

## LETTERS TO THE EDITORS

Letters to the Editors are welcome and encouraged. Letters must raise points of current interest or address topics that have been previously addressed in the *American Journal of Critical Care*. Keep your letter concise. Letters are subject to editing. Include your name, credentials, title (optional), city and state, and telephone number (for verification, not for publication). Address to Kathleen Dracup, RN, DNSc, School of Nursing, University of California at Los Angeles, Factor Building, Box 956918, Los Angeles, CA 90095-6918; fax, (310) 794-7482; or e-mail, [AJCC@sonnet.ucla.edu](mailto:AJCC@sonnet.ucla.edu).

### Nursing Practice and Advanced Degrees

I read with interest your editorial (“Doctor of Nursing Practice—MRI or Total Body Scan?”) about the proposed doctorate in nursing practice (DNP) program (July 2005: 278-281). A clinical nurse specialist (CNS) at the end of a 50-year career, I started as a diploma nurse, obtained a bachelor of science in nursing (BSN), and finally earned a master of science in nursing. I too had feelings initially of being disenfranchised and concerned about the quality of education that was being provided in the academic setting and felt “punished” because I had to practically start over to obtain my BSN. Why don’t we learn from our past “mistakes” and look at what is good for the public and the entire healthcare system? We made a mistake 40 years ago that has caused much dissension in our profession, and we should recognize that we need to move deliberately now to avoid repeating the past.

As an advanced practice nurse (CNS), I can see the value of building on my practice degree to the next level—that of a doctorate! You mentioned a natural progression through the system, and that is the way it needs to be. We are not all at the same stage of professional development, and we need to practice a while at each level as we grow and recognize the strengths of academic degrees versus clinical experience and then decide what is best for us. I am completely opposed to jumping from a BSN level to the doctorate level without taking the opportunity to “hone” your skills first.

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I am always concerned about the confusion we bring upon ourselves as a profession with all of the different regulations and titles that we use from state to state. Advanced practice nurses have so many varying initials after our names—ANP, NP-C, NP, CNP, APRN, and so on—that even someone within the profession has a hard time keeping them all straight. I think we need to agree from state to state on some uniformity in what we call ourselves first and foremost.

As far as doctoral preparation, I think that multiple titles are less confusing than the above. It is my belief that adding a doctorate in nursing practice (DNP) as a postgraduate degree would add less confusion than

explaining to every patient who calls me “Doc” that I am not a “Doc.” Physicians have multiple doctoral degrees within their profession, including MD, DO, MD/PhD, DMD, DPM, and more. Their patients know them only as Doctor. Any doctoral degree will help give our profession the credibility we continue to fight for. Advanced education is always a plus for our profession and, more importantly, for our patients.

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### Varying Approaches to End-of-Life Care

Having faced the situation described in “Questions Concerning the Goodness of Hastening Death” (May 2006: 312-314) the very weekend I read the article, I had a vehement reaction to it. The author seemed to assume that patients, families, and healthcare providers function at a level of ignorance that can be overcome only by research and advanced degrees. True, many people are unable to talk about death before they’re confronted with a life-threatening illness. But many patients and their families incorporate religious beliefs, cultural mores, knowledge about their disease process, and personal values into decisions about how death should be approached.

As a patient advocate I strive to develop relationships with patients and their families that will make me privy to the process by which decision making occurs, without imposing my own beliefs. As I have become more experienced at the bedside, I have rethought calling certain actions “withdrawing care” and identified actions as interventions in the face of redirection of the plan of care. In end-of-life circumstances, I reassure families that the intensity of care will not change, even if the goals of care do.

The minute-by-minute, hour-by-hour family experience of death cannot be dissected by a cerebral dialogue like Pascal’s Gamble. After 30 years of nursing, mostly in critical care, I feel that no death has ever been the same. The tone of this article devalues knowledge gained from experience, and the rhetoric certainly depersonalizes this basic human event.

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