EDITORIAL

Doctor of Nursing Practice—MRI or Total Body Scan?

By Kathleen Dracup, RN, DNSc, and Christopher W. Bryan-Brown, MD. From the School of Nursing, University of California, San Francisco, San Francisco, Calif (KD), and the Department of Anesthesiology, Albert Einstein College of Medicine, Bronx, NY (CWB-B).

Nursing as a profession appears destined to argue about educational preparation. This year we celebrate the 40th anniversary of the American Nurses Association's resolution that entry into practice will be at the bachelor's degree level (as a bachelor's of science degree in nursing or BSN). Despite the decades that have passed since that 1965 resolution, the majority of applicants to nursing programs continue to choose associate degree nursing programs, often for reasons of convenience and cost. The number of nurses who have a BSN has increased during the past 4 decades, and yet only 44% of the 2.7 million nurses in this country currently hold a bachelor's degree or higher,[1] making the entry into practice discussion a continuing hot topic.

Although we have not achieved the 1965 goal of a BSN-prepared workforce, we have managed to embitter several generations of nurses who feel that their education was discounted in that historic resolution. And now we appear to be headed down a similar path at the level of advanced practice. In October 2004, the American Association of Colleges of Nursing passed a resolution to support the doctor of nursing practice (DNP) as a terminal practice degree.[2] The degree is to be distinguished from the PhD, which has wide acceptance as a research-focused degree, and is to supplant the master's degree (ie, the DNP would be required for nurses who want an advanced practice role such as nurse practitioner or nurse anesthetist). Once again, we have a deadline: 2015.

To date, only one school, the University of Kentucky, has embarked on this new educational path, offering the DNP degree. Several schools also are awaiting approval for the degree to take the place of the master's of science (MS) degree for nurse practitioners, while many others are deliberating their course. By entering into this debate, nurses are collectively creating the future of our profession.

During the past 2 decades, graduate programs in nursing have multiplied like weeds in the rainy season, fueled somewhat by changes in healthcare in the 1990s. At last count, 351 schools offer an MS degree, while 25% offer a doctoral degree.[3] As states and professional nursing organizations have become clearer about the requirement of an MS degree for certification as an advanced practice nurse (ie, clinical nurse specialist, nurse anesthetist, nurse practitioner, or midwife), as well as for teaching and administrative roles, an increasing number of nurses have obtained an MS degree. Although the number of nurses prepared at the doctoral level remains small (less than 1%), the number of nurses who have gained an MS degree has doubled during the past decade and is now more than 10% of all nurses.[1] Thus, discussion about the MS degree becoming a DNP degree affects several hundred thousand nurses who already hold an MS degree, more thousands who are considering the best course for graduate study, the professional organizations who represent various nursing specialties, the credentialing bodies, the state boards of nursing, and the public.

Advantages of the DNP

In putting forward the argument for embarking on what many admit will be yet another mêlée in nursing, individuals have pointed to a number of advantages to having the DNP replace the MS degree. One of the most commonly identified advantages is parity with other healthcare disciplines.[4,5] Medicine and dentistry have long been identified with the professional doctorate, but other disciplines have either recently or are currently moving their entry into practice to begin at

the doctoral level. Pharmacists are now required to hold a doctor of pharmacy (PharmD) degree in order to practice. Other disciplines moving in the same direction are physical therapy, occupational therapy, optometry, and audiology. Consumers will soon know all of their healthcare providers as "doctor," and proponents of the DNP suggest that nurses should be included in this trend. For example, Olshansky[6] suggests that a DNP is necessary if nurses are "to 'be at the table' in an equal capacity with other healthcare providers and policymakers, providing input into and leadership for major decisions that affect the health and health care of our citizens."

A second reason offered by advocates of the DNP is the "credit creep" seen in MS degree programs in nursing.[2] Graduate nursing students are sometimes required to take double the amount of credits of other MS degree programs at the same university. The number of nursing credits is often the result of state-mandated clinical hours or clinical experiences required for certain roles (eg, nurse practitioner or midwife), as well as the complex clinical knowledge required to be a safe practitioner. Thus, it seems unlikely that nursing faculty will be able to reduce the number of credits required to get an MS degree even if they wanted to do so. According to proponents of the DNP, these same credits could be applied to a practice doctorate without substantially increasing the time it takes to earn a graduate degree.

The third reason supporting a DNP is that a terminal practice degree is required to prepare nurses for the complexities of clinical practice today and for their intense and far-reaching responsibilities. The suggested curriculum in the DNP recommendation includes clinical science, evidence-based practice methods, system leadership, information technology, health policy, and interdisciplinary collaboration.[2] Some university schools of nursing are considering adding the recommended curriculum topics to their nurse practitioner specialties, thus replacing their 2- year MS program with a 3- to 4-year curriculum.

Concerns

In the spirit of encouraging the debate that must precede any widespread adoption of a change in educational requirements, we pose 4 questions. First, will a new degree (the DNP) add to the public's confusion about educational requirements in the nursing profession? When a patient consults with a physician for care, that individual must, by law, hold an MD degree. When a patient meets a "nurse," that person must, by law, be an RN. The individual may hold a diploma in nursing, an associate degree, or a BSN. When a nurse says that he or she holds a doctoral degree in nursing, that degree may be a PhD, a DNS or DNSc (doctor of nursing science), a DSN (doctor of science in nursing), or an ND (a doctor of nursing). The confusion surrounding doctoral degrees in nursing reflects the profession's history within universities. At times, nursing faculty wanted to identify their research as being based in clinical practice (so opted for a professional degree rather than a PhD) or universities argued that nursing faculty did not have the resources or science base to offer a PhD, but allowed them to offer a professional degree instead.

During our decades of confusion around the entry into practice degree (diploma, AD, or BSN) and the doctoral degree (DNS, ND, DSN, or PhD), there has been one beacon of clarity: the MS degree. The MS degree increasingly became recognized as the degree required for all advanced practice and faculty roles. It is the one degree on which the profession (and state boards of nursing) seemed to agree. Now we worry that by replacing MS programs with programs awarding a DNP, we will compound the confusion that has existed at the BSN and PhD levels. The public, healthcare colleagues, and even nurses have difficulty sorting through the variety of educational options and paths already available in the profession, and we wonder if the DNP will add to the confusion. The BSN, MSN, and PhD are now recognized as the preferred degrees for each level of practice in nursing. 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. Will we lose that clarity by adding a practice doctorate? Does the DNP 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?

Second, we wonder if adding a practice doctorate will threaten the already tenuous supply of nurses who pursue a PhD. Nursing has been characterized by an extremely small percentage of nurses (fewer than 500 graduates annually) who obtain a PhD in nursing. In general, nurses seek graduate degrees later than do students in other disciplines (the average age of a nurse awarded a PhD is 45, which is a decade older than most other disciplines). Nurse academics 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 worry that the DNP may serve as an impediment to nurses entering PhD study relatively early in their professional careers. Students may feel required to obtain a DNP to have legitimacy in the

practice arena, and thus add years to their graduate study if they indeed persevere to earning a PhD. They also may see the DNP as an alternative to the PhD and decide not to pursue preparation for an academic career by earning a PhD. The adoption of the DNP by the profession may serve to diminish both the number of nursing PhD graduates and their years of productivity, thereby decreasing new contributions to the scientific basis of practice and diminishing the role of nursing on university campuses.

Third, we worry that the DNP will enlarge the gap that already exists between academic and clinical nursing and increase discord within the profession. To require a DNP for advanced practice that does not build on the MS degree will permanently separate basic and advanced practice nursing. Nurses working in critical care units 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 bachelor's degree level whether they want a career in clinical practice or research. We also worry that the current advanced practice nurses who hold MS degrees will feel disenfranchised. When nursing education moved from the hospital to the university or college setting, diploma nurses found themselves with an education that provided little or no college credit. We had an entire generation of embittered nurses who saw nursing academics as out of touch with clinical practice, and we continue to have difficulties articulating nurses from associate degree programs into bachelor programs. The current plan to convert all MS programs to professional doctoral programs would once again disenfranchise a large number of advanced practice nurses who believe 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 American Association of Colleges of Nursing 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 American Association of Colleges of Nursing proposal.[7]

Finally, we are concerned that adoption of the DNP by nursing programs will unnecessarily extend the length of time it takes a nurse to be prepared for advanced practice. We have a plethora of data showing that current advanced practice nurses have skills and competencies that produce equal or better patient outcomes than do physicians,[8] which means we do not need a practice doctorate to convince society of the value of advanced practice nurses. We also worry that requiring a DNP instead of an MS for advanced practice may diminish the number of programs available in the country. Universities that currently have MS nursing programs will not all be given approval by their administration and academic senates to offer a doctoral degree. Thus, the DNP will not improve access to care, cost of care, diversity of providers, or quality of care.

MRI or Body Scan

The development of magnetic resonance imaging (MRI) revolutionized medicine and our ability to detect pathology or disease. MRIs frequently are ordered in emergency rooms and intensive care units to confirm or rule out a life-threatening condition. In the 1990s, MRI trailers in hospital parking lots across the nation became a familiar site until hospitals were able to accommodate MRI facilities inside their walls. Today, we can't imagine life without MRI. Although discussions about the cost-benefit ratio of using them occurred during their early adoption, they are an important (and unquestioned) staple in our diagnostic armamentarium.

Similarly, the body scanner seemed like a miracle machine when first introduced. Abnormalities (perhaps indicating cancer or heart disease) could be identified early, leading to appropriate diagnostic testing. Thus, disease could be identified early when it was still treatable. Touting an innovation in healthcare, industry advertisements bombarded the public and healthcare providers with the wonders of a body scan. What happened? Initially, the public did show interest and even paid out of pocket for the test, but physicians were wary of the results. The findings from a body scan were nonspecific and led to expensive diagnostic tests, often with no benefit to the patient. Healthcare providers refused to order body scans and insurance companies were unwilling to pay for them. Ultimately, body scanners were an expensive healthcare fad.

We wonder if the DNP is the MRI of nursing education—the right degree at the right time—or if in the years to come the DNP will be viewed like the body scan—a fad that confused the public and ultimately was destructive to the nursing profession. We hope that the discipline will move slowly, encouraging input from the public, other types of healthcare professionals, and state accrediting boards before the DNP is adopted in university schools of nursing. We also hope that if universities decide the professional doctorate is important for nursing, that they will build the DNP as a post-master's degree. Maintaining an MS degree in nursing would allow nurses the flexibility to select a doctoral program that meets their career

goals. A post-master's practice doctorate would allow time for states that have regulatory language mandating the MS degree for advanced practice to consider the issues, particularly those related to "grandfathering" in the thousands of nurses who are already certified in advanced practice.

Currently, this debate is taking place in the relative isolation of association and academic meetings. We wonder what clinicians think of the proposal. Please write to us at AJCC@sonnet.ucla.edu with your opinion. We hope to be inundated with letters and will try to publish all of them! If we are not to suffer negative unintended consequences of this resolution, we will need to explore all the options available. Your view of the DNP resolution is important and will help bring those options to light.

REFERENCES

1. The Registered Nurse Population: Findings from the National Sample Survey of Registered Nurses, March 2000. Available at http://hrsa.gov/bhpr/rnsurvey2000/rnsurvey00.pdf. Accessed May 16, 2005.
2. AACN Position Statement on the Practice Doctorate in Nursing, October 2004. Accessed May 16, 2005 at http://www.aacn.nche.edu/DNP/pdf/DNP.pdf.
3. Berlin LE, Wilsey SJ, Bednash GD. 2004-2005 Enrollment and graduations in baccalaureate and graduate programs in nursing. Washington, DC: American Association of Colleges of Nursing; 2005.
4. Marion L, Viens D, O'Sullivan A, Crabtree C, Fontana S, Price M. The practice doctorate in nursing: future or fringe? Topics in Advanced Practice Nursing E-Journal. Available at http://www.medscape.com/viewarticle/453247. Accessed May 16, 2005.
5. NONPF Practice Doctorate Resource Center. Available at http://www.nonpf.org/cdhome.htm. Accessed May 16, 2005.
6. Olshansky E. Are nurses at the table? A new nursing degree could help. *J Prof Nurs.* July-August 2005;20:211-12.
7. National Association of Clinical Nurse Specialists White Paper on the Nursing Practice Doctorate, April 2005. Available at http://www.nacns.org. Accessed May 16, 2005.
8. Mundinger MD, Kane RL, Lenz, et al. Primary care outcomes in patients treated by nurse practitioners or physicians: a randomized trial. *JAMA.* 2000;283(1):59-68.