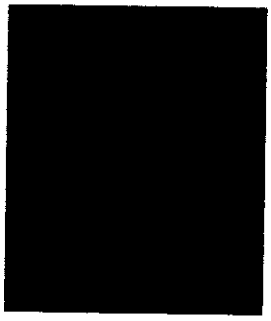
*From the*
# Editor

# Constructive debate and dialogue in nursing



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"What we have to do . . . is find a way to celebrate our diversity and debate our differences without fracturing our communities"
. . .Hilary Rodham Clinton

It has been many years since a plethora of debate about any substantive issue within the nursing discipline has taken place. The development of a new post-baccalaureate degree option—the Doctor of Nursing Practice (DNP) sponsored by the American Association of Colleges of Nursing[1]—has been the impetus for a resurgence of polite discourse in many public forums of nursing, as well as some less polite "parking lot conversations."

I noted to a colleague recently that these increasingly public "conversations" reminded me of similar earlier debates by theorists ("nursing theory" vs "practice theory") and nurse researchers (quantitative vs qualitative methods). My colleague disagreed, remarking that there were no competing paradigms in this current debate. I disagree—I think this current debate is, in fact, an exemplar for competing paradigms about the real role of education in nursing, what type of knowledge counts for "power" and "prestige," and, in this particular argument, how research preparation (eg, the PhD/DNS degree) is still seen as so very different and divorced from everything else in nursing.

I, for one, applaud the debate and dialog—one must admit it does get the creative and intellectual juices going! In the past few months, many position papers, editorials and resolutions have been published about the DNP degree.[2-6] These papers pose questions about the purpose of this new credential and point out some of the salient issues concerning the processes by which this initiative has developed and evolved. Yet, with the exception of Loretta Ford,[2] no one seems willing to discuss the real "elephant in the room" and the real crises at hand that the DNP does not address. These are need for the Bachelor of Science (BSN) as the entry level degree and the impending faculty shortage. Instead, the focus has been placed on advanced practice–where no crisis has been documented. This situation is actually pretty ironic given the recent resolution by the Association of Nurse Executives[3] who should know, if anyone does, what credentials are crucial in tomorrow's health care system for the survival of the nursing profession. It appears many stalwart leaders who have fought the entry into practice battle for many years have diverted their energy into areas where few would agree any crisis is, or will be, in 10 years. This seems to me to be the real fracture in our profession, one from within that poses the real threat. In the worlds in which most of us live, there are very real issues related to scarce resources and a clear need to focus all intellectual energies, collaborative efforts, and financial resources where they will make the most impact.

A quick look at the data related to the need for more BSN-prepared nurses and the faculty shortage would make anyone question just where the profession is heading. After reading the available literature on the subject, it appears we have a situation full of ambiguities, misconceptions, and solutions for the wrong problems. Leaders in nursing practice are calling for college-educated (BSN) nurses as a minimum and, yet, some nurse educators are planning other pro-

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grams. And the assumption that the only reason advanced practice nurses have not chosen to go on for the traditional doctoral preparation in nursing is because they aren't interested in research is shortsighted and very simplistic. A corollary assumption (and one which is completely ungrounded in reality) is that nurses in practice are not engaged in research.

I will leave you to read the 2 articles in this issue, written by leaders in our discipline who feel very strongly about this new initiative, as well as refer you to other papers on the topic.[1-6] Ideally, much more dialog and consensus should have taken place before now. Most of the literature, as this editorial is being written, is asking for more time, more assessment, and more engagement of all leaders in the profession. The development of new educational programs seems to be a symptom of a larger problem. Any action on the part of one group clearly has implications for all of us. It is very important that the profession not appear, one more time, to be divisive and contentious. Other, more pressing issues must be examined and leaders must come together, dialog, debate, and propose some meaningful strategies to address important issues around entry into practice and the faculty shortage. Each of these is a very real and immediate issue. It is critical that all segments of the profession are given an opportunity to be heard. Nurses throughout the profession are asking for transformative leadership that will solve the problems we are all living with day-to-day. This is the time to call for a summit to discuss just what the priorities are for the discipline.

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# Rebalancing our health care systems paradigm

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In presenting a paper recently, I once again reviewed some of the issues related to the relentless nursing workforce shortage. As well, at a recent invitational meeting, I had the privilege of debating the models, standardization, and fundamental quality issues related to instigating a clinical practice doctorate. These events rekindled some thinking about 3 elements related to our care systems paradigm and nursing issues. First, the nursing shortage related to acute care dominates the workforce dialogue but remains skewed and not fully comprehensive. Secondly, staring us in the face is a huge potential opportunity to create care systems better matched to a progressively aging population with "at risk" lifestyles contributing to obesity, chronic illness and functionality (mental and physical) declines. Thirdly, we would do well to link this need for care systems better matched to population health needs to the growing movement within nursing to embrace clinical practice doctorates.

Public discourse related to the nursing shortage most often target hospital care. The reasons are obvious given our history, how many RNs practice there, and our current biomedical-dominated health care system that is highly focused on acute care. Fellow Linda Aiken and her team have done much to provide strong evidence linking well-educated nurses to high quality care and patient safety. While well-warranted, most activities and policies have been oriented toward those of recruitment, retention, and reinstatement of nurses in acute care. Through the United States Health Resources and Services Administration (HRSA), federal monies were and are being made available to develop and test incentives for recruiting new and retaining already-practicing hospital nurses. Hospitals have instituted strategies including sign-on and recruitment bonuses, increased governance participation, tuition access, flexible hours and other innovations. Controversial are the emerging strategies for recruitment and rapid readying of foreign-educated nurses for hospital practice, along with relaxation of policies governing eligibility. We have seen high profile advertising promote new interest in nursing as a career choice and some growth in available scholarship monies. Consequently, nursing schools have seen large increases in applications. Largely funded through state and private funding, nursing schools and colleges have received little increased monies to expand educational capacity. Some schools have increased capacity but generally with little in the way of extra resources and, not uncommonly, at the expense of the current faculty workloads. Sources often outside of nursing are advocating for growth of the nursing programs that educate in the shortest amount of time, spurring more investment in community college and even diploma programs. Yet, this dynamic runs counter to what we know to assure care quality and patient safety in acute care settings. Even though projections indicate that the supply of nurses, no matter how well-maximized, is not likely to be sufficient over time for existing care systems, initiatives to modulate the utilization of nursing expertise in acute care settings (ie, demand) remain under-emphasized. Not to ignore 2 examples in this realm, our American Academy of Nursing (AAN) Commission on Nursing Workforce, having done exemplary fieldwork, continues to seek corporate partners for creating technology supportive of maximizing nursing practice in acute care settings. As well, the Robert Wood Johnson Foundation Transforming Care at the Bedside initiative has led to design and testing of efficiencies that make nursing practice more effective and compelling.

While the focus on acute care is dominant, there is a huge opportunity for us to have a different but major influence on the health care of our nation. Possibly, we should be arguing another form of nurse shortage. Setting the delivery care system and its financing aside, the aging of the population and the increasing prevalence of chronic disease (eg, diabetes), not to mention functional (eg, fibromyalgia), socially-derived (eg, substance abuse) or mental (eg, major depression) disorders, is revealing the mismatch of our health sys-

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tem to the needs of our population. Chronic disease management and prevention or functionality restoration and preservation are looming large. Effective interventions are bound to encompass competence in comprehensive assessment/screening, monitoring, and the shaping of healthy behaviors through patient/population education and coaching/guiding toward self-monitoring self care—the essence of advanced nursing practice. Comprehensive care means that much more of our attention should be paid to this domain of health care and nursing practice. With over 200,000 (and growing) advanced practice nurses, we are well-positioned to create innovative models of care and systems of practice integrated with acute care. We would do well to have much more of our dialogue, policies and resources oriented to this domain.

Perhaps the growing movement towards establishing clinical practice doctorates is a key to shifting the paradigm toward more continuous or comprehensive care. Some debate the need for such a degree. I take the stand that through our nursing and health care science development, we have earned the right to teach its application in the form of advanced clinical practice competencies at a level for which awarding of a doctorate is warranted; not to ignore that it will advance how we play our part in interdisciplinary health care transformation. Another debated issue is whether and how much a clinical practice doctorate should go beyond the study already within our specialty practice master's degree. Many believe that we have leveraged our master's study to what, in other disciplines, would earn a doctorate. When people have looked at lengths of study and science exposure within doctoral programs, study within many of our nursing specialty practice master's programs is comparable. If a doctorate warrants more competency-building, debated is what those competencies entail. Various thought leaders have argued that we have been remiss in teaching the competencies of systems level leadership and influence. If we are to add to the competencies expected for a practice doctorate, it will likely include (at least) direct clinical practice and population health practice management, health informatics, as well as practice, program, and systems evaluation.

Relative to a clinical practice doctoral degree, Fellow Mary Mundinger, Dean at Columbia University School of Nursing, has called for an emphasis on direct clinical practice and has pleaded for standardizing the nature of the competencies to be mastered. Nursing practice is broad since we practice across a variety of the current delivery system venues, including primary care, public and occupational health, acute, long-term and home care. We practice at the grassroots level but also as administrative leaders and teachers within the systems. Often our approach is to be "all-encompassing" when we define degree requirements, seen by some to be shortchanging the direct practice dimensions of study. On the other hand, being knowledgeable only in the ways of the "guild" and its historical practice patterns, to the exclusion of being knowledgeable in navigating systems, perhaps retards our abilities to transform health and care systems. Much work is needed by us to envision care systems better matched to contemporary demographics. We would do well to make the competencies for the practice doctoral degree highly aligned with that vision and a strong blend of direct patient care along with systems navigation, evaluation and transformational skills.

In summary, there are several policy implications and points of intersect in these ideas. It is imperative that we address how to solve the growing hospital nurse shortage in a comprehensive manner. Policies and resources to maximize faculty and new graduate capacity and to design practice models that modulate demands for nursing are especially warranted. Given today's demographics, and in collaboration with other disciplines, we in nursing are well-positioned to promote the creation of care systems for preventing or managing chronic disease or illness integrated with acute care, helping individuals maintain high functionality in the context of aging or illness through the strengthening of self- and family-care. We are in need of policies and resource allocations that promote novel care systems encompassing this care and "care continuity" through a rebalance of hospital-based rehabilitative care with community/home-based pro-habilitative care. From innovations for smooth transitioning across acute, long-term, community or home care, novel collaboratives between acute care and primary care nurses should emerge. Leadership will come from having clinicians highly skilled in delivering comprehensive direct and systems-savvy care and with credentials at parity with collaborators in complementary health disciplines.

# Letter to the Editor

*To the editor*

I was disappointed to open the letters section of the March/April 2005 issue of *Nursing Outlook* and not see any letters in response to your editorial of January/February 2005 on plagiarism and self-plagiarism. This is a serious matter that deserves the kind of dialogue you challenged us to have.

As the editor-in-chief of the *American Journal of Nursing* (AJN) for nearly 7 years, I have had numerous discussions about these issues with the journal's editorial and legal staff. Early on, I discovered that I was not clear about what constitutes plagiarism and self-plagiarism. How is it that I graduated from 3 leading schools of nursing without an accurate understanding of plagiarism? I'm convinced that schools are not doing an adequate job of teaching these violations of ethical and legally responsible writing to students and discussing its implications for faculty, clinicians, and others who are writing for professional publications.

Because of the resources available to *AJN*, we fact-check manuscripts during editing and often uncover plagiarism. I believe that most of the time the author simply does not understand the parameters of plagiarism and its legal and ethical implications. Consider the following examples:

- One author quoted exactly and extensively (about 60% of the paper) from a government Web site. Though she included the citation, she did not put quotation marks around the verbatim passages. When confronted with the facts, she said that she thought government writings were in the public domain and didn't need to be quoted.
- Another author of a manuscript on a bioterrorism topic cited an article on the same topic from the *Journal of the American Medication Association* (JAMA). When we checked her paper against the *JAMA* article, we discovered that she had reworded each sentence from the article but the order of sentences and paragraphs was the same. While she had eliminated some paragraphs and added additional material specific to nurses in her paper, she believed that she had not plagiarized because she had "paraphrased" and cited the *JAMA* article. In fact, this is a common misconception, even among academics. It is simply not sufficient to change a few words in each sentence. Copyright covers the sequencing and arrangement of words, sentences, paragraphs, and tables, not just direct quotes.

Logue[1] has provided some excellent tips for academics who want to stem plagiarism by students.

The issue of self-plagiarism is more challenging, particularly for specialists and researchers who are writing often on a focused topic. Here is the argument that many, including me, have put forth: "Why do I have to rewrite the literature review and methods section of my research paper if I'm publishing a second paper on additional data I collected during my study? My time is precious and my priority is disseminating this important work, not trying to be a literary or journalistic icon. I shouldn't have to rewrite everything each time. And even if I'm not cutting-and-pasting from one paper to the next, I'm likely to word a discussion of the methods section close to the same way I did in the first paper."

Some of the *AJN* staff who are journalists have argued that it's simply intellectually dishonest to not tell the reader that you've written the exact same thing in another publication. *AJN* managing editor Joy Jacobson says, "These ethical concerns matter just as much to me in my work as nursing ethics matter to nurses." But even if you believe that biomedical publishing should be held to a different, lower standard, holders of copyright (usually publishers) can mount a legal challenge to your self-plagiarism.

So what are the options for very busy nurse authors?

- Retain copyright to your writings (and risk not getting them published, since many publishers are reluctant to accept such arrangements except in isolated cases). This is not an option at many journals, including *AJN*, except on rare occasions.
- Cite the original work and put quotations around any passages that are worded or sequenced the same. If such passages are long, you will need to get reprint permission from the holder of copyright on the original work.
- Refer the reader to the original work and simply summarize what you wrote there.
- Write fresh each time and check back to make sure you've not self-plagiarized.
- Have a colleague take the lead on one paper and you lead the writing of the other paper. I recently read 2 papers that were written in this manner and could find absolutely no self-plagiarism, even for the background and methods sections. The second paper reported on a subset of the data from the first paper, so discussed the same methodology and literature but in a very different way.
- The International Academy of Nursing Editors (INANE) could convene a meeting of publishers of nursing journals to discuss the extent of self-plagiarism that the publishers are willing to tolerate. As Joy Jacobson asked me: Is it okay to plagiarize a sentence but not a paragraph? A paragraph but not a page? A page but not a whole article?

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There may very well be other options that I'm not seeing. These issues are not unique to nursing. Scholars and journalists are losing jobs because of plagiarism and self-plagiarism. And as Joy Jacobson pointed out to me, the public has become very distrustful of journalists; if nurses are to retain their standing as the most trusted professionals, don't they have to be trustworthy in all of their work, including their writing?

Joy Jacobson is in the process of determining the journal's policy on plagiarism. In doing so, she will be interviewing nursing and medical scholars, nurse ethicists, working journalists, and other leaders in the field. She would appreciate hearing from nurse authors on this topic: jjacobso@Lww.com.

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# Who's who in nursing: Bringing clarity to the doctor of nursing practice

*Mary O'Neil Mundinger, DrPH*

**Advanced practice nurses across the country are informally learning expanded skills and are assuming significant autonomy. The growing complexity and acuity of care, the aging of the US population, and the dwindling number of primary care physicians all contribute to the need for increased knowledge and practice competency. A formal and standardized educational process leading to a doctoral degree is essential for quality assurance, to clarify and validate authority/responsibility, and to recognize and identify these practitioners. The Doctor of Nursing Practice (DrNP) degree will formalize the acquisition of the knowledge and skills necessary for fully accountable and broader scope clinical nursing practice.**

For more than 50 years, advanced practice nurses (APNs) educated at the master's degree level have provided exemplary care to millions of individuals and families. These nurses are—and will continue to be—fundamentally important and useful in the nation's health care system. Many of these extraordinary pioneers have also advanced their knowledge and learned expanded skills, but they have been doing so without formal education or training, and without broad acknowledgment of their abilities. Standardizing the educational process is necessary for quality assurance and to anchor and fully establish these new levels of APN practice. Without rigorous evaluation of the adequacy of those informally learned skills, responsibility cannot legitimately be advanced, and accountability will not be widely acknowledged. The conferral of a doctoral degree clarifies and validates authority beyond the Master of Science (MS) degree. The new degree—the Doctor of Nursing Practice—embodies a higher level of overall knowledge and responsibility and the same accountability and scope of practice as other clinical doctorates.

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## HOW DOES DOCTORAL ROLE DIFFER FROM MS-LEVEL PRACTICE?

The Doctor of Nursing Practice (DrNP) graduate differs from an APN with a master's degree in several ways. Overall, the DrNP has attained a greater depth and breadth of knowledge and practice. Significant additional science education is provided by courses in genetics, advanced pathophysiology, pharmacology, differential diagnoses, chronic illness, bioinformatics, research methods, and identification and use of medical evidence. Courses in practice management, ethics and legal issues add policy and systems strength. These courses complement MS-level education and, in combination, allow the DrNP graduates to assume greater responsibility and accountability for their patients.

The clinical components of the DrNP curriculum focus on integrating new knowledge into clinical practice. Students admit, co-manage, and discharge patients from the hospital. They conduct emergency room (ER) evaluations and recommend resolutions. They learn how to find the best specialist when referrals are necessary, how to work with those specialists, and how to evaluate those recommendations. These clinical interactions are not "silo" experiences but are embedded in the continuity of care of a given patient population. If the student enters with a primary care background, most of the initial clinical training occurs in the inpatient/ER/acute care settings. The reverse is true if the student enters with an acute care background. All students graduate with the full skill set on inpatient/outpatient management.

The second year of post-MS study is a full-time residency in which students practice at the new level, develop 15–20 complex case studies demonstrating their new competency attainment, and publish papers attesting to their achievements. Practice is no longer time- or site-specific but can span all settings. The degree would not change regulations at the outset. Hospital admitting privileges will still be the purview of hospital medical boards. Independent prescribing or billing are state and payer prerogatives. Nonetheless, regulations inevitably change and advance when competency is demonstrated and patient need is apparent. DrNP graduates will be the instrument of such changes. Even before the regulations catch up with practice, DrNP graduates are exerting more influence, demanding access and joint decision-making for their patients

wherever they are being treated. DrNPs are raising questions, offering resolutions, stepping in with welcome wisdom and, importantly, patients are demanding that their DrNP providers have access and authority for their care. These clinicians will change health care and profoundly improve the nation's image of nursing. But this can happen only if the public knows—with assurance—that every DrNP is a *clinician* with the appropriate level of education and training.

## MUDDYING THE WATERS

A doctorate in any discipline should reflect equal standing with other professional doctorates. This new clinical role in nursing is measurably more than master's level practice, demonstrates the same level of wisdom and responsibility as those in other doctoral roles, and is distinctively different from a research doctorate. Voila the doctorate in nursing practice.

Some who are skeptical say: "We have too many degrees in nursing, we will confuse the public. We should build these advanced skills into existing degrees." Nothing could be more confusing to the public than having one degree that means many things. If there were no Doctor of Medicine (MD) degree, but just different kinds of PhDs, patients would be understandably wary and confused about which PhD to turn to for their health care.

Others say: "Nursing practice is anything a nurse does—administration, clinical care, teaching . . ." Where were these people when "advanced practice nursing" was coined? The public knows these nurses are educated as clinicians, not as administrators or teachers. And therein lies APNs' influence and success. "Practice" has meaning and is equated with clinical care by the public; why destroy that clarity and substitute confusion?

Hidden in these specious arguments is the knowledge that practice is clearly valued and that a DrNP will be a powerful title; nurses want to be under that umbrella when they earn a doctorate. After all, doctoral degrees in administration and teaching are already available. So there is a movement—headed by our own professional organization, American Association of Colleges of Nursing—to lump all doctoral education (except research) under the "practice" doctorate title.

One does not have to search far into nursing's checkered history to see that a practice doctorate could easily recapitulate the failure of the ND (Nursing Doctorate) with its disparate missions and outcomes. Being "inclusive"—whether in nursing or elsewhere—leads inevitably to confusion and to settling for the lowest common denominator.

We are at a point in time where nursing can achieve the standing necessary to give millions of individuals access to uniquely valuable care. Nursing has a long history of throwing away such opportunities—the diluted professionalism in the Associate degree, refusing to incorporate the idea of a Physician Assistant into nursing curricula, diffusing the potential of the Doctor of Nursing (ND) degree by lack of standardization. But this time we could do it right by requiring clarity and standards, common purpose, and yes, exclusivity.

## PRIMARY CARE AND THE FUTURE OF NURSING

The health care needs of this country are daunting. In 1996, the Institute of Medicine provided a general definition of primary care:

> "Primary care is the provision of *integrated, accessible health care services* by clinicians who are *accountable* for addressing a large *majority of personal health care needs*, developing a *sustained partnership with patients*, and practicing in the *context of family and community*."[1]

Who will provide this kind of comprehensive primary care? The decade-old but still-current IOM definition nowhere uses the words "physician" or "medical" care. The comprehensiveness required can be supplied by a nurse with a clinical doctorate.

Who are the expert practitioners needed to manage chronic illness? As the nation ages, the prevalence of chronic disease will increase. Nurses with the clinical doctorate have the required scope of knowledge and skill, the ability to provide necessary referrals and follow-up.

Who can assure patients adopt—not just adhere to—necessary preventive and health promotion activities? "Compliance" suggests a passive and outdated clinician/patient relationship. Nurses with the clinical doctorate combine traditional nursing proficiency in teaching and coaching with sophisticated diagnostic and therapeutic skills. They are the providers of choice for those needing guidance to change behaviors.

Who will assure timely and knowledgeable translation of science into practice, selecting the best research to enrich patients' lives? Nurses with the clinical doctorate can evaluate evidence, apply it appropriately, and gain patients' acceptance of the resulting therapies.

Who will generate new evidence for constant improvement in practice? Expert clinicians with analytical skills and sophisticated use of informatics can begin this process, which is sadly lacking in health care today.

Midwives, anesthetists, acute care clinicians and nurse practitioners have evolved in the 50 years since MS-level education became associated with advanced practice. Their services and beneficial outcomes (sometimes with identifiable value-added contributions) are exemplary, but patients need more advanced care than graduates with current APN education can provide. If the nursing profession is to capture this unique opportunity, it must create a formal and standardized program for nurses interested in additional knowledge and a higher level of practice, and we must be clear who the graduates are and what they can do. If we do not

embrace this opportunity, others will, and nursing will have truncated its own discipline.

## A DECADE OF PROMISE AND PROOF

We at Columbia have more than a decade of experience with this expanded model, and as of April 2005, 13 newly minted graduates from the first clinical doctoral program in nursing. These recent graduates say there is a fundamental and even profound difference in how they practice now, after completing the program, even though they are the same pioneers who developed the expanded APN role over the last 12 years.

In 1993, Columbia University School of Nursing was asked by Presbyterian Hospital to establish 2 new ambulatory clinics to meet the growing demand for primary care in our underserved immigrant community. The faculty accepted and proposed conducting the first randomized trial comparing independent nurse practitioners with primary care physicians. To reduce the variables and strengthen the study, the School asked the hospital's medical board to grant the faculty nurse practitioners admitting privileges.

During the medical board's deliberation, several physician chairmen provided additional training for our faculty nurse practitioners in dermatology, radiology and cardiology and helped mentor them through the processes of admitting and co-managing patients and conducting emergency room evaluations. The results of the randomized trial, published in The *Journal of the American Medical Association* in 2000,[2] contributed to a change in the hospital by-laws, which now give faculty nurse practitioners statutory permission for admitting privileges. Today, more than 30 faculty are practicing in this broadened role. The informal learning and new advanced authority was only the beginning. All the DrNP graduates who have completed the formal educational program, and the students in the process of completing the degree, see themselves as "emissaries," not just graduates.

The first class—all Columbia University School of Nursing faculty—represent pediatric, adult, family, and women's health primary care as well as midwifery, acute care and psych/mental health. In their final exit interviews, these first DrNP graduates responded in interesting and similar ways to a question about how the program had changed their practice.

There is a strong theme of increased confidence, more assertive accountability and responsibility, especially in clinical arenas, and emerging roles they had not before considered. In the transplant units, DrNP graduates describe their role in resolving ethical and legal issues and taking the lead on these issues in team meetings with transplant surgeons. The midwives now more often co-manage patients in the emergency room and hospital, handling their patients' non-pregnancy health issues. All the DrNPs have instituted informatics tools to document their practices and analyze them in formal ways, and they have begun working with their research colleagues to develop evidence for best practices. Many cite the increased influence they now have to establish nursing-specific interventions in their previously conventional, medically oriented practices. Some point to specific policy changes they have instituted that are the direct result of their DrNP learning. For example, expensive allergy medications are no longer ordered after an outcomes assessment from chart review; all pregnant women on selective serotonin reuptake inhibitors are required to have a joint psychiatrist/DrNP decision on drug therapy during pregnancy; all DrNP referrals to the emergency room are required to have the DrNP sign-off before patients can leave the emergency room. They say they know more and are more confident and assertive about having their wisdom accepted, more often cite the literature and use evidence in their decisions, and more often co-manage patients rather than simply referring them (nurse practitioners more often admit and co-manage; acute care clinicians more often actively manage patients when they leave the acute care site). One DrNP graduate says she now considers herself a "sole-keeper" rather than a "gatekeeper."

Columbia University School of Nursing faculty members have demonstrated a level of clinical practice beyond that achieved with a MS degree. We know that thousands of nurses aspire to this level of education, and schools are responding by developing new degrees. We know that a research degree is asynchronous with these goals, and we know from every other profession that when you reach competency associated with doctoral achievement, one should receive a doctorate, not another MS degree.

Not only do nurses want very much to attain a higher level of expertise, but the health care system needs these DrNP graduates as the population ages, and people live longer with more treatable illness. The aging boomers—big consumers of everything—are poised to be big consumers of health care. At the same time that demand grows, the primary care physician resource is diminishing. It's a perfect storm, when the DrNP can calm the waters and resolve the crisis.

## WILL NURSING TAKE ADVANTAGE OF THIS OPPORTUNITY?

Major questions remain. Will the practice doctorate succeed if it becomes a catch-all, non-research degree? If the DrNP signifies nothing more than that the graduate is not a researcher, the advanced clinical role is in jeopardy of reaching its full potential. While nursing has a long history of nuanced difference (diploma/AA/BS/MS) which only nurses understand, the public doesn't get it and doesn't care. Neither patients nor payers will take the time to find out what kind of a DrNP someone is (clinician? educator? administrator? systems expert?). For safety and quality reasons, those

aspiring to the clinical doctorate must go through a rigorous winnowing process. A title should mean something.

It may be that this clarity of title is already doomed. Schools contemplating establishing a practice doctorate are already taking disparate paths (Kentucky's program is not a clinical degree; others may have "tracks" where graduates with the same title might be experts *only* in clinical care *or* informatics *or* administration.) If this continues to play out as it is now unfolding, differentiation other than by title is imperative for the advanced clinical role to succeed. Certification, or other ways to clearly and reliably identify the clinical experts, is essential.

The most important goal will be to provide exquisitely sensitive and knowledgeable care to patients who desperately need this resource. But there will be several other effects, only some of which are predictable today. Raising the bar on what a nurse can attain (the clinical doctorate) will change the public's view of nursing and encourage ambitious young people to reconsider a nursing career. The very presence of a DrNP in a hospital can ameliorate the general understanding of what nurses can do and, perhaps, help change the stultified nature of hospital nursing. With the growing demand for medical specialists, there is already a strong pattern of medical students fleeing primary care. Perhaps with the clinical doctorate in nursing, there will finally be the productive teams of nurses and physicians at comparable levels of value and demand. Perhaps with the advent of nurses with the clinical doctorate, more individuals will have access to those who can effect optimal prevention of illness and promotion of health. Maybe these new nurse doctorates are the answer to many ills. It is imperative that we clarify the title, standardize the degree, and identify these experts for our patients, the payers, the public, and policy makers.

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# Reflections on the doctorate of nursing practice

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**A debate is currently raging in many academic nursing circles about a new degree, the Doctor of Nursing Practice (DNP). The degree is envisioned as the terminal degree in the discipline that focuses on clinical practice, and it is proposed to supplant the master's degree by 2015. There are a number of driving forces fueling the proposed change, including the hoped-for parity it will create with other health care disciplines and the potential for addressing the complexity of today's health care system. However, we believe that a substantive debate is required prior to a full-scale adoption of this new degree. In this article, we pose the potential unintended consequences of adopting a practice doctorate within our profession—the ones that might be negative for the nursing profession, for health care, and for society as a whole. We discuss these 3 dimensions and suggest that the DNP may erode the major progress nursing as a scientific discipline has made in universities over the past 3 decades. We suggest that the adoption of a DNP will threaten the generation of theory-based science in our discipline, either by decreasing the number of PhD-prepared nurses that will enter the field in the future or by lengthening the course of study to a PhD, thereby significantly shortening productive scientific careers. We question whether the creation of 2 doctoral tracks will further widen the chasm between nurse scientists and clinicians and result in many nurse clinicians feeling disenfranchised. We also pose questions about the impact of the DNP on health care and society. We are concerned that the number of nurses prepared at an advanced practice level will decrease and that the DNP will, thus, have negative impacts on quality, cost, and access to care. Finally, we question whether the DNP will create confusion among colleagues and consumers. We recommend that the adoption of the DNP only occur after thoughtful discussion both within and outside the profession.**

Nurses are currently engaged in a stirring debate around the proposal approved by the American Association of Colleges of Nursing (AACN) at its Fall 2004 meeting to support the Doctor of Nursing Practice (DNP) as a terminal practice degree.[1] As delineated in the proposal, the degree is to be distinguished from the PhD, which has wide acceptance as a research-focused degree, and is to supplant the MS degree for nurses in advanced practice or leadership roles by 2015. A few schools have already embarked on this new educational path and offer the degree to nurse practitioners or administrators, while many others are deliberating their course. By entering into this debate, nurses are collectively creating the future of our profession.

As authors of this article, we welcome this bold move on the part of AACN, a professional organization representing 578 schools/departments of nursing[2] and believe that the current debate will provide all of us with the opportunity to clarify and reaffirm our academic traditions and goals. The driving forces for this recommendation appear to be the following: (1) parity with other health care disciplines such as medicine, physical therapy, and pharmacy; (2) the high amount of credits required in advanced nursing practice curricula that exceed the amount required for a masters degree in other disciplines (although how widespread this excess is has yet to be documented); (3) the current and projected shortage of faculty that could be addressed by nurses with a terminal practice degree; and (4) the changes in the health care system that require nurses to become increasingly expert in the complexities of care management.[3] We want to offer our thoughts and questions as a means of increasing the current discourse. Specifically, we want to pose what we believe are the potential unintended consequences of adopting a practice doctorate within our profession—the ones that might be negative for the nursing profession, for health care, and for society as a whole.

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## IMPACT ON NURSING IN THE ACADEMY

One of the profession's highest achievements was extricating its educational system from the hospital diploma school structure, where it had little autonomy and academic legitimacy. This movement occurred over half a century ago and, over time, nursing has achieved an amazing degree of consistency in the preparation and educational credentials required for clinical practice and doctoral preparation. Although there were decades of confusion and struggle in individual states, the BSN, MSN, and PhD are now recognized as the preferred degrees for each level of practice. At the graduate levels, we have achieved consistency between the educational and regulatory worlds and parity with other disciplines in the scientific and academic world.

We wonder if the diversion of resources required to create a practice doctorate will undermine the graduate programs already in place that are often tentatively funded. We also worry that the DNP will lead to fewer nurses seeking PhDs because they have already achieved (through years of graduate work) a terminal practice doctorate. If either or both occur, it will undermine what the profession has achieved in doctoral education and diminish our value to science and to universities over time.

## DECREASED NUMBERS OF PhD GRADUATES

We worry that the small number of students graduating annually with PhDs in nursing (approximately 400 per year) will diminish even further if the DNP is widely adopted. We are concerned that nurses will view the DNP as a terminal degree, not just the terminal "practice degree", and will be encouraged to pursue careers in academe without gaining a PhD. In fact, at the 2005 National Academy of Nurse Practitioner Faculty (NONPF) meeting, a resolution was introduced to adopt a position acknowledging parity between the DNP and PhD. If nurses who might have considered studying for a PhD view the DNP as a viable *alternative* to the PhD, they will choose it instead of PhD study, either because they desire advanced practice education and credentials or, in some cases, because they view the DNP as an "easier" route to obtaining a doctorate because of lesser requirements for independent scholarship. Reducing the pipeline of nurses who are prepared to conduct independent research on our practice and assume academic (tenure track) positions in our universities will have a negative impact on the further development of our science.

We also worry that adoption of the DNP will lengthen the program of study for many future nursing PhD graduates. Our discipline has had the unfortunate characteristic of having nurses enter scientific careers at least a decade later, on average, than other disciplines. The average age of the PhD in nursing who is awarded a first R01 grant from the National Institutes of Health is fully a decade older than his or her peers in other disciplines. Thus, the scientific career of the nurse researcher is often far shorter and, therefore, less productive over the life of a research career, than that of peers in other disciplines. As a discipline, we are trying to alter that pattern by encouraging nurses to enter graduate school and prepare themselves to conduct independent research early in their career trajectory. What will the institution of a practice doctorate do to that trend? We believe that the DNP will serve as an impediment to having nurses prepared at the doctoral level relatively early in their professional careers. Students may be required to gain a DNP to have legitimacy in the practice arena, and thus add years to their graduate study if they indeed persevere through to earning a PhD. Thus, the adoption of the DNP by the profession will serve to once again diminish both the numbers of PhD graduates and their years of productivity, thereby decreasing new contributions to the scientific basis of our practice.

## THE ROLE OF THE DNP IN ACADEME

One of the arguments for a DNP is that it is perfectly legitimate to have a practice doctorate in a practice discipline—many fields do. People with Doctor of Education (EdD), Psychology (PsyD) or Public Health (DrPH) degrees are trained in programs that offer an alternative to the research-intensive PhD. The primary career path is to practice—as a superintendent of schools, as a school psychologist, as a director of public health. Overall, the percentages of people with these degrees teaching in *university* schools of education, psychology, and public health are very low. People who aspire to faculty careers primarily choose the PhD rather than the practice doctorate, and it's not a particular problem for schools of education, psychology, or public health to offer their practice doctorates with primarily PhD-prepared faculty. These professional doctorates in other disciplines were partially the basis for establishing the plethora of professional doctoral degrees in nursing (eg, DNS, DNSc, DN, DSN, ND) that have plagued our profession and confused our colleagues and the public for the past 3 decades. Many of these programs were oriented to clinical practice but included a significant amount of training in the generation and use of science.

The disciplines we are choosing as models for our practice doctorate proposals, however, are different than the disciplines used to fashion the original professional doctorates. The practice doctorates in pharmacy, medicine, dentistry, and physical therapy force people to the practice doctorate *in order* to practice. The primary training for practice in these disciplines occurs with the doctorate. The amount of research training is relatively insignificant, and the graduates are viewed as

users of research, not generators. Their faculties must be drawn primarily from people with practice doctorates (because no one else is qualified to prepare people for practice at this level), leaving the generation of knowledge for the discipline either to PhD's in basic and behavioral sciences who partner with doctorally-prepared clinicians, or to the intrepid individuals who have gained both practice and research degrees.

Thus, we worry that the adoption of a DNP will threaten the generation of theory-based science in our discipline, either by decreasing the number of PhD-prepared nurses that will enter the field in the future or by lengthening the course of study to a PhD and, thereby, significantly shortening productive scientific careers. We also worry that the DNP will mean that our university-based faculties will not be vibrant PhD-prepared faculties with the research training necessary to lead interdisciplinary research teams and to be Principal Investigator's (PI's) and co-PI's with faculties of other schools. If a high percentage of nursing faculties have DNPs rather than PhDs, they will take secondary roles in the advancement of science in the university community and the profession will lose the hard-won rights to autonomy and leadership in academe. This is a particularly important loss as the National Institutes of Health directs PhD-prepared scientists to optimize opportunities to collaborate in scientific discovery in its recent Roadmap Initiative.[4]

## VARIABILITY IN DNP PROGRAMS AND TITLING

Universities impose consistency on the meaning of PhD degrees across disciplines. No such guidelines exist with respect to professional doctorates, and the respect each is accorded varies significantly as a result. The DNP (or DrNP as used at Columbia University and Drexel University) is being developed with curricular variations and requirements that are not controlled by the university and already vary across universities even in these early years of adoption. Some programs are being proposed as theory-based, with research courses and a dissertation requirement that appear quite similar to existing professional doctoral degree programs in nursing (forexample,http://cnhp.drexel.edu/News/news.asp?view=show&ID=113). Others are being developed as an expansion of a traditional MS program (for example, http://www.tri-college.org/trinursing/DNPcompletion.doc or http://www2.uchsc.edu/son/sonweb.asp?content=education/content/NDdefault.htm&section=Education&LNav=education/lnav/educationLNav.asp). Some schools have added an additional requirement of a year's clinical residency to their master's curriculum (for example, http://cpmcnet.columbia.edu/dept/nursing/academics-programs/drnpfaq.html) Some programs require a master's degree prior to entry (eg, http://www.rushu.rush.edu/nursing/pos/doctor_nursing_nd.html), while others supplant the masters degree (for example, http://cpmcnet.columbia.edu/dept/nursing/academics-programs/drnpfaq.html). These variations will undermine the branding of the degree, the quality of the graduates and their productivity.

## IMPACT ON CLINICAL SCHOLARSHIP

The argument has been advanced that, unlike PhD programs in nursing which are research-based, DNP programs do not need to include "theory" since they are not preparing graduates for scholarly roles. We argue, however, that clinical scholarship requires the ability to engage in critical theoretical discourse and discern gaps in knowledge related to clinical practice. Choosing between different types of evidence, and translating evidence into clinical practice, requires knowing different theoretical frameworks with their various assumptions and theoretical propositions. Students in doctoral programs in nursing require opportunities to engage in philosophical, theoretical and research discourses. Hence, we are back to the dilemma of several decades ago when we failed to differentiate between what is expected from a PhD-bound candidate and a DNS-bound candidate. It may be assumed that the only difference between the 2 types of programs is the dissertation requirement. But, as schools of nursing try to distinguish the difference between the MS and DNP, we anticipate that they will respond to universities' requirement for a scholarship project for all doctoral programs that will quickly take on the characteristics of a dissertation.

A doctorally-prepared graduate is expected to both utilize and develop knowledge. These are 2 sides of the same coin, and one cannot exist without the other. Whether scholars choose a PhD or a DNP route, they must engage in practice, and their scholarly work must be driven by clinical practice. The very act of critical utilization of theory and research requires simultaneous development and advancement of knowledge. Separating them is artificial at best but, at worst, provides the potential for constraining progress in the discipline of nursing.

## IMPACT ON NURSES AND THE PROFESSION

The history of nursing is filled with decisions and events that have left clinicians feeling disenfranchised. When nursing education moved from the hospital to the university/college setting, diploma nurses found themselves with an education that provided little or no college credit. That change created an entire generation of embittered nurses who saw nursing academics as out of touch with clinical practice. The current proposal to convert all masters degree programs to professional doctoral programs would once again disenfranchise a large number of advanced practice nurses who believe that they were appropriately prepared for roles as nurse practitioners, nurse midwives, anesthetists, and clinical

nurse specialists. This sense of disenfranchisement is seen in some of the documents of the specialty organizations written in response to the AACN proposal. For example, the National Association of Clinical Nurse Specialists published a white paper on the proposed nursing practice doctorate offering 5 positive points and 24 negative points related to the AACN proposal, particularly as it may influence the clinical nurse specialist role.[5]

We are also concerned that the development of the DNP will increase the gap between nursing academia and clinical practice. The development of 2 separate tracks—one to practice (DNP) and one to research (MS/PHD)—underscores the separation of the 2 worlds. Nurses working at the bedside now see an educational continuum of associate degree to doctorate that provides a clear career path. In the proposed DNP, the paths diverge with clinicians being forced to choose at the bachelors level whether they want a career in clinical practice or research. We worry that this choice will only widen the academia-clinical practice gap.

We are concerned that nurses with a passion and talent for clinical practice will see the DNP as a way to insure that their graduate degree experience is grounded in clinical issues. If those nurses get DNPs, however, who will enter nursing PhD programs? If School of Nursing faculties don't offer an integration of professional ethics, practice, and science in our PhD programs, some university administrators are certainly going to wonder why nursing PhD programs are needed at all. Couldn't we just hire nurses who get PhDs in a variety of basic sciences as medicine and pharmacy do now? We worry that the adoption of the DNP will lead to a future where nurses with DNPs teach all the clinical courses in a curriculum and PhD-prepared faculty (with PhDs in disciplines other than nursing) teach doctoral students and research courses. Is this our preferred future?

## IMPACT ON HEALTH CARE AND SOCIETY

For all the threat we believe the proposed doctorate holds for the place of nursing in the academy, we are equally concerned about the impact on health care in general, to patients and families, and to our society. Dissociating the DNP from traditional academic degrees will contribute nothing to society's issues of quality, cost and access to health care.

We, as a society, are grappling with how to *reduce*, not *increase*, the costs of health care. Heath care costs have escalated, in part, because of the high salaries expected at the end of a long course of study. As training has increased for various health professionals, salaries have increased concomitantly to deal with deferred income and large student debt. The administrators of health care systems (particularly those with 24/7 responsibility) have responded to high salary costs, particularly in medicine, by trying to negotiate lower reimbursements (resulting in lower physician incomes) and by hiring lower-cost alternatives whenever possible (eg, anesthetists instead of anesthesiologists and nurse practitioners instead of physicians). Rising expectations for salaries among all people with practice doctorates is appropriate, but it decreases the impetus for use of more cost-effective providers or creates pressure for the production of new, less costly personnel. A common strategy to constrain cost in the health care industry has been to hire a single doctorally-prepared practitioner and to augment that individual with people with little or no college education (eg, the pharmacist assisted by pharmacy technicians and the orthopedist supported by orthopedic technicians). We believe that society needs more college-educated (ie, baccalaureate level-educated) professionals in each field, instead of more doctorally-prepared people leading masses of untrained helpers. The health care system cannot afford to have an army of doctorally-prepared healthcare workers delivering hands-on care, and we worry that the DNP will lead patients to receive nursing care from a few select nurses and an army of unlicensed personnel.

## A DECREASE IN THE SUPPLY OF ADVANCED PRACTICE NURSES

One concern that has not been voiced in the discussions around instituting the DNP is the potential constraints put on the supply of advanced practice nurses. Many schools or departments of nursing are approved to offer a masters degree, while not approved to offer doctoral degrees in any field. Although the number of schools who could offer a practice doctorate but currently only offer a masters degree are not known; we are concerned that only one-quarter of the 351 schools that offer the MS also offer the PhD.[6] If advanced nursing practice is set at the doctoral level, how will these institutions continue to prepare advanced practice nurses? Many will not be able to convert their MS degree programs to DNP programs, thereby reducing access to preparation for advanced practice in many parts of the country if the DNP becomes the entry into advanced practice.

A related concern is that many schools that are able to offer a doctorate in nursing will not be able to afford to mount 2 doctoral programs well, and will have to reduce the number of nurses accepted into the DNP compared to their current MS programs. Universities often have regulatory language around the requirements for written and oral qualifying examinations, scholarly projects and defenses related to the doctoral degree. All of these absorb faculty resources and many schools can barely martial appropriate resources for one doctoral

program. Thus, schools may have to reduce the number of students they accept into the DNP program compared to the MS program in order to meet the university requirements for a professional doctorate. Extending the length of advanced practice programs and diminishing the number of programs available in the country will not improve access to care, cost of care, diversity of providers, or quality.

## THE VIEW OF THE CONSUMER

An often unspoken argument of advocates of the DNP is to achieve parity with other healthcare professionals who hold a professional doctorate and, therefore, can request to be called "Doctor." With some trepidation, we believe that it's not helpful to patients and families to have everyone they meet in the health care system be a "doctor." The PhD-prepared nurse earns something akin to a "peer" seat at the table with physicians because of the high societal value and legitimacy of that traditional degree in our society. But the peer status exists primarily in the realm of science and the academy, not in the general public. Patients are likely to be increasingly confused by what education their "doctor" has and deny increased status to this new group of "doctors" in the health care system. Many states have addressed this confusion of new professional doctorates in a variety of disciplines by creating state regulations that restrict the use of the title "doctor" when providing patient care.

We have a plethora of data showing that current advanced practice nurses have skills and competencies that produce equal or better patient outcomes than physicians.[7] We do not need a practice doctorate to convince society of the worth of advanced practice nurses. But what will be the consequences of having graduates of doctoral programs that range from a brief residency that follows a standard masters curriculum, to a curriculum that includes new courses over and above what is currently taught in a master's program, to a curriculum that looks like our current DNS programs (options that are all being discussed in schools of nursing across the country)? What will society make of programs that prepare nurses for administration, teaching, public policy work *or* practice? For some, a DNP might mean something similar to current DNS programs—almost indistinguishable from PhD programs. For others, it might be a chance to focus on the methods of science now associated with practice-based learning and improvement. If the DNP can mean any or all of these things, does it really strengthen the societal image of nurses prepared at the graduate level, or does it just fuel the confusion that our entry into practice debates have engendered in the public?

## RECOMMENDATIONS FOR THE FUTURE

We recommend that the profession carefully debate the wisdom of adopting the DNP as a terminal degree. If the profession, with the support of colleagues and the public, agrees that the professional doctorate is important for nursing, then we hope that faculties will build the DNP as a post-masters degree. If nurses obtain advanced practice education and certification at the MSN level, and then have a choice of seeking either a practice doctorate or PhD, we could potentially add value without suffering significant losses to the profession and society. We would keep producing a very good health care provider for society without lengthening programs, thereby minimizing costs to both society and individuals seeking initial preparation for advanced practice or other advanced roles.

Is a practice doctorate that focuses on administration, teaching, public policy work *or* practice really a *practice* doctorate, or is it a professional certification for administrative and policy roles, much like the EdD? The practice doctorate that replaces a clinically focused Masters' Program for preparing advanced practice nurses will dilute the actual amount of scholarship and focus on advanced clinical nursing practice. Some DNP programs may elect, due to their setting and resources, to focus only on the non-clinical aspects of the practice doctorate. Creating a large number of such programs, we believe, would be a major step back in terms of knowledge development in nursing practice that focuses on patient care nursing contributions to societal health in community and public health nursing practice. To make the practice doctorate a viable and robust alternative for nursing practice knowledge, skill development, and ethical comportment, we urge that the practice doctorate alternative occur only at the post-master's level.

Finally, a post-master's practice doctorate would allow states that have regulatory language that mandates the MS degree for advanced practice time to consider the issues. For a good period of time into our future, we recommend that we maintain regulatory and accreditation options that do not force premature closure on the topic of the practice doctorate.

## SUMMARY

We have traveled a long, difficult road to achieve status and legitimacy within American universities and scientific communities. The practice doctorate, in our view, threatens our relatively recent and, therefore, fragile hold in both academe and science by reducing the number of nurses prepared at the PhD level and changing the nature of our university-based faculties of nursing.

We hope that the profession (including state regulatory and accrediting bodies) will take the time to be

thoughtful on the issue of the DNP. If we are not to suffer negative, unintended consequences, we will need to explore all the options available and engage our public and other health care disciplines in serious debate. Nurses and others must be encouraged and welcomed to share their views of the pros and cons of the various paths currently proposed.

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