GUEST EDITORIAL

DOCTOR OF NURSING PRACTICE: IN NEED OF DEFINITION

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I appreciate the opportunity to respond to the editorial[1] "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.* I work as a nurse practitioner and an educator at the graduate and undergraduate level, but more importantly, I am a nurse with a nursing doctorate (ND). My experience in academia and my work as a professional clinician have me struggling with ambivalent feelings about the wisdom of adopting the doctor of nursing practice (DNP) degree without truly redefining advanced clinical nursing practice.

I would like to address the first point discussed in the editorial, that another new doctoral degree will "add to the public's confusion about educational requirements in the nursing profession."[1(p279)] It is my position that the new degree might confuse not only the public but also the nursing profession itself, and perhaps even graduates of DNP programs, if great care is not taken to define and delineate the role of DNPs before the degree is adopted as a model for a clinical doctorate in both "direct" and "indirect" patient care.

In the position statement of the American Association of Colleges of Nursing on the practice doctorate in nursing,[2] advanced nursing practice is admittedly broadly defined as

> any form of nursing intervention that influences health care outcomes for individuals or populations, including the direct care of individual patients, management of care for individuals and populations, administration of nursing and health care organizations, and the development and implementation of health policy.

A curriculum model is proposed in the recent draft of DNP essentials[3] by the American Association of Colleges of Nursing; the model includes 8 essential competencies for practicing at the advanced level, with additional suggestions for supplemental course work in each student's chosen advanced specialty, whether direct or indirect healthcare. In general, these core competencies include the following: scientific underpinnings for practice, organizational and systems leadership, evidence-based practice, technology and information management, healthcare policy, collaboration, clinical prevention, and improving the delivery of healthcare. Although impressive, these competencies are both vastly broad and tremendously complex. In truth, few professionals exist today who are competent and equipped to effect change on organizational, fiscal, policy, community, and individual levels as part of their daily practice. Is it possible to educate an expert in policy, healthcare systems, information technology, and health prevention strategies in a short 4 years, perhaps on top of existing master's-level course work? If so, who is prepared to teach students to master these competencies? The DNP is intended to supplant all existing practice-focused doctoral programs, but the redundancy of the language describing this degree and other doctorates make the DNP sound like a nebulous "advanced generalist" degree without a clear direction for practice.

I am impressed and awed by the breadth of doctoral-level practice degrees currently available to nurses: NDs, DNSs, DNScs, and DSNs. Existing definitions of what advanced nursing practice should consist of are as varied as the positions these nurses hold after graduation. For example, the State University of New York at Buffalo defines its DNS program as a "research-focused degree that emphasizes the application of research to clinical practice, and role development in education, research, and policy leadership,"[4] whereas Florida Atlantic University describes the DNS as follows: "grounded in the philosophy of caring and focuses on the integration and application of advanced nursing research for improvement of nursing practice and the betterment of mankind."[5] At Case Western Reserve University, students can choose from 2 tracks to complete a post-licensure ND degree: in educa-

tional leadership or clinical leadership; the latter includes course work on policy, information management, and organizational behavior.[6] The recently phased-out ND program at the University of Colorado was described as an entry-into-practice "clinically professional degree," providing advanced preparation in "nursing-theory guided evidence-based models of care; a holistic perspective on the human experience of health, illness, and healing; models of case management and the continuum of care in the emerging health care system; and management and measurement of outcomes of care and utilization of information technology systems."[7]

I felt remarkably prepared for case management and community health when I graduated with my ND degree from the University of Colorado, and I absolutely enjoy the holistic, entrepreneurial nursing perspective the degree engenders in my practice. Nonetheless, in order to work at the advanced practice level, I had to return to school to earn my master's degree as an NP. In academia, I am unlikely to earn tenure as a professor unless I return to school and earn my PhD. With my ND, I have been unable to achieve true parity clinically or academically, and when I am asked "What is an ND, exactly?" I find that even after 6 years, I still have trouble describing what I learned in the concrete terms that colleagues expect.

The responsibility to introduce ourselves and represent what we know lies with individuals and the profession, not the degree. Non-MD professional doctors come in all shapes and sizes, from chiropractors, osteopaths, psychologists, and dentists to lawyers, pharmacists, physical therapists, audiologists, and doctors of philosophy. The fact that all these professionals can be called "doctor" does not seem to confuse the public any more than these graduates are confused about what they are trained to do. The confusion in nursing lies in the trouble we often have in discussing what it is we do, and unfortunately this confusion occurs not just at the doctoral level but at all levels as nurses struggle to describe and circumscribe their profession in a threatening healthcare system. The confusion over all levels of degrees offered in nursing education is a reflection of the difficulty in defining nurses' crucial, but often intangible, intuitive and qualitative professional domain. I agree that the debate over the DNP could be seen as an extension of the debate about what nurses really need to know to do their job professionally, competently, and expertly at all levels, from entry into practice to final professional degree.

To start, a new definition of advanced nursing practice is needed, and narrowing that definition must be the first step. Focusing on what we are doing right in the profession, drawing from the richness of the existing professional clinical doctorate degrees and the clinical rigor offered in many master's programs may lead us to develop the DNP as an expert nurse clinician rather than an advanced generalist with superficial skills in many areas but expertise in none. Room must be made within the DNP degree for a new nursing science, one that is interdisciplinary but with concrete clinical application and a unique, discrete set of skills.

I am truly excited by the opportunity to reconceptualize advanced nursing practice to better serve the needs of our profession and our patients. A great opportunity to cultivate focused goals and produce a professional clinician who addresses an as-yet unfilled professional niche is before us, and careful deliberation is needed with a vigilant, critical eye toward what we hope to accomplish, in light of our past mistakes. I look forward to much more debate on the DNP.

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

REFERENCES

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