THE NEED FOR SOME SENSE MAKING: DOCTOR OF NURSING PRACTICE

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ABSTRACT

The American Association of Colleges of Nursing has developed a general proposal for a practice doctorate for nursing and the National Organization of Nurse Practitioner Faculties has developed a proposal for the practice doctorate for nurse practitioners. This article describes the current initiative for developing the practice doctorate and argues that the proposed practice doctorates raise substantial concerns for the discipline of nursing. The concerns addressed in this article include the rationale offered for the new degree, confusion over the focus of the degree, the impact of the degree on educational and economic resources for both students and employers, and the regulatory issues arising from the implementation of the degree. The authors recommend thorough debate by all involved stakeholders before moving forward with this degree.

Key words: Practice doctorate, nursing, education

The current discussion about creating a practice doctorate in nursing - also referred to as a clinical or professional doctorate - is not new (Christman, 1980; Fitzpatrick, 1989; Grace, 1989; Newman, 1975; Schlotfeldt, 1978). During the 1970s the newly created Doctor of Nursing Science (DNS) programs were expected to fill the need for a practice doctorate as an alternative to the research-focused doctorate, the PhD. However, shortly after the DNS programs were introduced, the curricula of DNS programs drifted toward a research focus resulting in minimal differences between the PhD and DNS. Today, both programs typically include courses in philosophy, research, nursing theory, and quantitative analysis (Wood, 2005). The history of doctoral programs in nursing, including the DNS, is well covered in other articles (Anderson, 2000; Gortner, 1991; Robb, 2005). Therefore this article will focus on the issues related to the most recently proposed practice doctorates. This article describes the current initiative for developing the practice doctorate...shortly after the DNS programs were introduced, the curricula of DNS programs drifted toward a research focus, resulting in minimal differences between the PhD and DNS.
and argues that the proposed practice doctorates raise substantial concerns for the discipline of nursing. The concerns addressed in this article include the rationale offered for the new degree, confusion over the focus of the degree, the impact of the degree on educational and economic resources for both students and employers, and the regulatory issues arising from the implementation of the degree. The need for thorough debate by all involved stakeholders before moving forward with this degree is emphasized.

The Current Initiative for Developing a Practice Doctorate

The National Organization of Nurse Practitioner Faculties (NONPF) and the American Association of Colleges of Nursing (AACN) have been the primary drivers of the Doctor of Nursing Practice (DNP) degree since 2002. Increasingly, nurse practitioner (NP) programs have been exceeding the number of academic credits considered appropriate for master’s degrees. As NP practice has continued to extend into primary care including prevention and disease management of both acute and chronic conditions, additional academic credits have been added to the NP programs (Sperhac & Clinton, 2004). NONPF, in response to this trend, began exploring a doctorate in nursing practice degree. NONPF began with a Teleweb conference on a clinical nursing doctorate in 2001. NONPF’s early recommendations included the creation of a practice doctorate that would prepare clinical leaders to improve individual, population, and systems level outcomes. One option within such a practice doctorate programs would be to prepare NPs as primary care providers with higher level competencies in dealing with more complex patients (NONPF, 2002). In June 2003, the NONPF Board of Directors accepted the following recommendation:

- A nursing practice doctorate program shall prepare expert standing in one of three practice arenas: health care, leadership, or teaching.
- Programs may prepare the fully accountable expert clinician who continues to provide care across settings and to patients with higher acuity of illness in acute and chronic care;
- Programs may prepare the expert teacher of clinical learning and decision making; or
- Programs may prepare the expert clinical leader, change agent, and policy maker prepared to work within the health and political systems to improve continuously the quality of care and delivery of services (NONPF, 2003).

Also in 2003 NONPF co-hosted with the American Association of Colleges of Nursing a national forum on the Practice Doctorate. In 2005 NONPF convened a national panel for the NP practice doctorate and began preparing a list of competencies expected for NPs holding a practice doctorate (www.nonpf.org/cdhome.htm). NONPF has recommended the title Doctorate of Practice of Nursing (DPN) as the title of the academic degree (O’Sullivan, 2005) and has four different curriculum models for achieving the practice doctorate (Marion, O’Sullivan, Crabtree, Price & Fontana, 2005).

The American Association of Colleges of Nursing has also proposed a practice doctorate (http://aacn.nche.edu). NONPF and AACN both support a common degree for the practice doctorate. However, AACN is recommending the degree title of doctorate of nursing practice (DNP) as the preferred title while NONPF is proposing the title of Doctor of Practice of Nursing (DPN) thus heading O’Sullivan’s (2005) concern that the DNP title will lead to the assumption that all graduates of practice doctoral programs will be prepared as NPs. While NONPF is concerned with developing a practice doctorate for the role of nurse practitioner, AACN’s proposal for a practice doctorate (DNP) includes many roles under a
The term *practice*, specifically nursing practice, refers to any form of nursing intervention that influences health care outcomes for individuals or populations, including the direct care of individual patients, management of care for individuals and populations, administration of nursing and health care organizations, and the development and implementation of health policy (AACN, 2004). Thus the AACN practice doctorate proposal offers one degree for three major categories of practice—direct care of individual patients, care of patient populations, and practice that supports patient care which includes roles in management, health policy, and informatics.

The AACN has stated that the proposed practice doctorate will differ from the doctor of philosophy (PhD) in nursing, or research doctorate, on several points and outlined the following differences for the practice doctorate as compared to the PhD:

- Less emphasis on theory and meta-theory
- Considerable less research methodology content, with a focus being on evaluation and use of research rather than the conduct of research
- Different dissertation requirements, ranging from no dissertation to theses or capstone projects (termed dissertations in some programs) that must be grounded in clinical practice and designed to solve practice problems or to inform practice directly
- An emphasis on practice in any research requirement
- Clinical practica or residency requirements
- Emphasis on scholarly practice, practice improvement, innovation and testing of interventions and care delivery models, evaluation of health care outcomes, and expertise to inform health care policy and leadership in establishing clinical excellence (Marion et al., 2003; AACN, 2004)

In proposing the practice doctorate AACN has engaged only a limited number of stakeholders in meaningful dialogue. Twenty five professional organizations and 16 academic institutions attended the one-day, invitation-only *National Forum on the Practice Doctorate in Nursing*, co-hosted by NONPF in December, 2003. The content presented at the forum consisted primarily of a report on AACN’s work toward a practice doctorate proposal. Feedback from those who represented organizations at the forum, including the author (Dr. Lyon), noted that while substantive issues—both pros and cons—were identified through small group work, the issues identified were not further discussed. However, AACN is portraying the *National Forum on the Practice Doctorate in Nursing* to the larger nursing community as evidence of stakeholder participation in the process of developing the DNP (Sperhac & Clinton, 2004). No proceedings of the forum, including small work group reports, are available for review either by those invited to attend and/or those not invited to attend.

AACN again discussed the DNP publicly at the semi-annual Fall Dean’s Meeting in October of 2004. At this meeting AACN requested a vote of the Deans present regarding whether to move forward with the Doctor of Nursing Practice (DNP) degree which would be in effect for Advanced Practice Nurses (APNs), including nurse practitioners, clinical nurse specialists, nurse midwives, and nurse anesthetists, as well as nurse administrators, by 2015. There are over 500 deans of AACN member schools; however, at the October, 2004, meeting only the 266 deans who were present were permitted to vote. Dean-approved representatives, such as associate deans attending in the place of a dean, were not permitted.
to vote. No proxy voting or absentee voting was permitted. Almost half of the membership did not have the opportunity to vote. Of the 266 deans present, 160 voted to move forward with a practice doctorate; 106 voted against establishing the DNP.

AACN continues work on an "Essentials" document outlining competencies for the practice doctorate. A revised draft dated August 18, 2005, was recently made available on AACN's Website (http://www.aacn.nche.edu/DNP/pdf/DNPEssentialsDraft_8-18-05.pdf). Meanwhile, NONPF is developing competencies for a practice doctorate for NPs (O'Sullivan, 2005). It is interesting to note that while NONPF has partnered with AACN in proposing a practice doctorate, it does not endorse all of the AACN recommendations including the 2015 target date by which all advanced practice nurses must hold a practice doctorate (NONPF, 2005). As a result of NONPF and AACN's efforts, there are two proposals circulating for a practice doctorate in nursing. Meanwhile, there are growing concerns by both professional organizations and individual nurse leaders about the impact of this doctoral degree on the generation of new knowledge for nursing and the advancement of nursing practice (Broome, 2005; Dracup, Cronenwett, Meleis, & Benner, 2005; Girard, 2005; McKenna, 2005; Milton, 2005; Mundinger, 2005; NACNS, 2005).

A Critique of the Rationale Offered for the Practice Doctorate

Multiple reasons have been offered to justify moving to the practice doctorate, including the need for safe practice, the increasing complexity of health care, the need for parity with other disciplines, the continuing explosion of knowledge, and the need for more nursing faculty. Each of these reasons will be discussed in turn along with the authors' concerns regarding the validity of such rationales in supporting the need for mandating the DNP.

AACN cites the Institute of Medicine's reports on quality and safety in health care – To Err is Human: Building a Safer Health System (IOM, 1999), Crossing the Quality Chasm (IOM, 2001), and Health Professions Education: A Bridge to Quality (IOM, 2003) as supporting the need for the DNP. However, the rationale for linking practice doctorates to safer practice is unclear. By suggesting that practice doctorates will improve safety, AACN appears to be implying that master's prepared advanced practice nurses are unsafe. Yet current evidence supports the safety of master's prepared advanced practice nurses in providing high quality and cost effective advanced practice nursing. Harm data about care provided by advanced practice nurses prepared at the master's level does not exist according to the American Nurses Association Malpractice Data Bank. There is no evidence to suggest that a practice doctorate will contribute to increased patient safety.

AACN stated in the practice doctorate proposal that "nursing has many of the answers to the predominant health care dilemmas of the future," thus "nurses prepared at the doctoral level with a blend of clinical, organizational, economic and leadership skills are most likely to be able to critique nursing and other clinical scientific findings and design programs of care that are locally acceptable, economically feasible, and which significantly impact health care outcomes" (AACN, 2004). Granted health care delivery is complex and addressing the dilemmas will take a concerted effort by many disciplines, including care providers and non-care providers. However, the success of practice doctorate graduates to improve service has

been shown to be linked to the practice milieu – where the practice milieu is unreceptive to change the value of the practice doctorate has been questioned (Ellis & Lee, 2005). The involvement of economists, public policy analysts, corporate leaders, epidemiologists, futurists, actuaries, and many others in addition to nurses holding a practice doctorate is essential to changing the practice milieu of health care delivery systems. Nationally, the intellectual capital exists to solve the current and future health care dilemmas. What is lacking is the political will to make needed changes. It is unlikely that a practice doctorate in nursing will solve our current or future health care dilemmas.

Parity with other disciplines is a rationale offered for the practice doctorate. Some other disciplines -- audiology (AuD), physical therapy (DPT), and pharmacology (Pharm D) -- have moved to clinical doctorates (Marion et al, 2005; Sperhac & Clinton, 2004). However, we need to examine the evidence to determine the impact this additional education has had on improved patient outcomes, increased the salary of these professionals, or enhanced enrollments in these programs. It is also appropriate to investigate whether the clinical doctorate has recruited potential PhD students away from research careers in these disciplines. In pharmacology there is expressed concern that the clinical doctorate is threatening the PhD pool and sustained research capabilities (Wurster, 1997). How important is parity with other disciplines if this parity does not result in improved health care outcomes?

The AACN also offers the continuing explosion of knowledge as evidence of the need for the DNP. Citing Lenz, Mundinger, Hopkins, Clark and Lin (2002), AACN notes that "practicing NPs identify content areas... in which they perceive the need for additional training" and concludes that the "knowledge required to provide leadership in the discipline of nursing is so complex and rapidly changing that additional or doctoral level education is needed" (AACN, 2004). Yet knowledge has been expanding exponentially for years and will continue to do so in the years ahead. Providing more content through more credit hours is not the answer. Adding additional education under the title of practice doctorate begs the question of where do you stop presenting more information in a knowledge-based society. Milton (2005) asked the question "How do the vocational needs for additional training relate to the proposed different kind of scholarship in the form of terminal practice doctoral degree?" (p. 113). We need to be asking ourselves different questions about how and what we teach at all levels including the undergraduate level. Perhaps if we taught nurses differently our graduate-prepared nurses would not be identifying the need for additional training and would be able to maneuver comfortably in the world of knowledge to solve problems amenable to nursing interventions.

It's an old metaphor, but still relevant that nursing practice, education, and research together represent a three-legged stool. AACN also offers the DNP as one solution for filling the current faculty shortage. This suggests that the practice doctorate will attract future faculty candidates who would not previously have considered doctoral education. Yet we wonder whether the DNP will be viewed as a doctoral degree with less academic rigor, an easy degree to achieve. We also question whether nurses holding the DNP degree are the right fit for our academic institutions. It is not clear whether persons prepared with a DNP will be hired in tenure track positions or clinical track positions. In universities which require a PhD for tenure track positions, what teaching advantage will the DNP offer over the clinical track faculty.
with master’s degrees in nursing? At academic institutions where no other faculty members hold practice doctorates, DNP-prepared faculty members may be viewed negatively and not permitted into selected academic forums. Furthermore, future faculty members who hold a DNP may face tenure/promotion difficulties. McKenna (2005) noted that without an adequate background in the knowledge and skills necessary for teaching and scholarship, faculty holding professional practice doctorates may be set up for failure in a university setting. In studying the professional doctorate in the United Kingdom, Ellis & Lee (2005) found that graduates doubted the value of a degree that lacked the academic equivalence, status, and currency of the PhD.

Tanner (2005) noted that AACN’s DNP proposal is directed toward preparing advanced practice clinicians. We wonder whether this focus will adequately prepare teachers of nursing. Tanner suggested that nursing faculty need a deep understanding of the enduring concepts of the discipline as a basis for developing the flexibility and creativity that is needed to help students use concepts as anchors. A deep understanding of the concepts of the discipline comes from grounding in the theory and meta-theory in the discipline, precisely what the DNP proposes to deemphasize. Whall (2005) noted that practice is not a stand alone phenomenon – practice is a direct outcome of philosophic belief. If DNP graduates are expected to teach nursing they will need to be grounded in the philosophy of science (or meta-theoretical) issues that define the nature of nursing practice and research. It’s an old metaphor, but still relevant that nursing practice, education, and research together represent a three-legged stool. Traditionally, PhD-prepared nurses contribute to strengthening practice, education, and research by having the ability to "think critically, identifying gaps in nursing knowledge, searching for truth without prejudice, taking risks with ideas, being creative and imaginative in solving problems and communicating clearly and effectively" (McKenna, 2005, p. 246).

A Confusion Regarding the Focus of the DNP

Despite the fact that there is no national agreement on the need for the degree or the outcomes of the degree, several programs have moved ahead to offer a DNP including the University of Tennessee Health Science Center in Memphis, Rush University, University of Kentucky, Columbia University, and Drexel University.

Table 1: Current practice doctorate programs in United States as described on each university’s website.

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<th>University</th>
<th>Focus</th>
<th>Degree Awarded</th>
<th>Credit Hours</th>
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<tr>
<td>University of Tennessee Health</td>
<td>Nurses seeking specialty preparation in advanced levels of nursing</td>
<td>Doctorate of Nursing Practice (DNP)</td>
<td>Post-Baccalaureate</td>
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<tr>
<td>Science Center in Memphis</td>
<td>practice in the following focus areas – primary care, acute critical</td>
<td></td>
<td>56 credits</td>
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<td>(2005)</td>
<td>care, forensic nursing, gerontology, nursing administration,</td>
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<td>psychiatric/family nurse practitioner, and public health nursing.</td>
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<th>Rush University (n.d.)</th>
<th>The program prepares graduates with expertise in outcomes management and to function as a leader in complex environments.</th>
<th>Doctorate of Nursing Practice (DNP)</th>
<th>Post-Master’s 39 credits</th>
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<tr>
<td>University of Kentucky (2005)</td>
<td>The program is designed to prepare expert clinical nurse leaders to change direct care practice or to change health care systems to address safety issues and to improve health care outcomes. Graduates are experts in designing, implementing, managing, and evaluating health care delivery systems and are prepared to lead at the highest clinical and executive ranks.</td>
<td>Doctorate of Nursing Practice (DNP)</td>
<td>Post-Master’s 54-56</td>
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<tr>
<td>Columbia University (2005)</td>
<td>The program is designed to prepare nurse practitioners for extending practice in primary care medicine and independently diagnosing and treating disease to fill an anticipated gap in primary care physician services.</td>
<td>Doctorate of Practice of Nursing (DrNP)</td>
<td>Post-Master’s 40 credits</td>
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<tr>
<td>Drexel University (2005)</td>
<td>The program has four tracks – Clinical scholar in Advanced Nursing Practice, Clinical Scholar in Nursing Education, Clinical Scholar in Nursing &amp; Health Research, and Clinical Scholar in Nursing Leadership and Healthcare Management.</td>
<td>Doctorate of Nursing Practice (DrNP)</td>
<td>Post – Masters in Nursing or Master’s degree in another field. 48 credits</td>
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Table 1 presents the focus of the five different programs as described on each university’s website. The University of Tennessee Health Science Center’s (2005) DNP provides an advanced practice focus that includes a variety of specialty clinical areas; however, the functional role of these graduates is unclear. Rush University’s DNP (n.d.) prepares graduates with expertise in outcomes management and leadership in complex environments. A review of the DNP projects completed by students and posted on the university’s web site include such topics as nurse retention, faculty retention, international studies, and reimbursement for nurse practitioners. University of Kentucky’s (2005) DNP program prepares expert clinical nurse leaders to change direct care practice or health care systems. Graduates are prepared as experts in designing, implementing, managing, and evaluating health care delivery systems.

Confusion is created when there is one degree proposed for varied outcomes and the functional role is not well articulated. Role refers to a constellation of functions for which an individual is responsible – educator, administrator, clinical nurse specialist, and so forth – and role preparation occurs in an academic setting where an individual learns to perform the

circumscribed role functions. Educational preparation for each role is accomplished through completion of a distinct curriculum that prepares graduates to function in the scope of practice of the role. Curricular content is determined by professional associations who represent experts in the role (Fulton, 2005). As in the situation at the University of Tennessee Health Science Center in Memphis (2005), what role competencies will a DNP graduate with a gerontology focus have, nurse practitioner or clinical nurse specialist? Is forensic nursing a functional role with distinct competencies or a specialty practice in the functional role of nurse practitioner, clinical nurse specialist, or nursing administrator? The lack of professional role competencies for the DNP focus areas suggests a lack of buy-in by professional nursing organizations.

In contrast to the clinical, administration/management, and systems focus of the programs at the University of Tennessee Health Science Center in Memphis, Rush, and Kentucky, the Doctorate of Practice of Nursing (DrNP) at Columbia University School of Nursing (n.d., a; 2005) prepares nurse practitioners for expanding practice in primary care medicine and independently diagnosing and treating disease to fill an anticipated gap in primary care physician services. Milton (2005) questioned this practice focus with content related to medical pathophysiology, algorithms for disease management, assessment for the purpose of diagnosis and treatment of disease, and pharmacology courses with a list of medications to be learned for the purpose of prescriptive authority, and asked, "What makes this degree nursing?"

The focus on disease management suggests the proposed new practice doctorate is not adequately grounded in the science of nursing. To develop a terminal degree in nursing which lacks emphasis on the discipline's philosophical framework and theories halts the progression and evolution of the science (Whall, 2005). Will the graduates of this program assume the practice values and skills of other disciplines, especially medicine? NPs argue that they do not practice medicine. However, when a premier doctorate of practice of nursing program for nurse practitioners advertises that it prepares nurses in the practice of primary care medicine, to independently diagnose and treat disease for the purpose of filling an anticipated gap in primary care physician services, it's hard to argue this is not doing the work of medicine. As further evidence that this NP program prepares graduates to work as physician substitutes, the Columbia School of Nursing Website states that "nurse practitioners are demonstrating that they are able to complement and even substitute for physicians in caring for stable inpatients" (Columbia University. n.d. b, para 9). In addition, the website notes that:

Because of substantial cuts in reimbursements, teaching hospitals are contemplating significant cuts in residency staffs. But who will provide the care now delivered by these physicians? Many in nursing contend that nurse practitioners are ideal replacements. They can perform most of the first-year resident's tasks under physician supervision, while incurring one-half the cost in salary and malpractice insurance. (Columbia University. n.d. b, para 9)

This statement implies that nursing is willing to do physician work for less money and that nursing is using its education resources to address the problem of physician residencies and

to save hospitals money. While nurses are busy substituting for physicians and subsidizing medicine, who is substituting for and reimbursing nursing in our current nursing shortage of crisis proportions?

NP programs have grown in academic credit because they are adding to a nursing curriculum the fundamentals of medical practice. To educate nurses as providers of medical care - to attain competencies in another discipline - more content, hence more academic credit is needed, well beyond the typical 40ish academic credits of a master's program that builds on the competencies of the discipline's baccalaureate education. On the other hand, when the focus of the practice is nursing at an advanced level - nursing practice built on baccalaureate competencies and focusing on expanding nursing knowledge based on nursing science - a more traditional 42 credit hour (semester) graduate program is adequate. Is nursing conflicted and confounded about the focus of our doctoral programs because we have avoided what is likely a painful and contentious conversation about the focus of our master's programs - particularly the advanced practice nursing options of clinical nurse specialist, nurse practitioner, nurse anesthetist, and nurse midwife.

Columbia University awards a Doctorate of Practice of Nursing with the credential DrNP, however, Drexel University developed a Doctorate of Nursing Practice and uses DrNP; same credential, with different meanings. In addition, Drexel has not limited its degree to clinical practice or the nurse practitioner role. Drexel's program offers four tracks under the DrNP: Clinical Scholar in Advanced Nursing Practice, Clinical Scholar in Nursing Education, Clinical Scholar in Nursing and Health Research, and Clinical Scholar in Nursing Leadership and Healthcare Management. Is the clinical scholar in nursing and health research a research-focused track? The Drexel DrNP curriculum includes courses in philosophy of science, the structure of scientific knowledge in nursing, epidemiology and biostatistics, quantitative methods, and qualitative methods. Is this not the drift toward research that occurred among DNS programs?

NONPF implies that knowledge and competencies gained from a PhD program are not necessary to "create, implement, and evaluate practice interventions, health delivery systems, and clinical teaching" (NONPF, 2003, recommendation 4) in stating:

The research emphasis in a nursing practice doctorate program differs from a traditional PhD program. Rather than preparing nurse scientists for research careers, this program shall prepare graduates to use research knowledge and methods to create, implement, and evaluate practice interventions, health delivery systems, and clinical teaching. As well, this program prepares graduates to assume a key role in establishing national practice guidelines and conducting clinical trials" (NONPF, recommendation 4).

...PhD programs can
who wish to become nurse researchers/scientists (Fitzpatrick, 1989)? That is, is the degree not appropriate or useful for nurses who intend to: (a) improve their own practice; (b) change clinical practice; (c) improve teaching; and/or (d) improve executive nursing administration? Second, are the theory development and testing competencies gained through a PhD too limited for disciplined inquiry in the practice setting such that program evaluation research is not a legitimate type of research to include in PhD programs?

Third, while PhD programs in nursing are expected to be congruent with the gold standard of research-intensive preparation, with well-funded faculty mentors who have research intensive careers, is this model of PhD education in nursing not the most appropriate for the preparation of nurse scholars who desire non-academic careers such as administration (Edwardson, 2004)? We believe that PhD programs can and do prepare nurse scientists for clinical settings and health care administration as well as academia.

Impact on Educational Resources

The impact of adding another degree with more credit hours on already scarce faculty resources is not known. Consistent with nationally approved standards that preceptors must have a degree greater than that of the student, master’s prepared advanced practice nurses may not be considered qualified to precept doctoral students who are obtaining a practice doctorate. This need to precept DNP students will pull doctorally prepared nurses in yet another direction.

Nursing has experienced a "brain drain" over the past 20 years as women have had many more educational opportunities (Anderson, 2000). Among the current potential applicant pool, competing priorities such as family and job responsibilities interfere with career development for many nurses. With a small applicant pool for doctoral studies, it is highly likely that the practice doctorate will compete with the PhD. Potential nurse scientists may unwittingly opt for the DNP as opposed to traditional PhD programs, thus reducing the number of nurse scientists, leading to a decreased evidence base for nursing practice and defeating one of the premises for creating the DNP - to bring an evidence base to practice (Dracup et al., 2005). While the DNP is proposed to be imbedded in practice, it lacks the rigor necessary for independent conduct of research. Specifically the AACN proposal states the DNP will have "less emphasis on theory and meta-theory and considerably less research methodology content with the focus being on evaluation and use of research rather than the conduct of research" (AACN, 2004). A PhD-prepared nurse scientist remains a licensed registered nurse and can work in clinical settings to translate research into practice. However, a nurse with a practice doctorate (DNP) is likely unprepared to generate new knowledge for practice through research as the curriculum will specifically not include research intensive content.

Additional resource concerns include a possible decrease in educational institutions currently preparing APNs. The 2004-2005 AACN Enrollment and Graduations resource (Berlin, Wilsey, & Bednash, 2005) provides data from 91 schools reporting PhD programs and 351 schools reporting master's degrees. If the DNP is to become the terminal degree for all advanced practice, some existing programs may need to close because they are not permitted by state statute to offer doctoral education or may lack the fiscal or faculty resources to do so. In addition, there are nurse midwifery and nurse anesthesia programs that are not
currently located in schools of nursing and not yet at the master’s level. The DNP proposal, which offers no consideration for the continuation of these programs, may result in decreased numbers of nurses for these important clinical roles.

Specifically the proposed DNP as the terminal degree for clinical nurse specialists (CNSs) presents a troublesome use of resources. Existing curriculums can prepare CNSs with the necessary core competencies identified by the professional association (NACNS, 2004) within in the typical 40 (approximately) academic credits with 500 clinical hours in a selected specialty area (Walker et al., 2003). CNS program content is grounded in nursing theory and research and centered between bachelor level competencies and PhD competencies. The nature of a CNS curriculum is such that up to 30 master’s credits are commonly counted toward a PhD in nursing. A PhD program typically includes 90 academic credits. Thus for most CNSs a PhD requires an additional 60 credit hours post master’s degree. DNP programs may require fewer credits which initially may appear appealing to prospective students; however, the course requirements for these DNP programs, especially in areas of leadership, systems thinking, program development, and evidence-based specialty practice, suggest duplication of content found in existing CNS programs. The nature of additional knowledge infused into the DNP curricula versus the knowledge in the present master’s level CNS curricula is not known.

Economic Issues Related to Outcome

There is ample evidence that doctoral programs (PhD) in nursing are resource intensive (Anderson, 2000; Ketefian, 1998; Wood, 2005). Any new program, but particularly a doctoral program, will compete for scarce university and school resources. From an academic perspective, the cost and affordability of shifting current master’s level curricula to the proposed DNP has not been determined. From a student perspective, costs in relation to increased tuition, time, and reduced income while enrolled in a lengthy DNP program have not been explored. There is no data to suggest that post-graduation salaries for advanced practice nurses with a DNP will offset the increased educational costs. From a health care employer perspective, it is not known if DNP-prepared advanced practice nurses will be affordable to employers and third party reimbursers. The American health care system will likely undergo revisions by 2015, and one must question whether the DNP-prepared nurse will be needed in that new era. Recently, the president of the American Academy of Family Physicians reacted to the Columbia University practice doctorate by saying that steps have been taken to increase the number of primary care providers and the trend in physicians not choosing primary care has bottomed out (Crousdale, 2005). Additionally, while the American Medical Association does not have policy specifically addressing primary care nursing doctorates, it does oppose advanced practice nurses giving medical care without physician supervision. It is important to dialogue with the medical community about the DNP before initiating this new degree.

Regulation of Nursing Practice

Regulatory considerations in the implementation of the DNP also need to be addressed. These considerations include differing state scopes of practice for APNs, the opening of
nurse practice acts, grandfathering, and changes in regulation the move to the DNP might bring about. The regulation of advanced practice nurses differs from state to state, and scope of practice for a doctorate of practice will be affected differently depending on the state’s nurse practice act. Certification mechanisms (new exams, portfolios, or other legally defensible options) that satisfy state boards of nursing will need to be developed.

In many states Nurse Practice Acts will need to be opened and modified in order to change language to incorporate doctoral competencies and scope of practice. Opening practice acts may invite the attention of stakeholders who wish to modify existing components of the acts as well as to block the changes required. In addition, states vary with regard to regulations involving the use of the title “doctor” in clinical settings.

Another regulatory consideration to be addressed relates to grandfathering of current MSN-prepared APNs. It is imperative that this issue be examined and that advanced practice nurses who are prepared at the master’s degree level be given authoritative assurance that they can be grandfathered, i.e., can continue to practice without additional graduate course preparation. Society needs the health care and direction these APNs can provide. The potential loss of employment for advanced practice nurses who choose not to pursue the proposed DNP is not known. Licensure and certification issues have not been articulated; they will need to be addressed.

The degree to which each state will elect to regulate these different types of providers and the functional roles that will be regulated, beyond the Registered Nurse role, remain uncertain. If functional roles within the DNP are regulated, it is not clear whether this regulation will include nursing administrators and nursing educators holding the DNP.

Conclusion

It is imperative that the entire nursing community – all stakeholders – participate in meaningful dialogue about the practice doctorate specifically and the future of nursing education in general. Previous discussion forums about the DNP sponsored by AACN have been limited, with meaningful dialogue truncated as described above. Discussion about the DNP has been limited to NONPF and the nurse practitioner community. The conversation and decision making regarding this very important matter must be expanded.

The nursing shortage is real. It is real at the bedside, in the boardroom, and in the classroom. Concerns about the safety and quality of health care are ominous and immediate. Now is the time for emphasis on collective and collegial action to bring forward innovative, cost-effective, solid ideas for reshaping our discipline for the future. Recently the National League for Nursing issued *Transforming Nursing Education: A Position Statement* calling for more comprehensive dialogue about nursing education (NLN, 2005). The American Organization of Nurse Executives, noting that nursing’s work of the future will be complex and challenging, stated that the educational preparation of the nurse should be at the baccalaureate level and that since the future will be different, there is a need to re-frame baccalaureate curriculum (AONE, 2005). The American Academy of
Nursing held a Special Interest Group on Nursing Education in July 2005 to envision new strategies for assuring a more highly educated future nursing workforce (http://www.aannet.org/meetings/education/). The time seems right to move forward together.

The proposed DNP represents a major professional paradigm shift in nursing practice and education that warrants extensive dialogue from a host of stakeholders. Opportunities for collegial dialogue in its many forms – regional and national meetings, Internet list serves and blogs, journal and newsletter articles – should precede a change of this magnitude. We must thoughtfully consider the questions raised in this article and other articles so as to make sense of the DNP.

AUTHORS

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Correction Notice:

References to the University of Tennessee were changed on November 14, 2005 to read University of Tennessee Health Science Center in Memphis to differentiate the doctoral program at the University of Tennessee Health Science Center in Memphis from the doctoral program at the University of Tennessee - Knoxville, which is a PhD program. On November 14, 2005, a correction was made to the spelling of Drexel University.

REFERENCES


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6/20/2005