

DOCTOR OF NURSING PRACTICE: OPPORTUNITY AMIDST CHAOS

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We appreciate this opportunity to respond to the editorial¹ “Doctor of Nursing Practice—MRI or Total Body Scan?” by Kathleen Dracup and Christopher Bryan-Brown, published in the July 2005 issue of the *American Journal of Critical Care*. As nurse practitioner educators, our experiences both as teachers and clinicians influence our thoughts and feelings about the proposed move to the doctor of nursing practice (DNP) degree. Although we share some of the concerns about the impact of the DNP, we also disagree with several of the points made in the editorial and are excited by some of the possibilities that the DNP presents.

We do not agree that the DNP will “enlarge the gap that already exists between academic and clinical nursing.”^{21(p280)} In fact, we feel strongly that the DNP can potentially do just the opposite. In the current model of nursing education, research and clinical practice are hierarchically organized, with clinical practice (at either the basic level or the advanced practice level) requiring less educational preparation than research and scholarship do. This hierarchy has often led to a devaluing of nurse clinicians. Often it is the least educated faculty members who teach clinical courses, and it is the faculty members who have master’s degrees who become “clinical faculty” and who are often viewed as second-class citizens. Within our practice profession, we have long recognized and valued a funded research study over great clinical expertise. Nurse researchers who have doctoral degrees have been propelled through easily identified tenure track positions, attaining the job security that comes with such a promotion, while the practitioners of the practice profession have struggled to find clinical tenure tracks. Development and acceptance of the DNP, and the requisite elevation of advanced practice nursing to a doctoral level, has the potential to put clinical practice on the same level as research, allowing a true choice of career tracks of equal value in

academic settings. Furthermore, the competencies required for the DNP, which are a combination of skills in advanced practice and skills in evidence-based practice and clinical leadership, may provide a heretofore unavailable mechanism to bridge the practice-research chasm that has haunted nurses professionally. The degree may additionally bring together the spectral ends of the continuum of professional life: the academican researcher and the clinician.

In the editorial, Dracup and Bryan-Brown argue that the DNP will force nurses to choose between clinical practice or research if the nurses desire to advance their education beyond a bachelor of science degree in nursing (BSN). In reality, this forced choice already occurs; every day, on the basis of their individual interests in practice or research, as well as their desires (or lack thereof) to go on for a PhD, nurses who have BSNs make decisions about whether to pursue a degree in advanced practice nursing (APN) or other master’s degrees. Many nurses are drawn to the profession because of a desire to practice the art and science of nursing. To imply that this is an either-or choice (researcher or practitioner) is unsubstantiated. Some nurse educators are successfully combining all 3 aspects of the faculty role: research, service/clinical practice, and teaching. But others are struggling to achieve the tripartite mission. Nurse educators should be able to be clinicians, at the highest degreed level, with or without a mantle of research layered over their shoulders.

Dracup and Bryan-Brown also claim that the DNP will “disenfranchise a large number of APNs who believe they are appropriately prepared for roles as nurse practitioners, nurse midwives, anesthetists, and clinical nurse specialists.”^{21(p280)} However, a recent study of nurse practitioners revealed that many think that they were inadequately prepared by their educational programs (A. M. Hart, PhD, FNP, BC, C. Macnee, RN, PhD, unpublished data, 2005).

Additionally, we have received overwhelmingly positive feedback about the DNP from practicing APNs in Wyoming. These APNs are eager to aspire to

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new levels of potential practice and see the entry-level degree at the doctoral level as a move that will result in both increased professional respect and new and improved APN competencies.

Although we agree that the move to the DNP will lengthen the time it takes for nurses to become APNs, and that an unintended side effect of this could be fewer APNs, we argue that the additional educational and clinical training will strengthen advanced practice nursing in ways that may offset some of these possible problems. Many APN programs are already 2 to 2.5 years long, which is fairly long for master's degrees. The program at the University of Wyoming requires almost twice as many credits as the university requires for other master's degree programs.

Thus, DNP programs that are 3 to 4 years long are really not all that much longer than the existing master's programs. As well, the competencies and experiences obtained during these extra few years should help shorten and ease the transition period currently required of most beginning APNs as they progress from novice to competent clinicians and will ultimately better prepare them for the realities of advanced practice nursing. Consequently, we think that focusing on the length of the DNP program is not useful; focusing on the potential role and the quality of care such a person could provide is essential.

Perhaps what is most concerning is the possibility that the "DNP will not improve access to care, cost of care, diversity of providers, or quality of care."^{1(p280)} This possibility is the real challenge in the DNP debate. It is also the greatest potential benefit of the DNP. To meet this challenge—to improve access, decrease cost, and decrease disparities—the DNP must be conceptualized as more than just the current APN with some more knowledge added on. We must fundamentally reconsider advanced practice nursing and what exactly it is that a DNP should or could be. The basic assumption of Dracup and Bryan-Brown's argument is that master's level preparation for APNs is good, and to a large extent we agree. On the other hand, healthcare in America remains broken, and APN education could and should be better. Studies² indicate that outcomes of patients treated by MS-APNs are equal to (and sometimes better than) the outcomes of patients treated by physicians. But is this result really the epitome of advanced practice nursing? To simply have the same outcomes as medicine? Or to be widely seen as physician extenders or substitutes?³ To a significant extent,

much of what we teach in APN programs is medically focused. The core of advanced practice nursing is advanced assessment, advanced pathophysiology, pharmacology, interpretation of diagnostic tests, and management of disease⁴; that content is fundamentally shared knowledge and is not significantly different from what is found in traditional medical education.

We posit that the heart and soul of nursing is in health promotion to both healthy persons and patients dealing with chronic illnesses. Yet, currently APNs are not being prepared to assume high-level roles in health promotion and disease management based on the most recent concepts in the fields of health behavior change, the behavioral sciences, exercise physiology, nutrition, medical anthropology, and so on. Although these concepts are reportedly addressed in most APN programs, they currently do not represent the core science basis of advanced nursing practice and need to be a critical part of DNP training. The DNP gives nursing the opportunity to reconceptualize what advanced practice is and should be and to develop the core sciences of true advanced nursing practice. Ultimately, our vision is for care provided by APNs to be consistently "different," yet just as essential as care provided by physicians, especially in the areas of health promotion and disease management.

We look forward to more debate on the merits as well as the possible barriers and challenges associated with the implementation of DNP programs. We are excited by the possibilities of reconceptualized advanced practice nursing with a clearer focus on nursing and positive health outcomes. We appreciate the efforts of Dracup and Bryan-Brown to start the dialogue and we urge others to share their voices. It is only through such scholarly processes that we can advance as a profession.

The statements and opinions contained in this guest editorial are solely those of the authors.

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