

# The Doctor of Nursing Practice Degree: Lessons from the History of the Professional Doctorate in Other Health Disciplines

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## ABSTRACT

Despite the American Association of Colleges of Nursing's adoption of the Doctor of Nursing Practice (DNP) degree as the appropriate level of education for advanced practice, a number of controversies have persisted, including questions of timing, academic support, grandfathering, diffusion of nursing research, and economics. This article discusses the path to the professional doctorate in optometry, osteopathy, public health, pharmacy, physical therapy, audiology, chiropractic, and naturopathy. It reveals similar struggles to professionalism and the consensus drawn from doctoral development in these fields. It concludes with lessons for a path forward for the DNP.

As a graduate of Rush University, I proceed from a rich tradition of nursing innovation and progress, including the prescient Luther Christman, who championed doctorally prepared nursing leaders at the bedside (Sullivan, 2002) at a time when the idea seemed ludicrous. Nevertheless, nursing has followed a circuitous, and sometimes tortuous, path to professionalism. Its history is full of stops and starts, controversy, and even confusion.

Yet from Florence Nightingale, who organized a team of nurses to reduce mortality rates in the Crimean War

(Nightingale, 1859/1992), to Rozella Schlotfeldt's cogent advocacy for the clinical doctorate (1978)—an idea that has languished for nearly 30 years—the nursing profession has always possessed leaders who herald its future. In 2002, the American Association of Colleges of Nursing (AACN) Task Force on the Practice Doctorate in Nursing (Lenz, 2005) convened to reexamine the need for and nature of the clinical doctorate. (In this article, the term *practice doctorate* is not used because we are not practicing, and the only other profession which refers to its doctorate in this manner is nutrition. Perhaps we have landed on *practice doctorate* because we are loathe to say that we have not always lived up to our professional intentions.) In 2004, on the basis of an increasingly complex health care system and expanding opportunities for nursing leadership in quality, safety, and chronic disease management, the AACN adopted the Doctor of Nursing Practice (DNP) as necessary preparation for advanced practice nursing (AACN, 2006). In October 2005, the Commission on Collegiate Nursing Education cut through the dizzying array of doctoral nursing titles and determined that the DNP would be the sole professional doctorate for accreditation (AACN, 2005). In August of 2006, *The Essentials of Doctoral Education for Advanced Nursing Practice* identified the core competencies distinguishing the DNP (AACN, 2006). Nevertheless, controversy has persisted over the historical timing, purpose, and substance (Dreher, Donnelly, & Naremore, 2005; Meleis & Dracup, 2005) of the DNP, academic support, regulatory issues, and economics related to the DNP (Fulton & Lyon, 2005), and even the ethical character (Silva & Ludwick, 2006) and exact title for the DNP (Dreher et al., 2005).

Certainly, nursing is not alone in its exploration and development of a clinical doctorate. Nor are we unique in encountering resistance from without and dissent from within our profession. This article seeks to explore the history of professional and clinical doctorate development

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in health care disciplines outside nursing. It is hoped that this discussion will benefit the current conversation regarding the DNP. As the 19th century French writer and politician Alphonse de Lamartine, who worked to abolish slavery and the death penalty, said, "History teaches everything, including the future" (Szasz, n.d.).

### OPTOMETRY

Although many of us have had our eye examinations performed by a doctor of optometry, few of us are familiar with the profession's history. In the late 1800s and early 1900s, optometry was a nascent profession borne of tradesmen jewelers who possessed the tools to work on glasses. Men who created spectacles and those who performed refraction gradually became known as *opticians*. In the early 1900s, optometry laws and professional organizations began to form. In the 1930s and 1940s, the idea of a Doctor of Optometry (OD) degree began to circulate and take hold. By 1970, all universities offered the OD degree (Goss, 2003). The emerging profession was greeted with scoff by ophthalmologists, whose public campaigns suggested optometrists were poorly trained in eye disease. Ophthalmology literature referred to optometrists as "quacks." Ophthalmologists accentuated their training in eye disease and eye surgery, whereas optometrists emphasized the need for refraction and the reduction of eye-strain, a concept ophthalmologists failed to recognize (Goss, 2003). However, optometry's emphasis on prevention and serving common eye problems won optometrists a wide public following. During the 1980s and 1990s, the profession began to gain prescriptive authority, state by state, for eye-related medications.

### OSTEOPATHY

In the late 1800s, osteopathy emerged from a following of Andrew Still, an MD who reasoned that medications were not the optimal treatment for many disease processes. Osteopathy emphasized the relationship between structure and function, the influence of one body system on another, and the concept of wellness—that through equilibrium, the body could heal itself (Lesho, 1999). In 1934, an advisory board for osteopaths was formed. Early osteopathic medicine was primarily focused on outpatient primary care. In 1950, Missouri, the home of the Kirksville College of Osteopathy, became the first state to allow osteopaths (DOs) to practice in public hospitals with the same unrestricted privileges granted to their MD counterparts. The American Medical Association (AMA) was initially intolerant of this alternative form of practice. Due to AMA opposition, DOs could not serve as medical officers in the armed services in the 1950s. In the 1960s, the AMA attempted to prohibit the licensure of DOs in California. Eventually, the California Supreme Court overruled their referendum. By 1973, DOs were able to practice autonomously in all 50 states (Lesho, 1999). Although DOs and MDs clashed for many years, DOs persevered to gain ac-

cess to prescriptive and surgical authority and now maintain doctoral education and residency programs that emphasize the discipline's peculiarities.

### PUBLIC HEALTH

By its nature, public health is an interdisciplinary field. Public health maintains itself as a discipline due to its distinctive emphases on populations, rather than individuals, and on service. The profession is distinguished through the use of social analysis and exploration of systemic effects on health and disease in populations. Public health makes the case that physicians know little about the management of health systems or about prevention and promotion of health in populations (Roemer, 1988). The Doctor of Public Health (DrPH) degree originated in the early 1900s. This professional doctorate was developed to prepare individuals for senior policy and management positions. Doctorally prepared public health officials design, implement, and evaluate health programs and policies, translate research, and communicate for policy and health system change (Drexel University, 2006). In the past several decades, the public health literature has recommended use of its professional doctorate to educate doctoral-level generalists who are qualified to provide community health leadership at local, provincial, and national levels (Roemer, 1988). There is little literature indicating much dissension over the long history of this professional doctorate.

### PHARMACY

Faced with discrimination by the University of Pennsylvania medical faculty and a deterioration in pharmacy practice standards, in 1821 pharmacists united to form the Philadelphia School of Pharmacy and a self-policing board. Supplementing the advance of this unified, principled, and definitive stance, the mid-1800s included the Shaker community's commitment to gathering and cultivating approximately 200 medicinal herbs. In 1852, the American Pharmaceutical Association (APhA) was launched with clear objectives, a constitution, and a code of ethics. The APhA continues as the sole organized voice for the pharmacy profession today (Griffenhagen, 2002).

In 1948, the APhA recommended that colleges begin establishing 6-year PharmD programs (Gans, 1990). From the 1950s to the 1970s, universities began adopting clinical doctorates. Initially, the PharmD was offered primarily as a 2-year program following an undergraduate education, but by the late 1980s and early 1990s, it was being more widely offered as an entry-level 6-year program, as endorsed by the APhA delegates in 1977. In 1977, arguments for a single professional doctorate were made on the basis of the public's lack of awareness about and appreciation for the services a pharmacist could render, the idea that multiple levels of training might be detrimental to the profession, and concern that a two-degree system would promote fragmentation in the profession (LaFran-

co, Tannenbaum & Cannon, 1977). The literature indicated frustration over the tendency of physicians to view pharmacists as an extension of themselves, or *dispensers*. From the viewpoint of pharmacy, pharmacists were overqualified for such a role and should be recognized as health professionals (Taylor & Harding, 1989). During this time, many schools began to develop residency programs that would provide clinical and management experience after these programs (Smith, 1988). Some maintained that baccalaureate training might serve a community orientation, whereas PharmD training might better prepare a clinician for the more complex hospital setting (Cox, Carroll, & Wolfgang, 1989).

The debate about the requirement of the PharmD as the sole entry level to practice reached its apex in 1992. In that year, various professional organizations, including the APhA, the American Society of Hospital Pharmacists, and National Association of Retail Druggists, issued a joint statement in support of the new requirement, whereas the American College of Clinical Pharmacy issued an equivocal statement (Guerrero, 1992). The idea was to eliminate a two-tiered approach to pharmacy while adding an extra year to “digest course information at a less frenetic pace” (Gans, 1990, p. 26).

Academic discussion was heated. Clinicians recognized that a doctoral degree would not be equivalent to experience but would provide the basis of contemporary knowledge required for modern standards of professionalism (Weinburg, 1986). The rationale for the opposition to the entry-level PharmD consisted of increasing educational costs, increasing consumer costs, underuse of the pharmacist’s preparation, a reduction in overall quality compared with a postbaccalaureate PharmD, and inadequate faculty to train PharmD students (McLeod, 1992). The relative return to the student was also challenged, given that pay did not seem commensurate with the proposed educational preparation (Tse, 1992). Some expressed concern that the degree might result in inadequate numbers of PhD-prepared pharmaceutical researchers (Wurster, 1997). Increased management responsibilities, standardization of professional training, an expanding realm of knowledge, the demand for highly trained clinicians, and the desire for greater responsibility in providing direct patient care were some of the rationales advanced in support of the move (McLeod, 1992).

Prescient pharmacists suggested that the change was “inevitable regardless of our musings” (Guerrero, 1992, p. 569). In addition, despite growing national demand for pharmacists and a limited number of prepared faculty, in 1997 the American Council on Pharmaceutical Education mandated the PharmD as the sole degree program for accreditation to be implemented in 2000.

## ALTERNATIVE MODELS OF EDUCATION

Although they embraced doctoral education from early in their histories, naturopathy and chiropractic initially developed outside the bounds of typical universities, with

less emphasis on science as their basis, resulting in a designation of complementary and alternative disciplines. By contrast, acupuncture, ayurveda, homeopathy, reflexology, Reiki, and other alternative health disciplines have not pursued doctoral education. The inclusion of naturopathy and chiropractic as examples provides insight into disciplinary formation and identity.

### Chiropractic

Chiropractic history began in 1895 when Daniel David Palmer gave the first chiropractic adjustment and claimed he had restored a man’s hearing (Palmer, 1910). Previously, he had identified himself as a magnetic practitioner and referred to himself as “doctor” (Keating, Cleveland, & Menke, 1993). In 1896, Palmer opened his School of Chiropractic. One of his graduates subsequently formed the American School of Chiropractic and Nature Cure (ASC&NC) in 1903 (Keating et al., 1993). From these humble beginnings, the first of many controversies and divisions appeared within chiropractic. The ASC&NC preferred *mixing* chiropractic theories with other cures, whereas *straight* schools such as Palmer’s vehemently defended a pure form of chiropractic. In the early years of the 20th century, the AMA, formed in 1847, began to assert its influence in each state, applying standards for medical colleges and rejecting unacceptable schools such as homeopathy (AMA, 2005). Chiropractic distinguished itself by theorizing that nerves control health (Keating, 1998; Palmer, 1910), whereas osteopathy’s founder, Still, claimed vertebral adjustments enhanced blood flow. Still proceeded to embrace licensure and developed the field parallel to medicine, whereas Palmer persisted in vitriol regarding allopathic medicine, anti-mixing rhetoric, and a firm stance against licensure (Keating et al., 1993).

Although not the first attempt to organize, in 1906, D.D. Palmer’s son, B.J. Palmer, formed the Universal Chiropractic Association (UCA). As chiropractic expanded into 30 different schools with unique identities, organized medicine became relentless in pursuing chiropractors, resulting in more than 15,000 prosecutions for practicing medicine without a license by 1931 (Hug & Clancy, n.d.). In 1907, when a case was brought against a chiropractic doctor practicing osteopathy without a license, UCA attorney Tom Morris differentiated chiropractic from osteopathy as emphasizing the “supremacy of the nerve” over the artery (Keating, 1999, p. 569). In court cases, he repeatedly referred to the discipline as “separate and distinct” from medicine; analyzing, rather than diagnosing, removing cause rather than treating (Hug & Clancy, n.d., p. 3).

However, B.J. Palmer’s organization’s emphasis on purely the straight forms of chiropractic led to division. The UCA was to be followed by the American Chiropractic Association, which intended to raise professional standards, and the Chiropractic Health Bureau, which finally opened its doors to mixers.

Currently, there are 17 accredited chiropractic institutions, as established by the Council on Chiropractic Education (CCE) (2008a). Entry criteria, teaching meth-

odology, and chiropractic philosophy vary considerably between programs, although a 2.5 grade point average is required for prerequisite courses. Each requires at least 4,200 hours of combined classroom, laboratory, and clinical experience (CCE, 2008b). Graduates must pass four examinations from the National Board of Chiropractic Examiners (NBCE) and attend continuing education (NBCE, 2008). Many chiropractic colleges offer postdoctoral training in specialty areas.

### **Naturopathy**

Naturopathy claims Hippocrates as its predecessor (American Association of Naturopathic Physicians, 2004), although the discipline grew out of German medical practices of the mid-1800s, including the work of the German priest Father Kneipp (Reddy, 2004). Father Kneipp met with Dr. Benedict Lust in 1892, who brought naturopathic practices to the United States in 1896 (Bastyr University, 2008; Reddy, 2004). In 1901, Dr. Lust established the American College of Naturopathy. However, medical science and other political factors led to the decline and closure of naturopathic schools in the 1930s (Reddy, 2004). Until 1956, naturopathy was closely aligned with chiropractic education (National Association of Naturopathic Physicians, 1968; Reddy, 2004). However, in 1956, the National College of Naturopathic Medicine opened in Portland, Oregon, offering 4-year naturopathic medical training for the first time (Reddy, 2004).

Naturopathy combines several philosophies, practices, and therapies emphasizing nutrition, homeopathy, botanicals, physical medicine, and health counseling (American Association of Naturopathic Physicians, 2004). Naturopathy distinguishes itself by reference to its six defining principles: support the healing power of nature, identify and treat the cause, first do no harm, treat the whole person, the physician as teacher, and prevention (Canadian College of Naturopathic Medicine, n.d.; Naturopathic Medicine Network, 2007). Its central understanding is that the cause of disease is stagnation and accumulation of toxins and that disease is a reaction to unnatural environments. The body's vital force is believed to be capable of effecting cures. Treatment is understood to be achieved through treating retention (i.e., opening pores, increasing respiration, ingesting adequate nutrients), invasion (i.e., tonic treatments to control and keep the symptoms within safe limits), and enervation (i.e., maintaining circulation, nutrition, emotional rest) (Hew Report, 1968). Gradually, the standard for professional naturopathic practice became 4 years and 4,100 hours of study from an accredited college and passage of the Naturopathic Physicians Licensing Examination (NPLEX®). This test evaluates a graduate's knowledge in basic sciences, diagnostic and therapeutic subjects, and discipline-specific clinical sciences. By 1999, naturopathic physicians were licensed as health care providers in 11 states and drew students from 3 accredited institutions (Bastyr University, 2008) and several other nonaccredited schools. These schools, as well as their associated postdoctoral residency programs, are accredited

by the Council on Naturopathic Medical Education (2006). Nevertheless, the field's lack of a formal residency program has been a source of criticism from within and without the discipline (Atwood, 2003; Shepherd, 2004).

### **PROFESSIONAL DOCTORATES STILL IN PROGRESS**

Some health professions have not yet coalesced around the requirement of the professional doctorate. These include nutrition, physical activity or kinesiology, occupational therapy, and Eastern forms of medicine. For the purposes of this article, nutrition will be used as an exemplar for professions still in the process of clinical doctorate development.

#### **Nutrition**

For most of its history, research in nutrition has been conducted by nutritionists and nonnutritionists with PhDs, DrPHs, EdDs, and doctorates of science (ScDs) (Keller, Ostbye, Edwards, & Johnston, 1999). Nutrition has tended to function from the notion of differential competencies. Although it has not sought consensus on a clinical doctorate for its advanced clinicians, more recently a chorus of voices in the profession has begun to express interest in proceeding along that path. The impetus for this direction has been increasing recognition of major advances in biologic sciences, genomics, and behavioral sciences. These developments have created new opportunities for nutrition experts to interface with other disciplines while continuing to maintain their unique professional identity (Allen, Bentley, Donovan, Ney, & Stover, 2002).

Some advocate for the emergence of the advanced dietetics expert in diagnosis, evidence-based practice, outcomes monitoring, and the conduct of research (Touger-Decker, 2004). Nutrition has recognized that educational barriers are the primary impediment to realizing dietetics-specific diagnostic practice. In 1993, a study among 100 nutritionists indicated strong interest in the clinical doctorate (Christie & Kight, 1993). A later study indicated interest in advanced practice competencies and a professional doctorate among a subset of registered dietitians and clinical nutrition managers in academic medical centers (Skipper & Lewis, 2006). In 2003, the School of Health Related Professions at the University of Medicine and Dentistry of New Jersey (UMDNJ) opened the first clinical doctorate program in nutrition (DCN) (UMDNJ, n.d.).

### **MORE RECENT DEVELOPMENTS**

#### **Physical Therapy**

In 1997, the American Physical Therapy Association identified the Doctor of Physical Therapy (DPT) degree to be one of six elements necessary in the transition to a fully professionalized discipline (Johanson, 2005). Most proposed this as a generalist education befitting an individual entering professional practice (Deusinger et al., 1993). In the same year, the Commission on Accreditation

in Physical Therapy Education provided that, as of 2002, only programs at the postbaccalaureate level would be accredited (Rothstein, 1998b). The entry-level doctorate was deemed to be the only appropriate educational preparation for the expanding body of knowledge required for practice (Rothstein, 1998a). It was also seen as a means toward direct access, or the ability of the physical therapist to treat patients directly without physician referral (Massey, 2001).

Like pharmacists, physical therapists made arguments for the DPT parallel to those made by nursing for DNP parity with other disciplines, student and employer demand, changes in the health care system, and leadership content (Marion, O'Sullivan, Crabtree, Price, & Fontana, 2005) and grappled with comparable effects. What will happen to currently practicing therapists? What about the costs of increasing standard education? Does a generalist education prepare graduates for increasingly specialized roles?

### Audiology

Alongside other health care professions, audiology is a fairly modern advancement. The profession was birthed after technology for measuring hearing was developed in the 1920s (American Speech-Language Hearing Association [ASHA], 2006). The term *audiologist* didn't appear until 1946, when treatment for war-related hearing loss began. The first state licensure of audiologists occurred in Florida in 1969. In 1976, a conference to discuss the professional doctorate demonstrated little support for the idea, as the majority of attendees possessed the PhD (O'Neill, 1987). The call for a practice doctorate came from the grassroots, as practicing audiologists were often frustrated by their dependence on physicians and hearing centers. A doctorate was seen as the means to professional autonomy and respect (Shafer, 2005). Meanwhile, academics remained concerned that a professional doctorate would undermine the research degree.

In 1983, the ASHA determined that a master's degree was insufficient professional preparation in the field of audiology. In 1984, the group recommended the professional doctorate. In 1986, ASHA further recommended the professional doctorate as the entry level for practice. In 1988, the Academy of Dispensing Audiologists held a conference paving the way for doctoral preparation. This was followed by a parallel ASHA conference in 2000 (ASHA, 2001). In 1994, the Audiology Foundation of America provided a grant to introduce the first university AuD program. However, debate ensued over the length of programs and clinical training (Shafer, 2005). In 1997, ASHA proposed full implementation of the AuD in 2012 (Academy of Doctors of Audiology, 2006). Ultimately, the profession came to acknowledge the distinction between the PhD and the professional doctorate, with its emphasis on clinical proficiency in the wide array of diagnostic, remedial, and other services associated with the practice of audiology and the importance of extensive externships. The American Academy of Audiology (2006) also has recognized that master's-

prepared audiologists are necessary during the transition to a fully doctoral profession.

## IMPLICATIONS FOR NURSING

### Our History

The modern explosion of health care information has resulted in numerous professional specializations and concentrations. With this expansion of knowledge and concentrated expertise has come the desire for autonomy, distinction, and public recognition by a growing number of health specialties. Increasing competency expectations and deepening bodies of relevant knowledge have resulted in nearly every health profession choosing the professional doctorate as the entry level for practice. So what can nursing learn from the various paths taken to the professional doctorate? First, perhaps we should reconsider certain aspects of our own history.

The word *nursing* is derived from the Latin word *nurtire*, or *to nourish*. Nursing likely evolved from the role of women in primitive civilizations in caring for their own families and tribes. Thus, nursing has been referred to as the oldest of arts and the youngest of professions (Donahue, 1996). It is instructive to recall that since the 1860s, when Nightingale outlined a model of nursing—the assistance of reparative processes, leadership, environmental assessment, patient education, and patient-centered holistic care (Nightingale, 1859/1992)—we, as a profession, have struggled to define the margins of caring, or nourishment. Nightingale training was known more for its moral imperatives than for its sound intellectual and educational preparation, a task taken up by later schools such as the Preliminary Training School (Weir, 2000). The initially fragmented curriculum and incoherent knowledge base led to a profession with ill-defined boundaries (Weir, 2000), while sexism, the institutionalization of care for the sick, and the growing power of physicians led to the exploitation—and a crippling paralysis—of nursing (Roberts, 2006). Internalization of inferiority and subordination to the values of medicine became the norm. Even today, nurses of every stripe are routinely molded in a system that denigrates their core values and fails to validate their identity. Nurses often become subsumed by their hospital or clinical environment's medical culture in order to be accepted (Roberts, 2006). Part of nursing's internal struggles has been a reflection of this culture of oppression. However, to thrive as a discipline, nursing must develop from within, remaining fully aware of how destructive in-fighting and division (note chiropractic's history here) can be to external recognition and full professional expression.

Although the Jamaican-born doctress Mary Grant Seacole, a woman who nursed British soldiers in the Caribbean and Central America and worked alongside Nightingale in the Crimean war, has been proposed as the first model nurse practitioner (NP) (Messmer & Parchment, 1998), historically it is Loretta Ford, working in association with Dr. Henry Silver in 1965, who is recognized as

the first nurse practitioner. An NP program developed as a result of this association at the University of Colorado. This program was intended to combine the best of nursing with advanced assessment and diagnostic skills. Instead, what followed was nursing's pattern of legal and financial dependence on physicians, slow implementation of standardized graduate programs, and the absence of a single organization to represent NP interests, with the American Nurses Association declining to serve as an umbrella organization at a national meeting in 1985 (Edmunds, 2000). This and the common status of NPs as employees led Edmunds (2000) to conclude that "there is no obvious move for NP independent practice" (Provider Status section, ¶5).

The DNP is the natural evolution of professional nursing that began with the introduction of NP programs in the 1960s and nursing doctorate (ND) programs in the 1970s (Hathaway, Jacobs, Stegbauer, Thompson, & Graff, 2006). It is a continuation of the original intentions of ND programs to educate nursing clinical leaders able to provide care management, critical and complex clinical judgment, nursing therapeutics, and the appropriate use of technology to effect change (Watson & Philips, 1992). These ideas are transformative, and when communicated in terms our clients and stakeholders can grasp, they have the potential to reform the way health care is designed and delivered. The Colorado ND program existed for the purpose of providing a broad-based generalist preparation, including program evaluation, health economics, and health policy, within the context of 3,800 hours or more of practicum experience (Phillips & Watson, 1993; Watson & Phillips, 1992). This is the disciplinary integrity we must maintain, refine, and promote. Like naturopathy, osteopathy, chiropractic, and optometry, we must coalesce around and enhance our distinctive form of proactive model in service to well-being in life. To completely embrace its doctoral education model, nursing must mature as a profession "which works jointly *with* other health professionals, not under them," fully accountable to the public (Watson & Philips, 1992, p. 22). Just as pharmacy refuses to be reduced to *dispensers*, advanced practice nursing cannot and should not be reduced—either from dissembling within or from external pressures without—to a *physician extender* or *mid-level* role.

Although nursing bears its failure to identify minimum educational preparation for the inclusion of the term *nurse* in an individual's title and to agree on minimal educational preparation for entry into professional practice, nursing's environment and sociopolitical context have been the principal barriers in the development of its doctoral programs. The history of nursing doctoral development reflects its marginalization and identification that was splintered among various university goals, paradigms, and nursing theories. In the early days of nursing graduate education, nurses obtained doctoral preparation via alternate disciplines. However, this process was found to be insufficient for disciplinary progress. Some nursing schools, wishing to distinguish themselves or, more often, facing the resis-

tance of university administration to grant nurses the opportunity to study for a PhD, offered the Doctor of Nursing science (DNS or DNSc) degree. Meanwhile, educators and nursing faculty valued the educational doctorate (EdD) degree. The DNS was sometimes offered by the school rather than the university (Meleis & Dracup, 2005). When schools were able to demonstrate a critical mass of doctorally prepared faculty and appropriate research programs, they transitioned to the PhD degree, allowing nursing faculty to claim a voice in university administration and to affect policies, budgets, and university priorities (Meleis & Dracup, 2005). Clarity about the DNP as the appropriate entry point for autonomous advanced practice, with opportunities for postdoctoral specialties, will permit clear clinical and research development, as well as specialization within the scope of our profession.

### Our Identity

Despite these many challenges, within nursing we can and must reframe our external struggles as merely a subset of our own larger struggle—to fully articulate our identity and true value to the greater world. Inadequacies in the conceptualization of nursing and the structuring of nursing knowledge restrict its work to preserve, restore, and promote human health (Watson & Philips, 1992).

*Nursing Values.* Although nurses sometimes struggle to articulate their profession's singular identity, over time, nursing has clarified its core values, particularly those of dignity, integrity, autonomy, altruism, social justice (Fahrenwald, et al., 2005), caring, and holism (Watson, 2002). Although it has suffered attacks on its competence, depth, and body of knowledge, maintaining focus on its fundamental purpose and emphasizing its disciplinary distinctives (i.e., prevention, holism, client advocacy, and humanistic compassion—indeed human betterment) will guide its way to the future. Professional nursing is autonomous, a discipline that is complementary to other health disciplines, and one that works to advocate for the client at the borders of other health professions. Nursing is exceptional not because we hold some guarded sphere of knowledge, but because our frame of prevention, education, and advocacy results in clients who are empowered, chronic conditions whose courses are altered, quality of life that is enhanced, and ultimately, reductions in costs and unnecessary intervention.

*A Profession of Autonomous and Complementary Advocacy at the Borders of Other Professions.* Like optometry and osteopathy, nursing has grown up alongside another profession—medicine. Phenomenological hermeneutics research into the borders between medicine and nursing have identified the two as autonomous but complementary professions (Wolf, 1989). In a sense, medicine is reactive and protective in its service to life. It stands in a negative relation to its primary objective (i.e., an ailment). Alleviation of or no ailment is the goal and end. Nursing is proactive and participatory in its service to life. It stands in a positive relation to its primary objective (i.e., well-being), and the no ailment goal is only the beginning. Nursing es-

entially begins where medicine ends, both in philosophical orientation and in practice, with overlap where both are well suited to serve. Practice follows principle in each case. The difference in professional practices flows from the difference in orientation to life.

*The Nursing Difference.* It is nursing that educates an aging population regarding noninterventionist, holistic, family, and community approaches to end-of-life quality of life. It is nursing that educates individuals, groups, and community planners to elucidate how behavior and social structures affect health. It is nursing that advocates for low-cost, practical, patient-centered approaches to self-care. It is nursing that must seize on each of the preceding notions and many more to transform the delivery of care from an illness-based model to a proactive wellness-based, life-affirming model of care. It is nursing that must convince health care payors of its value in reducing costs and improving quality, benefits such as those already found in postnatal home visits by nurses (Lipman & Tiedje, 2005), nurse practitioner case management (Paez & Allen, 2006), and overall cost analysis of nurse practitioners in primary care (Curtis & Netten, 2007). Rather than becoming embroiled in politics (recall here the current stalemate between our dueling political parties in the states), it is nursing that must—client by client and change initiative by change initiative—convince American citizens of its ability to change life, through a distinctly nursing approach to health, for the better. We must remain convinced of this compelling purpose, for ceding this territory to others will only erode our professional identity.

### Future Directions

With the DNP, we stand at a critical juncture in our stage of development. It is a conjuncture of nursing development that is not to be unexpected and one in which we cannot be disheartened. It is also a conjuncture of invitation as we consider the challenges ahead. In a world experiencing an unprecedented proliferation of knowledge, diagnostic, pharmaceutical, and therapeutic options, expert DNP-prepared clinicians draw from a comprehensive knowledge base to analyze available research and data to apply the best art and science toward the care of individuals and groups. In the midst of tremendous pressures to prescribe rather than educate, expert DNP-prepared clinicians add value by taking the time to address prevention and wellness, and to consider the client within a holistic context at every consultation. In a culture that provides immediate access to massive amounts of data, individualized direct to consumer marketing of products, and encouragement of self-diagnosis, expert DNP-prepared clinicians advocate for and educate individuals and groups to differentiate relevant and irrelevant information. In a nation straining from the public health plights of obesity, diabetes, and environmental toxins, DNP-prepared clinicians develop culturally appropriate, data-driven, innovative programs that address stakeholder concerns while building on previous research to effect organizational and societal change.

The responsibility we bear and what is at stake is the American health care system itself.

In a health milieu that has become receptive to holistic (although not yet recognized as nursing) paradigms, nursing must weigh the consequences of an internal lack of consensus and the cost of ongoing vicissitudes. We cannot permit our past, our politics, or internal paralysis to impede our progress toward our ultimate goal—service to our clients, health organizations, and nation. Until every advanced practice nurse—actually, until every nurse—can articulate this compelling vision of transformative nursing, we will remain professionally handicapped. The DNP not only affords nursing students a sufficient educational background for the provision of expert nursing care, but also imparts an adequate comprehension of their revolutionary role.

### Recommendations

*The Clinical Residency.* Nursing, in a manner akin to naturopathy, has remained ambivalent about requiring a residency component. Certainly some of this is reactive, related to concerns of mimicking medicine. But we must also bear much of the responsibility for failing to support the elevation of our colleagues and of our profession to fully serve our clients, communities, organizations, and health systems.

The PhD educational provision culminates in original research, whereas the DNP's essential educational component is the clinical residency precisely because advanced expertise in nursing care and nursing leadership is what our country needs. Through research, our PhD colleagues determine what works well, whereas our DNP colleagues put this work into practice, disseminating innovation to improve quality of life, reduce health disparities and overall costs, and enhance the quality of care delivered. Along with our public health doctorally prepared colleagues, DNPs translate research into practice to lead change and to evaluate outcomes to transform the underlying principles and delivery of health care (AACN, 2006).

Perhaps due to an obstructed vision, we have not defined nor have we crafted a strategy to implement the educational and clinical experiences all advanced nurse clinicians must possess for comprehensive client care. A minimum year-long residency following current preceptor placements must be advanced not for ourselves, but for credibility with our stakeholders and those we serve. Ensuring quality standardized educational programs with nursing distinctives and a standard residency for advanced practice nurses will prepare future graduates for the advocacy and expert preventive programming nursing means to contribute. Flinter (2005), clinical director of a Connecticut federally qualified health center, effectively communicated the clinical residency as integral to initial practice parity and synthesized graduate competencies.

*Dual Doctoral Paths.* Along with our audiology colleagues, we can create a safe space for complementarity. With our PhD colleagues generating new information and our DNP colleagues translating these concepts into prac-

tice, the PhD and DNP invaluable complement each other in service to our profession and to our patients, our organizations, payors, and the citizenry who support much of American health care. Nursing must transition its DNS, DNSc, DrNP and other clinical designations to a clear commitment to one research doctorate (the PhD) and one clinical doctorate (the DNP).

*Entry to (Basic) Advanced Practice.* From pharmacy, audiology, physical therapy, law, and others, we see that a clinical doctorate is meant for basic preparation for advanced practice. Residencies, postdoctoral specialty training, and even research doctorates may follow, dependent on individual professional goals. Here is where nursing may have strayed. In our recent penchant for change, have we not gone far enough? Have we failed to define a core within the clinical doctorate as the preparation for entry into all advanced practice with subsequent specialization? Envisioning a future with basic certification for NP generalist practice based on doctoral education, followed by specialization is consistent with the National Council of State Boards of Nursing's recent "Vision Paper: The Future Regulation of Advanced Practice Nursing" (2006), and seeks to correct the lack of uniformity in practice and education across various states. However, many issues remain unresolved, such as whether residencies should apply to all advanced practice registered nurses, the role of the clinical nurse specialist, and whether NPs would be granted licensure based on a generalist or specialist examination or both (American Academy of Nurse Practitioners, 2006; Lancaster, 2006).

*Grandmothering.* Like physical therapy, occupational therapy, audiology, and pharmacy, we learn that competent practitioners without a doctorate need not fear losing their positions. We do not devalue the master's-prepared advanced practice nurse, as some have proposed (Meleis & Dracup, 2005). Rather, we embrace the richness of clinical experience former graduates offer, granting implicit credibility, requesting input as to future educational developments, and providing fast-track doctoral programs for experienced clinicians, while advocating for adequate educational preparation for our future.

## CONCLUSION

Like those in pharmacy and physical therapy, we in nursing have debated, we have discussed, and we have struggled with the transition to an entry-level clinical doctorate. Although we still have concerns, we must advance. We must acknowledge that our insurers and payors, the regulators, our health care system, and our patients depend on the clarity of nursing's internal vision. We must recognize that, given the explosion of health and nursing research, the need for advanced preparation and specialization of nursing practice, and a health care system in disarray the DNP is—dare we say it?—inevitable.

The DNP is not only inevitable, but also necessary. Our patients, clinics, hospitals, insurers, and nonprofit organizations are silently pleading for competent, comprehen-

sively *nursing* practitioners. It is these and other stakeholders who need energized doctorally prepared nurses at the table advocating a whole, well-being oriented vision of health care on their behalf. Nevertheless, we are not released from the responsibility of the regulatory, practice standard, and professional development work that remains to be done. To garner the external reinforcements that would rise up if only our stakeholders better understood our profession, nursing must possess the confidence that comes from assurance of its own internal clarity and purpose.

In the words of a professor of optometry, "Every profession justifies its existence by being better at something than another profession—a niche" (Goss, 2003, p. 9).

Nursing's niche is its caring and healing client-centered ethic and work at the intersection of other disciplines to proactively advocate holistic, evidence-based, empowering healing for the client. Nursing exists to guide individuals through the labyrinth of health care choices, to guide populations toward lifestyle change, to advocate beyond chronic disease to wellness, and to guide a health care system back to sanity. In abdicating this responsibility and power to others, we abandon our patients.

It is vital that these changes be substantive, not merely cursory; be genuine and not superficial; be sustained rather than transitory; and that a total commitment to this evolution be made by both educators and practitioners in the profession (LaFranco et al., 1977).

Let us reconcile, reconvene, and roll up our sleeves, tackling the regulatory, licensure, educational, and structural issues associated with the DNP. As nursing does, let us not cling to the ways of old, but rather move toward our future. Luther Christman, Rozella Schlotfeldt, and Alphonse de Lamartine would be proud.

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