stated that their curriculums were substantially integrated were asked to describe how satisfied their faculty and students were with the integrated programs.

Respondents' Satisfaction with Various Models

Table 18 presents the numbers of respondents in the total sample who were very satisfied, satisfied and not satisfied with their models. Most satisfied were the 15 respondents who claimed their curriculums were organized around either concepts or mixed models. Least satisfied

Table 18

Frequency and the Percentage of Respondents' Satisfaction with Their
Existing Curriculum Model

Satisfaction with existing curriculum	Curriculum Models					
	Medical	Integrated	Partially Integrated	Concepts	Multiple	Total
	8 (4.5) N(%)	74 (41.8) N(%)	65 (36.7) N(%)	12 (6.8) N(%)	18 (10.2) N(%)	177 (100.0) N(%)
Very satisfied	0	32 (43.2)	17 (26.2)	6 (50)	9 (50)	64 (36.1)
Satisfied	5 (62.5)	33 (44.6)	35 (53.8)	5 (41.7)	8 (44.4)	86 (48.6)
Not satisfied	3 (37.5)	9 (12.2)	13 (8.3)	1 (8.3)	1 (5.6)	27 (15.3)
Totals	8 (100)	74 (100)	65 (100)	12 (100)	18 (100)	177 (100)

were respondents whose curriculums were organized around the medical model. Almost twice as many respondents from integrated models (32 of 74) were very satisfied with their curriculum structure compared with respondents from partially integrated programs (17 of 65). Whereas 44.6% of respondents from integrated models expressed satisfaction with their structure, 53.8% of those from partially integrated programs did so.

The above comparisons need to be interpreted with caution since the distribution of respondents across models was so uneven. Overall, 64 respondents (36.1%) were very satisfied with their curriculum models; 86 (48.6%) were satisfied and 27 (15.3%) were not satisfied.

Respondents' Perceptions of Faculty and Student Satisfaction

The perceptions of 107 respondents from substantially integrated programs relative to their faculty's and students' satisfaction with their curriculum models were obtained from the responses to items 22 and 23. Faculty satisfaction will be described first.

Faculty satisfaction. Table 19 reports faculty satisfaction with substantially integrated curriculums according to the specific model they indicated was implemented in their baccalaureate nursing programs. Thirty-two respondents (29.9%) of the 107 respondents perceived their faculties to be very satisfied; 43 (40.2%) considered them satisfied; 24 (22.4%) considered them somewhat satisfied; and 3 (2.8%) did not think them satisfied. Five individuals did not respond. Both conceptual models were perceived to be very satisfactory or satisfactory to faculty. Fifty-four of the 68 integrated programs (79.4%) were perceived

Table 19

Faculty Satisfaction With the Substantially
Integrated Curriculum Models

Perceived satisfaction	Types of models				Totals
	Integrated	Partially Integrated	Conceptual	Multiple Response	
	N(%)	N(%)	N(%)	N(%)	
Very satisfied	27(39.7)	3(10)	1(50)	1(14.3)	32(29.9)
Satisfied	27(39.7)	14(46.6)	1(50)	1(14.3)	43(40.2)
Somewhat satisfied	13(19.1)	8(26.6)	0	3(42.9)	24(22.4)
Not satisfied	1(1.5)	2(6.6)	0	0	3(2.8)
No response	0	3(10)	0	2(28.6)	5(4.7)
Total	68(100)	30(100)	2(100)	7(100)	107(100)

to be very satisfactory or satisfactory to faculty. Only 3 of the 30 partially integrated models (10%) were perceived to be very satisfactory to faculty; 14 (46.6%) were thought to be satisfactory and 8 (26.6%) somewhat satisfactory. Two of the 30 programs (6.6%) were perceived to be not satisfactory.

Student Satisfaction. Table 20 reports student satisfaction with substantially integrated curriculums according to the specific model respondents stated was implemented in each baccalaureate nursing program. Thirty-two respondents (29%) perceived students to be very satisfied; 48 (44.8%) described them as satisfied; 19 (17.8%) thought they were somewhat satisfied; and 5 (4.7%) believed students were dissatisfied. Four respondents (3.7%) did not answer to item. As with faculty satisfaction, respondents perceived students in integrated programs to be more satisfied with a substantially integrated program than those in partially integrated programs.

Curriculum Revisions

Subproblem 6 asked to what extent nursing programs were planning revisions of their curriculum either toward integration or away from it. On the questionnaire, items 13-16 and 21 were related to this subproblem. Reasons given by programs for developing an integrated curriculum will be discussed prior to discussing the findings regarding planned curriculum revision either towards integration or away from integration.

Table 20

Student Satisfaction with the Substantially
Integrated Curriculum Models

Perceived satisfaction	Types of Models				Totals
	Integrated	Partially Integrated	Conceptual	Multiple Response	
	N(%)	N(%)	N(%)	N(%)	
Very satisfied	26(38.2)	5(6)	0	0	31(28.97)
Satisfied	31(45.6)	12(40)	2(100)	3(43)	48(44.8)
Somewhat satisfied	9(13.2)	8(27)	0	2(29)	19(17.8)
Not satisfied	2(3)	2(7)	0	1(14)	5(4.7)
No Response	0	3(10)	0	1(14.3)	4(3.7)
Total	68(100)	30(100)	2(100)	7(100)	107(100)

Reasons Given For Developing Integrated Curriculums

Information regarding the reasons why integrated curriculums were developed by the substantially integrated programs of the study group were ^{was} solicited by item 21. The reasons reported by 101 of 107 respondents are placed in Table 21. There are eight categories under which 101 reasons are tallied. The categories related to "meets

Table 21

Reasons for Developing an Integrated Curriculum as
Reported By Respondents In Substantially Integrated Programs

Reasons Given	Number	Percent
Facilitates use of concepts/conceptual framework	5	4.7
Helps to meet students' learning needs	8	7.5
Encourages curriculum development process/faculty preparation and planning	9	8.4
Enhances use of nursing process model	11	10.3
Prepares generalists/wholistic nurses	12	11.2
Promotes efficiency, flexibility, and creativity and is educationally sound	23	21.5
Meets recommendations of the NLN, and consultants	23	21.5
Keeps current	<u>10</u>	<u>9.3</u>
Subtotal	101	94.4
No Response	<u>6</u>	<u>5.6</u>
Total	107	100.0

recommendations of the NLN and Consultants" and "promotes efficiency, flexibility and creativity and is educationally sound" included the highest percentage of reasons (21.5% each).

The category having the next highest number of reasons (11.2%) related to the preparation of generalist/wholistic nurses. The enhancement of the nursing process model came next with 11 reasons (10.3% of the total). The remaining three categories accounted for 20.6% of the reasons. Two referred to curriculum planning. Only 8 reasons (7.5%) related to students' learning needs.

Intent to Revise Existing Curriculums

Item 13 asked whether the faculty was planning to revise their existing curriculum structures. First the number and percentage of respondents who are definite about changes in their model, not certain about change, or have no intention to change are presented. Then types of changes desired are described. Finally, reasons for change are listed. Models preferred by respondents are reported next.

Table 22 provides a summary related to whether or not there are plans to to change according to curriculum model. Fifty-six programs (31.7%) definitely planned to change; 37 (20.9%) were not sure; and 82 (46.3%) had no intention of changing. Two respondents (1.1%) did not answer this item.

A comparison of the models in relation to intent to change shows that 5 (62.5%) of the 8 medical models definitely planned to change. Only 19 (26%) of the 74 integrated models had definite plans to change. About one-third (21 of the 65) partially integrated models and 38% (11 of the 30) of the multiple model curriculums definitely planned to change.

Table 22

Respondents' Report on Intent to Revise Their
Existing Curriculum Model

Intention to Revise	Types of Curriculum Models				Totals N(%)
	Medical N(%)	Integrated N(%)	Partially Integrated N(%)	Multiple Response N(%)	
Definite	5 (62.5)	19 (26)	21 (32)	11 (38)	56 (32)
Not certain	3 (37.5)	11 (16)	18 (28)	5 (17)	37 (21)
No intent	0	43 (58)	26 (40)	13 (43)	82 (46)
No response	0	1 (1.4)	0	1 (3.3)	2 (1.1)
Totals	8 (100)	74 (100)	65 (100)	30 (100)	177 (100)

Table 27 in Appendix F provides detailed data about the number of programs in relation to plans for change, according to the number of years the school or department has existed and the percentage of integration in the current program.

Types of Changes Planned

Item 14 asked respondents who definitely planned to revise their curriculum to indicate the changes that were planned. Fifty-six respondents indicated definite plans to change. Table 23 presents suggested changes and the number of times they were listed by one or more of the respondents. Not all the listings were contemplated changes. Some referred only to the fact that revision was underway or that research should be done on whether or not revision was needed.

Table 23
Number of Planned Revisions Reported

Type of Revision	Number
A. Refining and improving on-going evaluation	3
B. Research of need to revise	4
C. Revision underway	3
D. New conceptual framework	6
E. Change in credit distribution:	
Conversion to semester	2
Smaller credit unit e.g., reduce 15 to 12 or 10 credits	7
Separate courses in physical assessment	1

Table 23 (Continued)

Type of Revision	Number
Change in length of classroom and clinical	1
Increase in Nursing I and II credits	1
Change in sequence	3
Change in scheduling	1
Change to upper division nursing major	<u>2</u>
Subtotal	34
F. Development of new curriculum model:	4
Eclectic	1
Integrated and conceptual	1
Nursing model	2
Partial integration	1
Systems and conceptual	<u>1</u>
Subtotal	10
G. Change of content:	
Add	
Research issues	2
Clinical speciality	1
Planned seminars (e.g., Psychiatry)	1
Research in nursing	1
More electives	1
Pharmacology to all nursing courses	1
Management course	1
Theory clinical research based	1
Theory clinical philosophy incorporated	1

Table 23 (Continued)

Type of Revision	Number
Leadership	1
Core content with speciality areas	<u>1</u>
Subtotal	12
Drop	
Pathophysiology from all nursing courses and further integration of concepts	1
Physicals	<u>1</u>
Subtotal	2
Increase	
Facts and concepts	1
Gerontology with transcultural model	1
Emphasis in research and technical skills and trends in nursing	1
Integration of physical assessment skills	1
Integration with less care and more prevention of illness	<u>1</u>
Subtotal	5
Decrease	
Focus on process	<u>1</u>
Subtotal	1
H. Miscellaneous changes:	
Separate nutrition and pharmacy	1
Separate maternity and pediatrics	1
Include core content with speciality areas	1
Change delivery of content	1

Table 23 (Continued)

Type of Revision	Number
Change selection of clinical settings	1
Change trends to moral and ethical issues	1
Family course versus integration	1
Need to prevent clinical experience preceding theory; e.g., psychiatry	1
Placement of community experience	1
Content rearrangement due to facility requirements	1
Change course titles	1
Career/educational mobility model (open curriculum) AD and BSN	1
Uncertain	5
Too detailed to report	3
Modification of integration for better student comprehension	1
Reevaluate the integration curriculum	1
List of intent and purpose of integrated curriculum due to administration change	1
Subtotal	23
I. Complex Responses	3
Total	90

Models Preferred by Respondents

Item 15 asked the respondents what type of curriculum structure they would choose if they were given a free hand. Table 24 presents the revised numbers of models that would be in existence if respondents were

Table 24

Preferred Curriculum Models Reported by Respondents According
to their Current Curriculum Models

Existing model	Preferred Curriculum Models (N=177)					
	Medical	Integrated	Partially Integrated	Conceptual	Multiple Response	No Response
Medical (8)	0	2	6	0	0	0
Integrated (74)	1	47	19	2	3	2
Partially integrated (65)	1	13	47	4	0	0
Conceptual (12)	0	0	5	7	0	0
Multiple response (18)	0	5	6	2	5	0
Changed total	2	67	83	15	8	2
Net change	6 (75%) Loss	7 (9.5%) Loss	18 (27.2%) Gain	3 (25%) Gain	10 (55.6%) Loss	

free to choose. Net gain or loss in numbers for each model is also provided. Instead of 8 medical models, there would be only 2. It is interesting to note that all present medical model curriculums would be changed, whereas 1 integrated and 1 partially integrated model would become medical models. The integrated model would decrease by 7 programs (9.5%), whereas the partially integrated model would gain 18 programs (a 27.2% increase). Three conceptual programs would be added (a 25% gain) and there would be 10 fewer mixed model programs (a 55.6% loss).

Change from Integrated to Non-Integrated Model

Item 16 in Part I of the questionnaire stated: "If your curriculum/program was previously but is no longer integrated, please give the reasons for the change." Twenty of the 177 individuals in the sample (11.3%) responded to the question and provided 33 reasons. However, 8 of the 20 respondents (40%) stated that they had gone from integrated to less integrated rather than to non-integration. The 8 programs accounted for 12 of the 33 reasons.

Table 25 categorizes the reasons according to whether they are related to faculty, students, content/curriculum, clinical setting or State Board scores. One third of the reasons given were faculty-related and they formed the largest group. Student-related and clinical setting-related reasons tied as the second highest groups. Some programs gave more than one reason. The reasons given for changing the curriculum model from integrated to less integrated and non-integrated curriculum models were as individualized as those reasons given for the

Table 25

Frequency of Reasons for Change From Integrated
to Less Integrated and Non-Integrated.

Reasons Given	Number of Programs
Faculty-Related	
1. Speciality background made it difficult to teach in all areas	2
2. Feelings of discomfort	1
3. Dissatisfaction of clinical specialities faculty	1
4. Need to reduce number of faculty (economy)	1
5. Too difficult to maintain with faculty change	1
6. Insufficient time to orient new faculty	1
7. Expertise not used efficiently/effectively	1
8. Dissatisfaction with repetition	1
9. Limited communication with faculty in area of expertise	1
10. Dissatisfaction with emphasis given some areas	<u>1</u>
Subtotal	11
Student-Related	
1. Dissatisfaction with this approach to learning	1
2. Dissatisfaction with repetition	1
3. Too little time in each area	1
4. Attrition due to stress	1
5. Difficult to learn	1
6. Too confusing	1
7. Content area not clear	<u>1</u>
Subtotal	7

Table 25 (Continued)

Reasons Given	Number of Programs ^a
Content/Curriculum Design-Related	
1. Loss of content	1
2. Difficulty of implementation	1
3. College change to credit courses	1
4. Pure integration too complex--even faculty had difficulty with it	
5. Nutrition not adequate	1
Subtotal	<u>5</u>
Clinical Setting-Related	
1. Not practiced within the clinical setting	4
2. Difficulty in arranging	1
3. Hospitals don't like student moving to different units	1
4. Not enough clinical knowledge	<u>1</u>
Subtotal	7
State Board-Related	
1. Lower	2
2. Results of State Boards consistently below 90%	<u>1</u>
Subtotal	3
Total	33

^aOf the 20 programs represented by the 33 reasons listed, 8 programs specified that they went from integrated to less integrated and gave 12 reasons for this change.

other revisions. It is not by chance that this list is very similar to the types of disadvantages of an integrated program which were reported and ranked earlier in these findings.

Evaluation Activities

Subproblem 7 asked what activities had been employed to assess the effectiveness of the integrated program. Data to answer this subproblem were provided by responses to item 26 in the questionnaire. In addition, respondents were requested on item 25 to describe what effect integrated curriculums had had on State Board scores. Items 25 and 26 were among the 6 items that were to be answered only by respondents who claimed that their programs were substantially integrated.

Activities

Ninety-eight individuals responded to item 26. Seventy-nine used some or all of the following activities to assess the effectiveness of their integrated curriculums: (1) course evaluation, (2) faculty evaluation, (3) program evaluation and (4) student evaluation, (5) follow-up study of graduates' satisfaction and achievement, (6) study of opinions of employers on the performance of graduates, (7) internal test evaluation and (8) comparative study of results of external examinations like State Boards and NLN accreditation reports.

Eighteen programs based their assessment on follow-up studies such as surveys of graduate and employer satisfaction. One program did not do any assessment up to the time the survey was taken.

Changes in state board scores.

Table 26 presents the changes in State Board scores after integration of baccalaureate nursing programs as reported by 78 respondents from substantially integrated curriculums. In addition, 24 comments made by 23 other respondents are listed later on in the presentation of the data. In Table 26, data are presented according to how respondents categorized their current curriculum models. Thirty-three of the 78 respondents (42%) stated that there had been no change in State Board scores. Nine individuals (12%) reported considerably higher scores whereas (6%) said that their scores were considerably lower. Seventeen (22%) reported somewhat higher scores, whereas 14 respondents (18%) said that their scores were somewhat lower.

Comments made by 23 other respondents included 10 remarks that indicated that the program had always been integrated; 5 that stated that no graduates had been tested since integration; 4 that described grades as above average to consistently higher; and 2 that indicated that scores were initially considerably lower but had increased to about the same values as before integration. One respondent said that there had been no trouble before; another didn't know whether there were changes; and 1 said that scores were not available unless students agreed.

Table 26

Changes in State Board Scores Since Integration

Changes in scores	Types of programs				Totals
	Integrated	Partially Integrated	Conceptual	Multiple Response	
	N(%)	N(%)	N(%)	N(%)	
Scores considerably higher	6(11)	2(11)	0	1(2.5)	9(12)
Somewhat higher	12(22)	5(28)	0	0	17(22)
About the same	25(46)	6(33)	0	2(5.0)	33(42)
Somewhat lower	8(15)	4(22)	2(100)	0	14(18)
Considerably lower	3(6)	1(6)	0	1(2.5)	5(6)
Total	54(100)	18(100)	2(100)	4(100)	78(100)

Discussion

The purpose of this study was to survey the status of the integrated curriculum in baccalaureate programs accredited by the National League for Nursing. Torres (1974, p. 2) wrote about the shift of focus from a medical model curriculum to an integrated approach. She described this as the most dynamic change in nursing education in the 10 years previous to 1974. It appears that there has been an even greater shift within the past 10 years. This study found that of the 146 respondents claiming to use a single curriculum model, 74 were utilizing an integrated curriculum and 65, a partially integrated curriculum. Only 8 respondents reported that their curriculums were organized around the medical model. It is not known how 110 individuals who did not accept an invitation to participate in this study would describe the organization of their curriculum.

There is considerable confusion about the exact definition of an integrated nursing program. According to Torres and Stanton (1982) "there is no consensus among educators on the characteristics of an integrated curriculum" (p. 75). Thus, there is confusion on "whether or not it truly exists and to what extent within any given program it is implemented" (Torres et al., 1982, p. 75). Because of this confusion, respondents were also asked to estimate the degree to which their nursing content was integrated. If a criterion of 50% integration of nursing content is used to define a substantially integrated program, then their responses can be interpreted as indicating that 107 of the 177 programs were integrated to this extent.

Another question of the study dealt with how satisfied respondents were with the curriculum model which was used in their nursing program and how satisfied they perceived their faculty and students to be with it. Information provided by the sample of this study indicates that respondents from integrated programs were most likely to be satisfied with their models; those from partially integrated programs were likely to be somewhat less satisfied with their curriculums, but more satisfied than were the respondents from medical model curriculums. If respondents had their wishes fulfilled there would be 18 more partially integrated, 3 fewer conceptual, 6 fewer medical models, 7 fewer integrated, and 10 fewer mixed model curriculums. Respondents' perceptions were that faculty were satisfied in about 70% of the substantially integrated programs and students in about 74% of these programs. Pardue (1979) compared the satisfaction of faculty who worked in blocked and integrated content baccalaureate programs. She concluded that faculty satisfaction is not a function of the type of curriculum organization.

A Likert scale was used to assess the overall attitude of the study subjects toward integration. Results did not indicate that the sample as a whole strongly favored integration. The average individual score was only 2.94 on a 5 point Likert scale. Typical favorable responses of the group were that integration helps students understand rationales and expected results; it makes it easier to give wholistic care; faculty are satisfied with student performance; students perform as well or better; there is a greater continuity of learning; nurse specialists can maintain their expertise; essentials can be integrated; and technical skills are not given too little emphasis.

Most of the typical unfavorable responses pertained to faculty problems and difficulty in constructing integrated curriculums. Responses of the majority of the 130 individuals who answered all 55 Likert items indicated that the confusion about terminology makes integrative efforts difficult; there is a risk of omitting important content; greater demands are placed on faculty; faculty load becomes a problem; there are difficulties with team teaching; faculty must be prepared in all disciplines; on employment most faculty are not prepared for integrative teaching and are apprehensive; it is hard to change faculty attitudes; integration sometimes causes poor classroom teaching; and students are not apt to have less difficulty in their first nursing position. The majority also indicated that they feared that at graduation, students had too little experience. However, it should be pointed out that such fear is not uncommon in faculties in programs that are not integrated. There was solid opinion that more research needs to be done on the effects of integrating the baccalaureate nursing program. The greatest number of respondents would not commit themselves about the future of integration in baccalaureate programs in nursing.

The above findings tend to reflect the variety of views expressed in the literature. There are a wide range of opinions on the integrated curriculum. Maloney (1978) concluded that although teaching in the integrated curriculum presents some problems for faculty who were prepared as clinical specialists, the problems are not insurmountable. Bach (1979) examined the concerns related to nurse educators who have been prepared as specialists, but find that they may be required to function as generalists in an integrated curriculum setting, and recommended duplicating the positive outcomes of a multi-disciplinary faculty.

Eisenhauer (1976) noted that it was important that anxiety be channeled toward positive action so that faculty members from various speciality backgrounds can progress from frustration to collaboration when working in an integrated setting. Strandell (1980) recommended that nursing educator's understanding of the integrated curriculum should be assessed when they are interviewed to teach in these programs. Maloney (1978) suggested and Strandell (1980) concurred that some of the solutions to the problems faculty have with the integrated curriculum could be resolved with changes in the content in graduate nursing education.

In 1972, Longway stated that "the integrated curriculum may be the highest level of organization of content possible" because it was able to "absorb change" (p. 120). The respondents in this sample also ranked flexibility high in listing the advantages of the integrated program. However, the advantage given the highest ranking was the enhancement and promotion of the use of concepts/conceptual frameworks. It will be interesting to note whether this advantage continues to receive such a high ranking now that the National League for Nursing has omitted the requirement of a conceptual framework as a criterion for accreditation. As many as 95 programs (53%) of those surveyed in this study have combined content for the primary or only reason of developing courses based on the conceptual framework. Although Hipps (1981) pointed out that nursing has ignored the trend of most other disciplines to specialize and has elected to "reach back to the 1930s and 1940s to the Progressive Education era, to develop a curriculum that purported to emphasize the whole rather than the parts..." (p. 976), she did list advantages of

the use of concepts. She said, "the worthiness of the goals of an integrated curriculum is unimpeachable: to provide an educational program that emphasizes concepts rather than the memorization of inert facts; to identify and teach concepts unique to nursing; and to emphasize the nursing process that can be implemented in many different settings" (p. 977). However, she did question whether integration is really attainable "beyond a few general concepts" in the nursing discipline (1981, p. 978).

Hipps (1981) was not alone in criticizing the emphasis on the use of an integrated curriculum in baccalaureate nursing education. Styles (1976) voiced concerns about its effects on performance of students and faculty and its application to clinical experience, team teaching and curriculum structure. Veith (1978) verbalized reservations about the use of integration and suggested some rethinking on the subject since there is still confusion about the meaning of the term. The present study found many of the concerns mentioned by Hipps, Veith and Styles reflected in the responses of the individuals who filled out questionnaires. However, there was no evidence that State Board scores, on the average, decreased. Twelve of the 177 respondents stated that they had gone from an integrated to a non-integrated program; 8 others said that they had changed their integrated program to a less integrated program.

Some of the limitations of this study include the fact that only 177 of the 287 persons who were invited to participate in this study completed questionnaires. It is not known what the opinions of the other 110 individual were in relation to integration. A second

reliability coefficient for the Likert scale used in this study was acceptable and an attempt was made to provide for content validity, problems about the difficulty of interpreting the meaning of Likert scale scores that are not close to either end of the continuum must be recognized. It is possible that some items contributed much less to the measurement of attitudes toward integration in baccalaureate nursing education than others. Further limitation involves the confusion regarding the meaning of the term "integrated curriculum."

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The purpose of this survey of the status of the integrated curriculum in baccalaureate nursing programs was to gather data that could be used to guide practice and to determine the extent to which integrated curriculums are being utilized.

Summary

The data were collected by mailing questionnaires to 287 National League for Nursing accredited baccalaureate programs in the United States. There was a 61.7% response. The study sample consisted of 177 respondents: 35 were teachers, 127 were administrators, and 15 had dual roles. The study subjects represented 84 public and 74 private institutions. Fifty-six institutions were state related and 40 were church related with only 66 reported to be coeducational.

The questionnaire developed for the purpose of the study contained open- and closed-ended questions as well as 55 Likert Scale items. Content validity of the total questionnaire was established by a panel of experts. The reliability of the Likert scale was .80. Descriptive statistics were used to report the data.

The findings were analyzed and interpreted according to how they related to the subproblems of the study. The findings are summarized as follows:

1. Almost all of the programs used integration to some degree

including the low number using the medical model. The majority of the programs surveyed were substantially integrated.

2. More disadvantages than advantages were reported.
 - a. The highest ranked advantage of the integrated program related to the promotion of the use of concepts and conceptual frameworks.
 - b. Lowest in overall rankings given to advantages of the integrated curriculum were related to students.
 - c. The highest ranked disadvantage of the integrated program related to increased faculty development needs and problems.
3. The overall attitude of the respondents toward integration in baccalaureate nursing programs was neither strongly favorable nor strongly unfavorable. The mean of the average individual scores was 2.94 on a scale of 1-5.
4. Respondents from programs using integration expressed considerably greater satisfaction with their curriculums than respondents from programs using the medical model. Faculty and students in substantially integrated programs were perceived by almost three-fourths of the respondents to be very satisfied or satisfied with their curriculums.
5. Proportionately more than twice as many respondents from medical model programs reported an intent to revise their curriculums than did other respondents.
6. After conversion to an integrated curriculum, most State Board scores remained about the same although there was a slight excess of higher scores over lower scores.

7. Based on the findings of this sample, it appears that integration within the BSN programs received greater emphasis between 1967 and 1980.

Conclusions

On the basis of the findings of this study, the following conclusions are reached:

1. The term "integrated curriculum" does not have the same meaning for all educators.
2. There are definite advantages to the utilization of integration in baccalaureate programs in nursing, but there are also major disadvantages.
3. Research needs to be conducted to solve problems related to curriculum models in baccalaureate nursing education.

Recommendations

Based on the analysis, findings and conclusions, the following recommendations are made:

1. A replication of this study be carried out with a larger number of faculty from a smaller number of randomly selected schools.
2. A delphi study be conducted to obtain a consensus on the terminology and definitions essential for nursing curriculum development practices.
3. A needs assessment tool be developed to obtain faculty perceptions of their curriculum development inservice needs.
4. Evaluation research be conducted to give direction to future curriculum development in baccalaureate programs in nursing.

APPENDICES

APPENDIX A

Cover Letter and Questionnaire

Dear Program Administrator:

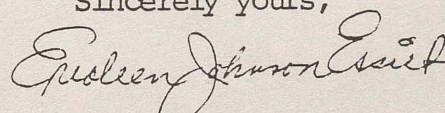
I am a nursing professor at the Community College of Allegheny County, South Campus, located in West Mifflin, PA. I am also enrolled in the School of Higher Education Ph.D. Program at the University of Pittsburgh. My dissertation research involves a National Survey of the Baccalaureate Nursing curriculum/program.

In order to complete the study, I am requesting that you please direct the accompanying questionnaire to the person most knowledgeable and/or responsible for the baccalaureate nursing curriculum. This survey asks for information about the nursing curriculum in baccalaureate programs. There are 81 items in all. Pre-testing indicated that it takes about twenty (20) minutes to complete the questionnaire.

I am requesting the respondents signature on the postcard as an indication of their permission to use their information in the study. In order to maintain confidentiality in the study, neither individuals nor institutions will be identified in any manner. Please mail the signed postcard separately from the questionnaire, but at the same time as the completed questionnaire is mailed. The returned postcard will permit the necessary follow-up to be conducted only on the non-respondents.

I hope to complete the study by August 1982. Your cooperation is greatly appreciated in making this survey a worthwhile source of data to all interested nursing educators. I am looking forward to sending you a summary of the completed study, if it is so indicated on the enclosed postcard.

Sincerely yours,



Evaleen Johnson Essiet

SURVEY OF BACCALAUREATE NURSING PROGRAMS

PART I

DIRECTIONS: Below you will find some questions about your nursing program/curriculum. Read each item carefully; please indicate your response by placing an X on the line before the answer, or by filling in the blanks. (Select only one choice per item except where indicated.)

1. Type of institution in which your program is offered (Check as many as apply).

- Private
- Public
- State Related
- Coeducational
- Church Related
- Other (Please specify) _____

2. Your program is located in the state of _____

3. What is the number of baccalaureate students currently enrolled?

- Generic Students
- R.N. Students

4. Please indicate the number of your undergraduate faculty.

- Full-time
- Part-time

5. How long has your institution offered a baccalaureate program in nursing?

- | | |
|--------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Less than 2 years | <input type="checkbox"/> 11 - 15 years |
| <input type="checkbox"/> 2 - 5 years | <input type="checkbox"/> 16 - 20 years |
| <input type="checkbox"/> 6 - 10 years | <input type="checkbox"/> Over 20 years |

6. Of the original group who planned the current curriculum, please indicate the number who are still on your faculty.

_____ Don't know

7. What is your major responsibility?

_____ Administration

_____ Teaching

_____ Other (Please specify) _____

8. How would you describe the structure of your present nursing program? (Check as many as apply)

_____ It is based on the medical model.

_____ It is integrated.

_____ It is partially integrated.

_____ Other (Please specify) _____

9. For how many years has the above structure been in operation in your institution?

_____ Less than 2 years

_____ 2 - 5 years

_____ 6 - 10 years

_____ 11 - 15 years

_____ 16 - 20 years

_____ Over 20 years

10. What is your estimate of the percentage of nursing content that is integrated in your current curriculum?

_____ 100%

_____ 75 - 99%

_____ 50 - 74%

_____ 25 - 49%

_____ 1 - 24%

_____ None

11. Following is a list of content areas which are generally included in baccalaureate nursing curriculums.

A. Please place an X before each of the following content areas which is taught as a separate course.

Content Areas

Nursing

Non-Nursing

- 1. Medical Nursing
- 2. Surgical Nursing
- 3. Maternity Nursing
- 4. Nursing of Children
- 5. Psychiatric Nursing
- 6. Mental Health Nursing
- 7. Community Health Nursing
- 8. History of Nursing
- 9. Nursing Ethics
- 10. Legal Aspects
- 11. Other (Please specify)

- 12. Nutrition
- 13. Pharmacology
- 14. Microbiology
- 15. Chemistry
- 16. Sociology
- 17. Psychology
- 18. Anatomy
- 19. Physiology
- 20. Research
- 21. Other (Please specify)

B. If two (2) of the content areas listed in Section A are integrated into a single course, kindly write the numbers before each content area (from Section A) on the lines below, to indicate which areas are combined together.

	Section A	Section B
Example:	1. Medical Nursing	a. 1, 2
	2. Surgical Nursing	

Some other individual courses may be composed of more than two (2) content areas. Please list the numbers (from Section A) of all content areas, included together on one of the lines below also.

Example: b. 1, 2, 4, 6

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____
- f. _____
- g. _____
- h. _____
- i. _____
- j. _____
- k. _____
- l. _____
- m. _____

- n. _____
- o. _____
- p. _____
- q. _____
- r. _____
- s. _____
- t. _____
- u. _____
- v. _____
- w. _____
- x. _____
- y. _____
- z. _____

C. The primary reason for combining the majority of the content areas in your curriculum/program was which of the following reasons?

- They have traditionally been taught together.
- These content areas logically fit together.
- There was a planned effort to develop courses based upon a conceptual model.
- There was a planned effort to develop integrative courses.
- Other (Please specify) _____

12. How satisfied are you with your present curriculum structure?

Very satisfied Satisfied Not satisfied

13. Does your faculty plan to revise your present curriculum structure?

Yes Maybe No

14. If you answered "yes" to the question above, describe the changes that are planned.

15. Given a free hand to plan and develop your own curriculum, which type of structure would you choose?

- A curriculum based on the medical model.
- An integrated curriculum.
- A partially integrated curriculum.
- Other (Please specify) _____

16. If your curriculum/program was previously but is no longer integrated, please give the reasons for the change.

17. In your opinion, what are five ADVANTAGES of an integrated nursing curriculum? (List in the order of importance, starting with the most significant.)

1. _____
2. _____
3. _____
4. _____
5. _____

18. In your opinion, what are five DISADVANTAGES of an integrated nursing curriculum? (List in the order of importance, starting with the most outstanding.)

1. _____
2. _____
3. _____
4. _____
5. _____

19. What are the major concepts in your conceptual framework underlying your current curriculum model?

20. Which are the major theories (theoretical formulations) underlying your present curriculum structure?

Questions 21 to 26 should be answered only by respondents whose nursing curriculum/program is substantially integrated. Other respondents should go on to PART II.

21. Why did your faculty decide to develop an integrated curriculum?

22. Which procedures (e.g. obtaining consultation from experts) did you find most helpful in assuring the success of integration in your curriculum/program?

23. How do you perceive the satisfaction of the majority of your faculty with your integrated curriculum/program?

_____ Very satisfied _____ Satisfied _____ Somewhat satisfied _____ Dissatisfied

24. How do you perceive the satisfaction of the majority of your students with your integrated curriculum/program?

_____ Very satisfied _____ Satisfied _____ Somewhat satisfied _____ Dissatisfied

25. What effect has the development of an integrated program had on the scores made by students on State Board Test Pool Licensing Examinations?

- Scores considerably higher Scores somewhat higher Scores about the same
 Scores somewhat lower Scores considerably lower

26. In what activities have you (the faculty) engaged to assess the effectiveness of the integrated curriculum?

PART II

DIRECTIONS: Below you will find frequently heard statements about integrated nursing curriculums/programs. After reading each statement, mark an X in the column which best expresses your opinion. (Please respond even if your program is not integrated.)

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
1. Students more frequently express their satisfaction with the teaching/learning strategies utilized in the integrated curriculum than with any other model.	_____	_____	_____	_____	_____
2. The integrated curriculum enables students to more easily gain an understanding of why they are performing certain activities and what results should be anticipated.	_____	_____	_____	_____	_____
3. True integration takes place only when the student is able to assimilate the integrated data and then utilize those data in his or her clinical experience.	_____	_____	_____	_____	_____

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
4. In an integrated program, it is easier for students to care for the whole person in all clinical settings.	_____	_____	_____	_____	_____
5. In the integrated program, students more readily achieve the terminal behaviors of the curriculum.	_____	_____	_____	_____	_____
6. Clinical evaluations of students' performance indicate that the integrated curriculum is fulfilling its purpose at least as well as if not better than other previously used curriculum designs.	_____	_____	_____	_____	_____
7. As graduation approaches, students begin to verbalize fears that they have obtained too little hard knowledge and experience in the integrated program.	_____	_____	_____	_____	_____
8. Graduates of integrated programs are likely to have less difficulty meeting employer's expectations in their first position.	_____	_____	_____	_____	_____

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
9. The student experiences greater continuity of learning from one course to another in an integrated curriculum.	_____	_____	_____	_____	_____
10. Students of integrated programs seek out their own learning experiences more often than students in other programs.	_____	_____	_____	_____	_____
11. The integrated curriculum is necessary because few students have the ability to integrate all of the separate units of study into a comprehensive pattern.	_____	_____	_____	_____	_____
12. Beginning students express less difficulty with the learning experience in an integrated curriculum than they do with most other curriculum models.	_____	_____	_____	_____	_____
13. It is more difficult to evaluate students in terms of content which is blended into the broad concepts of an integrated curriculum.	_____	_____	_____	_____	_____

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
14. Faculty must be well prepared in all disciplines to guide students effectively in the clinical setting in the integrated curriculum.	_____	_____	_____	_____	_____
15. All faculty are not experts in all areas of practice, therefore students may be denied the expertise of the specialist in integrated programs.	_____	_____	_____	_____	_____
16. The integrated curriculum requires more faculty-student interactions.	_____	_____	_____	_____	_____
17. The integrated curriculum requires the employment of faculty with a generalist background.	_____	_____	_____	_____	_____
18. Faculty believes that there is a decrease in the students' ability to apply theoretical concepts to the clinical practice setting in the integrated program.	_____	_____	_____	_____	_____
19. The majority of the faculty of integrated programs are satisfied with their student's achievement in meeting their program objectives.	_____	_____	_____	_____	_____

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
20. The majority of nursing faculty are accepting/supportive of the integrated curriculum approach.	_____	_____	_____	_____	_____
21. The majority of faculty members are adequately prepared to function in the integrated curriculum upon employment.	_____	_____	_____	_____	_____
22. Faculty understanding of group dynamics is necessary in making curriculum decisions in an integrated program.	_____	_____	_____	_____	_____
23. Inexperienced faculty find teaching in an integrated curriculum no more difficult than in any other model.	_____	_____	_____	_____	_____
24. Inability of faculty to identify and accept strengths and weaknesses within their team teaching group is often a problem in the integrated curriculum.	_____	_____	_____	_____	_____
25. Nursing faculty who teach in an integrated program can retain their speciality expertise.	_____	_____	_____	_____	_____

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
26. Initially, faculty often are apprehensive about functioning in a setting different from their clinical speciality.	_____	_____	_____	_____	_____
27. Faculty relate that the integrated curriculum looks great as a model but does not work well in practice.	_____	_____	_____	_____	_____
28. Faculty members complain about the additional work that is required with the integrated curriculum.	_____	_____	_____	_____	_____
29. The majority of faculty teach integrated concepts in the clinical setting without difficulty.	_____	_____	_____	_____	_____
30. In integrated programs there is sometimes the problem of poor teaching of classroom theory because some of the faculty members find it difficult to adjust to this new model.	_____	_____	_____	_____	_____

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
31. Attitudes and behaviors of the faculty specialist are not very difficult to shift toward the generalist functioning role of an integrated setting.	_____	_____	_____	_____	_____
32. Faculty perceive the changes toward integration as unsettling, difficult and time consuming.	_____	_____	_____	_____	_____
33. The integrated curriculum requires greater commitment on the part of faculty.	_____	_____	_____	_____	_____
34. An integrated curriculum is not difficult to construct.	_____	_____	_____	_____	_____
35. It has been demonstrated and documented that essential concepts from all the traditional specialities can be meaningfully integrated.	_____	_____	_____	_____	_____
36. Team-teaching is less difficult in integrated programs than it is in other types of programs.	_____	_____	_____	_____	_____

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
37. More research is needed to document the effectiveness of the integrated curriculum.	_____	_____	_____	_____	_____
38. Lack of agreement on definitions and terminology regarding integration makes efforts to use the integrative approach difficult.	_____	_____	_____	_____	_____
39. Nursing educators have adopted the integrated curriculum without identifying specific rationale for doing so.	_____	_____	_____	_____	_____
40. The use of the integrated curriculum is necessary because of the knowledge explosion.	_____	_____	_____	_____	_____
41. Technological advances in nursing require the use of the integrative approach.	_____	_____	_____	_____	_____
42. The integrated program is more apt to require constant revision.	_____	_____	_____	_____	_____

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
43. The integrated curriculum takes a greater amount of time and effort to plan and coordinate than any other curriculum.	_____	_____	_____	_____	_____
44. An integrated nursing curriculum de-emphasizes the teaching of technical skills.	_____	_____	_____	_____	_____
45. There is a tendency towards superficiality in handling content in an integrated curriculum.	_____	_____	_____	_____	_____
46. There is no risk of omission of important factual learning with the integrated curriculum.	_____	_____	_____	_____	_____
47. It is easier to provide greater consistency in clinical expectations in an integrated curriculum/program.	_____	_____	_____	_____	_____
48. Nursing integration is logical regardless of the trend towards more specialization in other professions.	_____	_____	_____	_____	_____

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
49. The selection of clinical activities that are consistent with the conceptual framework is not a problem in the integrated curriculum.	_____	_____	_____	_____	_____
50. A serious problem for the integrated curriculum faculty is the lack of textbooks which present integrative nursing content.	_____	_____	_____	_____	_____
51. An integrated nursing curriculum facilitates a comprehensive approach to the teaching of total patient care concepts.	_____	_____	_____	_____	_____
52. The popularity of integrated nursing program is increasing.	_____	_____	_____	_____	_____
53. Most programs which are utilizing the integrated curriculum will not return to former models.	_____	_____	_____	_____	_____

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
54. Some of the major problems of teaching in an integrated program might be resolved by changes in graduate nursing education programs.	_____	_____	_____	_____	_____
55. Integrated curriculums create administrative problems in terms of faculty load.	_____	_____	_____	_____	_____

APPENDIX B

Establishment of Content Validity

Reworded Questionnaire Items

Percentage of Agreement of Experts

REWORDED QUESTIONNAIRE ITEMS
(Obtained 100% Agreement)

Item 3 Old Wording

Each students participation in the process of learning is where true integration takes place.

Item 3 New Wording

Ture integration takes place only when the student is able to assimilate the integrated data and then utilize that data in his or her clinical experience.

Item 37 Old Wording

There has been minimal documentation of the effectiveness of the integrated curriculum.

Item 37 New Wording

More research is needed to document the effectiveness of the integrated curriculum.

Item 54 Old Wording

Difficulties related to the need for faculty to function as generalists in integrated curriculums could be rectified by changes in graduate educational programs.

Item 54 New Wording

Some of the major problems of teaching in an integrated program might be solved by changes in graduate nursing education programs.

Percentage Of Agreement Of Experts In Relationship
To Content Validity Of Likert Scale Items

Item	Yes	No	?	Reworded	Item	Yes	No	?	Reworded
1	67.7	0	33.3		27	100	0	0	
2	100	0	0		28	100	0	0	
3	33.3	0	67.7	100	29	100	0	0	
4	100	0	0		30	100	0	0	
5	100	0	0		31	100	0	0	
6	100	0	0		32	100	0	0	
7	100	0	0		33	100	0	0	
8	100	0	0		34	100	0	0	
9	100	0	0		35	100	0	0	
10	100	0	0		36	100	0	0	
11	67.7	0	33.3		37	100	0	0	
12	100	0	0		38	100	0	0	
13	100	0	0		39	100	0	0	
14	100	0	0		40	100	0	0	
15	100	0	0		41	100	0	0	
16	67.7	0	0		42	100	0	0	
17	100	0	0		43	100	0	0	
18	100	0	0		44	100	0	0	
19	100	0	0		45	100	0	0	
20	100	0	0		46	100	0	0	
21	100	0	0		47	100	0	0	
22	100	0	0		48	100	0	0	
23	100	0	0		49	100	0	0	
24	100	0	0		50	100	0	0	
25	100	0	0		51	100	0	0	
26	100	0	0		52	67.7	33.3		100
					53	100	0	0	
					54	33.3	67.7		100
					55	100	0	0	

APPENDIX C

Letter to Pilot Group

Dear Colleague,

Thank you for agreeing to participate in the pilot study concerning the Current Status Of The Use Of The Integrated Curriculum In Baccalaureate Nursing Programs. Your kindness, and time spend are greatly appreciated. I will use your comments on the final questionnaire.

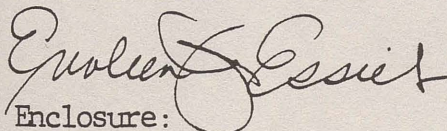
It would be helpful if you would keep account of the time it takes to complete the questions. Please record the time you start and finish above the title.

Please feel free to place question marks beside those questions that appear to lack clarity. Please feel free to indicate your suggestions for rewording any questions and to share any comments you may have.

Please indicate if you would like a summary of the study. I would be glad to share it with you.

Many thanks,

Evaleen Johnson Essiet



Enclosure:

APPENDIX D

Follow Up Cards

 (signature of individual completing the questionnaire)

 (name of institution)

 (date questionnaire mailed)

Ms. Essiet,

I would like a summary of your findings. Yes No

*I have returned the questionnaire under separate cover. Yes No

Dear _____

Two weeks ago you received a questionnaire concerning the integrated nursing curriculum at baccalaureate institutions. This is just a reminder to ask your help in completing and returning that questionnaire. If you have already done so, thank you. If not, your reply is needed to help in completing the study.

Please check one of the following options:

- Questionnaire mailed previously / date _____
- Am still planning to participate / date to be mailed _____
- I need another questionnaire.
- I do not choose to participate.

Evalcen Johnson-Essiet

 (signature)

 (name of institution)

*I have returned the questionnaire under separate cover. Yes No

I would like a summary Yes No

APPENDIX E

Likert Scale Statistics

1. Students more frequently express their satisfaction with the teaching/learning strategies utilized in the integrated curriculum than with any other model.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING * OPINION
SD	1	13	7.6	MEAN 2.941	Disagree
D	2	50	29.4	STD. DEV. 1.059	
N	3	52	30.6	MODE 3.0	
A	4	44	25.9	C. V. (%) 36.0	
SA	5	11	6.5		
		<u>170</u>	<u>100.0</u>		

2. The integrated curriculum enables students to more easily gain an understanding of why they are performing certain activities and what results should be anticipated.

SD	1	8	4.6	MEAN 3.468	Agree
D	2	39	22.5	STD. DEV. 1.164	
N	3	22	12.7	MODE 4.0	
A	4	72	41.6	C. V. (%) 33.6	
SA	5	32	18.5		
		<u>173</u>	<u>100.0</u>		

*PREVAILING OPINION = Most frequently occurring opinion

3. True integration takes place only when the student is able to assimilate the integrated data and then utilize those data in his or her clinical experience.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	1	0.6	MEAN 4.407	
D	2	3	1.7	STD. DEV. 0.690	
N	3	5	2.9	MODE 5.0	
A	4	79	45.9	C. V. (%)15.7	Agree
SA	5	84	48.8		
		<u>172</u>	<u>100.0</u>		

4. In an integrated program, it is easier for students to care for the whole person in all clinical settings.

SD	1	6	3.5	MEAN 3.665	
D	2	32	18.5	STD. DEV. 1.168	
N	3	24	13.9	MODE 4.0	Agree
A	4	63	36.4	C. V. (%)31.9	
SA	5	48	27.7		
		<u>173</u>	<u>100.0</u>		

5. In the integrated program, students more readily achieve the terminal behaviors of the curriculum.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	6	3.5	MEAN 3.341	Agree
D	2	38	22.4	STD. DEV. 1.126	
N	3	50	29.4	MODE 3.0	
A	4	44	25.9	C.V. (%) 33.7	
SA	5	32	18.8		
		<u>170</u>	<u>100.0</u>		

6. Clinical evaluations of students' performance indicate that the integrated curriculum is fulfilling its purpose at least as well as if not better than other previously used curriculum designs.

SD	1	7	4.1	MEAN 3.480	Agree
D	2	26	15.2	STD. DEV. 1.059	
N	3	43	25.1	MODE 4.0	
A..	4	68	39.8	C.V. (%) 30.4	
SA	5	27	15.8		
		<u>171</u>	<u>100.0</u>		

7. As graduation approaches, students begin to verbalize fears that they have obtained too little hard knowledge and experiences in the integrated program.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SA	1	24	14.4	MEAN 2.575	Agree
A	2	74	44.3	STD. DEV. 1.127	
N	3	28	16.8	MODE 2.0	
D	4	31	18.6	C.V. (%) 43.8	
SD	5	10	6.0		
		<u>167</u>	<u>100.0</u>		

8. Graduates of integrated programs are likely to have less difficulty meeting employer's expectations in their first position.

SD	1	10	5.9	MEAN 2.882	Disagree
D	2	55	32.4	STD. DEV. 0.978	
N	3	57	33.5	MODE 3.0	
A	4	41	24.1	C.V. (%) 33.9	
SA	5	7	4.1		
		<u>170</u>	<u>100.0</u>		

9. The student experiences greater continuity of learning from one course to another in an integrated curriculum.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	3	1.8	MEAN 3.765	
D	2	18	10.6	STD. DEV. 0.975	
N	3	33	19.4	MODE 4.0	Agree
A	4	78	45.9	C.V. (%) 25.9	
SA	5	38	22.4		
		<u>170</u>	<u>100.0</u>		

10. Students of integrated programs seek out their own learning experiences more often than students in other programs.

SD	1	3	1.8	MEAN 3.290	
D	2	34	20.1	STD. DEV. 0.972	
N	3	62	36.7	MODE 3.0	Agree
A	4	51	30.2	C.V. (%) 29.5	
SA	5	19	11.2		
		<u>169</u>	<u>100.0</u>		

11. The integrated curriculum is necessary because few students have the ability to integrate all of the separate units of study into a comprehensive pattern.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	12	7.2	MEAN 2.850	
D	2	62	37.1	STD. DEV. 1.051	
N	3	40	24.0	MODE 2.0	Disagree
A	4	45	26.9	C.V. (%) 36.9	
SA	5	8	4.8		
		<u>167</u>	<u>100.0</u>		

12. Beginning students express less difficulty with the learning experience in an integrated curriculum than they do with most other curriculum models.

SD	1	13	7.7	MEAN 2.679	
D	2	67	39.9	STD. DEV. 0.962	
N	3	56	33.3	MODE 2.0	Disagree
A	4	25	14.9	C.V. (%) 35.9	
SA	5	7	4.2		
		<u>168</u>	<u>100.0</u>		

13. It is more difficult to evaluate students in terms of content which is blended into the broad concepts of an integrated curriculum.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SA	1	14	8.3	MEAN 2.964	Agree
A	2	62	36.7	STD. DEV. 1.159	
N	3	21	12.4	MODE 2.0	
D	4	60	35.5	C.V. (%) 39.0	
SD	5	12	7.1		
		<u>169</u>	<u>100.0</u>		

14. Faculty must be well prepared in all disciplines to guide students effectively in the clinical setting in the integrated curriculum.

SA	1	27	15.8	MEAN 2.708	Agree
A	2	65	38.0	STD. DEV. 1.192	
N	3	17	9.9	MODE 2.0	
D	4	55	32.2	C.V. (%) 44.0	
SD	5	7	4.1		
		<u>171</u>	<u>100.0</u>		

15. All faculty are not experts in all areas of practice, therefore students may be denied the expertise of the specialist in integrated programs.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SA	1	28	16.6	MEAN 2.941	Disagree
A	2	49	29.0	STD. DEV. 1.303	
N	3	12	7.1	MODE 4.0	
D	4	65	38.5	C.V. (%) 44.3	
SD	5	15	8.9		
		<u>169</u>	<u>100.0</u>		

16. The integrated curriculum requires more faculty-student interactions.

SA	1	20	11.8	MEAN 2.724	Agree
A	2	65	38.2	STD. DEV. 1.099	
N	3	34	20.0	MODE 2.0	
D	4	44	25.9	C.V. (%) 40.3	
SD	5	7	4.1		
		<u>170</u>	<u>100.0</u>		

17. The integrated curriculum requires the employment of faculty with a generalist background.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SA	1	11	6.5	MEAN 3.018	Disagree
A	2	59	34.9	STD. DEV. 1.110	
N	3	25	14.8	MODE 4.0	
D	4	64	37.9	C.V. (%) 36.8	
SD	5	10	5.9		
		<u>169</u>	<u>100.0</u>		

18. Faculty believes that there is a decrease in the students' ability to apply theoretical concepts to the clinical practice setting in the integrated program.

SA	1	4	2.4	MEAN 3.604	Disagree
A	2	25	14.8	STD. DEV. 1.001	
N	3	32	18.9	MODE 4.0	
D	4	81	47.9	C.V. (%) 27.8	
SD	5	27	16.0		
		<u>169</u>	<u>100.0</u>		

19. The majority of the faculty of integrated programs are satisfied with their student's achievement in meeting their program objectives.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	2	1.2	MEAN 3.455	
D	2	25	15.0	STD. DEV. 0.890	
N	3	49	29.3	MODE 4.0	Agree
A	4	77	46.1	C.V. (%) 25.8	
SA	5	14	8.4		
		<u>167</u>	<u>100.0</u>		

20. The majority of nursing faculty are accepting/supportive of the integrated curriculum approach.

SD	1	6	3.6	MEAN 3.251	
D	2	42	25.1	STD. DEV. 1.051	
N	3	39	23.4	MODE 4.0	Agree
A	4	64	38.3	C.V. (%) 32.3	
SA	5	16	9.6		
		<u>167</u>	<u>100.0</u>		

21. The majority of faculty members are adequately prepared to function in the integrated curriculum upon employment.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	15	8.8	MEAN 2.629	
D	2	87	51.2	STD. DEV. 1.065	
N	3	21	12.4	MODE 2.0	Disagree
A	4	40	23.5	C.V. (%) 40.5	
SA	5	7	4.1		
		<u>170</u>	<u>100.0</u>		

22. Faculty understanding of group dynamics is necessary in making curriculum decisions in an integrated program.

SD	1	1	0.6	MEAN 4.141	
D	2	7	4.1	STD. DEV. 0.779	
N	3	14	8.2	MODE 4.0	Agree
A	4	93	54.7	C.V. (%) 18.8	
SA	5	55	32.4		
		<u>170</u>	<u>100.0</u>		

23. Inexperienced faculty find teaching in an integrated curriculum no more difficult than in any other model.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	18	10.7	MEAN 2.923	Disagree
D	2	57	33.9	STD. DEV. 1.184	
N	3	26	15.5	MODE 2.0	
A	4	54	32.1	C.V. (%) 40.5	
SA	5	13	7.7		
		<u>168</u>	<u>100.0</u>		

24. Inability of faculty to identify and accept strengths and weaknesses within their team teaching group is often a problem in the integrated curriculum.

SA	1	24	14.2	MEAN 2.550	Agree
A	2	74	43.8	STD. DEV. 1.080	
N	3	32	18.9	MODE 2.0	
D	4	32	18.9	C.V. (%) 42.4	
SD	5	7	4.1		
		<u>169</u>	<u>100.0</u>		

25. Nursing faculty who teach in an integrated program can retain their speciality expertise.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	2	1.2	MEAN 3.850	
D	2	10	6.0	STD. DEV. 0.804	
N	3	26	15.6	MODE 4.0	Agree
A	4	102	61.1	C.V. (%) 20.9	
SA	5	27	16.2		
		<u>167</u>	<u>100.0</u>		

26. Initially, faculty often are apprehensive about functioning in a setting different from their clinical specialty.

SA	1	54	32.1	MEAN 1.744	
A	2	105	62.5	STD. DEV. 0.589	
N	3	7	4.2	MODE 2.0	Agree
D	4	2	1.2	C.V. (%) 33.8	
SD	5	0	0.0		
		<u>168</u>	<u>100.0</u>		

27. Faculty relate that the integrated curriculum looks great as a model but does not work well in practice.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SA	1	20	11.8	MEAN 2.724	Agree
A	2	61	35.9	STD. DEV. 1.077	
N	3	42	24.7	MODE 2.0	
D	4	40	23.5	C.V. (%) 39.5	
SD	5	7	4.1		
		<u>170</u>	<u>100.0</u>		

28. Faculty members complain about the additional work that is required with the integrated curriculum.

SA	1	29	17.0	MEAN 2.515	Agree
A	2	66	38.6	STD. DEV. 1.054	
N	3	38	22.2	MODE 2.0	
D	4	35	20.5	C.V. (%) 41.9	
SD	5	3	1.8		
		<u>171</u>	<u>100.0</u>		

29. The majority of faculty teach integrated concepts in the clinical setting without difficulty.

OPINION	CODE	NUMBER OF RUSPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	7	4.1	MEAN 3.000	
D	2	64	37.6	STD. DEV. 1.032	
N	3	26	15.3	MODE 4.0	Agree
A	4	68	40.0	C.V. (%) 34.4	
SA	5	5	2.9		
		<u>170</u>	<u>100.0</u>		

30. In integrated programs there is sometimes the problem of poor teaching of classroom theory because some of the faculty members find it difficult to adjust to this new model.

SA	1	9	5.4	MEAN 2.744	
A	2	77	45.8	STD. DEV. 0.997	
N	3	36	21.4	MODE 2.0	Agree
D	4	40	23.8	C.V. (%) 36.3	
SD	5	6	3.6		
		<u>168</u>	<u>100.0</u>		

31. Attitudes and behaviors of the faculty specialist are not very difficult to shift toward the generalist functioning role of an integrated setting.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	20	11.8	MEAN 2.491	Disagree
D	2	79	46.7	STD. DEV. 0.952	
N	3	39	23.1	MODE 2.0	
A	4	29	17.2	C.V. (%) 38.2	
SA	5	2	1.2		
		<u>169</u>	<u>100.0</u>		

32. Faculty perceive the changes toward integration as unsettling, difficult and time consuming.

SA	1	21	12.6	MEAN 2.503	Agree
A	2	83	49.7	STD. DEV. 1.035	
N	3	26	15.6	MODE 2.0	
D	4	32	19.2	C.V. (%) 41.4	
SD	5	5	3.0		
		<u>167</u>	<u>100.0</u>		

33. The integrated curriculum requires greater commitment on the part of faculty.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SA	1	39	22.8	MEAN 2.363	Agree
A	2	77	45.0	STD. DEV. 1.157	
N	3	18	10.5	MODE 2.0	
D	4	28	16.4	C.V. (%) 49.0	
SD	5	9	5.3		
		<u>171</u>	<u>100.0</u>		

34. An integrated curriculum is not difficult to construct.

SD	1	55	32.2	MEAN 2.146	Disagree
D	2	71	41.5	STD. DEV. 1.110	
N	3	14	8.2	MODE 2.0	
A	4	27	15.8	C.V. (%) 51.7	
SA	5	4	2.3		
		<u>171</u>	<u>100.0</u>		

35. It has been demonstrated and documented that essential concepts from all the traditional specialities can be meaningfully integrated.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	12	7.0	MEAN 3.450	
D	2	21	12.3	STD. DEV. 1.080	
N	3	37	21.6	MODE 4.0	Agree
A	4	80	46.8	C.V. (%) 31.3	
SA	5	21	12.3		
		<u>171</u>	<u>100.0</u>		

36. Team-teaching is less difficult in integrated programs than it is in other types of programs.

SD	1	15	8.8	MEAN 2.836	
D	2	58	33.9	STD. DEV. 1.072	
N	3	49	28.7	MODE 2.0	Disagree
A	4	38	22.2	C.V. (%) 37.8	
SA	5	11	6.4		
		<u>171</u>	<u>100.0</u>		

37. More research is needed to document the effectiveness of the integrated curriculum.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SA	1	66	38.4	MEAN 1.820	Agree
A	2	79	45.9	STD. DEV. 0.814	
N	3	20	11.6	MODE 2.0	
D	4	6	3.5	C.V. (%) 44.7	
SD	5	1	0.6		
		<u>172</u>	<u>100.0</u>		

38. Lack of agreement on definitions and terminology regarding integration makes efforts to use the integrative approach difficult.

SA	1	38	22.1	MEAN 2.279	Agree
A	2	79	45.9	STD. DEV. 1.028	
N	3	28	16.3	MODE 2.0	
D	4	23	13.4	C.V. (%) 45.1	
SD	5	4	2.3		
		<u>172</u>	<u>100.0</u>		

39. Nursing educators have adopted the integrated curriculum without identifying specific rationale for doing so.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SA	1	23	13.5	MEAN 2.994	Disagree
A	2	43	25.3	STD. DEV. 1.238	
N	3	34	20.0	MODE 4.0	
D	4	52	30.6	C.V. (%) 41.3	
SD	5	18	10.6		
		<u>170</u>	<u>100.0</u>		

40. The use of the integrated curriculum is necessary because of the knowledge explosion.

SD	1	11	6.4	MEAN 3.088	Agree
D	2	44	25.7	STD. DEV. 1.062	
N	3	47	27.5	MODE 4.0	
A	4	57	33.3	C.V. (%) 34.4	
SA	5	12	7.0		
		<u>171</u>	<u>100.0</u>		

41. Technological advances in nursing require the use of the integrative approach.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	11	6.4	MEAN 2.906	
D	2	52	30.4	STD. DEV. 1.013	
N	3	61	35.7	MODE 3.0	Disagree
A	4	36	21.1	C.V. (%) 34.9	
SA	5	11	6.4		
		<u>171</u>	<u>100.0</u>		

42. The integrated program is more apt to require constant revision.

SA	1	9	5.2	MEAN 3.017	
A	2	52	30.2	STD. DEV. 1.017	
N	3	46	26.7	MODE 4.0	Disagree
D	4	57	33.1	C.V. (%) 33.7	
SD	5	8	4.7		
		<u>172</u>	<u>100.0</u>		

43. The integrated curriculum takes a greater amount of time and effort to plan and coordinate than any other curriculum.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SA	1	46	26.9	MEAN 2.257	Agree
A	2	72	42.1	STD. DEV. 1.108	
N	3	21	12.3	MODE 2.0	
D	4	27	15.8	C.V. (%) 49.1	
SD	5	5	2.9		
		<u>171</u>	<u>100.0</u>		

44. An integrated nursing curriculum de-emphasizes the teaching of technical skills.

SA	1	9	5.3	MEAN 3.506	Disagree
A	2	21	12.4	STD. DEV. 1.028	
N	3	35	20.6	MODE 4.0	
D	4	85	50.0	C.V. (%) 29.3	
SD	5	20	11.8		
		<u>170</u>	<u>100.0</u>		

45. There is a tendency towards superficiality in handling content in an integrated curriculum.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SA	1	16	9.4	MEAN 3.269	Disagree
A	2	36	21.1	STD. DEV. 1.217	
N	3	30	17.5	MODE 4.0	
D	4	64	37.4	C.V. (%) 37.2	
SD	5	25	14.6		
		<u>171</u>	<u>100.0</u>		

46. There is no risk of omission of important factual learning with the integrated curriculum.

SD	1	28	16.5	MEAN 2.276	Disagree
D	2	96	56.5	STD. DEV. 0.967	
N	3	22	12.9	MODE 2.0	
A	4	19	11.2	C.V. (%) 42.5	
SA	5	5	2.9		
		<u>170</u>	<u>100.0</u>		

47. It is easier to provide greater consistency in clinical expectations in an integrated curriculum/program.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	11	6.5	MEAN 3.059	Agree
D	2	48	28.2	STD. DEV. 1.092	
N	3	46	27.1	MODE 4.0	
A	4	50	29.4	C.V. (%) 35.7	
SA	5	15	8.8		
		<u>170</u>	<u>100.0</u>		

48. Nursing integration is logical regardless of the trend towards more specialization in other professions.

SD	1	9	5.4	MEAN 3.333	Agree
D	2	32	19.0	STD. DEV. 1.070	
N	3	39	23.2	MODE 4.0	
A	4	70	41.7	C.V. (%) 32.1	
SA	5	18	10.7		
		<u>168</u>	<u>100.0</u>		

49. The selection of clinical activities that are consistent with the conceptual framework is not a problem in the integrated curriculum.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	14	8.2	MEAN 2.982	
D	2	61	35.9	STD. DEV. 1.164	
N	3	22	12.9	MODE 2.0	Disagree
A	4	60	35.3	C.V. (%) 39.0	
SA	5	13	7.6		
		<u>170</u>	<u>100.0</u>		

50. A serious problem for the integrated curriculum faculty is the lack of textbooks which present integrative nursing content.

SA	1	25	14.7	MEAN 2.571	
A	2	67	39.4	STD. DEV. 1.042	
N	3	36	21.2	MODE 2.0	Agree
D	4	40	23.5	C.V. (%) 40.5	
SD	5	2	1.2		
		<u>170</u>	<u>100.0</u>		

51. An integrated nursing curriculum facilitates a comprehensive approach to the teaching of total patient care concepts.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	3	1.8	MEAN 3.894	
D	2	15	8.8	STD. DEV. 0.930	
N	3	20	11.8	MODE 4.0	Agree
A	4	91	53.5	C.V. (%) 23.9	
SA	5	41	24.1		
		<u>170</u>	<u>100.0</u>		

52. The popularity of integrated nursing program is increasing.

SD	1	11	6.4	MEAN 2.959	
D	2	47	27.3	STD. DEV. 0.987	
N	3	59	34.3	MODE 3.0	Neutral
A	4	48	27.9	C.V. (%) 33.4	
SA	5	7	4.1		
		<u>172</u>	<u>100.0</u>		

53. Most programs which are utilizing the integrated curriculum will not return to former models.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	PREVAILING OPINION
SD	1	6	3.6	MEAN 3.018	Neutral
D	2	41	24.3	STD. DEV. 0.909	
N	3	75	44.4	MODE 3.0	
A	4	38	22.5	C. V. (%) 30.1	
SA	5	9	5.3		
		<u>169</u>	<u>100.0</u>		

54. Some of the major problems of teaching in an integrated program might be resolved by changes in graduate nursing education programs.

SD	1	5	2.9	MEAN 3.612	Agree
D	2	17	10.0	STD. DEV. 0.956	
N	3	42	24.7	MODE 4.0	
A	4	81	47.6	C. V. (%) 26.5	
SA	5	25	14.7		
		<u>170</u>	<u>100.0</u>		

55. Integrated curriculums create administrative problems in terms of faculty load.

OPINION	CODE	NUMBER OF RESPONDENTS	FREQUENCY (%)	LIKERT STATISTICS	OVERRIDING OPINION
SA	1	26	15.3	MEAN 2.565	
A	2	64	37.6	STD. DEV. 1.048	
N	3	42	24.7	MODE 2.0	Agree
D	4	34	20.0	C.V. (%) 40.9	
SD	5	4	2.4		
		<u>170</u>	<u>100.0</u>		

Key:

SD = Standard Deviation

Mode = Most frequent occurring score

C.V. (%) = Coefficient of Variation

Likert Scale Coding

Direct		Reversed
5	Strongly Agree	1
4	Agree	2
3	Neutral	3
2	Disagree	4
1	Strongly Disagree	5

APPENDIX F

Table 27

Intent to Revise Shown According to Years Program
Was in Operation and the Percentage
of Integration Utilized

Table 27

Responses Related to Major Concepts and Major
Theories Utilized in Curriculum Models

Responses	Used as concept	Used as theory
Theorists' names		
Bevis	0	1
Caplan	0	1
Chater's model	1	0
Dubois	1	0
Dunn	0	6
Duvall	1	3
Eirkson	1	17
Freud	0	1
Henderson	0	2
Holmes	0	1
Johnson	0	3
King	0	1
Lewin	0	1
Maslow	14	25
Newman	0	4
Nightingale	0	4
Orem	10	18
Peplau	0	1
Piaget	0	6

Table 27 (Continued)

Responses	Used as concept	Used as theory
Rogers	0	8
Roys	4	18
Salye	0	8
Stevens (cognitive processing)	0	1
Sullivan H. S. (interpersonal)	0	1
Wilson (adaptation)	13	0
Yura and Walsh	<u>0</u>	<u>1</u>
Subtotals	45	132
Nursing Related Terms		
Nurse	12	0
Nurses competences	1	0
Nursing theory/science	81	3
Nursing process	78	16
Nursing research	11	5
Wholism	10	7
Electric	0	9
Ethics/values	1	2
Problem solving	8	0
Decision making	0	7
Scientific method	0	1
Evaluation	0	1
Professional	5	1

Table 27 (Continued)

Responses	Used as concept	Used as theory
Professional development	30	0
Prevention	7	0
Rehabilitation	1	0
Humanity	5	2
Caring	0	2
Integration of conceptual theories	<u>1</u>	<u>0</u>
Subtotals	25	58
Man-related Terms		
Individual/man	67	5
Client	1	1
Family	4	7
Group	1	6
Community	11	0
Society	30	9
Social needs	1	0
Man and family	1	0
Man and community	2	0
Man and society	2	0
Man and environment	4	0
Man and systems	1	0
Individual/family/community	2	0
Student/subject/setting	1	0

Table 27 (Continued)

Responses	Used as concept	Used as theory
Environment external	25	0
Cultural	1	2
Socio-cultural	2	0
Sociolization	0	1
Political	1	1
Life span/cycles/phases	<u>1</u>	<u>0</u>
Subtotals	158	32
Theory-related terms		
Motivational theory	0	2
Change theory	8	17
General systems theory	18	54
Communication theory	20	17
Coping theory	1	2
Growth and development	24	13
Adaptation theory	0	40
Stress/adaptation theory	25	30
Needs theory	0	20
Self care theory	18	2
Role theory	0	16
Teaching-learning theory	14	15
High levels of wellness	12	0
Conflict theory	0	1

Table 27 (Continued)

Responses	Used as concept	Used as theory
Simple to complex theory	6	0
Crisis to complex theory	1	10
Health Care system	2	0
Family theory	4	9
Health promotion	89	0
Group process theory	1	6
Health - illness	20	24
Health - wellness	9	0
Leadership theory	9	12
Personality theory	0	1
Community health agency	10	0
Hemeostasis	1	3
Education	3	5
Organizational theory	1	1
Reality theory	1	0
Management theory	3	1
Independent/dependent theory	1	0
Behavioral theory	0	3
Body integrity	1	1
Developmental	<u>4</u>	<u>14</u>
Subtotals	306	319

Table 27 (Continued)

Responses	Used as concept	Used as theory
Communication-related terms		
Therapeutic self	1	0
Helping relationship	1	0
Loss	1	0
Death	1	0
Disequilibrium	1	0
Safety	1	0
Bio-socio-phychological	5	0
Epidamological	1	3
Environment internal	<u>3</u>	<u>0</u>
Subtotals	24	15
Totals	614	567

APPENDIX G

Table 28
Responses Related to Major Concepts
and Major Theories Utilized
in Curriculum Models

Table 28

Intent to Revise Shown According to Years in Operation
and the Percentage of Integration Utilized

Percentage of integration	Years in operation						Totals
	Under 2	2 - 5	6 - 10	11 - 15	16 - 20	Over 20	
Programs which had definite plans to revise their curriculums							
100	0	3	4	0	0	0	7
75 - 99	1	3	6	1	0	0	11
50 - 74	0	4	4	1	0	0	9
25 - 49	0	6	7	1	0	0	14
1 - 24	0	2	5	2	0	2	11
None	0	2	0	0	0	0	4
Totals	1	20	28	5	0	2	56

Table 28 (Continued)

Percentage of integration	Years in operation						Totals
	Under 2	2 - 5	6 - 10	11 - 15	16 - 20	Over 20	
Programs which were not certain about revising their curriculums							
100	0	0	4	0	0	0	4
75 - 99	1	4	4	0	0	0	9
50 - 74	0	2	7	3	0	0	12
25 - 49	0	2	2	2	0	0	6
1 - 24	0	1	3	2	0	0	6
None	0	0	0	0	0	0	0
Totals	1	9	20	7	0	0	37

Table 28 (Continued)

Percentage of integration	Years in operation						Totals
	Under 2	2 - 5	6 - 10	11 - 15	16 - 20	Over 20	
Programs which were not planning to revise their curriculums							
100	4	4	10	4	0	0	22
75 - 99	3	5	10	5	1	0	24
50 - 74	2	4	3	1	0	0	10
25 - 49	2	4	5	2	0	0	13
1 - 24	1	5	0	0	0	1	7
None	4	1	1	0	0	0	6
Totals	16	23	29	12	1	1	82

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