THE DOCTORATE OF NURSING PRACTICE (DNP)
Synopsis of Literature and Practicing APN Concerns

WHAT IS THE DNP?

The DNP degree has been proposed by the AACN (American Association of Colleges of Nursing) as an alternative to the traditional PhD[1, 2] and to be the entry level degree to advanced nursing practice by the year 2015. The DNP would be the terminal professional degree representing the highest level of clinical competence[3] and a higher level of overall knowledge and responsibility with the same accountability and scope of practice as other clinical doctorates[4]. The DNP is considered a clinical or practice-oriented doctorate and involves skills beyond the baccalaureate degree without the necessity of an intermediary master's degree[5]. Other examples of this first professional doctoral degree include the doctor of medicine (MD) and the doctor of pharmacy (PharmD). These degrees are intended as entry into practice by the year 2015.

TIMELINE:

1979: The first practice-focused doctoral degree originated at Case Western Reserve University[2,3]. Since that time, a variety of doctoral programs emerged with a variety of titles including the ND, DNP, DrNP, DNS, DNSc, and DSN[6]. Results from a survey of 78 doctoral programs[6] showed a shift away from clinical doctorates to research doctorates, although few differences exist within the research focus of doctoral nursing programs.

2000: Mary Mundinger[7] published a randomized study in JAMA showing that nurse practitioners (prepared at Masters level) provided care that is at least equivalent to that of a physician.

2001: University of KY founded the first doctor of nursing practice (DNP), but a different model than proposed by Mundinger and Kane[7.]

2001: **January:** formal discussions among varied organizations regarding the practice doctorate were initiated at the AACN Doctoral Conference[3].

2002: **March**: the American Association of Colleges of Nursing (AACN) charged an 11 member task force with examining the status of current clinical or practice nursing doctorate programs in the US and with making future recommendations. All of these members were in academia, with the exception of one, who was the AACN staff liaison. Over the next two years, in partial collaboration with the National Association of Nurse Practitioner Faculties (NONPF), the task force worked on this issue.

2003: **January**: Limited discussions at AACN's doctoral education conference

February: A tele-web conference with NONPF and AACN was held regarding the practice doctorate[3].

March: Master's Education Conference open discussion

December: the AACN cosponsored with NONPF an open discussion on practice doctorates with representatives from key nursing organizations and schools of nursing with present or planned practice doctoral program.

December: a National Forum on the Practice Doctorate, an invited event, was held in Washington, DC[8]. Representatives from 25 national nursing organizations and 16 academic health centers attended, including the American Academy of Nurse Practitioners, American Association of Nurse Anesthetists, American College of Nurse Midwives, American College of Nurse Practitioners, the American Nurses Association, the American Nurses Credentialing Center, the National Association of Clinical Nurse Specialists, the National Association of Nurse Practitioners in Women's Health, the National Association of Pediatric Nurse Practitioners, the National Council of State Boards of Nursing, and the National League for Nursing. The minutes of this meeting were not distributed to the attendees or the larger nursing community.

2004: **February:** Limited discussion at AACN's doctoral education conference

February, an invited External Reaction Panel with 10 persons representing a wide array of perspectives an disciplines outside of nursing to respond to Draft Position Statement of practice doctorate. This external Reaction Panel included representatives from National Quality Forum, national Academy of Sciences, American Organization of Nurse executives, Association of Academic Health Centers, Department of Veterans Affairs, Yale University Law School, Council of Graduate Schools, and Association of American Medical Colleges.

October: American Association of Colleges of Nursing (AACN) endorsed the Position Statement on the Practice Doctorate in Nursing[9].

October: AACN member institutions voted to move current entry level (MSN) to advanced nursing practice to the doctorate level by 2015. This passed by a margin of 160 "for" and 106 "against" with only about 53% of eligible schools voting. Only those in attendance were able to vote, despite membership of over 500 schools[10, 11]. Dean-approved representatives, such as associate deans attending in the pace of a dean, were not permitted to vote. No proxy voting or absentee voting was permitted[11].

March: Limited discussion at annual Spring meeting (AACN)

2005: **January:** the AACN Doctoral Education Conference was held.

April: The National Association of Clinical Nurse Specialists published a White paper on the Nursing Practice Doctorate describing multiple reasons for their decision to not support the DNP proposal[12].

June: The American College of Nurse Midwives Division of Accreditation Governing Board affirmed the DNP as one option for some nurse-midwifery programs, but does not support the DNP as requirement for midwifery education[13].

June: the American Association of Nurse Anesthetists held a summit of the DNP and there was no support to move nurse anesthesia education to the doctoral entry level by 2015[14].

October: The American Academy of Nurse Practitioners published a discussion paper on the DNP, acknowledging that while transitioning to the clinical doctorate might be worthwhile, it is important that present masters prepared nurse practitioners not be disenfranchised or denigrated in any way. They also affirmed that care given by present, masters prepared nurse practitioners is safe and high quality care[15].

November: there are now 8 DNP programs and 2 DrNP programs accepting students in the US.

2006: **January**: the PA State Nurses Association publishes position statement against the DNP proposal[16].

March: Although there is much controversy over this issue and there is no national consensus, the AACN has moved forward with this proposal. CCNE has taken a position that it will only accredit DNP programs, not DrNP programs. NLN-AC's position is that it will accredit practice doctorate programs regardless of title

AACN PROPOSAL RATIONALE AND CONCERNS OF PRACTICING APNS

RATIONALE (AACN)	CONCERNS
Parity of status with medicine, pharmacy, psychology and academicians in other fields by raising the level of academic preparation for clinical teaching and expert clinical practice to doctorate level[17, 18, 1]. Nurses holding the DNP would be prepared and credentialed as independent practitioners like other professional disciplines such as pharmacy, psychology, and medicine and this would blur traditional titles such as doctor and nurse[19].	1. Medical backlash may occur as economic competition among providers is perceived or actually occurs [20,19]. 2. The legal use of the title "doctor" varies from state to state[21]. 3. The DNP would not change regulations at the onset. As noted above, state nurse practice acts would have to be opened and changed [3,11]. 4. Hospital admitting privileges would

	still have to be reviewed and approved by hospital medical boards[4] 5. Independent prescribing privileges would be state and payer perogatives[4]. 6. Multiple degree models exist for other disciplines, even medicine, dentistry, and veterinarians[22, 23]. 7. It is important to examine if the movement to the practice doctorate in other disciplines has improved patient outcomes. Parity should not be important if the result is not an improvement in health care outcomes[11].
Development of nurse scientists and researchers, with research originating from practice[24].	1. The DNP may threaten the meager supply of PhD trained, active researchers, leading to decreased evidence for which to base nursing practice and thus defeating one of the premises for creating the DNP[25, 22, 11]. 2. There are fewer than 500 nursing PhD graduates yearly [26]. 3. Nursing has traditionally sought graduate degrees at later ages than in other disciplines[26]. 4. It is important to investigate whether the movement to a practice doctorate in other disciplines has recruited potential PhD students away from research careers in that discipline[11].
Acquisition of practice doctorate as entry level into advanced practice by 2015[9].	1. Entry level into nursing practice has not yet been established[26]. 2. The masters degree has become increasingly recognized as the degree for all advanced practice and faculty roles and is the one degree that most (including state boards of nursing) are able to agree upon[26]. 3. There are more than 106,000 NPs currently practicing in the US[27]. 88% have graduate degrees, only 4% have doctorate degrees[3]. 95%

	are female and the average age is 48[27]. There are more than 69,017 CNSs currently practicing in the US, and 14,643 individuals who are qualified to work as a CNS or an NP. It is not feasible to expect there would be sufficient number of clinical doctorate programs to accommodate all these APNs[3]. 4. Current masters prepared APNs may be disenfranchised[28,,26,19] and grandfathering is imperative, although grandfathering may be only applicable as long as the practitioner remains within the state they are currently licensed[28]. 5. There is a potential for loss of employment for APNs who choose not to pursue the DNP[11]. 6. It is ultimately up to the individual state boards of nursing to mandate this degree for licensure eligibility[3]. This would require opening up each state's nurse practice act, inviting the attention of stakeholders who wish to limit or diminish existing scopes of practice[11]. 7. It is unlikely that the cost of further education will be rewarded with a commensurate higher salary [11,28]. It is also unknown if the DNP graduate will be affordable to employers and 3rd party payors[28]. 8. This timeline is not even supported by the NONPF[29]. A suggested 25 year timeline was viewed as more realistic by the American Association of Nurse Anesthetists[14]. 9. There is concern that there will be an assumption that all DNP graduates will be prepared as NPs. It is essential that the NP and CNS title remain protected and that all APN roles be recognized[30]. 10. This proposal is for a single practice doctorate that would

	include many roles of advanced practice such as the CNS, NP, nurse anesthetists, and the nurse midwife[11].
A terminal practice degree (the doctorate) is required to prepare nurses for the complexities of clinical advanced nursing practice today and the DNP would provide NPs with a higher level of knowledge that could advance clinical practice, enhance leadership skills, provide greater career goals, and flexibility[31,32,26,18]. Patients need more advanced care than graduates with current APN education can provide[4] due to the complexity of patients and continuous advances in care.	1. There is no evidence-based research that shows the doctorally prepared advanced practice nurse (APN) will provide safer, better or equal care to the masters prepared APN[24]. 2. The implication is that masters prepared APNs are unsafe, contrary to the growing body of evidence that masters prepared APNs provide cost effective and quality care[11,24,32]. 3. There is no harm data about care provided by the masters prepared APN according to the ANA malpractice data bank[11]. 4. The nature of additional knowledge in the DNP curricula versus the knowledge in the present masters level curricula is not known[11]. 5. There are no essential empirical and theoretical underpinnings to argue in favor of the DNP[11]. Just as practitioners are required to provide evidence-based practice, so should academia provide an empirical basis for decisions about doctoral provision[24]. 6. The DNP should be researched over time and outcomes examined longitudinally[11]. This would provide the above. 7. This debate has taken place primarily within association and academic meetings, not with practicing clinicians and not with specialty organizations such as ONS[26].
The current and projected shortage of nursing faculty could be addressed by nurses with the DNP as a terminal practice degree[1, 17, 21, 32].	1. The widespread initiation of DNP programs could potentially drain faculty and budgetary resources[21,22]. 2. The cost of moving to the proposed DNP is not known[11].

	3. The definition of the DNP suggests that more will be required of the student than in a PhD program, potentially devaluing the PhD[5,24]. 4. Contrary to the above, the DNP may not have the academic equivalence, status, and currency of the PhD[5,24]. 5. DNP graduates who practice in academia may be marginalized[33,34,11,12,22]. It is questionable that the DNP graduate who leaves clinical practice for academia would be eligible for tenure-tract faculty positions, thus excluded from the academic Senates and having a voice in decision making regarding educational and faculty policies [11,22]. 6. Currently, the AACN annual report shows that only 49.7% of nursing professors in baccalaureate or higher nursing education are currently prepared at the doctoral level[9]. 7. Nationally approved standards mandate that preceptors must have a degree greater than that of the student[5,11]. This gives forth the concern over who will be teaching and precepting in the DNP programs given the lack of existing professionals with these credentials. 8. The DNP may not adequately prepare graduates to teach, as the proposal for the DNP is not to ground students in the philosophy of science (or meta-theoretical) issues that define the nature of nursing practice and research[11]. 9. The need for preceptors for DNP students will pull doctorally prepared nurses in yet another direction[11].
Opportunity for shared learning due to	1. The DNP may enlarge the gap

inter-professional focus, collaboration, and communication across disciplines[21,24].	between academia and clinical nursing and increase the discord already present in the profession[26]. 2. Already there is debate over the title of this terminal degree: the AACN is recommending the DNP, while the NONPF is recommending the DPN[11,30].
The availability of a practice-oriented doctorate will attract "highly able" individuals to the field thus increasing the workforce[32]. At present, prospective graduate students from other fields may shy away from nursing as it does not offer a comparable credential after 4 years of professional preparation like pharmacy or medicine[19]. The high amount of credits needed for a masters in advanced nursing curricula exceeds the amount required for a masters degree in other disciplines[3,17,18,32].	1. Adopting the DNP by nursing programs will unnecessarily extend the length of time it takes to become an APN[26]. 2. None of the suggested models are less than 2 years, full time, in length (from masters in nursing to DNP) and models from high school graduate through DNP are from 8-9 years in length[35]. 3. The course requirements for the DNP programs suggest duplication of content already found in existing CNS programs. Most CNS curriculum is such that up to 30 masters credits may be counted toward a PhD in nursing[11].
The DNP should provide ideal preparation and credentialing for clinical teaching. Currently, most undergraduate faculty are master's prepared individuals who do not qualify for full faculty status because they have not earned a terminal degree in the discipline.	1. The very definition of the DNP is not clear as even the existing programs are vastly different[11,24]. Already there is debate that the DNP should not be the only practice doctorate degree model offered[20,22]. 2. There is great potential for more confusion (both collegial and public) regarding the merits, equivalences, and differences among the different forms of doctoral qualifications[24,26,33]. 3. The DNP is not universally endorsed by colleges and universities with graduate nursing education programs[22]. 4. There is a fear that many masters nursing programs will close[22]. 5. There is concern that few college faculties will be willing to amend

	their charters to permit nursing to offer their first doctoral degree, especially a professional doctorate[22]. 6. There may be a decrease in the number of educational institutions preparing APNs as many existing programs will close if not permitted by state statute to offer doctoral education or lack the fiscal or faculty resources to do so[11,18,21,32]. This would result in a decrease number of APNs providing much needed care.
Improvement in health care delivery by addressing the complexity of health care today[3,4,17,32,35].	1. There is no evidence that the DNP will improve access to care, cost of care, diversity of providers or quality of care.[26] 2. The timing of this debate is ill-timed, as there is a critical shortage of nurses, difficulty with retention, and threats to quality and safe care[25].

RECOMMENDATIONS:

- Carefully examine why change is needed (Cartwright & Reed, 2005; Clement, 2005)
- Move slowly
- Encourage input from public.
- Encourage input from other types of healthcare professionals.
- Encourage input from state boards of nursing.
- Bring academians and practitioners together and listen to one another (Olshansky, 2004).
- Examine other fields who have moved to clinical doctorates, such as audiology, physical therapy and pharmacology for the impact on improved patients comes, increases in salary, and enhanced enrollments in these programs (Fulton & Lyon, 2005). It is also important to examine if the clinical doctorate recruited potential PhD students away from research careers in these disciplines.
- Systematically evaluate outcomes of the DNP (Olshansky, 2004)
- If universities decide that the DNP is important for nursing, build the DNP as a post-master's degree. This will allow APNs the flexibility to select a doctoral program that meets their career goals (Dracup & Bryan-Brown, 2005). This would also allow states with regulatory language mandating the MSN for advanced practice to consider the issues, particularly in relationship to the issue of

"grandfathering" the already thousands of nurses certified in advanced practice (Fulton & Lyon, 2005).

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