Certification Is the Answer: What Is the Question?

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The plan for a doctoral degree in clinical nursing grew out of a series of informal and innovative advancements in advanced practice nursing at Columbia University School of Nursing. Beginning in 1993, when the New York Presbyterian Hospital Medical Board granted admitting privileges to faculty nurse practitioners as part of a randomized trial to compare NPs and MDs in primary care, until 1999, when the trial was completed, a full scope of new knowledge and care became formalized and served as the basis for this new degree proposal.

Columbia nurses pioneered and evaluated a clinical role that had taken hold in practices providing care to the underserved and in a landmark midtown Manhattan primary care practice staffed solely by faculty NPs who were reimbursed at MD rates by commercial insurers. This new model of care, with authority for patients across all sites of care, utilized advanced and sophisticated care expertise for individuals across the life span, experience in taking call, emergency room evaluation, and comanagement of acutely ill hospitalized patients and added conventional medical primary care skills to these NPs' seasoned nursing armamentarium. The result was a comprehensive clinician new to the health care system.

As Columbia's DNP degree proposal went through the university and state approval processes, we established a Council for the Advancement of Primary Care in 1999. This council, composed of deans of leading medical center nursing schools, distinguished physicians, and health policy experts, has met 12 times in the intervening years. Its first agenda was to build standards for the new clinical doctorate and then to develop a national certification for eligible graduates. As our understanding grew about this new degree, it became clear that it was of value to all advanced practice nurses, not just those involved in primary care, and the council changed its title to the Council for the Advancement of Comprehensive Care (CACC).

We were certain, as the first clinical doctorate entered the professional landscape, that this was an idea that filled an enormous gap in health care and in our profession. Nursing was the last clinical profession to develop a doctoral degree in its core discipline. Nursing expertise across sites and seamlessly over time requires more education, experience, and time than can be accomplished in MS degree programs. The acute shortage in access to primary and coordinated care for complex or chronic illnesses is growing rapidly as the population ages and experiences more needs as a result of surviving serious illnesses. Physicians are leaving primary care careers, and patients are more in need of this kind of comprehensive care than ever before. With this new degree, nursing adds depth to its core competencies and authority, meets a profound and growing medical need, and provides a new destination for those contemplating a nursing career.

CACC was established with the full expectation that the new degree would be extremely attractive to schools and prospective students and that early action was necessary to ensure common high standards as schools developed these new degrees. We believe it is essential that the public should be able to rely on a clinician's degree title to mean the same thing wherever or whenever care is sought from such an individual.

We knew there would be variation among degree programs and were well aware that it takes time and committed resources—both within the nursing faculty and physician colleagues—to fully establish a credible program. It had, after all, taken us 15 years to do so at Columbia, with pilot programs, formal evaluations, policy changes, and university and state approvals. What we did not foresee was the

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erosion of purpose for the degree to develop into a degree program, called the Doctor of Nursing Practice, that might be an advanced clinical education *or* could have core content and outcomes that had nothing to do with clinical practice. Nurses who wanted a doctorate and who did not choose to become researchers now had an opportunity to get a DNP in almost anything. This "inclusive" policy to make the DNP a catchall is a sad commentary on our accountability to patients. Surely a patient selecting an authoritative comprehensive care provider is not expecting to have his or her DNP be an expert in administration, with no distinguishing clinical acumen from that of a nurse with a BS or an MS degree. When this kind of foggy purpose arises in medical care, patient safety requires defaulting to the lowest common denominator, robbing the truly advanced clinicians of their earned recognition.

CACC struggled with this emerging outcome and realized that the visible standards necessary to distinguish the advanced clinician would not be anchored by a degree title. Therefore, our focus became certification of DNP graduates. Certification will provide the distinction patients and payers should have when choosing a clinician from among the variably educated DNP graduates.

We have developed criteria for certification that will limit access to only those who have completed a DNP in clinical practice, with a significant patient care residency. To do so, we asked three well-regarded certification groups to provide us with proposals on developing such a certification. We have determined that the very best partner possible available to us is the National Board of Medical Examiners (NBME), which is part of a larger organization, the U.S. Medical Licensing Exam. They provide the final testing mechanism for MD candidates to be licensed. The NBME is developing for the DNP candidates an exam that is "comparable in content, similar in format, and will measure the same set of competencies and apply similar performance standards as the USMLE Step 3 exam."

The public's strong reliance on the quality and rigor of those with an MD license will now have an understandable and high-quality designation for DNPs who fulfill the education requirements and successful testing process. The DNP exam will be derived from the same materials used for MD licensure. We believe this is a very exciting accomplishment and look forward to welcoming the first Diplomats in Comprehensive Care by the end of 2008.

Certification is the answer to the question we first posed to the council in 1999: How can we assure the public of quality and reliable standards for these new clinical nurse experts?

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