Models of initial training and pathways to registration: a selective review of policy in professional regulation

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Aim To provide a synthesis of literature on international policy concerning professional regulation in nursing and midwifery, with reference to routes of entry into training and pathways to licensure.

Background Internationally, there is evidence of multiple points of entry into initial training, multiple divisions of the professional register and multiple pathways to licensure.

Evaluation Policy documents and commentary articles concerned with models of initial training and pathways to licensure were reviewed. Item selection, quality appraisal and data extraction were undertaken and documentary analysis was performed on all retrieved texts.

Key issues Case studies of five Western countries indicate no single uniform system of routes of entry into initial training and no overall consensus regarding the optimal model of initial training.

Conclusions Multiple regulatory systems, with multiple routes of entry into initial training and multiple pathways to licensure pose challenges, in terms of achieving commonly-agreed understandings of practice competence.

Implications for nursing management The variety of models of initial training present nursing managers with challenges in the recruitment and deployment of personnel trained in many different jurisdictions. Nursing managers need to consider the potential for considerable variation in competency repertoires among nurses trained in generic and specialist initial training models.

Keywords: midwifery, nursing, policy, regulation, review, training

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Introduction and background

Nursing and midwifery were among the first professions to require state-regulated entry to practice (Pearson 2005). In 1902, state regulation of midwives in the United Kingdom was established under the Midwives Registration Act, and in the United States the first laws regulating nurses were passed in 1903. Registration legislation for nursing in the UK and Ireland was enacted in 1919. In pursuing state regulation, nursing leaders underplayed character development, as espoused by Nightingale, and instead emphasized professional scientific training (Rafferty 1996); in the words of Margaret Huxley, a leading proponent of state regulation, 'if you do not educate your nurse, in the end the public must suffer' (House of Commons 1905, p. 22). Hence, the public mandate of nursing and midwifery, **qua**-regulated professions, is to provide a professional service that is competent, safe and effective, and this public mandate is met through the standardization of initial preparatory training and the maintenance of a professional register of practitioners. While these two processes have long been the main pillars of state regulation, increasingly regulation incorporates mechanisms for assuring post-registration competence maintenance through continuing professional development, involving peer review and/or objective performance appraisal.

Regulation of training remains a fundamental element of state regulation, and involves control of entry to initial training and to the professional register on successful completion of initial training. The competent regulatory authority sets the requirements and standards for entry into initial training and for the conduct of that training. The competent authority ensures public safety in its dealings with the profession that it regulates, and professionals are responsible to the public to maintain practice standards in return for professional status and remuneration (Pearson *et al.* 2002). Registration, or licensure, is determined by agreement on what constitutes competence to practice and by the individual nurse or midwife having demonstrated that s/he is competent, and it carries explicit grounds for statutory removal from the professional register (Pearson 2005). State regulation is thus concerned with the criteria of fit-for-purpose and fitness-to-practice. It not only protects the public, but also safeguards the individual registrant, as well as the good name of the profession.

Method

A systematic search of published works indexed in CINAHL and MEDLINE and including policy statements, reviews, commentary articles and related documentary texts, such as editorials and research reports, was undertaken. A further search of government websites and nursing and midwifery regulatory authorities was conducted. The bibliographies of articles retrieved were examined for the occurrence of key search terms in cited titles. Indexing search terms used were nursing, midwifery, training, regulation, registration, licensure, entry to practice, academic level and policy. The search was confined to English language publications and the review period was 1 January 1990 to 30 March 2009. Texts were included if they constituted policy reports or commentary concerned with those aspects of professional regulation of concern to the review. Item selection, quality appraisal and data extraction were independently undertaken by two of the reviewers using a common approach. Documentary analysis was performed on all retrieved texts.

Modes of entry into initial training and pathways to registration

Historically, registration legislation established a number of parts or divisions of the professional register of nurses as well as separate routes of entry to each part. The various parts of the register reflected the particular type of nursing extant at the time of enactment of the legislation, and aside from a 'general' part, the early registers included special divisions for fever nurses, mental nurses, children's nurses and, later, tuberculosis nurses. Some parts, including parts for fever, tuberculosis and male nurses, were later removed in accordance with developments in nursing and healthcare (Fealy 2006). Historically, legislation provided for a separate register of midwives.

Multiple parts of the register gave rise to multiple points of entry into initial training for that part, a position that still remains in a small number of countries, most notably the United Kingdom, Ireland and some other European countries. For example, Austria provides direct entry into children's and psychiatric nursing, Belgium provides direct entry into psychiatric nursing and Germany into children's nursing (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 2001). Globally, having the multiple points of entry into single specialist divisions of nursing for the purpose of initial training is the exception, with comprehensive generic training leading to a generalist nursing qualification being the international norm.

Initial training: specialist or generic?

In the broadest sense, there are two models of initial training in nursing. These are the specialist model and

the generic model. From the perspective of developing practice competence, the specialist or direct entry model makes a distinction between branches of nursing, such as children's nursing, psychiatric nursing, nursing in intellectual disability and general or 'adult' nursing (Norman 1998). The model provides for entry into a single branch of nursing prior to registration as a nurse, specialist initial training for that branch and entry to a specialist division of the professional register upon completion of initial training. In providing focussed instruction related to the care of a specific client group, it aims to assure practice competencies commensurate with exclusive preparation for a branch of nursing that generic preparatory training may not assure. Nurses so prepared are deemed to be competent to deal with the unique needs of a particular client group. Additionally, the specialist model carries subsidiary merits, including assured recruitment into the associated specialist services and professional socialization of students into that branch through their sustained encounter with the services during training.

The specialist model has been criticized as being restrictive in its focus, uneconomical and at variance with the World Health Organisation position, which advocates the preparation of generalist nurses (Grant 2002). In restricting registrants to a specialist practice field, the model also reduces workplace mobility. Despite these shortcomings, there have been calls for a return to the specialist model as a result of shortcomings of the generic-comprehensive model, including a lack of nurses' preparedness for practice in services such as mental health care (Stuhlmiller 2005).

As its name implies, the generic model of initial training prepares graduates to the point of registration with a broad and comprehensive knowledge and with generic practice competencies to enter registered practice as a **generalist** practitioner. While the model makes no distinction between specialist branches of nursing, it does not deny the existence of specialist branches, or the variety of client groups and specialist care settings, and does not exclude post-basic specialist preparation (Barr & Sines 1996). Rather in its operation, it prepares graduates with practice competencies to nurse multiple client groups in multiple and varied settings. Accordingly, the term 'generalist' may be used to denote the **product** of generic preparatory training, i.e. a generalist nurse.

In preparing graduates in a **comprehensive** way, the generic model is sometimes referred to as the 'comprehensive model'. Based on the development of a repertoire of generic competencies, transferable across both hospital and community settings, the model assumes that the generalist practitioner can assess the needs of all patients, regardless of age or healthcare setting, and that services will enjoy the benefits of a multi-skilled practitioner (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 2001). It assumes that graduates prepared with beginner-practitioner competencies can differentiate, integrate and generalize from knowledge gained (Grant 2002). It also presupposes that branch specialization will take place after initial registration and, accordingly, disciplinary maturity in a given branch will occur after initial registration (Tyrell & McCarthy-Haslam 1998). When elements common to all branches are brought together in a generic curriculum, it is assumed that initial training is rendered as both rational and efficient (An Bord Altranais 1991). A single qualification permits more flexible working and easier movement of nurses, addresses shortages in specialist areas, improves the supply of new recruits and enhances career mobility (Rowen 1993).

Opponents of generic-comprehensive preparation have charged its advocates with having ulterior motives related to managerial concerns with cost effectiveness and ease of staff deployment (Smith & Long 2002). Others point to the risk of inequality across subjects in the classroom and in the practicum (Glasper & Charles-Edwards 2002, Grant 2002), and the attendant risk that initial training fails to provide nurses with sufficient knowledge and skills to offer high-quality care within specialist fields (Bradley 2003). This concern is of particular importance in the light of the need for particular skills in the care provision for vulnerable groups such as children and persons with intellectual disability (Barr & Sines 1996). Grant (2002) points to a dearth of research concerning knowledge and skills transfer in the generic-comprehensive model and, in a forthright criticism of the model, with particular reference to mental health nursing in Australia, Holmes (2001: 237) writes:

> 'The stark anomaly is that the only route into a career in mental health nursing [in Australia] is via … [the] comprehensive course … [and] these years of 'comprehensive' nurse training are a needless and unethical waste of resources, counterproductive to the task of creating an effective mental health care workforce'.

It is also argued that generic training can adversely affect recruitment to specialist services (Holmes 2001) and can result in the marginalization of specialist branches of nursing (Barr & Sines 1996).

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Possible alternative models

After a review of the specialist model of initial training by the United Kingdom Central Council (United Kingdom Central Council for Nursing, Midwifery and Health Visiting Commission for Nursing and Midwifery Education 1999), the UKCC's Post-Commissioning Development Group proposed a number of possible models for initial preparation in the UK (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 2001). These included the retention of the common foundation and branch-specific programmes but with possible revised emphases during training, dual registrations in fields such as nursing and social work, hospital and community nursing or adult and child nursing, and the introduction of a generalist nurse who would undertake specialization after registration (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 2001). Emphasizing the need to 'ensure public protection [and] meet workforce planning needs to deliver service requirements', the UKCC also stressed the need for inter-professional learning (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 2001, p. 57). In a commentary on the proposed models, the Royal College of Nursing (RCN) remarked that 'the crux of the issue lies in decisions about what specialist and generalist nursing practice is' (RCN 2004, pp. 6–7), and it called for 'flexible systems of learning…with multiple routes to initial professional registration', in order to recognize and accredit numerous routes to nursing registration and practice (RCN 2004, pp. 11–12).

In Australia in 2002, efforts to introduce a combined 4-year nursing and midwifery 'double degree' were thwarted when the proposed programmes did not meet the requisite standards of the Australian College of Midwives Incorporated (ACMI), such that graduates would be rendered as 'internationally incompatible' (Stuhmiller 2005). In Ireland, efforts to introduce a dual registration degree in children's and general nursing were more successful when, a new integrated programme leading to a bachelor's degree and dual registration commenced at three Irish universities in 2006. The new programme reprised a similar dual registration hospital certificate course that had operated successfully in the 1970s and 1980s.

Training and regulation policy and practice

The majority of European countries regulate nursing through legislation emanating from state governments and individual practitioners are also guided by relevant codes of conduct (Fleming & Holmes 2005). In developed countries such as Australia, New Zealand, Canada and the United States, a similar position obtains, although individual states regulate and licence practitioners working in their respective jurisdictions. While professional regulation has common aims across countries, much variation exists in the ways that initial training in nursing is structured and academically accredited, and in the pathways towards practitioner licencesure, and these matters continue to be the subject of debate resulting in a range of discussion papers, policy documents, directives, legislation and rules and regulations.

Policy and practice in Europe

When the core European Economic Community (EEC) was established in the post-World War II period and later expanded in the 1970s, new European laws were enacted to permit the free movement of labour within the EEC's constituent states. This legislation required the contiguous development of special directives relating to the mutual recognition of professional qualifications in health care, in order to assure agreed minimum standards of training and thereby permit professionals to practice in any or all of the member states of the EEC (Fealy 2006).

In the 1970s and 1980s, the EEC agreed a common framework for programmes of initial training; Directive 77/453/EEC set criteria for establishing eligibility for the mutual recognition of professional qualifications and Directive 89/595/EEC defined the relative balance of theoretical and clinical instruction. Similarly, Directive 80/155/EU defined the work of a midwife, set down the requirements for midwifery training and outlined the modes of entry to midwifery. It is from these various directives that member states of the European Union (EU) derive their respective requirements and standards for registration education programmes.

While there are agreed EU directives on training courses, there is considerable variation across member states in relation to the level of academic award that is required for registration as a nurse or midwife. In addition, while the new post-2004 accession states of Central and Eastern Europe have been engaged in developing and updating their respective initial training programmes, many are not yet compliant with the relevant EU directives (An Bord Altranais 2004). A problem in implementing the directives among post-accession countries such as Poland, Hungary and the Czech Republic relates to the difficulty in attaining supervised practice as a result of a shortage of nurses

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and the predominance of medical doctors in the practicum (Keighley 2003). For example, in the old post WWII Czechoslovakia, most decisions concerning nursing were taken by physicians, and it was only after 1989 and the political reforms in Eastern Europe and later accession to the EU that nursing became a fully independent discipline in that country (Tóthová & Sedláková 2008).

As part of its Simplification of Legislation on the Internal Market (SLIM) initiative aimed at improving the quality of EU legislation (European Commission 2008), the European Commission published directive EU Directive 2001/61 on the recognition of professional qualifications for a number of professions, including nurses and doctors. While the Directive aims to effect the free movement of workers through a **recognition** model, concern has been expressed that it will constitute a risk to public protection in its provision which permits a professional to work in a host member state for up to 15 weeks per year without the authorization of that state's regulatory authority (An Bord Altranais 2004).

From time to time, the World Health Organisation (WHO), through its various regional offices, publishes policy statements on nursing and midwifery education; in its **Nurses and Midwives for Health: A Strategy for Nursing and Midwifery Education**, the WHO declared that as nurses and midwives must practice as competent care providers, then their educational experiences must foster the requisite competencies and, consequently, 'the academic level of baccalaureate degree is a prerequisite for professional practice' (WHO 2001, p. 6). Published in 2005, a report of a 4-year longitudinal study across the 36 WHO European Region countries examined nursing and midwifery education programmes with reference to the educational principles subscribed to in the WHO Strategy and provided self-report data on their progress in implementing the Strategy (Fleming & Holmes 2005). In all but five, non-EU Eastern WHO European Region countries, nursing and midwifery were controlled by central government with practitioners subject to legislation and a code of professional conduct. While the academic level of the nursing or midwifery qualification was that of a university (or higher education institution) degree in 60% of countries, initial training programmes in nursing and midwifery continued to be offered below the recommended baccalaureate degree in approximately 40% of the countries.

It has been argued that since the Western, Central and Eastern regions of WHO Europe are very different in terms of size, culture and complexity, and have fundamentally different needs in relation to the preparation of their nurses and midwives, attaining standardization may not be possible, and it may be inappropriate to transplant a Western European model into the Centre or the East (Eberhardie 1998). As the WHO European Strategy asserts that initial training should be competence based, the question arises as to **which** among the specialist or generic modes of initial training is best suited to achieve the requisite competencies for practice.

Initial training and pathways to registered practice: selected case studies in international policy

Entry to initial training and pathways to registered/licensed practice is possible through varied routes, and international developments and trends in routes of entry to nursing and midwifery indicate much commonality, but also some considerable variance. As a way of illustrating these developments and trends, the pathways leading to professional registration of the United Kingdom, Ireland, Australia, New Zealand and the United States are briefly reviewed.

The United Kingdom

In the UK, while registration programmes incorporate a common entry point to the national pre-registration training scheme, prior to registration, students enter into a specialist branch of nursing, such as adult or mental health nursing. The level of academic award is a diploma but many UK universities also provide registration training to a degree level. Arising out of the **Fitness for Practice (Peach) Report** (United Kingdom Central Council for Nursing, Midwifery and Health Visiting Commission for Nursing and Midwifery Education 1999), new pre-registration programmes were introduced in the period 2000–2002, placing greater emphasis on practice learning, on the achievement of competence and a shortened common foundation element in favour of increased branch preparation. Also arising out of Peach, new pre-registration midwifery programmes were introduced after 2001.

A new regulatory and registering authority for nursing and midwifery for the UK was established in 2002. The new body, the Nursing and Midwifery Council (NMC) sets the minimum educational standards for entry to initial training and for admission to the Register (Nursing and Midwifery Council Incorporated 2009). The NMC replaced the UKCC as the statutory regulatory body for nursing and midwifery, and established a new three-part Register for Nurses, Midwives

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and Specialist Community Public Health Nurses (RSCPHN), replacing the 15-part Register of the former UKCC. Contained within the Nurses' part are multiple sub-parts, including parts for adult, mental health, learning disabilities and children's nursing.

In 2005, concerned with a 'perceived variation in competence or fitness for practice at the point of registration', the NMC initiated a review of initial training programmes for nurses (Nursing and Midwifery Council 2005, p. 1). The review focused on the identification and assessment of certain essential skills, including the mechanisms for confirming a student's competence and fitness for practice, and on determining the specific point or points in a programme at which the competence of a nurse or midwife should be confirmed. As part of this review, in 2007 the NMC initiated consultation with a range of stakeholder groups with the view to examining the future framework of pre-registration nursing education in the UK (Nursing and Midwifery Council 2009). Findings from the review indicated that while key stakeholders wish to see a move towards generalist training and graduate entry to practice, the majority of nurses support the retention of branch preparation for adult, child, mental health and intellectual disability nursing. Among the principles arising from the review were that a bachelor's degree should be the minimum outcome-award for pre-registration nursing programmes in the UK and that registration should denote one field of practice in adult, children's, mental health or learning disability nursing. Phase 2 of the review was ongoing at the time of writing and focuses on the development of generic and field specific competencies needed to practice (Nursing and Midwifery Council 2009).

Ireland

In Ireland, a 4-year registration honours degree was instituted on a national basis in 2002, rendering all initial training as fully integrated into the higher education sector. In the move to graduate entry to registered practice, the new degree programme preserved multiple points of entry into nursing and multiple divisions of the register of nurses, such that undergraduates pursue a degree in one of three distinct branches of nursing, namely general, psychiatric and intellectual disability. In 2006, an integrated degree combining children's and general nursing was instituted and the first direct-entry midwifery degree also commenced in that same year.

The professional regulatory authority for nursing and midwifery in Ireland, An Bord Altranais (the Nursing Board), is responsible for setting the standards for programmes of initial training in nursing and midwifery, and entry to the register occurs after completion of the relevant degree programme. A review of the specialist model of initial training in Ireland, commissioned by An Bord Altranais, recommended the retention of distinct registration education programmes for the multiple divisions of nursing, on the grounds that 'there exist unique client groups with unique needs … [and] there are various aspects of the health of the population, which need to be addressed by nurses and midwives with specialist training' (Carney *et al.* 2005, p. 303).

Australia

Australia is constituted as a federation of states and territories, comprising both state and federal legislatures, with a separate autonomous regulatory and registering authority for each constituent state. Since 1989, the basic entry level to professional practice as a registered nurse is a 3-year ordinary university degree, and the training model is a comprehensive-generic programme (Tyrell & McCarthy-Haslam 1998). Preparatory training leading to midwifery registration is undertaken at post-registration level, although in some states direct entry into midwifery is possible. Some states impose restrictions on professional licensure, requiring nurses to have a special registration to practice in certain branches of nursing, such as mental health nursing (Commonwealth of Australia 2002). Training in mental health nursing is achieved through further post-graduate study.

Conducted under the auspices of the National Review of Nurse Education in 2002, a major review of nursing education in Australia (Commonwealth of Australia 2002) recommended the retention of the bachelor degree as the minimum entry level to registered practice, and it endorsed the generic-comprehensive model of initial training as 'the best option for the flexible use of nurses in the health community and aged care systems' (Commonwealth of Australia 2002, pp. 25 and 161). Nevertheless, some reports into the effectiveness of the generic comprehensive model in Australia have pointed to problems related to the degree of preparedness of graduates to work in some areas of practice, such as mental health (Farrell & Carr 1996, Happell 1998, Stuhlmiller 2005). Evaluation studies of Australian programmes also suggest that graduates function better in community than in hospital settings (Tyrell & McCarthy-Haslam 1998). The Review also recommended the establishment of national standards of competency for registration (Commonwealth of

Australia 2002 p. 22), and the Australian Nursing and Midwifery Council and other professional nursing bodies in Australia continue to advocate a system of national registration for the health workforce and national accreditation of registration courses (AAustralian Nursing and Midwifery Council Incorporated 2008).

New Zealand

Since the late 1970s, initial training of nurses in New Zealand has been conducted in the polytechnic colleges system and by the end of the 1990s all diploma-level programmes were upgraded to degree level (Lusk *et al.* 2001). A generic comprehensive initial training model was initiated and the regulation of nurses is the responsibility of the Nursing Council of New Zealand. Entry to the register follows completion of professional training and the successful completion of the New Zealand Qualifications Authority state examinations.

Evaluations of the pre-registration generic programme in New Zealand point to a problem of nursing graduates' inability to make the transition from undergraduate student to professional licensed practitioner, with many transitioning to professional practice as apprentices and experiencing difficulty in coping with unexpected events (Tyrell & McCarthy-Haslam 1998). Comprehensively-trained graduates working in mental health care in that country can experience a lack of preparedness for dealing with complex situations in the practicum (Prebble & McDonald 1997). Policy debate in that country has also included discussion of the suitability of the polytechnics for educating nurses (Tyrell & McCarthy-Haslam 1998).

United States of America

In the United States, each individual state nursing board is empowered to specify its own requirements for state registration and to give a licence to an individual nurse to practice in that state. Licensure may be granted for applicants holding a 3-year hospital diploma, a 2-year associate degree, a 4-year baccalaureate degree or a master's degree. The various pre-licensure programmes provide generic training and eligibility to enter professional practice as a 'registered nurse' (RN). Registration is granted after successful completion of the national licensing examination, the NCLEX-RN. In the last decades of the 20th century, a gradual decrease in the numbers entering practice from hospital diploma programmes has meant that the majority of RNs hold an associate degree, with approximately 40% of the total workforce only holding a full baccalaureate degree (Amos 2009). A decline in applicants to entry-level baccalaureate programmes in the late 1990s was reversed in the early 2000s.

In its position paper **A Vision of Baccalaureate and Graduate Nursing Education** the American Association of Colleges of Nursing declared that the preparation of nurses at the baccalaureate degree level 'is the minimum qualification to function in professional practice roles', and asserted that while opportunities for upward mobility for non-baccalaureate-prepared RNs should continue, reliance on such provision should not decrease the profession's efforts to encourage direct entry into baccalaureate and higher-degree programmes (American Association of Colleges of Nursing 1999). The National Advisory Council on Nursing Education recommends that at least two-thirds of the nursing workforce should hold a baccalaureate degree or higher by 2010 (Amos 2009). However, in the workplace setting, there is evidence of little differentiation of work roles based on level of academic preparation (Long 2003) and the present arrangement of multiple pathways to undifferentiated licensure is seen as a barrier to the advancement of nursing in that country (Lusk *et al.* 2001, Long 2003, Spear 2003). Calling for a shift in focus from 'the old issue of entry level for professional practice' to 'meaningful differentiation', Long (2003, p. 124) advocates differentiated licensure and differentiated scopes of practice built on educational requirements, writing:

> 'Continuing to deploy a homogenized RN workforce, using a single scope of practice for those with substantively different entry-level preparation, is dangerous for patients and demoralizing for nurses'.

Conclusions

Professional regulation of nursing and midwifery involves regulation of entry to training and entry to licensed practice and it is possible to have multiple routes of entry into initial training, multiple divisions of the professional register and multiple pathways to professional registration or licensure. The routes of entry into initial training, the level of academic award leading to eligibility for registration and the procedures and pathways to state licensure are interdependently connected. As professional disciplines, nursing and midwifery are responsible for preparing clinically competent nurses and midwives for their respective practice fields and for enabling registered practitioners

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to maintain practice competence. Professional regulation needs to be flexible in order to accommodate changing patterns of healthcare delivery, changing consumer expectations and changing needs for professional education and training in the light of new technologies, new knowledge and skills and new nursing and midwifery roles. Changing patterns of migration also present particular challenges in relation to professional regulation.

Policy debate concerning the academic pathways to licensed practice reflects professional concerns to assure practice competence for context-specific care, to assure an adequate supply and retention of registered nurses and midwives and to advance disciplinary development. An abiding concern for both developing and developed countries' national health services is the need to assure an adequate supply of registered nurses and midwives to meet their service demands. While recruitment from developing countries such as India and the Philippine Islands has for some time been an important source for the supply of nurses in developed countries, the principal source remains the cadre of newly-qualified nurses who exit initial training programmes. In the face of multiple regulatory systems and multiple pathways to professional registration, host countries must be satisfied that the processes and procedures for registering immigrant nurses are sufficiently robust to maintain their own national standards. Supplier countries also face challenges related to workforce planning, particularly when faced with large-scale outward migration of nurses.

Globally, having the multiple points of direct entry into single specialist branches of nursing for the purpose of initial pre-registration training is the exception and not the rule, with generic-comprehensive training leading to a generalist nursing qualification being the international norm. Consideration of alternative modes of entry to initial training is not unrelated to the concern to match supply and demand for nurses and midwives. Given the variety of countries, cultures and health systems, it is likely that establishing a one-size-fits-all model of initial training will be difficult to achieve and that debate concerning the optimum routes of entry into initial training and pathways to registered practice will continue. Nevertheless, what is not in dispute is the fact that any initial preparatory training programme should be built on explicit and shared understandings of the newly registered nurse's pre-requisite core competencies, including her/his transferable knowledge and skills. In addition, the case for an all-graduate profession is now generally not in dispute, given the level of knowledge and skills required to meet the ever complex needs of the clients of national healthcare systems.

The worldwide shortage of nurses challenges nursing authorities and state legislators to examine models of preparatory training and to ensure that initial preparatory training is effective in attracting recruits to nursing, developing optimum practice competence at the point of registration and retaining registered nurses, particularly in specialist fields of practice. The varied models of preparatory training present nursing managers with challenges when recruiting and deploying nursing personnel trained in many different jurisdictions. Nursing managers need to take account of the potential for considerable variety in the repertoires of competencies between nurses trained in the generic preparatory training model and those trained in a specialist model.

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