Licensure
and
Credentialing
It is with a sense of professional urgency that we present these proceedings from the Northeast Regional Assembly of Constituent League of National League for Nursing held in New Haven, Connecticut on June 5, 1955. The foremost topic of the assembly was Licensure and Credentialing, a concern of those who are involved in the education of nurses, nursing educators, service directors, and administrators. The need for such credentials has been magnified by the proliferation of issues in licensure and credentialing.

The necessity and prominence of nursing in the 1960's and early 70's is of the utmost importance. The efforts of these nurses and the nurses who are just beginning their career are critical to the future of nursing. The demands of nursing practice have changed, and the demands of the nurse have increased. The nurse must be prepared to meet these new demands.

One example of the changes in nursing practice is the need for advanced education. Many nurses are returning to school to upgrade their qualifications. This is essential for maintaining the quality of care that patients deserve. The role of the nurse has also changed. Today's nurse is not only a technical worker, but also a leader in patient care. The nurse must be able to work in collaboration with other healthcare professionals to provide the best possible care for patients.

Another example of the changes in nursing practice is the importance of continuing education. Nurses must maintain their knowledge and skills in order to provide the best possible care for patients. Continuing education is essential for maintaining the quality of nursing care.

The national league for nursing believes that nurses must be prepared to meet the challenges of the future. The league is committed to supporting nurses in their efforts to provide the best possible care for patients. The league is committed to promoting the advancement of nursing and the rights of nurses.

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FOREWORD

It is with a sense of professional urgency that we present these proceedings from the Northeast Regional Assembly of Constituent Leagues for Nursing Conference held at Windsor Locks, Connecticut on June 9–10, 1977. For two days, over 175 participants and 17 speakers, including government spokesmen, credentialing experts, nursing educators, service directors, clinical specialists, and students, grappled with the proliferating issues in licensure and credentialing.

The promise and problems of nursing in the 1970s are sharply defined in these papers as the writers explore specific aspects of the overall topics. As an example, among the issues discussed are the minimum requirements to assure continued competency in basic nursing practice and the certification of advanced nursing practice.

Today, two nurses holding the same license to practice could have dramatically different capabilities. One nurse may return to work after a 30-year absence, having kept up with nothing professionally except her license. The other may be working in independent practice, having continually kept up with her clinical area. The quality of care that can be provided by the independent practitioner was apparent to all attending the conference who viewed Jane Steel in an excellent film entitled, The Portrait of a Nurse.

If nursing is to keep the mandate for its own professional standards, we must adhere to certain guiding principles over the next few turbulent years. We are told that since licensing and credentialing issues will buffet nursing from within and without, the profession must insure a united front as it dialogues for change. This unity is exemplified by the cooperation of the National League for Nursing with
the American Nurses' Association's credentialing study so thoughtfully outlined in these proceedings. We are advised to support and build upon current structures in licensing, credentialing, and certification while waiting for the ultimate implications of the ANA study. We must not discard existing structures until better replacements are available.

Greater unity between service and education is critical as we stress the need for peer review and for ongoing clinical development of faculty preparing nurses at all levels. Such professional unity decreases the possibility of government takeover of health manpower—a takeover which would upset the balance of power provided by the natural tension between the academies, the professionals, and the licensing agencies.

The serious and articulate attention which individual nurses give to licensure and credentialing issues, as exemplified in the forum which prompted this publication, encourages the hope of continued self-regulation of nursing standards of practice. We invite your responses and consideration of the issues presented in the following papers.

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Collaboration between service and education is critical as we approach the next era of peer review and for ongoing clinical development of faculty preparing nurses at all levels. Such professional unity describes the possibility of government takeover of health manpower—a move which would upset the balance of power provided by the current division between the academic, the professional, and the regulatory agencies.

The need to articulate attention which individual nurses give to licensing and credentialing issues, as exemplified in the forum which accompanied this publication, encourages the hope of continued synthesis of nursing standards of practice. We invite your responses and your engagement of the ideas presented in the following pages.

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Margaret A. Collier, O.N.Sc.

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LICENSURE AND CREDENTIALING: PURPOSES, PROBLEMS, AND IMPLICATIONS

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SEVENTY-SEVEN PHYSICIANS INDICTED IN CORONER’S COVER-UP OF PRACTICE INDUCED DEATHS
STUDENTS SUE COLLEGE FOR LACK OF COMPETENCY UPON GRADUATION
STATE BOARD OF MEDICINE ASSERTS ITS ROLE IN CERTIFICATION OF SPECIALTY GROUPS

These headlines are but a few examples of the increasing interest in, and concern for, credentialing processes, particularly as they relate to the human services professions and occupations. Probably no area involving health manpower has received more attention over the past ten years than that of credentialing. The “why” of the concern is related directly to growing social, economic, and political forces, some of which will be addressed later in this paper.

Improved health care that is available and accessible at an acceptable cost is obviously one of the nation’s highest priorities. At least, this is what Congress keeps telling us. What they are actually doing about it seems to be a different matter. The Great White Father continues to speak with forked tongue.

Assuming that this concern is real, one can begin to understand the intensified interest of the public, since health manpower represents the key element in developing a national health strategy. It also represents a key element in creating jobs for this nation’s poor and disadvantaged, and in providing a life-line to colleges and universities badly in need of “bodies” to justify their existence.

I will admit from the onset of this discussion that I am biased. I
believe in the value of credentialing mechanisms. I have worked diligently in support of mandatory licensure, national accreditation of nursing programs, and professional certification of practitioners. However, contrary to the popular beliefs of nursings' critics, my convictions are not founded on maintaining or establishing "territorial" rights or "elitism," but rather on a genuine concern for the quality and safety of nursing practice in this country. I recognize that the four reports issued on the credentialing of health manpower (1971, 1973, 1976, and 1977 by the U.S. Department of Health, Education, and Welfare), all allude to the fact that credentialing processes established by the healing arts professions and schools are self-servicing and that, they are instituted by professionals for professionals. I cannot speculate on who DHEW talks to other than God—but I certainly know that they must not talk to people—or in today's vernacular, consumers.

Consumers are interested in credentials and they express shock over the lack of credentialed persons involved in delivering health care. DHEW has confused the deliberate attempt of health care agencies and personnel to confuse and withhold information about credentials and qualifications from consumers (which is in simple language, outright consumer fraud), with the lack of interest or concern on the part of consumers. I have had clients, friends, acquaintances, and neighbors question me about the credentials of those who are caring for their loved ones—and I defy any panel studying health credentialing to prove that citizens are not vitally concerned with the credentials of the healing arts professionals.

A system for the credentialing of the health professions is essential for the protection of consumers. In our highly mobile and shifting society, it is the only system by which we can offer consumers assistance in identifying the qualified from the unqualified, the competent from the incompetent.

Credentialing is a broad generic term that may be defined as the formal recognition of professional or technical competence. When applied to health manpower, credentialing takes three forms: 1. licensure by an agency of the government; 2. certification by a non-governmental agency or association; 3. accreditation of educational programs by an approved agency or organization.

The three aspects of the credentialing processes are clearly interrelated and, at times, the terminology is employed interchangeably. For example, teachers are certified by state governments rather than by associations or nongovernmental agencies. Educational programs in nursing are accredited by the National League for Nursing as well as by the Office of Education of DHEW and certain state boards of nursing. Educational programs in nursing are approved by all state boards of nursing as part of the process for meeting pre-licensure requirements.
Confused? So is the average consumer who may have limited interest in attempting to understand our systems of social stratification, but have marked interest in assuring increased accountability from professionals in the healing arts. For purposes of this paper, two of the forms of credentialing will be discussed briefly as discrete entities, while emphasis will be placed on licensure.

CERTIFICATION AND ACCREDITATION

Certification is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association. It is voluntary and it carries no legal sanction. In nursing, certification has been a fast moving development of the American Nurses’ Association because of its relationship to larger social issues. I do not mean to imply that the process of validating selected qualifications for providing quality professional nursing care in a specific area of practice is not in and of itself a good or legitimate role for a profession. However, it must be obvious to anyone who has monitored the development of certification for nurses that much of the opposition to the process expressed last June (ANA Convention, 1976) came from those who lacked knowledge of, or sympathy for, the professions need to move rapidly into this complex situation. Currently the authority to certify practitioners is invested in the five Divisions of Practice of the American Nurses’ Association and I believe that the authority to certify for practice is an appropriate activity of the professional association (ANA). The authority to certify practitioners of nursing is directly related to the purposes and by-laws of the American Nurses’ Association and it provides the Association with a mechanism for the recognition of professional achievement and excellence. In addition to the obligation of a professional association to establish mechanisms for the formal validation of the knowledge and skills of its practitioners in specific practice areas, there are, as I previously indicated, larger social issues involved in the need for certification. Specifically these issues include:

1. **Rising Consumerism.** Health care is a commodity for which the consumer is charged considerable sums. As a purchaser of a service available on the open market, the consumer has the right to assurance that his health care dollar is buying a full measure of safe and competent care. As man’s knowledge and technology continue to grow, specialization in the practice of the healing arts is inevitable. Assuring the quality of specialized practice is the function of certification.

2. **A National Health Insurance Plan.** If past and present experience
are any predictors of future events, it can be safely assumed that reimbursement under any insurance plan will be tied to discrete elements of service. Certification provides a mechanism that will identify nurses' qualifications for specific clinical expertise in discrete areas of service, and consequently, will lay the appropriate groundwork for securing direct reimbursement for nurses.

3. **The Need for Nurses to Exercise their Authority in Defining and Developing the Parameters of Nursing Care.** Because of time limitations I will not dwell on this point, but I will stress the absolute necessity for nurses to assert their right to define the standards and scope of nursing practice. This is a crucial issue which must be addressed far more aggressively than we have to date.

4. **The Attempt of Other Health Disciplines to Control Certification for Nurses.** This issue is, of course, related to Issue 3 and I will not go into a discussion of the issue of certification for pediatric nurse practitioners. It will suffice to say that they are being certified by a group outside of professional nursing.

Before I leave the topic of certification, I should like to say a few brief words about the utilization of the certification process by a profession. I was appalled during the 1976 ANA Convention to see and to hear administrators of nursing service demand that a process of certification be developed for them. We were fortunate enough to defeat a similar attempt on behalf of nurse educators and nurse researchers. It is essential for nurses to understand that certification is only one of several ways to credential an individual and although I believe it is the most appropriate way to credential nurses for specialized areas of practice, I also believe that it is absolutely inappropriate for nurse educators. Academic institutions have their own well developed systems for validating the ability, effectiveness, and *up-datedness* of their faculty. Which provides a logical lead into the next aspect of credentialing—accreditation of educational programs.

Accreditation is a process by which an agency or organization evaluates and recognizes an institution or program of study as meeting certain predetermined criteria or standards. Accreditation is a form of regulation or control that is exercised over educational institutions and/or programs by external organizations or agencies. It developed in this country as a procedure of *voluntary* self-regulation by peer groups of educators in contrast to the review and regulations of educational institutions as a governmental activity in other countries. The purposes of accreditation as they have evolved in this country are many and varied by the more important ones include:

1. Certifying that an institution has met established standards.
2. Assisting prospective students in identifying acceptable institutions.

3. Creating goals for self-improvement of institutions and stimulating a general raising of standards among educational institutions.

4. Assisting in the identification of institutions/programs for the investment of private and public funds.

Surprisingly enough, the functions of accreditation have never been directly identified as assuring the degree of knowledge or competencies of the institution's graduates. Such an outcome may be implicit in the functions attributed to accreditation, but it has never been made explicit. There are absolutely no scientific studies that validate any positive relationship between accreditation of educational programs and the degree of excellency of graduates. There have been studies on the success of graduates from certain academic institutions, but these studies have not attempted to relate "success" of graduates to the accreditation status of the institution. As a matter of fact, in nursing, there appears to be no positive correlation between the three forms of credentialing utilized—i.e., accreditation, certification, and licensure. I find this state of affairs distressing and probably symptomatic of certain deficiencies in our credentialing processes which should receive immediate attention. During the recent NLN Convention in Anaheim one of the speakers indicated that there was no difference in the performance on the certification examination in Psychiatric/Mental Health Nursing between candidates with doctoral degrees and those simply licensed as RNs. This is either a serious indictment against educational programs or against the validity and reliability of the certifying examination.

Accreditation of educational programs in nursing is currently assumed as a function of the educational Councils of Member Agencies of the National League for Nursing. I believe that the accreditation of schools of nursing is an appropriate function for the League based on the organization's defined purposes and structure. As strongly as I support the right of the ANA to certify nurses, and the right of state boards of nursing to license nurses, I am equally strong in my conviction that the NLN is the appropriate organization for accrediting schools of nursing.

My convictions are not founded on any blind loyalty to the League. I have heard the arguments pro and con and I remain convinced that accreditation of nursing education programs is not an appropriate function for the American Nurses' Association nor for any other purely professional association. The recent challenge to the approval of the Liaison Committee on Medical Education as the accrediting body for medical schools was based solely on the relationship of this committee
to the Council on Medical Education of the American Medical Association. My comments are not meant to imply that the current system of national accreditation as implemented by the League is faultless. Quite the contrary. There are serious deficiencies in the current structure and functioning of accreditation services, but unfortunately, none of the educational councils seem to be able to approach the problem in a holistic and objective fashion. However, deficiencies in a system do not alter the fact that accreditation is appropriately the function of an organization of educational institutions whose lay and professional representatives have similar backgrounds of knowledge, experience, and expertise to bring to the resolution of common problems.

**LICENSURE**

The last form of credentialing to be considered in this paper is licensure. Licensure is the process by which an agency of the government grants permission to persons to engage in a given profession or occupation by validating that those licensed have attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably protected. Although most sources attribute the forming of licensing boards to the professional associations, it is important to note that the first profession to be licensed was medicine and that the demand for assurance of the doctor's competency to practice was made by citizens, not doctors. In 1903, New York and Virginia adopted the first nurse practice acts to license nurses. Thirteen years later, forty states had enacted nurse practice acts. Today all states have such acts. From their inception, nursing practice acts have been permissive or mandatory. The permissive laws allow anyone to practice nursing in a state, but forbid the nonlicensed person to use the professional title. As of 1975, licensure was mandatory for registered nurses in all states except Indiana, Oklahoma, and Washington, D.C. and practical nurse licensure was mandatory in 39 states.

**The Purposes of Licensure**

Licensing acts are designed to protect the public from incompetent practitioners and consequently, such acts must contain a realistic definition of the practice which it seeks to regulate. Licensing boards are, by their very nature, consumer advocacy boards. They have basically two functions: 1. to establish entry level standards which will assure safe practice; 2. to monitor the continued competency and ethicalness of the licensee's practice. All other activities of nursing boards flow from these two functions.

There is no question that many health professionals misconstrue the purposes of licensure. Legitimate purposes for licensing a profession
or occupation are not related to establishing the "turf" rights of the group involved, advancing professionalization goals, protecting licensee's from undue competition, or providing a mechanism to assure social status. If licensing boards are sincerely dedicated to the purposes for which they exist, they may often be in conflict with goals or pronouncements of professional associations as well as with the perceptions of individual licensees. Unfortunately, licensed health practitioners tend to believe that a license, once obtained, is a God-given right. As you well know, ignorance is always difficult to cope with, but such ignorance on the part of individual practitioners should not be laid at the doorstep of the licensure system. The privilege of retaining a license carries with it specific responsibilities and commitments.

In February of 1975, the Board of Directors of the National League for Nursing approved a position statement on nursing licensure. The League's statement stresses the following points:

1. Licensure should be mandatory for RNs and LPNs.
2. Individual practitioners should be licensed, rather than institutions.
3. Nurse licensure should remain the prerogative of state governments.
4. Policy decisions regarding the practice of nursing require nursing expertise and should continue to be made by a separate licensing board composed of a majority of RNs.
5. Consumers should be appointed to serve on nurse licensing boards.
6. Where licensing boards have combined authority for RNs and LPNs, LPNs should be appointed to serve on nurse licensing boards.
7. A national standardized licensing examination should be administered by all state licensing boards.
8. Candidates for the registered nurse or practical nurse licensure examination should be graduates of their respective state-approved programs of nursing.
9. A continuing education requirement for the relicensure of nurses should be carefully planned and gradually implemented.

The above positions of NLN reflect my own convictions concerning licensure. As I reviewed the statement, it seemed as timely and appropriate today as it did two and a half years ago.
Licensing Boards Under Fire: Is The Criticism Justified?

One of the more complexing problems currently confronting nursing is the constant barrage of criticism against licensing boards and the untiring efforts on the part of state legislators, federal government, and other professions of the healing arts to control and manipulate nurse practice acts. Before examining the most crucial issues, let me make a few general statements about the existing state of affairs.

First, the criticisms being levied against licensing boards are couched in broad generalizations and no attempt is made to distinguish between licensing boards who may be functioning effectively and appropriately and those who clearly warrant the negative reactions they elicit. Nursing boards have an excellent track record. They are not guilty of the sins laid at the doorstep of licensing, but unfortunately, the critics have elected not to weed out the good from the bad. Consequently, nursing boards are subjected to the same negative stereotypes as other boards and criticisms have been leveled against them which are not warranted and cannot be validated.

Secondly, institutional licensure as an alternative method for credentialing nurses does not appear to pose a current threat to individual licensure. In the 1977 "Credentialing Health Manpower" report of DHEW, the Public Health Service has concluded "that the institutional licensure approach [because of the intense controversy that it generated] should not receive further consideration at this time." However, note please the modifier "at this time." I suspect that those wedded to the concept will survive to raise the issue again, some other day in some other way. I am not fully convinced that the sudden attacks on nursing boards from all sides is not part of a grand scheme to discredit boards so that eventually, alternative methods for licensing nurses will be perceived as much more acceptable.

Thirdly, that the intensified interest in the activities of nursing boards is directly related to the economic welfare of this country and the need to place people in a lucrative job market. The practice of nursing is perceived as the economic steppingstone for the rehabilitation of criminals, for the advancement of minority and disadvantaged groups, and for the utilization of ex-military personnel. To achieve this goal requires considerable alteration in existing nurse practice acts and in rules and regulations promulgated by boards of nursing. The hole in the dike has occurred. How long the dike can withstand the pressure exerted by that hole is a crucial question.

And fourthly, among the most destructive groups to our existing system of licensure are nurses themselves. External forces may never have the power to defeat us, but I am convinced that internal forces will.

Vital Issues Confronting Nurse Licensing Boards

And now let us turn to a review of issues confronting licensing boards and more specifically, nurse licensing boards. Time prohibits
consideration of all of the issues, but I will attempt to address those that may be of primary importance to this group.

The first issue is the current argument raging over educational requirements for licensure as a professional nurse and other levels of licensing for nurses. Before nursing expends too much energy over this issue (at the expense of far more crucial issues), consideration must be given to validating the inability of the current process of licensure to assure public safety and welfare. Are the health care needs of consumers of such a nature that nursing boards can not assure safe competent practice under existing practice acts? Do we need a change to protect the public from quackery, exploitation, or ignorance? Is nursing concerned with restraining incompetent and unethical practitioners, or is it concerned with upgrading the professional status or image of professional nursing? Decisions related to altering current licensing practices must be founded on nursing's concern for assuring safe, quality care for consumers at a reasonable cost. Professional status and professional image-building are laudable goals, but there are mechanisms of credentialing other than licensure that are far more appropriate for achieving them. I do not mean to imply that there is no need for re-examination of current eligibility requirements and licensure laws, but I do mean to caution you that changes must be based on proven consumer needs.

The lack of requirements to assure the continued competency of licensed practitioners is the second issue. I have been a strong and vocal supporter of mandatory continuing education for the relicensure of nurses and other health professionals since 1966. It was not a popular concept eleven years ago and the major reason for its acceptance by the nursing profession today is based more on pragmatism than altruism. The profession is aware of the fact that licensing boards have been strongly criticized for failing to assure competency and that other governmental agencies are prepared to take action if licensing laws continue to ignore this area of public concern. I don't know how many of you bear the scars earned from attempting to introduce mandatory continuing education amendments, but you see before you a badly scarred human being. I understand and sympathize with nurses who are fighting legislation, but I can not understand the posture of legislators who respond to the irrational fears of these nurses. Nurses have a right to fight for their own self-interest, but legislators have an equal obligation to the welfare of the residents of their states. Unfortunately, the behavior of most state legislators is appalling. They are blatant in their favoritism toward specific lobbying groups and are equally obvious in their attempts to manipulate the powers of licensing boards for their own political trade-offs.

The third issue is the reluctance of boards to exercise their police
powers and to ferret out illegal practices and incompetents. Among the health professional boards, medical boards are infamous for their inability or unwillingness to police the practice of physicians. One wonders what will happen now that we have turned physician assistants loose on society. The record of nursing boards in this area, contrary to the opinions expressed by Nathan Hershey, is not bad. Difficulty in policing the practice of licensees results from inadequate budgets to employ knowledgeable investigators and the unwillingness of nurses to monitor and report their professional peers. Yet peer monitoring is recognized as the responsibility and earmark of any profession. Although I believe nurses are better at reporting violations of the Nurse Practice Act to the board than physicians, I still believe that there is room for marked improvement in the assumption of this responsibility by nurses. There is no way for nurses to reconcile their claims as patient advocates with the coverup of incompetent practitioners.

The problem of legalizing the practice of so-called “nurse practitioners” who perform acts of medical diagnosis or medical therapeutics is another issue. Many boards of nursing are attempting to resolve this problem by developing rules and regulations (or legislation) to certify nurse practitioners as a subgroup of licensed registered nurses. There is precedence for the use of this approach by licensing boards—examples include nurse anesthetists, nurse midwives, physical therapists, etc. Unfortunately, as with many other board activities, the move to legalize such practice seems to have created mass confusion. Nurses practicing nursing under expanded definitions confuse themselves with nurses who are practicing nursing under expanded definitions but also performing clearly defined medical acts. Other nurses confuse the certification process of ANA (which carries no legal authority), with the attempt to legalize their practice by providing for certification within state practice acts. However, if you reflect on the purposes of licensing boards, to assure the safety and welfare of the public, concerned boards of nursing have very little choice in this matter. They must find an equitable system for validating the knowledge and competency of nurses performing medical acts or they must prosecute nurses for malpractice. Certainly boards of nursing may elect to use the ANA certification process as the basis for determining eligibility for legal certification by the state, but boards of nursing are responsible for establishing a legal process. Needless to say, efforts to do so are being opposed—understandably by physicians and physician assistants, but less understandably by nurses.

Attempts to usurp boards of nursing’s authority to establish pre-licensure requirements for licensure candidates is another problem. As you well know, these efforts have already resulted in the elimination of citizenship requirements and now appear to be focusing on the
board's right to establish educational requirements for state-approved schools of nursing, to determine passing scores on licensure examinations, and to limit the number of times that candidates may write examinations or the length of time between completion of a program of study and writing the licensing examination. The process of licensure must assure at least two things—that the candidate has the required knowledge and the skill to practice safely. Knowledge is tested by a written national examination. Assurance of required skill is certified by the administrative officer of an approved school of nursing when that officer signs the candidate's application. Approval of programs is the only method available to boards to validate a candidate's skills unless boards return to the practice of administering practical and written examinations. For states with six to seven thousand licensure candidates a year, administering practical examinations hardly seems feasible.

Privacy acts, right of information acts, fair trade laws all represent a whole new set of problems for boards of nursing. Unlicensed graduates are suing schools for not preparing them adequately enough to pass licensure examinations. Graduates are suing boards of nursing for sharing the results of their examinations with schools of nursing. Applicants to nursing schools are demanding access to information about the failure rate and the mean scores of schools' licensing examinations. All of the new and emerging consumer-focused legislation presents a whole new set of problems for boards of nursing to resolve. And I am not prepared to predict where any of it may end.

The last issue that I will discuss is related to questions concerning the actual content and structure of the licensing examination. As all of you know, candidates are required to pass examinations in Medical Nursing, Surgical Nursing, Obstetrical Nursing, the Nursing of Children and Psychiatric Nursing. The titles alone will probably assist you in perceiving the problem. If basic nursing programs are preparing generalists, then why are we testing discrete clinical areas of practice. If we test knowledge in these areas, the implication is that we must validate skills in all five of the clinical areas. This is becoming extremely difficult in at least three areas, i.e., Obstetrical Nursing, the Nursing of Children and Psychiatric Nursing. As a matter of fact, the educators in this audience are well aware of the fact that modern nursing education is not structured on discrete clinical areas of practice and that your students and your faculty are running themselves ragged in their attempts to combine the education of a generalist with the requirements for specialized areas of practice.

Questions have also been raised about the reading level of the examinations and the timing of examinations. Candidates are refusing to take the sixth examination, which as you know, provides the necessary pre-testing phase for standardization of new examinations.
And last but not least, boards of nursing are being pressured to develop examinations in foreign languages. The major thrust is on producing the examinations in Spanish or permitting translators to read the examination to licensure candidates.

As previously stated, this is not an all inclusive list of the issues confronting licensing boards in today's rapidly changing society. Licensure and boards of nursing are under constant attack and I can not begin to convey my concern over the apathetic and even destructive behavior of our fellow nurses. It is difficult to understand our inability to muster the support necessary to defend what we purport to believe in. Without renewed interest, dedication, and support of what you believe to be essential for the credentialing of nurses, our whole system of credentialing will continue to lose ground.
LICENSURE, CERTIFICATION, AND ACADEMIC DEGREES

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The purposes of this paper are two-fold: to present an overview of the uses of credentialing by the professions and technical occupations; and to explore the broad social uses of credentials. This is the perspective from which I will approach my topic and, in the process, will argue that nursing should adopt the same approach. My discussion draws heavily upon the deliberations and the draft report of the American Council on Education Task Force on Educational Credit and Credentials, and related working papers. The Task Force will report later this year.

I would like to establish the background for the discussion by quickly reviewing the credentialing scene in the United States, the social reasons for credentials, the types of credentialing authorities and the purposes of the credentials they confer, and the process of credentialing.

THE REASONS FOR CREDENTIALS

First, we live in a mobile and complex society that is supported by a highly technological economy requiring esoteric services and skills. Members of society require assistance in identifying the qualified and want protection against the incompetent and the fraudulent.

Second, since the advancement of the human condition is dependent upon the expansion of knowledge and its application to human and environmental problems, learning and the attainment of competency should be encouraged and rewarded. Credentials identify the talented and provide a basis for rewards.

Third, the credentialing process also tends to identify and sanction a
body of knowledge and skills that society deems important to the commonweal. That body of knowledge and skills establishes professional identity, which in turn encourages social subgroups to advance their own interests, hopefully in a manner consistent with the social interest.

Credentials issued by government agencies, voluntary associations, and educational institutions, then, generally accomplish these purposes by identifying the qualified, encouraging learning, and sanctioning a body of knowledge and skills. That leads me to a brief discussion of the types of formal credentials in our society. Take special note of the pluralistic control of credentialing.

**TYPES OF CREDENTIALS**

**Certification, Licensure, or Registration Issued by Government Agencies**

Frequently referred to as a license, such a document is evidence of the state's permission to engage in a specified activity. It is issued to those meeting certain requisites, usually after examination. Practice by the uncredentialed is often, but not always, prohibited. Thus, government credentials may be mandatory for practice or they may be advisory in the sense that the holder, in the view of the state, is qualified to engage in certain activities. Keep in mind the *advisory concept*. It is important in the discussion that follows.

**Certification or Registration Awarded by Voluntary Organizations**

These documents are issued by occupational and professional organizations, attesting that the holder meets certain requisites or occupational standards. That could be ASCP registration for a medical technologist or an M.D. specialty certified in a practice area. The credential is an advisory opinion by the issuing agency that the holder is qualified to engage in specified practices. It has the authority of government behind it only when specified in legislation or regulations. It may duplicate, supplement, or complement credentials issued by government agencies.

**Diplomas**

Attesting to degree or certificate status, diplomas are conferred by educational institutions for successful completion of a specific program of study or for equivalent accomplishment. Educational credentials may be an award for educational accomplishment, or an advisory document regarding qualification for employment, or both. In some cases, a degree or certificate from an accredited institution may be one requirement in qualifying for governmental or voluntary credentials.
DISTINCTIONS BETWEEN TYPES OF CREDENTIALING

Special note should be made of the difference between an educational credential and voluntary or governmental certification. Because of time limitations, I will limit my comments to educational credentials designated as degrees at the undergraduate level. Traditionally, degrees have included at least three areas of accomplishment:

1. Accomplishments specified by the awarding institution as necessary to be a broadly educated person.
2. Sophistication in analytical, communication, quantitative, and synthesis skills.
3. Accomplishment in a specialized area of study covering a set of integrated learnings requiring analysis, understanding of principles that have judgmental application, and a theoretical knowledge base.

It will have to suffice to say that the hallmark of occupational programs using the degree as a credential should be a liberal or general education base that enhances competent judgment and application of knowledge in the work setting in a way that takes into consideration all the facets of the human environment. That distinction, in my view, separates the professional from the highly competent technician.

Thus, the purposes of educational credentials go beyond those issued by governmental and voluntary associations. Like voluntary and governmental credentials, educational credentials also assist in identifying the qualified and sanctioning a body of knowledge and skills. But as society's highest recognition for learning, they also undergird intellectual standards, encourage learning in the most difficult and rigorous areas, and serve to broaden the knowledge and skill base of people who pursue degrees as an educational objective.

THE CREDENTIALING PROCESS

Credentialing involves three parties: 1. the authority issuing the credential; 2. the individual issued the credential; 3. persons, groups, or agencies which benefit from or use the judgments of the credentialing authority. It involves four principle steps: 1. definition of the attitudes, competencies, experiences, knowledge, or skills to be certified; 2. identification of the requisites necessary to qualify for the credential; 3. assessment of individuals to determine whether they meet the requisites; 4. issuance of a document to witness the individual's possession of the requisites. Increasingly and ideally,
credentialing may involve a fifth step: periodic recertification that the holder continues to possess the requisites for the credential, or has achieved new ones made necessary by advances in the field.

THE PRINCIPLES AND MEANING OF CREDENTIALS

I come now to what I believe is the most misunderstood aspect of credentials: their meaning. Perhaps it would sound less arrogant if I phrased that another way. The meaning of a credential, particularly its limitations, is not fully appreciated.

My discussion of this point is taken from a draft of the Final Report of the ACE Task Force on Educational Credit and Credentials, as follows:

A valid credential means the issuing source has evidence of the holder's qualifications which entitle him to authority and confidence within the area certified. It does not guarantee adequate performance by every person credentialed or by any credential holder in every given situation. It is an expression of the central tendency of the body of those deemed qualified to deliver adequate services with substantially more consistency than the noncredentialed. Given the difficulty of defining and assessing the necessary requisites for delivery of esoteric services, credentialing cannot be expected to provide absolute protection to society. It has social utility because it increases the likelihood of delivery of satisfactory services.*

While I have long-accepted the notion that credentialing is socially useful and necessary and that its advantages far outweigh its disadvantages, I did have to confront some questions. Outlined in a paper for the Commission on Education for Health Administration in 1973, these questions include:

1. What attitudes, competencies, experiences, knowledge, and skills can be validly, reliably, and usefully credentialed?

2. When is it in the interest of society to credential?

3. Who should be the credentialing authority?

I noted then, and I underscore it now: there are no universally accepted answers to these questions. But there are some principles, I believe, that could be identified to guide the considerations. With some modification from the earlier writing, those principles are also contained in the draft of the Task Force Report. They are as follows:

*The text cited here is from an early draft of the Final Report of the ACE Task Force on Educational Credit and Credentials. The final wording may vary considerably—in content, scope, and emphasis—from that printed here. Readers should therefore not infer that the statement represents the opinion or position of any member of the Task Force or the Task Force as a whole.
1. Credentialing should seek to minimize risks to the public health, safety, and welfare by identifying the qualified.

2. Credentialing which recognizes and encourages pride in accomplishment and the mastery of knowledge and skills is in the public interest because it contributes to the advancement of society and the improvement of the human condition.

3. Mandatory credentialing should be exercised only where there is a demonstrable relationship to the health and safety of the public.

4. Credentialing is substantially involved with the system of economic and social rewards in society. Therefore, it is incumbent upon all credentialing systems to recognize pertinent requisites, regardless of how or where they are achieved.

5. Credentialing activities of agencies and institutions, whether they are governmentally or publicly controlled or sponsored by occupational and professional organizations, substantially intersect the public interest. Their policy-making and governing boards, therefore, should be representative of broad social interests.

6. Credentialing intimately related to the health and safety of the public should periodically require proof that the credentialed still possess the necessary requisites and have kept pace with advances in the field.

**PROBLEMS**

The major problem in credentialing rests on three points: 1. it is heavily dependent on professional subjective judgment and group values; 2. it is substantially handicapped by limitations inherent in the evaluation of human endeavor; 3. it is ripe with potential for abuse by professional groups which control voluntary certification, tend to control licensure, and also exert enormous influence on educational institutions through the process of programmatic accreditation.

Lest I be misunderstood, I believe professionalism is in the best interests of society, but I am not so naive that I believe that the professions can always be counted upon to act in accordance with the commonweal. George Bernard Shaw has asserted that professions are a conspiracy against the public. I disagree, but I also believe they warrant watching. I do not believe in benevolent professions anymore than I believe in benevolent dictators—a rather risky comparison, but it does make my point.

If history teaches us anything, it teaches us that power tends to corrupt. At least we should tend to be suspicious of power. Our democratic government is structured on that premise. Yet in credentialing, society is largely at the mercy of the professions, and
increasingly so, in identifying those qualified to deliver essential services that, if provided by the incompetent, could have a negative impact on the public health and safety. That, because—put in the vernacular—it takes one to know one.

Previously, I noted that credentialing in American society is under pluralistic control. This is an appropriate course for a democratic society and one we ought to encourage. Beyond that, however, it is appropriate because we need a balance of power in credentialing to keep it from being used in ways that are not in the public interest.

Although government has the ultimate responsibility for credentialing, its activities are mainly restricted to mandatory credentialing that is essential to protect the public health and safety and the body politic from fraud. The works are legion which tend to show that governmental licensure, in and by itself, is not the sole answer. I would argue, however, that in many fields it is essential.

But, in my view, it is also good social policy to encourage the credentialing role of voluntary associations. Properly sensitive to their social responsibilities, voluntary associations can continue to serve society and their members by identifying attitudes, competencies, knowledge, and skills which can be defined, communicated, learned, and assessed and which the associations believe are generally essential to the delivery of adequate services in its field. Their advisory credentialing functions are useful in establishing occupational identity, promoting pride in accomplishment, and advances in the field, and in encouraging self-regulation as an alternative and balance to governmental control.

Educational institutions, even though their programs have close professional ties through faculty and accreditation, also have an important social role in credentialing. Throughout history, a principal role of the academy has been to provide a place in society where contemplative, analytical, and scholarly activities could be encouraged and nourished. To advance the understanding of a culture, the environment, or a professional specialty, and to transmit this knowledge to others has been an end in itself, establishing the life of the mind and education as a high calling. The academy traditionally has maintained its own set of values that are not always congruent with those of society and which most often go beyond the more narrow practical concerns of a given profession.

I hope the natural tension that has traditionally existed between the academies, the professionals, and licensure agencies continues. It's some evidence that no one has absolute control over the others, and that there may be some balance of power in operation. Out of that (some have called it creative tension), I believe, comes progress over the course of human affairs.
ISSUES AND RECOMMENDATIONS

I come now to issues in credentialing. I see three: 1. membership on policy-making boards; 2. improving task analysis and measurement of practice requisites; 3. continuing validity of credentials.

Policy-Making

I have been an observer of the professions and their organizations long enough to note that there is too much overlap among those who educate, those who accredit, and those who sit on licensure and specialty registration boards. If the pluralistic aspects of credentialing are to be permitted to continue, some remedies are in order. In that respect, I need only note that the Federal Trade Commission has discovered the professions. First, it was medicine and now, accounting. There will be others.

I have advocated opening up membership on policy-making bodies for a long time. Members from related disciplines and others generally knowledgeable about credentialing, relationships among the professions, and who have nothing to gain from their actions and decisions can go a long way in boosting the credibility of credentialing whether it be governmental, voluntary, or educational. And, I suggest, such broader membership will help improve the quality of decisions, though we have to continue to rely primarily on knowledgeable professionals. I would like to see nursing lead the way.

Validity

The second major issue I would identify in credentialing is validity. Malpractice suits have become commonplace in health care, though I sense some waning in numbers. Such litigation, I note with considerable glee, is spreading to law. There have been an increasing number of court suits attacking various aspects of credentialing. My layman's reading of the decisions, corroborated by a close friend who is a respected legal scholar in this field, suggests no definitive trend. Nonetheless, I believe all three areas of credentialing will come under increasing pressure to delineate more specifically the meaning of the status conferred. I am certain that is the trend in educational credentialing.

I suspect the science of task analysis and description, and proficiency measures are substantially ahead of their application in many areas of credentialing. I think it wise that all the professions, and educators in particular, give increasing attention to this area to ward off further governmental activity.

Recredentialing

The third major issue is recredentialing that assures practitioners are keeping pace with developments in the field and, indeed, are advancing their skills commensurate with their experience. Nursing, I hear, has this one under consideration.
I sense too great a reliance on participation in continuing education programs as a means of assuring that a practitioner has kept pace with developments in the field. I believe there is a principle we follow in obtaining the threshold credential that has merit for recertification purposes, namely that without direct examination of the person to assure that they have requisite knowledge and skills, the credential has little meaning. Recredentialing, if it is to have credibility and meaning, will have to follow the same tack.

**SUMMARY**

In summary, I believe that our pluralistic approach to credentialing—governmental, voluntary, educational—serves a democratic and free society well by providing an informal system of checks and balances and by diffusing control. It allows professional groups to make their unique contributions and allows the academy to follow a tradition that has served society well. It can minimize the ever-growing government presence in regulation and control.
THE COMING CRISIS FOR NURSING FACULTY: JOINT APPOINTMENTS IN A PRACTICE DISCIPLINE

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RETURNING PRACTICE TO EDUCATION

In the event that future licensure and credentialing will require nurse educators to demonstrate currency and excellence in nursing practice—and if nursing faculty do not qualify—then the entire profession of nursing will be in crisis. Yet those that are most current and excellent in practice should be the teachers. If new licensure and credentialing developments stir us to return practice to education, we will indeed make progress.

Returning practice to education is certainly not an original idea. I vacillate from thinking that the idea is either obvious, heretical, or on the positive side, visionary. Perhaps, in reality, all these thoughts are applicable, and they simply reflect the dilemma of nursing in its efforts to ensure relevance in nursing education. Relevance, I believe, is made possible by reconsidering faculty's relationship to service.

The distinct function of faculty is teaching students. Singling out teaching is not intended to slight faculty's responsibility for theory-building, research, consultation, and committee work, but simply highlights the raison d'être of faculty. Primarily, I hope my faculty colleagues and I will accomplish the following regarding our students: 1. facilitate their acquisition of knowledge, judgment, and skills which enable them to assume nursing positions with reasonable productivity and comfort; 2. aid their development of a method for continuing to grow professionally by analyzing and reflecting on one's own practice for the purpose of modifying and advancing theories and skills. Basically, I am concerned that students entering a work situation are able to practice, rather than expending energy dealing with feelings and problems evoked by one's own inadequacies, or by the discrepancies between the ideal and the real world.
THE GAP BETWEEN IDEALS AND REALITY

Our suspicion that nursing education has not been providing the student with relevant education is confirmed by the work on reality shock by Kramer. There is very little doubt that the ideal and real worlds in health care do not overlap. The new graduate's entry into the health care work system is perilous. While she may quickly internalize the prevailing values and behaviors, the student is seldom successful in spearheading change. Clearly, formal nursing education, to a significant extent, is not relevant.

There are historical and valid reasons why nursing education falls short in fulfilling its mission. Over many years, it has been important to identify and deal with issues on a national basis. Solutions and change have not come quickly. We have been absorbed with the placement of nursing education in the appropriate academic setting. This process has required increased academic preparation of faculty and the assumption of responsibilities inherent in academia. It is not surprising that faculty's involvement in clinical practice diminished.

The difficulties in transposing nursing education from hospital-based settings to academic settings were compounded by the emergence of the associate degree and graduate programs in nursing. Considerable amounts of faculty time and effort have gone into identifying and differentiating curricula for the three levels of nursing programs. Within and among these levels, curricular changes have been substantive, as indicated by the move to an integrated curriculum on the baccalaureate level and toward clinical specialization on the graduate level. But the pendulum continues to swing. Undergraduates need more clinical experience. Graduate students need skill in more indirect functions.

In this highly complex, unsettled state, perhaps the most important issue of all is lack of unanimity and clarity about nursing regarding its purpose, process, and expected outcomes of practice. The emphasis on this issue during the late 1950s and early 1960s was replaced by the emphasis on expanded and extended roles. Concomitantly emerging health fields also demanded our attention and forced us to realign our own functions, as well as relate to the new health care workers.

With all of these circumstances and change, it becomes alarmingly obvious that more has been done around and for the practice of nursing as compared to the attention and emphasis which have been placed on practice itself. And yet, it is the practice of nursing that we purport to teach students.

The lack of relevant education for the student may in part stem from

the difference between what is taught and what applies in the real world. Faculty have had little time to test theories clinically, yet they pass untested theories on to the student. Because the student has so little opportunity to apply a theory, its inapplicability may not surface until the student begins practice. At that time, the neophyte must try to function in the real world. If there is a disparity between what was learned and what appears to be practiced, she will all too frequently adopt the attitude of, "In Rome, do what the Romans do." Thus, the education provided by service supercedes that provided by the formal educational program. Moreover, the hope of faculty for affecting changes in service by their former students is shattered.

PRACTICE: ITS RELATIONSHIP TO TEACHING VALID THEORIES

This state of affairs requires that we look more closely at education. Argyris and Schon reinforce the idea that practice is an important ingredient in teaching. They submit the view that the current practice experience of faculty is basic for the reflection and analysis of practice, out of which theories to teach are validated or emerge. Argyris and Schon differentiate between espoused theory and theory-in-use. An espoused theory is what one says should be done in a given practice situation, as compared to theory-in-use which is what actually determines what one does in a situation. When these theories are not congruent and if one teaches espoused theories, relevance for practice is sacrificed.

In order for the espoused theories to be congruent with theories-in-use, two conditions must exist. First, the practitioner must be clear about what constitutes effectiveness in nursing, and second, she needs to reflect upon and analyze the nursing experience for identifying the circumstances, actions, and their relationships which contribute to outcome. Articulating the implicit constitutes theory-building. Focusing on conflicts and incongruities in the real situation leads to the identification of significant theories.

Kramer recognizes that the student needs in her formal preparation

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2Chris Argyris and Donald A. Schon, Theory in Practice: Increasing Professional Effectiveness (San Francisco: Jossey-Bass, 1974).
3Ibid., pp. 6-7.
6Argyris and Schon, Theory in Practice.
the means for resolving conflicts between the ideal and real world in nursing. Toward this end, Kramer states "they [the faculty] themselves must have had nursing practice experience in which they faced the challenge of the conflict and worked it out in a constructive way." For this process to be useful to students, faculty must analyze their experiences and distinguish between espoused theory and theory-in-use.

This process is ongoing and never ending. In other words, faculty must continually examine their theory in the practice situation. This is important for two reasons. First, technological and social changes occur so rapidly that the nurse is constantly challenged by new situations. Only through clinical validation will we know if espoused theories are applicable. The second reason shows my optimism for the professional development of nursing. As we in nursing gain in our ability to nurse more effectively, the clinical situation will change and we will, in turn, change the focus of our theories. I envision that as effective theories-in-use alter nursing practice, we will reach a point where we spend far less practice effort on conflict situations and much more on innovative care for patients. The nursing provided to a breastfeeding mother in the hospital serves as a good example of a collision between the ideal and real world. For many of us in maternity nursing who care for breastfeeding mothers, reflection and analysis of clinical situations reveal that much too frequently our nursing practice focuses on reducing conflict between those who support breastfeeding and those who do not.

THE RELATIONSHIP OF FACULTY TO CLINICAL PRACTICE

At this point, I wish to discuss the crucial requirements of faculty's involvement in clinical practice. Of prime importance is that the main portion of a nurse educator's clinical practice take place in a setting in which she is an identified and recognized member of the health care system.

This requirement is necessary because of the nature of nursing, which is far more than a dyadic relationship with a patient in a vacuum. Instead, it involves and requires interaction between the nurse and a complex system which includes and operates for the benefit of the patient. In order to apply and advance theory in relation to practice, the faculty member must interact within the system as a nurse, not as an outsider who comes and goes at will and who does not learn the system sufficiently to perceive and react as a member of the system.

Perhaps several personal experiences will serve as illustrations. Knowing how to fill out forms, where to find equipment, or how to make a new gadget work are the kinds of things that I find vary from site to site and from week to week. It is true that I can ask or look up how and where, but this process interrupts the focus of my attention and blinds me to experiencing nursing practice as those in the setting experience it.

Being up to date includes not only familiarity with the setting, but also being current in practice with technical skills. This means not allowing previously learned skills to become rusty, in addition to acquiring new skills as they become accepted and expected practice.

In addition to the effect which lack of orientation has for the faculty by diverting attention from practice to one's own learning, orienting activity also influences how those inside the system view the outsider. I am fascinated by the title, "A Guest in the House," by Glas, and indeed many nurse faculty are just that—guests. Glas skillfully and insightfully identifies the cross-pressures in which the guest becomes entangled as she endeavors to reconcile the various conflicts between guest and staff status. Attending to conflicts by faculty and students (who also get caught up in the entanglements), hardly expedites the teaching and learning of nursing practice. Moreover, guests are not expected to have responsibility for the direction of nursing care. But, as members of the system, they would. As insiders, faculty could participate in increasing nursing's effectiveness rather than remaining on the periphery and perpetuating the disdain that nursing education and service have for each other. The outcome should be a setting for student learning more closely in line with the ideal or a demonstration of why the faculty's ideal cannot become reality.

With the disadvantages of the guest role, it seems logical to reverse the trend, if at all possible, back to the faculty member being "at home." By suggesting faculty involvement in service activities, I am very aware that it is in conflict with nursing's efforts to separate service and education. Our nursing history documents the hazards of combining service and teaching responsibilities, as well as the efforts to separate the two functions. The pitfalls of separatism, however, are serious and warrant reconsideration. Indeed, this reconsideration has in fact been


5Committee for the Study of Nursing Education, Nursing and Nursing Education in the United States (New York: Macmillan Company, 1923).
occurring sporadically throughout the past twenty years. My concern, however, is that we must now make speedy and more consistent progress in clarifying the relationship of faculty to practice and nursing service.

RESTRUCTURING THE ROLE OF NURSE FACULTY

In reinvolving faculty in practice, there must be a restructuring of the role which the nurse assumes as a faculty member. Common to all nurses is the direct nursing function of providing patient care. When indirect functions are combined singularly or collectively with direct care, roles should not blend and become similar. They must be different.

The challenge for nursing is to structure the role of faculty so that it becomes workable, has its own value system, and subsequently will have its own role models. It needs to allow for practice, teaching, research, and other scholarly and educational activities which are inherent in faculty responsibilities. In essence, we need to recover the most essential function—practice—and at the same time determine how to incorporate other functions attributed to faculty into the role.

Our slowness in restructuring the faculty role might stem from our inability to date to deal successfully with dilemmas which are invariably encountered when faculty assume practice responsibilities. It has been of some comfort and a great deal of interest to find that my colleagues in various parts of the country are struggling with the same problems I have confronted. I do not profess to have identified all possible dilemmas which joint appointments between service and education or a triple commitment of practice, teaching, and research.


create, but I wish to discuss the problems which I believe are most important and amenable to change, and then present some recommendations.

PROBLEMS AND RECOMMENDATIONS

The first dilemma is the necessity to allocate large amounts of time to nursing practice when time is a precious commodity for faculty. Nursing, by its very nature, requires patient care involvement around the clock. Services are frequently patterned by eight to ten hour shifts or by half-day clinic sessions. I recognize the merit of flexibility of schedules for nurses in special fields, but I believe a fundamental part of nursing is "in being there" in case the patient presents a need for help. Indeed, as we in nursing increase the extended role functions, we must be careful to preserve this fundamental distinction of nursing. In addition to being available for scheduled blocks of time, nursing also requires follow-up in many instances. For example, a commitment to a half-day clinic may become a commitment to a week of intermittent follow-up on lab reports, consultation, patient telephone calls and so forth.

A second dilemma is created by the demands of diverse activities inherent in combining practice, teaching, and research. Doing so, I am convinced, leads to what I call the "overwork syndrome of the nurse-juggler." This syndrome is characterized by fatigue and frustration of trying to perform too many functions in too short a time for too long. The etiology is easily identified: we race from activity to activity, many of which should not occur serially, and none of which should occur simultaneously.

A third dilemma comes from spreading one's intellectual activities too broadly. Nurse-midwifery illustrates this well. The field now encompasses not only normal obstetrics but also family planning and neonatology, any one of which is difficult to keep on top of. To be sure, competence in all areas should be maintained in practice. It is impossible, however, to be equally expert and knowledgeable in all areas to the depth that is required for teaching and research.

A fourth dilemma is the inevitable stress which is created when faculty reenter the clinical area following periods of absence from practice. The necessity and validity of the absences for activities such as research and doctoral study do not offset the discomfort of admitting rustiness and ignorance in a setting where others act as though faculty should always be the epitome of excellence.

My recommendations for change revolve around joint appointments for faculty. Simultaneously, faculty should be appointed to the school of nursing and to a nursing service. Thus, regardless of specific
functions and allocation of time, there will be commitment to the performance and productivity of both institutions by faculty, as well as the acceptance of faculty by the service.

My first recommendation is that long range planning occur. As we have moved nursing education into academia, we have assumed the responsibilities implicit in faculty appointments but have failed in our efforts to recognize and put them all together. And therein, perhaps, lies the answer. We cannot put them all together at one time. Instead, there needs to be deliberate grouping and sequencing of activities for a specific group of individuals.

A means for deciding how to group and sequence faculty activities is to identify faculty functions which do or do not go well together, their individual time frames, as well as when and how often the functions must be performed. The compatibility of functions is crucial and often overlooked.

For example, if clinical practice requires a series of eight-hour shifts, it is unreasonable to place any other demands on the faculty during that time. The most we should expect is that she reflect on practice experience and jot down ideas for validating or developing theory. Another example of an activity that requires almost 100 percent concentration is during the stages of research and writing. Activities which require creative, analytic thinking suffer from interruptions. The amount of necessary free time will vary according to the complexity and magnitude of the task to be accomplished—it may range from a day to a week to an entire quarter or semester. Individual faculty must help project time requirements.

Combining compatible functions which nurse faculty would juggle within the same time period requires careful consideration of many factors. Capability of faculty, developmental stage of activities, emotional stress associated with an activity, and estimated time of activity are examples. In any event, all of the functions would be characterized by fairly predictable time assignments and content areas which should be familiar to faculty or fairly readily handled. Examples of functions which might be logically combined could include limited clinical practice, perhaps one day a week with others doing the follow-up, a reasonable teaching load, student advisement, and various committee obligations. The risk one takes, however, with multiple functions, no matter how compatible they might be, is that too many may be combined or that an unexpected one may crop up. We must protect ourselves by having unallotted time for such contingencies.

Nevertheless, once all functions have been grouped and those which must be done at specific times have been identified (such as teaching and administrative activities), then it is time to put them all together. This requires reviewing the commitments of the faculty within a highly interrelated and interdependent group of individuals which often
seems to be a nursing specialty group.\textsuperscript{15}

Taking into account all commitments rapidly demonstrates the need for long range planning. Faculty will have to schedule research and writing functions, and also some clinical practice, in relation to others' needs. Thus it may take as many as three years for a faculty member to demonstrate productivity in all areas of responsibility. We have usually been impatient, expecting productivity without providing the necessary time to enable faculty to be productive.

Long range planning may justify the need for additional faculty. On the other hand, effective planning may facilitate better utilization of existing faculty. It is also important to acknowledge the potential financial source of service unit budgets. If the faculty's practice is of value, it is reasonable to expect some type of financial responsibility by service.

An important condition of long term planning is faculty and administration's commitment to appointments of more than one year. A minimum of three years would be helpful in allowing faculty time for engaging in research projects.

Another recommendation I propose is that a distinction be made between a nursing specialty and a subspecialty. Practice usually relates to a specialty: e.g., nurse-midwifery—but a subspecialty within nurse-midwifery might be family planning, newborn care, care of the adolescent mother. For the sake of economy of time and the promotion of scholarly work, I believe that a faculty member should choose a subspecialty as early in her career as possible.

My final recommendation relates to decision making. If faculty members are to be involved significantly in a service setting, they should participate in the policy decisions of that service. Likewise, all faculty should participate in educational policy. Policies related to implementation, however, might be more efficiently made by small groups of faculty members whose schedules and activities overlap or cluster.

\textbf{CONCLUSION}

In order to achieve relevance in nursing education, the \textit{sine qua non} of faculty activities is practice. Having singled out practice, I quickly emphasize that faculty exist because of teaching and research responsibilities. The point is, however, that the inclusion of practice is essential. It is from practice that faculty learn to teach and what research questions to ask.

\textsuperscript{15}\textsc{Schlotfeldt and McPhail, "An Experiment,"} pp. 284-285.
Furthermore, if we are functioning well as nursing faculty, we will be engaged in practice. We will be current and we hope we will be moving toward excellence. We should, therefore, have no difficulty at all in terms of licensure and credentialing, if they are defined by currency and excellence.
CREDENTIALING STUDY IN NURSING: A FUTURISTIC VIEW OF LICENSING AND CREDENTIALING*

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As more people become aware of the Credentialing Study in Nursing, it seems reasonable to assume that input will increase. The more input we have regarding the goals and expected outcomes of the project, the greater the chances of success. Before attempting to resolve any given issue, however, it is always necessary to start from a basic and common understanding. Bearing this in mind, it seems appropriate to discuss past and present events before I offer some speculations on the future of credentialing.

BACKGROUND OF THE CREDENTIALING STUDY

The 1974 American Nurses' Association (ANA) House of Delegate's resolution "to examine the feasibility of accreditation of basic and graduate education," gave impetus to the consideration of all of the credentialing mechanisms in nursing and highlighted the need to explore the adequacy of those mechanisms for assuring quality health care to the larger society.

Pursuant to the ANA resolution, the ANA Commission on Nursing Education sponsored three conferences on accreditation. While the resolution addressed the limited context of "accreditation," the presentations and discussions during the first invitational conference at Denver, November 18-20, 1974, revealed that accreditation is intricately interrelated with other considerations of credentialing, such as

*Much of the material in this presentation is taken directly from the Project Proposal which serves as a base for the Credentialing Study.
licensure and certification of individuals and agencies. These credentialing mechanisms also function as a means toward the overall goal of assuring the quality of nursing's contribution to health care for the public. Therefore, the outcome of the ANA invitational conference on accreditation was the recognition of the need to link program accreditation to the larger whole of quality assurance through the various credentialing mechanisms and to formulate a proposal for studying the adequacy of those mechanisms and for recommending future directions.

At the second conference in New Orleans on January 15-17, 1975, the conferees developed a draft of a proposal for a study of credentialing in nursing, based upon an outline developed by a sub-committee of the group composed of Mary F. Liston, Mary K. Mullane, and Margretta M. Styles. In August, 1975, the ANA contracted with the Center for Health Research, College of Nursing, Wayne State University, to complete the proposal, utilizing the documents emanating from conferences, including a draft prepared by William Selden in February, 1975. A proposal committee established by the ANA Commission on Nursing Education met at Wayne State University, College of Nursing on September 20 and 21, 1975, to further extend the work on the proposal and conferred briefly by phone on October 24. Dr. Margareta M. Styles, Dean of the College of Nursing, Dr. Jean E. Johnson, Director of the Center for Health Research, and Center Staff completed preparation of the proposal for submission to the ANA. This proposal is the basis for the Credentialing Study in Nursing.

Types of Credentialing

Historically, credentialing mechanisms for programs or individuals have been designed to provide quality care to the publics they serve. The most generally recognized credentialing mechanisms are accreditation, certification, and licensure, as defined below and are taken from the Study of Accreditation of Selected Health Educational Programs (SASHEP) Report.

Accreditation is the process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. It shall apply only to institutions and their programs of study or their services.

Certification is the process by which an agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

Licensure is the process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or use a particular title or grants permission to institutions to perform specified functions.¹

However, there are sometimes more subtle types of credentialing. Registration, for example, has been defined as the process by which qualified individuals are listed on an official roster maintained by a governmental or nongovernmental agency.

Degree Designation, another type of credential, is defined by Wooten as an officially recognized grades or steps in one or more branches of learning; such official recognition being manifested by the bestowal of a title on the person by whom the step has been made. Although the definition is taken from a document from the nineteenth century, it has consistently been accepted throughout the twentieth century and indeed goes back some eight centuries. The exception is that prior to the seventeenth century, the baccalaureate degree was not defined as above, but was used for matriculation purposes only. This is still true in some of the European countries.

Approval is another very subtle credential. Its value and meaning depends on the source of the approval and the standards on which the approval is based. It is defined for the purposes of this study as the recognized status of an agency or institution for a particular function.

Such credentialing mechanisms serve a variety of publics, including the consumer of the services, the consumer of the educational programs, the consumer of educational products, and the professions or vocations themselves. Nursing, like other professions, has used these credentialing mechanisms largely for quality assurance, but also for purposes of information and identification. In some instances, credentialing mechanisms have been used selfishly, such as in establishing territorial rights in the universities' use of clinical facilities.

Organized nursing as we know it today evolved during the mid-nineteenth century in England. Nurses' leaders in the western world recognized that standards for individuals, schools, and services were necessary, and further that standard setting was meaningless without the measurement of performance based upon those standards. Periodically throughout history, different groups have reached this position and taken action. The system appears to remain stable for 100-200 years when it falls into disuse and the cycle begins again.

Maintaining Effective Credentialing Mechanisms

To maintain reasonable assurance of quality of nursing care for the general public, credentialing mechanisms in nursing have been developed, revised, and transformed over the past seventy-five years to meet the changing needs of society and of the nursing profession. In some instances, changes have been instituted or proposed by an

organization, or the government within one state, with little regard for the development of a coherent and efficient credentialing system. An uncoordinated approach to certification not only tends to devalue the credential, but also creates divisiveness within the nursing community making us vulnerable to outside forces. If we are to survive as a viable profession in control of our own destiny, we must take time to study the problem and to create an orderly credentialing system—one which is coordinated, comprehensive, realistic, operationally and financially feasible, representative of broad public interest and consistent with related credentialing systems. Further, it must be professionally autonomous and have broad acceptability within nursing and related health occupations. Such a credentialing system must be dynamic, based upon built-in review and evaluation mechanisms of the total system.

The above description emerged from the serious deliberations of many of our current leaders in several different meetings. Again let me reiterate some of the more pertinent historical events leading to the study:

In 1973, the ANA established an ad hoc committee on accreditation for continuing education programs. In 1974, the ANA House of Delegates adopted a resolution to move with all deliberate speed to establish a system of accreditation for continuing education programs in nursing, and to move just as expeditiously to examine the feasibility of accreditation of basic and graduate education and ... to seek the cooperation and assistance of SNAs (State Nurses' Associations) as is appropriate and necessary in this critical effort.

As a consequence, the American Nurses' Association invited representatives of the National League for Nursing and the American Association of Colleges of Nursing to meet with representatives of the ANA to plan two invitational conferences which would be convened by the ANA Commission on Nursing Education, for the purpose of discussing and planning a cooperative study of accreditation in nursing. As a result of this planning, invitational conferences were held as noted earlier. The participants included a broad representation from the field of nursing education and practice, from nursing organizations and government agencies, as well as several individuals from organizations involved in credentialing in other professions.

**PROBLEMS IN ESTABLISHING A CREDENTIALING SYSTEM**

But activities, like streams of water, cannot be stayed, for in spite of the understood need for planning, in August, 1975, the ANA implemented a mechanism for accrediting programs for the preparation of nurses functioning in expanded roles and for maintenance of competency. And at the same time, the Board of Directors of the NLN approved as a goal, "to continue to develop accreditation criteria and
to evaluate continuing education offerings sponsored by nursing schools and nursing service agencies." These two actions show the overt divisiveness of the twin organizations which in 1952 were created to solve nursing's problems, and to involve the community while maintaining professional autonomy in matters where it was appropriate.

To compound the problem, other specialty nursing organizations had set up their own credentialing programs and, as the many new specialty organizations formed, they too began to set standards and considered the feasibility of developing credentialing programs. To their credit, some of these are now acting in conjunction with the ANA.

In spite of all these activities, the move to study the entire problem of credentialing gained momentum. At the second conference, the following statements were adopted as a preamble to the current study proposal:

Developments within society at large (for example, pending enactment of national health insurance legislation), within health care delivery systems, and within the nursing profession mandate that there be undertaken with all deliberate speed, the reassessment of existing philosophies and processes in nursing credentialing as well as the exploration and development of new approaches to credentialing, recognizing the necessity for increased public accountability.

The diverse concerns of individuals and groups within the nursing profession, particularly as they relate to the complex fragmented system of credentialing which as evolved, lead us to believe that a system of cooperation and collaboration is imperative if the profession as a whole is to meet its public responsibilities, now and in the future.

After considerable deliberation, the conferees recommended to the ANA Commission on Nursing Education that the scope of the proposed feasibility study be enlarged to include an assessment of credentialing mechanisms for organized nursing services, certification and licensure, as well as accreditation of basic, graduate and continuing education. They saw such a comprehensive investigation as vital to the professions' effort to discharge its social responsibilities for insuring the competence of its members and the quality of nursing care. They further recommended that the NLN be invited to join the ANA in sponsoring the study. This invitation was declined by the NLN Board of Directors who consequently sent a letter to their members stating the reasons for rejection. While the explanation of the NLN seemed reasonable, in retrospect they also seem negotiable.

After the NLN declined co-sponsorship of the study, the ANA Board of Directors decided to become the sole sponsor of the project in order to move it forward because it had been over two years since the House of Delegates had requested action. It was then suggested that the NLN might become a Cooperating Group of the study. I am delighted to
report that the invitation has been accepted and I look forward to their participation with great pleasure. A study committee was appointed. This distinguished inter-disciplinary group of eleven nurses and five others met in November, 1976 and recommended the following modified purposes of the study which were subsequently approved by the ANA:

1. To assess current credentialing mechanisms in nursing including accreditation, certification, and licensure.
2. To suggest ways for increasing the effectiveness of credentialing.
3. To recommend future directions for credentialing in nursing.

Then, they moved with speed to select a project director and a site. My involvement began on January 15, 1977, as project director. After two months of study, I felt the need to modify the statement on the qualifications of the project director by adding “and it would be helpful to have an earned halo and be able to walk on water.” Needless to say, my attitude has changed. I no longer believe that I can save the world of nursing alone. History tells us that all forces must work in the same direction if change is to occur. So it is you who will ultimately decide your destiny. The Study Committee, based upon the findings of the Study Staff, will make recommendations to you and then it will be in your hands.

Now let me tell you where we are. We have been in operation almost five months. In addition to me, there are three researchers (all non-nurses), two secretarial staff members, and two students. A fourth researcher will be added and will be a nurse. This summer we will have three nurses who will work with each of the non-nurses to insure that all problem areas are, if not covered, at least recognized. We fully realize that we cannot cover everything. It is possible that we will end up with more questions than we started with!

Credentialing is defined for the purpose of this study as the range of mechanisms (not systems) assessing the performance of individuals or agencies. Figure 1 (see p. 37) will give you some idea of the variety of mechanisms utilized and a partial listing of agencies involved in utilizing the various mechanisms.

Credentialing can be divided into two categories: i.e., individuals and agencies. Agencies can be subdivided further into nursing education and nursing service. Credentialing mechanisms can be either governmental or non-governmental. This approach is deceptively simple until one begins to complete the chart, then the problems become apparent.

Our approach to the development of new directions or a reorganized credentialing system will be an assessment of all the existing mechanisms, the identification of the viable elements and apparent gaps of the
current mechanisms, the exploration of new mechanisms and the consideration of an interlocking system which is dynamic and responsive to both nursing’s and society’s changing needs. At the present time, we are exploring the flow of interest forces, the influence of the job market on credentialing, and the impact of credentialing in the educational area.

**Individual Credentialing**

*Figure 1* shows the complexity of involvement of organizations in credentialing individual nurses or agencies, both nursing service and nursing education. This chart is incomplete and must serve only as an example of the complexity of the problem. It has been suggested that the categories of *governmental* and *non-governmental* be used rather than *legal* and *voluntary* since some legal (*governmental*) agencies are also voluntary in matters of credentialing: e.g., Health Service Agencies.

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**Figure 1**

**ORGANIZATIONS INVOLVED IN CREDENTIALING MECHANISMS IN NURSING**

<table>
<thead>
<tr>
<th>Legal</th>
<th>Voluntary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary</td>
<td>Governmental</td>
</tr>
<tr>
<td>Individual</td>
<td>Agency</td>
</tr>
</tbody>
</table>

**Nursing Education**

- **Legal**
  - State Boards of Nursing
  - State Accrediting Bodies
  - Specialty Organizations
  - State Educational Boards of Control
  - AHA

- **Voluntary**
  - American Nurses Association
  - National League for Nursing
  - Joint Commission on Accreditation of Healthcare Organizations

**Nursing Service**

- **Legal**
  - State Boards of Control of Health Services

- **Voluntary**
  - American Nurses Association
  - National League for Nursing
  - Joint Commission on Accreditation of Healthcare Organizations

**Legend**

- ANA: American Nurses Association
- NLN: National League for Nursing
- JCAH: Joint Commission on Accreditation of Healthcare Organizations
- AHA: American Hospital Association

**Notes**

- Some State Boards of Nursing have both licenses and registrations.
- Some State Boards of Control are under other State boards.
Figure 2 is the flow chart developed by the sponsors of the study to give order to the broad coverage desired in the Study.

**Figure 2**
FLOW CHART SHOWING ORGANIZATIONAL STRUCTURE FOR STUDY OF CREDENTIALING IN NURSING

CREDENTIALING (NURSING)

INDIVIDUAL

AGENCY

EDUCATION

SERVICE

Figure 3 indicates the credentialing mechanisms through which individuals are recognized for some particular attribute(s). Licensure assures a minimal knowledge base for safe practice for public protection. It is a function of the government. Certification assumes a pre-determined level of competency in a special field of nursing and can be either a legal or voluntary function. Registration is a listing of nurses for pre-determined reasons and can be on a legal or voluntary basis. Degree designation indicates the academic level achieved by individuals and is granted by institutions chartered to do so. Recognition is a broad category and is generally, but not always, non-governmental. It includes diplomas and certificates, awards, and memberships or fellowships in organizations. Generally recognition carries with it a connotation of high achievement.
Figure 4 demonstrates the different paths to specialty practice and the difficulties involved in rectifying the situation. Note the irregular knowledge base for examination leading to a license to practice and the great variation in types of continuing education.

Figure 5 demonstrates the influence of legal and voluntary Boards of Control e.g. Boards of Directors, Boards of Regents through an awarded degree.

**Agency Credentialing**

Figure 6 depicts the difficulty in use of terms for credentialing mechanisms. Such difficulty might be rectified by use of common terminology.

Figure 7 shows the conflict of jurisdiction which frequently occurs in the health professions particularly nursing. Since not all schools of nursing are under legal educational boards this remains a necessity but the conflict should be studied for possible resolution.

The voluntary credentialing agencies for educational institutions are seen (partial list only) in Figure 8. Regional accrediting agencies are involved when schools are located in accredited institutions of higher learning. Eligibility for NLN accreditation includes a requirement that the parent educational institution be accredited by the appropriate regional accrediting agency.
Figure 9 demonstrates legal involvement in the basis for voluntary accreditation as well as the prestigious results of such accreditation. State licensure is used in the broad sense of accreditation or approval which is also an eligibility requirement for NLN Accreditation.

The Credentialing Agencies for organized nursing service are also complex and several areas of conflicts of jurisdiction can be identified. These may or may not be a problem but where they exist, the problem should be studied and resolved. Figure 10 indicates two areas of conflict.
DEGREE DESIGNATION AS A MECHANISM OF CREDENTIALING

INDIVIDUAL

DEGREE DESIGNATION

LEGAL

STATE EDUCATION BOARDS OF CONTROL

LPN

AD—AA—ADN

BS—BA—BN—BS(N)—BA(N)—BSN

MN

DN

VOLUNTARY

HOSPITAL BOARDS OF CONTROL

LPN

RN

AD

MN

CREDENTIALING MECHANISMS FOR EDUCATIONAL AGENCIES

CREDENTIALING

AGENCY

EDUCATION

LEGAL

VOLUNTARY

LICENSED

ACCREDITATION

APPROVAL

REGISTRATION

SCHOOL DEGREES
Our final figure, Figure 11, again demonstrates the multiplicity of agencies involved in voluntary credentialing functions at various levels. These should be studied for similarities and differences. Particularly, J.C.A.H. should be the subject of study since it is the most common credentialing agency involved and has very little nurse input.

These then, are some of the current problems of credentialing. As you can see, there are excellent mechanisms as well as poor and mediocre mechanisms—but there is no system. If credentialing survives, and I trust that it will for it is the measure of performance by which we determine quality, then we must develop a system.
AGENCIES INVOLVED IN VOLUNTARY CREDENTIALING MECHANISMS FOR NURSING EDUCATION

- NLN Accreditation Registration
- ANA Approval Basic Graduate
- SPECIALTY ORGANIZATIONS Approval CE
- REGIONAL ACCREDITING AGENCIES

LEGAL CONTROL AS A BASIS FOR VOLUNTARY ACCREDITATION WHICH HAS PRESTIGIOUS RESULTS

- NLN ACCREDITATION
- GRADUATE EDUCATION
- PRACTICE

STATE BOARDS OF NURSING → STATE LICENSURE
STATE BUREAU OF LICENSURE
Figure 10
AREAS OF CONFLICT AMONG CREDENTIALING AGENCIES FOR ORGANIZED NURSING SERVICE

CREDENTIALING

AGENCY

SERVICE

LEGAL

STATE BOARDS OF CONTROL

HEALTH SERVICE AGENCIES Approval

FEDERAL GOVERNMENT Approval Accreditation

SERVICE Licensure

EDUCATIONAL Approval

CONFLICT OF JURISDICTION

Figure 11
VOLUNTARY CREDENTIALING AGENCIES INVOLVED IN ORGANIZED NURSING SERVICE UNITS

CREDENTIALING

AGENCY

SERVICE

VOLUNTARY

JCAH Accreditation

AHA Registration

NLN Accreditation

SPECIALTY ORGANIZATIONS Approval
PURPOSES OF THE STUDY

Our project is charged to assess the current mechanisms, identify their viability, and recommend one or more alternate systems. This does not mean that we will decide who goes out of the business of credentialing or who retains the business of credentialing. While it is conceivable that we might do either of these, it is the system we are charged with developing.

When the 1974 ANA House of Delegates adopted the resolution which eventually spawned the Credentialing Study, they were manifesting only a symptom of the larger problem. Without a comprehensive study on the scope of credentialing, the implementation of that resolution would have caused chaos and undue expense. Commendably, the ANA Staff and Board of Directors chose to investigate several vital issues before arriving at a decision on credentialing mechanisms. What do credentialing mechanisms accomplish? How are their activities coordinated? What controls and countercontrols exist? What enhances the quality of nursing care and what doesn’t? These are among the questions which we are in the process of identifying.

My only regret is that other nursing organizations have not recognized the same need. Let me give you an example. The Pediatric Oncology Nurses Association is in the process of developing a certification program. We already have at least two other pediatric groups who offer certificates. Do we need another? Are they really so different? Are we not speaking only of the disease condition of the child rather than the basic nursing care of the child? Are there enough potential candidates for the Pediatric Oncology Nursing Certificate that a valid mechanism of testing and evaluation can be developed on a cost effective basis?

FUTURE DEVELOPMENTS

What then do I see as the future? I wish that I could outline to you today the ideal system to which every nurse, every educator, every health care administrator, every legislator and every patient or potential patient could agree. While I cannot present an ideal system, let me try to envision some of the possible outcomes of the development of a variety of credentialing systems. Let us forget for the time being that this study will try to develop a “comprehensive, non-duplicative, realistic, and acceptable” system and let us just speculate together as nurses on possible outcomes of various systems.

The NO System

We could, of course, just destroy the current mechanisms or let them self destruct. In that event, the extent of nursing’s control would be reduced to nineteenth century levels. Ultimate control would be
exercised by employing groups. Without licensing, registration, certification, and accreditation of schools and services, measurements of performance would be limited to those desired only by the employer or employing agent. This system would only be acceptable in a utopian world populated by totally enlightened consumers, providers, and employers.

However, it would not be the first time that credentialing in the health professions and occupations has been allowed to deteriorate or self-destruct. It has been said that those who neglect history deserve to repeat it. We are in the midst of the development of a proliferation of nursing organizations which diminishes our strength and which may ultimately lead to the powerlessness of nurses that was apparent in the first half of the twentieth century.

The Hierarchical System

We could go to the other extreme of the NO System and develop a system so controlled and coordinated that creativity and movement toward higher quality would be developed only by decree by those in control. We might have a hierarchical system with everything emanating from the top. The orderliness of this type of system appeals to many persons and it is possible that it will occur. The most likely control group would be the bureaucratic government—the appointed staff, not the elected members of the government. Do you want this type of system?

Viable Alternative Systems

Between these two extremes are many possible systems. One system might incorporate all credentialing mechanisms into one of the nursing organizations and create a coordinated system to which all members of the organization could have access to change by consensus. The solid voice of our one million nurses in accord sounds fascinating, but is it possible? Are the hazards of single bureaucratic control also inherent in this type of system? Is there enough coherence and cohesiveness in our composite decisions that we can be certain that we will all be in accord and willing to support the system? Do we have enough cohesiveness as a group of nurses that the system couldn’t be eroded by outside forces? We have only to look at our system in nursing education to know that such cohesiveness does not exist. And I might ask is it desirable? Might we not kill the creativity which should lead to higher quality nursing care if we set up a System which is not responsive to the needs of a changing society?

The credentialing system could be consolidated under the Council of State Boards or the State Nurses’ Associations, thus dispersing central power and placing it into the control of the fifty plus states and jurisdictions. In the case of the state boards of nursing, the constitu-
tional guarantees of states rights might legally prohibit uniformity of action which could lead to problems stemming from different standards within different states. It is a minor miracle that we have the National Test Pool Examinations! But the “Sunshine Laws” may result in the demise of some of the state boards or at least reduce their power to continue this pattern of cooperation.

There could be a balanced system out of the variety of current credentialing mechanisms. There could be developed a coordinated system of government, professional, and public standard-setting and quality control. The viability of current mechanisms, cost effectiveness, quality care, public needs, and professional needs could result in a balance of control for one purpose—to better serve the public in its nursing needs without undue costs, undue exploitation of nurses, inequality of access to nursing care, and all of the other problems cited during this conference.

SUMMARY

Although it sounds as if I have a preconceived idea of the outcome of this study, I assure you I have not! I have simply taken this opportunity to speculate on the possible credentialing systems which could occur.

In actuality, the Credentialing Study is only beginning to identify the problem(s) and we have barely touched the surface. During the next 18 months, we hope to have input from as many groups involved in nursing as possible. We are handicapped in number of staff and limited funding—$400,000 over a 24-month period is not a large amount for the scope of this study. But we want input from all interested sources and we have already contacted individuals and groups from the myriad governmental, educational, and service-oriented organizations who may have an interest in the Credentialing Study.

We particularly want to know the specific problems of nurses, and even more importantly, ideas that might lead to a resolution of those problems. You can participate by sending us materials, articles, position papers, court cases, and testimonies. Write us letters. Develop local groups to accumulate knowledge about the total scope of credentialing—not just one or two of the mechanisms. As well as helping the Credentialing Study, these activities will nurture informed judgement when you vote on our recommendations two years hence.
We could go to the other extreme of the NO system and develop a system so controlled and conformist that creativity and movement toward higher quality would be effectively restrained by bureaucracy in a way similar to escaping from a cage with walls even tighter than before. Vacuuming the walls of the cell or the cage to make it appear more spacious and more inviting to its occupants is of no avail in a vacuum. The walls remain or are replaced with more walls, making the cell or the cage seem larger and more inviting but in reality becoming more insurmountable than ever. It is an infinite game to be played as long as a population adheres to its governing system.

The hierarchical system of nursing education has long been a source of concern. Nurses have traditionally been educated through a system that emphasizes the importance of adherence to established protocols and procedures. This system has been criticized for its rigidity and lack of flexibility, which can lead to lower quality care and a lack of innovation and creativity in the profession. As a result, there has been a call for a system that is more responsive to the needs of a changing society.

The credentialing system could be consolidated under the Council of State Boards of the State Nurses' Associations, thus dispersing central power and placing it into the control of the fifty plus states and jurisdictions. In the wake of the state boards of nursing, the enrollment...