

The Practice Doctorate: Innovation or Disruption?

Susan K. Chase, EdD, APRN, BC; and Rosanne H. Pruitt, PhD, APRN, BC

ABSTRACT

Advanced practice nurses, particularly nurse practitioners, have been described as a disruptive innovation. The American Association of Colleges of Nursing (AACN) has proposed that by 2015 all advanced practice nurses be prepared with a Doctor of Nursing Practice (DNP). This article uses critical reflection on published literature to examine the potential difficulties that mandating such a change may present to potential students, practicing advanced practice nurses, colleges of nursing, and doctoral education in general.

After considering the pressures in the nursing profession to prepare nurse faculty and reviewing the success of current models of education for advanced practice, we explore in depth the unintended consequences of the AACN recommendation. Implications for academic nursing, curriculum, advanced practice nurses, doctoral education, titling and licensure, economic issues, and the lack of evaluation research are addressed. We recommend abandoning the 2015 deadline for implementation of advanced practice nurse preparation with the DNP.

Advanced practice registered nurses (APRNs) have been described as a disruptive innovation in health care (Christensen, Bohmer, & Kenagy, 2000). Key

features of disruptive innovations are that they arise as economical and efficient solutions to increasing complexity. By providing a simpler solution to customary modes of action, they disrupt the current processes and procedures in use. Because of this, they are frequently resisted by stakeholders in the status quo. In addition, innovations can be disruptive by causing unintended consequences in the systems into which they are introduced. Some of these consequences are fortuitous, opening doors to new opportunities and possibilities, while others can be destructive to features of the environment, causing losses to both individuals and organizational stakeholders.

It is important to evaluate innovations based on their contribution to solving problems efficiently, as well as their effects on current structures and processes. The recent American Association of Colleges of Nursing (AACN) (2004a, 2004b) recommendation of the Doctor of Nursing Practice (DNP) as the required preparation for all APRNs by 2015 can be considered a potentially disruptive innovation. The purpose of this article is to explore the possible unintended consequences of the DNP movement to help individual and group stakeholders in preparing for the changes this movement will produce.

The practice doctorate is not a new phenomenon. Existing in medicine for the past century and recently adopted by pharmacy, physical therapy and other health care professional groups, these programs are viewed as "undergraduate" in that they provide the first professional degree. Nurses have argued about the proper preparation for the first professional degree for decades. The Nursing Doctorate (ND), which was limited to a very few institutions is being phased out, following AACN recommendations. The curriculum models for Doctor of Nursing Practice programs (Marion, O'Sullivan, Crabtree, Price, & Fontana, 2005) primarily focus on the DNP as added content after the master's preparation for advanced practice roles. This is, by nature, a different degree than the prelicensure programs developed for medi-

Received: August 9, 2005

Accepted: December 6, 2005

Dr. Chase is Interim Assistant Dean for Doctoral Programs and Associate Professor, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, Florida; and Dr. Pruitt is Professor and Director, Clemson University School of Nursing, Clemson, South Carolina.

Address correspondence to Susan K. Chase, EdD, APRN, BC, Interim Assistant Dean for Doctoral Programs and Associate Professor, Christine E. Lynn College of Nursing, Florida Atlantic University, 777 Glades Road, Boca Raton, FL 33431; e-mail: schase@fau.edu.

cine, pharmacy, and others. In fact, half of the four models presented by Marion et al. (2005) and most current programs require certification in advanced practice roles before admission. The question is: Does the DNP movement provide an innovation that solves a problem of complexity by providing a simpler solution to problems, or does it add increasing complexity and enhance the position of key stakeholders?

CRISIS IN NURSING

Nursing is in crisis, and as in any crisis, there are opportunities and dangers. The major crises in nursing revolve around shortages of frontline providers and acute shortages of nurse educators to prepare nurses at all levels. Key factors in this crisis are technological advancement in the care environment, an imbalance between the number and preparation level of nurses needed to function in that environment, and aging of the current faculty workforce. Technology, which often decreases the need for workers, has paradoxically increased the demand for nurses with greater skill sets.

Research supports that nurses prepared at the baccalaureate level improve quality of care and are able to positively affect health care outcomes (Aiken, Clarke, Cheung, Sloane, & Silber, 2003). Baccalaureate and higher degree level nurses can only be prepared by faculty with doctoral level analytic skills. The rising popularity of the movement toward Magnet status for hospitals (AACN, 2002), further strengthened by the research of Aiken et al. (2003), has gained the attention of many hospital administrators. Many of these administrators are now looking at the skill mix of their employees and the need to balance the large percentages of technical nurses with nurses who possess baccalaureate and higher degrees to meet the Magnet guidelines.

With doctorally prepared faculty in short supply due to attrition and retirements, nursing programs across the country have increased numbers of part-time faculty members to supervise clinical learning. Recent research has demonstrated decreased satisfaction among students of part-time, compared to full-time, faculty related to teaching ability and competence (Allison-Jones & Hirt, 2004). The increasing use of part-time faculty may also influence students' educational outcomes. Now that staff nurse salaries have risen in response to the competition for nurses, nurses with advanced degrees are finding that teaching in colleges or universities brings comparatively higher pressure and less pay than positions in the service sector.

SUCCESSES IN INNOVATION

The nurse practitioner (NP) movement, while it began as predominantly certificate programs, has rapidly advanced to graduate-level preparation. Preparation of NPs has dominated graduate programs at the master's level for the past 2 decades. For several decades, the National Organization of Nurse Practitioner Faculties (NONPF) and others have worked diligently to establish and promote standardization of core preparation, resulting in increased quality in NP education across the country (NONPF, 2002). Research has

demonstrated acceptance of the NP by the public, the federal government, and payers (Roblin, Becker, Adams, Howard, & Roberts, 2004). The value of the NP role is demonstrated by the success of nurse-managed centers (Barkauskas et al., 2004) and the exemplary care provided to the consumer, at times using entrepreneurial models (Donald & McCurdy, 2002). In addition, the NP movement has attracted postdoctoral students and is highly valued by graduates from other fields who seek nursing as a second degree. The NP has changed the landscape of nursing.

Nurse practitioners have been a major force in promoting legislation to enable more autonomous practice in most states (Pruitt, Wetsel, Smith, & Spitler, 2002). Nurse practitioners working with other APRNs (certified nurse midwives, nurse anesthetists, and often clinical nurse specialists) have gained increased autonomy and garnered prescriptive authority in most states. Advanced practice registered nurses as a group have changed the practice of nursing. Other APRN roles have also been successful models and were developed many years before the advent of the first NPs. The expanding scope of practice and success of all the advanced practice nursing roles has not been hindered by the fact that most APRNs have been prepared at the master's level.

INNOVATION FOR INNOVATION'S SAKE

Most system changes come about as a result of changes in inputs, processes, or outputs in response to varying pressures or unsolved problems. It is unclear what is driving the DNP system change. Have nurses who wish to be prepared as APRNs asked for educational programs with more credits, longer time to graduation, and higher costs? Have employers expressed dissatisfaction with the preparation of current APRNs? Did the majority of colleges who prepare APRNs ($n = 351$) seek the challenge of building doctoral programs in institutions that may or may not even be approved to grant the doctorate?

Currently, 91 nursing programs offer the doctorate in some form (AACN, 2005a). An external observer would be prompted to ask what problem is being solved by the DNP movement and who stands to benefit from it. One rationale for the DNP has been that current master's degree nursing graduates are "undercredentialed." That is, most universities require 30 semester hours for the master's degree, whereas advanced practice nursing programs frequently require 45 to 50 credits for the master's degree. The logic of requiring significantly higher numbers of credits to prepare for advanced practice roles is difficult to grasp, even with the change in degree title.

UNANTICIPATED CONSEQUENCES: EFFECTS ON ACADEMIC NURSING

The nursing profession has worked hard for many decades to be a part of academia. Moving from diploma training programs to centers of nursing education and leadership was not achieved without difficulty. The nursing professorate now enjoys senior ranks in academia at leading universities across the United States. Nursing scholars successfully con-

tribute to the tripartite mission of these institutions through scholarship, teaching, and service. Having an advanced practice credential, once considered a detriment, has become an asset for those who have successfully blended scholarship and practice with teaching. With university degrees, graduates enjoy a smooth articulation between undergraduate, master's, and doctoral programs across the country. However, this institution is endangered by impending faculty shortages. The AACN has said that DNP graduates are not expected to assume a faculty role without additional education (AACN, 2004b). By preparing graduates whose credentials will not prepare them for full participation in the academic community, the DNP disrupts the flow of graduates to a single terminal degree. Doctor of nursing practice graduates will be diverted from the potential to prepare for tenure-earning faculty positions because of the need for additional credentials.

The DNP is designed to support leadership development in nursing practice and is not meant to prepare educators, and DNP programs largely ignore the skill set required to provide quality education. Unfortunately, PhD programs also fail to prepare educators who understand curriculum development and evaluation, but many PhD programs do provide students the opportunity to serve as teaching assistants. In addition, PhD graduates have the research skills required for the faculty role.

What will be the consequences of the DNP movement in colleges of nursing? Current programs that prepare APRNs number 351 and produced 9,765 graduates in 2004 (AACN, 2005a). Will students interested in being prepared as NPs, for example, be prepared to register for 80 to 100 postbaccalaureate credits, compared to a traditional 45-credit master's of science in nursing program? What type of financial aid will private colleges need to provide for potential students whose tuition bills will run as high as \$80,000 to \$100,000? Will the allure of a doctorate degree make up for the additional cost when schools attempt to recruit students?

How will the more than 200 current advanced practice programs in institutions that do not offer the doctorate transition to providing a doctoral degree? Partnerships between nondoctoral institutions and those that produce doctorate degrees have been discussed; however, the quagmire of credit allocation, control of admission and curriculum, and faculty preparation make these partnerships extremely difficult to envision. Faculty members frequently have difficulty obtaining approval for an interdisciplinary course within one university because of departmental budget issues. In addition, many master's degree programs currently use master's-prepared APRNs to teach at least some of the courses in the master's-level clinical tracks. What credentials and preparation will accrediting agencies require for faculty in DNP programs?

The effect of a move to the DNP on current doctoral program enrollments has not been examined. There has been only a small increase in doctoral program enrollments in recent years. Will nursing programs be able to support two different doctoral programs in the same institution? Will enrollment in PhD or DNS programs actually decline, as students are offered multiple paths to doctoral preparation? What is

the optimal educational path for students who want both advanced practice preparation and the PhD to support an eventual teaching position at a university?

TITLING AND LICENSURE

A variety of paths to advanced practice nursing have been shown to be effective. The public is beginning to recognize and value advanced practice nursing roles. They recognize the titles of "nurse practitioner," and "nurse midwife" and have come to expect services based on competencies. The nursing profession has, until fall 2004, accepted that the master's degree in nursing prepares nurses to be competent providers of advanced practice nursing. Certifying bodies have performed extensive job analyses, developed certification examinations, and are credentialing master's-prepared nurses in advanced practice roles. State boards of nursing, albeit with a good bit of variety, credential advanced practice nurses with the master's degree to practice in the expanded role. In the absence of evidence that competence is lacking, a variety of programs should be available to students seeking advanced preparation. The DNP, as proposed by the AACN, is an academic degree. It is unclear how state boards of nursing, which control scope of practice in each state, will credential DNP graduates. If there is no change in scope of practice, then how will care delivered by DNPs differ from care already delivered by APRNs?

The current title of the practice doctorate also causes controversy and confusion (Gennaro, 2004). As a part of the 2015 implementation, the AACN is holding to the title of the practice doctorate as the Doctorate of Nursing Practice (DNP). The "NP" in this title clearly confuses the public since not all DNPs will be nurse practitioners. A title such as Doctor in the Practice of Nursing or DPN would be less confusing to the public.

CURRICULA

Preparation for the new DNP role is an important consideration. After the decision to require the DNP, the AACN has continued to develop suggested content for DNP programs (AACN, 2005b). The September 23, 2005, draft of the DNP "Essentials" recommends preparation for roles in administration, policy, and advanced practice nursing. Suggested content includes philosophy of science, biology, pathophysiology, nursing science, middle-range practice theories, quality improvement, evaluation for cost effectiveness, business planning, finance, health law, organizational dynamics, clinical policy and procedure assessment, change, care delivery models, risk management, conflict negotiation, marketing, ethics, research critique, evaluation research, epidemiology, information systems, database development, legislative and regulatory processes, policy analysis, advocacy, international models of health care, culture of professions, team building, cultural diversity, emerging infectious diseases, emergency preparedness, health assessment, clinical reasoning, evidence-based practice, patient safety, advanced pharmacology, and advanced care management (AACN, 2005b). Surprisingly, little content in the discipline of nursing is present in

TABLE 1

Doctor of Nursing Practice Programs Listed on the American Association of Colleges of Nursing Web Site (as of August 1, 2005)

<p>Case Western Reserve University http://fpb.cwru.edu/DNP/index.shtm</p>
<p>Columbia University http://www.cumc.columbia.edu/dept/nursing/programs/dnnp_approved.html</p>
<p>Drexel University http://www.drexel.edu/cnhp/dnnp_program/about.asp</p>
<p>Rush University http://www.rushu.rush.edu/nursing/pos/doctor_nursing_nd.html</p>
<p>Tri-College University Nursing Consortium (Concordia College; Minnesota State University, Moorhead; North Dakota State University) http://www.ndsu.nodak.edu/tricollege/trinursing/DNP.htm</p>
<p>University of Colorado, Denver http://www2.uchsc.edu/son/sonweb.asp?content=education/content/NDdefault.htm&section=Education&LNav=education/lnav/educationLNav.asp</p>
<p>University of Kentucky http://www.mc.uky.edu/Nursing/academic/dnp/default.html</p>
<p>University of South Carolina http://www.sc.edu/nursing/gradfaq.html</p>
<p>University of Tennessee, Memphis http://www.utmem.edu/nursing/academic%20programs/DNP/index.php</p>

this list, which although not exhaustive, does represent the majority of suggested content. Will graduates of programs with this content be prepared to articulate the nursing profession's contribution to health care or develop knowledge that advances the discipline of nursing?

The current curricula used for DNP programs differ widely (Gennaro, 2004). In preparation for this article, the curricula of all current DNP programs listed with on the AACN Web site were analyzed based on their own posted Web sites (Table 1). In addition to the DNP, all of the programs offer master's degrees to prepare for advanced practice roles. All of them admit students after they have achieved the master's degree and are certified, and two offer direct DNP admission after achievement of the baccalaureate degree (Columbia University, University of South Carolina). Three use a portfolio evaluation process (Columbia University; Tri-College University Nursing Consortium; University of Colorado, Denver). Only one requires a dissertation (Columbia University). Others require an applied research project, a research utilization project (University of Kentucky, University of South Carolina), or a practicum or residency project (University of Tennessee, Memphis). Some curriculum innovation is evident with the Educational Leadership track

at Case Western Reserve University, which offers courses in curriculum, and a focus on interdisciplinary courses at the University of Tennessee, Memphis.

Curriculum models and proposed program outcomes for the schools vary widely. Most discuss influencing practice and having skill in role performance. When did these stop being the objective of master's level programs? Management and leadership courses are evident in most programs. Courses in the DNP curricula are listed in Table 2. These curricula are surprisingly weak on nursing content, given that the title is related to nursing practice.

One of the stated reasons that additional education is needed at the DNP level is so that graduates can participate more actively in the interdisciplinary environment. To truly participate from a disciplinary perspective, one needs a clear grasp of the features and strengths of one's own discipline, so it can be represented well. As DNP curricula continue to develop, nursing faculty need to press to include the knowledge of the discipline itself in these plans of study. What evidence is being applied in evidence-based practice? How much of it is based in a nursing model?

One feature of many of the DNP curricula is an extensive residency. The argument has been that this is necessary for full skill acquisition. Questions that should be posed include: Is this not the model for preparation that college-based programs argued was not necessary for quality education in earlier generations? Experience by itself is not necessarily illuminating. The structure and support for such experiences will be the key to the success of the new programs, if new skills are to be implemented. Description and evaluation of the early programs will be essential to planning for the future. Publication of such papers should be a top priority for leaders of the new programs. We suggest that time be taken to determine the optimal curriculum for advanced practice in nursing (Marion et al., 2005). Paradigm-shifting recommendations have thus far been made based on very little data.

PRACTICE: OPPOSITION FROM APRNs

Publicity about the fall 2004 vote by AACN to move all advanced practice education to the practice doctorate model has disenfranchised many APRNs in the field. These APRNs, who have not been a part of the decision and were largely left outside any discussion, feel threatened. Changing the preparation of all APRNs makes the assumption that the current system does not work. Representatives of all APRN groups challenge that their current education is not broken (Nelson, 2005). The biggest confusion will be generated by the fact that not all DNP graduates will be NPs, a regulatory title with national recognition.

Most of the current DNP programs are based in academic health centers. Will a model that has begun in such a setting carry over to community-based settings where nursing programs may or may not be approved to grant the doctorate and where most APRNs function in community-based settings and practices? Advanced practice registered nurses have already obtained admitting privileges to hospitals, if that is the measure of success.

Current NP competencies have adequately guided advanced practice nursing educational preparation to this point. Is there any evidence that separate courses in epidemiology, policy, or information systems will be used by the majority of frontline APRNs? We suggest that research be conducted on the different practice patterns DNP graduates are able to demonstrate. Plans are underway for the Task Force on the Essentials of Nursing to prepare an Essentials document for the DNP. With so few graduates thus far, will these competencies be based in practice, as they were for the master's Essentials document, or will they be developed by stakeholders in the DNP movement, based on projected practice patterns? Until the time that clear advantages are shown, multiple paths of preparation for APRNs should be supported.

DOCTORAL EDUCATION

Doctoral programs in nursing are growing at a moderate pace, although the number of students enrolling in these programs has not increased greatly during the past 5 years (AACN, 2005a). The subject of the meaning of a doctoral degree has been discussed often recently, both inside and outside of nursing (Gumpert, 1990), and these discussions have not included an argument for elimination of analytic skills and independent research. Nursing is still a relative newcomer in the academic community. Doctoral-level educators have pushed hard to maintain the rigor of the educational experience, so graduates of nursing doctoral programs will be prepared to contribute to interdisciplinary research and program development. Milton (2005) argued against the practice/applied science aspect of the proposed DNP models and advocates for doctoral degrees based in theory.

Nursing has learned over decades that having multiple pathways to the same title (RN) has led to confusion. To now support a degree that allows graduates to be recognized as doctorally prepared when the same level of rigor in their preparation has not been required risks dismantling the hard work of doctoral educators over the past 50 years. What skills, abilities, or knowledge can potential employers expect from doctorally prepared nurses when different educational paths are presented?

At a deeper level the question is: Along with much of higher education, what is the fundamental meaning of doctoral education? Doctoral education should be for increasing graduates' capacities and quality of thought. Graduates should be expected to be able to think creatively and independently and communicate clearly. They should have conceptual skills that allow them to propose innovative solutions to human problems. They should have analytical skills that allow them to evaluate and use evidence from a variety of sources to draw conclusions about the world. They should be developing knowledge for the discipline and have developed expertise in at least one facet of that knowledge. They should approach problem identification and problem solving from a theoretic perspective (Whall, 2005).

Nurses with expertise as practitioners are the source of important research questions in nursing. The idea that some nurses are scientists and some are practitioners will move

TABLE 2
Course Topics in Current
Doctor of Nursing Practice Programs

Action research
Biostatistics
Business planning
Clinical genetics
Diversity and social issues
Economic and financial aspects
Epidemiology
Evidence-based practice
Health care organizations
Health care systems
Human resource management
Implementing change
Information systems
Leadership
Management in advanced practice
Nursing administration
Nursing research
Organizational theories
Outcomes management
Policy issues
Program development and evaluation
Role transformation
Theoretical foundations of nursing

our profession backwards. The idea that a doctoral program would have a training mentality with a residency attached does not move doctoral education forward; it looks backward and borrows from other professions. When will nursing celebrate its own strengths and not build programs patterned after other professions?

CURRENT NURSING DOCTORATES

The nursing profession currently has many doctorally prepared APRNs who function in a variety of roles, including administration, education, and practice. These APRNs with doctoral degrees enrich nursing with their strong research foundations, which have been the distinguishing feature of doctoral education. The curriculum models for the proposed DNP prepare graduates for advanced practice and, with few exceptions, minimize research preparation. In addition, practice doctorate models, with few exceptions, are not designed to prepare future nurse educators. Most DNP graduates will not have the necessary skill set for postdoctoral academic positions. Thus, we conclude that the DNP does not address nursing's most critical need—preparation of future nurse educators.

THE REAL PROBLEM IN NURSING

Our primary concern is that this radical restructuring of APRN education does not address the real problem in nursing associated with shortages of nurses, especially nurse educators. Transition to a practice doctorate will be expensive in terms of time and other costs. Resources are always scarce and most likely better spent addressing real problems in nursing and the health care arena. If nursing graduate schools wish to prepare the DNP, then they should be allowed to do so to recognize additional coursework preparation. If small colleges that prepare quality APRN graduates wish to remain a master's degree-granting program, they should be allowed to do so. By preparing a mix of programs, the nursing profession can conduct real educational and practice research, and determine which model truly is responsive to both market and practice demands. Which model prepares APRNs for high-quality practice the most efficiently?

RELATED ECONOMIC ISSUES

Colleges of nursing, whether public or private, are under tremendous pressure to recruit students, maintain adequate tuition and/or state funding levels, and recruit for and keep faculty lines. Making programs more arduous and expensive has real potential to weaken nursing programs when they are vulnerable. Programs of varying sizes have faced closure in recent years. How does a private university recruit baccalaureate graduates into an APRN program when the price tag is \$80,000 or more? The differential earning capacity of APRNs, compared to staff nurses, has decreased in recent years. The argument for graduate study will be even more difficult to make when additional coursework will be required. With the increasing costs and credit allocation in nursing education, more potential nurses may opt for the more lucrative option of medical education.

The cost of the DNP to health care delivery is another critical issue. With increasing preparation costs, the number of NPs will decrease, yielding fewer primary care providers. A resultant demand for increased salary from graduates of longer, more expensive programs will contribute to the upward spiral of health care costs. Much of the nursing profession's success with federal support and training funds is partly a result of role preparation as cost-effective care providers. As a disruptive innovation, NPs have provided efficient, cost-effective alternatives to health care delivery. Increasing the cost and complexity of APRN preparation does not, by itself, improve the health care system.

PROPOSED SOLUTIONS

We appreciate those who have pushed to raise the bar on education for delivering quality health care in a complex health care environment. However, we recommend caution in rapidly expanding untested and currently evolving ideas. Time and evaluation are needed to examine ways to strengthen the theory-practice links through the DNP or other models to advance the discipline.

Innovative programs evolve based on evaluation data. A key component is the thoughtful review of the effects and outcome of program changes. Without pressure or deadlines, programs can choose to emulate one of the proposed models or create a different model. Recommendations to avoid a crisis would include removal of the AACN's 2015 deadline.

It is essential for the nursing profession to recognize the contributions of its current doctorally prepared advanced practice nursing workforce and avoid alienating those who have already made advancements in practice and academic settings. Articulation models need to be carefully crafted to recognize and use the skill and knowledge base of master's prepared APRNs, with a focus on enrichment through coursework to enhance their skills in navigating and influencing health care systems. The profession must avoid the devaluation and burdensome accumulation of credits consistent with early models at the undergraduate level.

Programs must also address preparation for the faculty role. On-the-job training will not promote quality educational outcomes. Programs that use multiple levels of preparation for faculty ranks must work to create clinical tracks that will enable these future nursing leaders to thrive in university settings. Programs must look for ways to provide support for faculty members who want or need additional academic preparation in the practice doctorate or other arenas. Attaining and maintaining clinical expertise is essential for faculty members who are guiding students in clinical arenas at all levels.

REFLECTION ON PROCESS

While some applaud the steps the AACN has taken to promote the DNP movement (Sperhac & Clinton, 2004), the policy implications of this change are extensive. There are multiple stakeholders who must be a part of the process, including universities, the health care system, payers related to reimbursement rates, as well as the nursing profession. Universities (and taxpayers) will bear significant cost in achieving this discipline-based change.

What is needed at this time is a series of open conferences that bring together all APRN organizations and include multiple stakeholders to discuss models for success in preparing for the future. In addition, it would be beneficial to include deans and program directors from many types of programs, employers from a variety of settings, representatives from the National Council on State Boards of Nursing, and perhaps colleagues from other disciplines. The focus of these meetings should be to address the real concerns of the health care system as a whole and those of the educational programs that prepare nurses for advanced practice. Evaluation data and innovative case study presentations can be aired as part of the conversation. There is much work to be done. The AACN's recommendation that all APRNs be prepared at the doctoral level with a specific degree title is premature. Any requirement that all programs that prepare advanced practice nurses be at the doctoral level by 2015 should be abandoned. The practice doctorate should remain an educational innovation whose worth can be evaluated.

REFERENCES

- Aiken, L.H., Clarke, S.P., Cheung, R.B., Sloane, D.M., & Silber, J.H. (2003). Educational levels of hospital nurses and surgical patient mortality. *Journal of the American Medical Association, 290*, 1617-1623.
- Allison-Jones, L., & Hirt, J. (2004). Comparing the teaching effectiveness of part-time and full-time clinical faculty. *Nursing Education Perspectives, 25*, 238-243.
- American Association of Colleges of Nursing. (2002). *Hallmarks of the professional nursing practice environment*. Retrieved May 3, 2005, from <http://www.aacn.nche.edu/Publications/positions/hallmarks.htm>
- American Association of Colleges of Nursing. (2004a). *Press release: AACN adopts a new vision for the future of nursing education and practice; 2004*. Retrieved May 5, 2005, from <http://www.aacn.nche.edu/Media/NewsReleases/DNPRelease.htm>
- American Association of Colleges of Nursing. (2004b). *AACN position statement on the practice doctorate in nursing*. Retrieved October 12, 2005, from <http://www.aacn.nche.edu/DNP/DNPPositionStatement.htm>
- American Association of Colleges of Nursing. (2005a). *2004-2005 enrollment and graduations in baccalaureate and graduate programs in nursing*. Washington, DC: Author.
- American Association of Colleges of Nursing. (2005b). *DNP essentials: Revised September 23, 2005*. Retrieved October 12, 2005, from <http://www.aacn.nche.edu/DNP/pdf/Essentials9-23.pdf>
- Barkauskas, V.H., Pohl, J., Breer, L., Tanner, C., Bostrom, A.C., Benkert, R., et al. (2004). Academic nurse-managed centers: approaches to evaluation. *Outcomes Management, 8*(1), 57-66.
- Christensen, C.M., Bohmer, R., & Kenagy, J. (2000). Will disruptive innovations cure health care? *Harvard Business Review, 78*(5), 102-112.
- Donald, F.C., & McCurdy, C. (2002). Review: Nurse practitioner primary care improves patient satisfaction and quality of care with no difference in health outcomes. *Evidence-Based Nursing, 5*, 121.
- Gennaro, S. (2004). A rose by any other name? *Journal of Professional Nursing, 20*, 277-278.
- Gumport, P.J. (1990). Transformations in American graduate education and research. *Educational Policy, 4*, 313-326.
- Marion, L.N., O'Sullivan, A.L., Crabtree, M.K., Price, M., & Fontana, S.A. (2005). Curriculum models for the practice doctorate in nursing. *Topics in Advanced Practice Nursing eJournal, 5*(1). Retrieved March 17, 2005, from <http://www.medscape.com/viewarticle/500742>
- Milton, C.L. (2005). Scholarship in nursing: Ethics of a practice doctorate. *Nursing Science Quarterly, 18*, 113-116.
- National Organization of Nurse Practitioner Faculties. (2002). *Nurse practitioner primary care competencies in specialty areas: Adult, family, gerontological, pediatric, & women's health*. Washington, DC: U.S. Department of Health and Human Services, Health Resources and Service Administration, Bureau of Health Professions, Division of Nursing.
- Nelson, R. (2005). Is there a doctor nurse in the house? *American Journal of Nursing, 105*(5), 28-29.
- Pruitt, R.H., Wetsel, M.A., Smith, K.J., & Spitler, H. (2002). How do we pass NP autonomy legislation? *Nurse Practitioner, 27*, 56, 61-65.
- Roblin, D.W., Becker, E.R., Adams, E.K., Howard, D.H., & Roberts, M.H. (2004). Patient satisfaction with primary care: Does type of practitioner matter? *Medical Care, 42*, 579-590.
- Sperhac, A.M., & Clinton, P. (2004). Facts and fallacies: The practice doctorate. *Journal of Pediatric Health Care, 18*, 292-296.
- Whall, A.L. (2005). "Lest we forget": An issue concerning the doctorate in nursing practice (DNP). *Nursing Outlook, 53*(1), 1.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.