Katie walked into her office, turned off the light, sat down in her black vinyl chair, leaned back, closed her eyes, and wondered. She wondered what was to become of her position. She felt slightly threatened since powerful nurse leaders seemed to be hell-bent on creating the doctor of nursing practice (DNP) as a terminal degree. At least that was the impression she got as she left a very contentious faculty meeting. In the darkened office, while contemplating the events of the day, she remembered all of the years of struggle she endured while getting her doctor of philosophy (PhD) in nursing. She was very proud of her accomplishments. Then, she thought of her predecessors who had devoted their lives to the development of the discipline so that nurses would be recognized as equals by others in university settings. Although influential nurses were crafting a proposal that recognized the necessity of a PhD for conducting traditional research, doubts began to creep into her mind about the implementation of such a proposal. Was she to be relegated only to the position of consultant to the DNP? Were her ideas concerning care to be discounted because she was not continually practicing in the healthcare system? She was even unsure if she was up to mounting a defense against the rising tide of those calling for a practice doctorate. For a period of time she wrestled with her doubts and then muttered to herself, “how did this happen anyway?” With that she opened her eyes, sat up, stood, turned on the light, and marched off to the library to grab copies of the Institute of Medicine (IOM) reports that seemed to be one of many factors driving the push toward a DNP.
through licensing, certification, and accreditation. Finally, the committee felt that systems assuring safety should be implemented at the delivery level (IOM, 2000).

The IOM broadened its perspective from the narrow focus of patient safety to include the much wider horizon of quality in healthcare. In the second report from this portentous group, Crossing the Quality Chasm: A New System for the 21st Century, a clarion call was put forth “to improve the American health delivery system as a whole, in all its quality dimensions, for all Americans” (IOM, 2001, p. 2). The assumptions of the IOM were that Americans fail to receive effective healthcare and that the healthcare system does not make best use of resources, and indeed overuses many services. Six aims evolved from the aforementioned assumptions including the ideas that all individuals in healthcare systems should be safe, receive effective interventions based on scientific knowledge, and command respect that includes being able to guide decisions. Furthermore, the IOM believed that the care provided should be timely, efficient, and equitable. Eleven recommendations were developed based upon the six aims. One recommendation was that “all health care organizations, professional groups, and private and public purchasers should adopt as their explicit purpose to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States (IOM, 2001, p. 6).

Other recommendations were concerned with conducting research on improving healthcare and dissemination of the knowledge in ways made useful for clinicians. Additionally, the IOM suggested that information infrastructures be built and that there be incentives for quality enhancement. An interesting proposal made by the group concerned rules that should be used to govern the redesigning of healthcare systems. Included were tenets that individuals receive customized care, be in control, have unfettered access to personal medical information, and be able to receive care independent from face to face interactions. Moreover, the IOM advised that care be evidence-based, safe, and cost-effective. It was also advised that all clinicians be cooperative and that there be transparency concerning organizational monitoring of such factors as performance, safety, and patient satisfaction. The recommendation by the IOM (2001) of great import for nursing was about preparing the workforce. Recommendation 12 stated:

A multidisciplinary summit of leaders within the health professions should be held to discuss and develop strategies for (1) restructuring clinical education to be consistent with the principles of the 21st century health system throughout the continuum of undergraduate, graduate, and continuing education for the medical, nursing, and other professional training programs; and (2) assessing the implications of these changes for provider credentialing programs, funding, and sponsorship of educational programs for health professionals. (IOM, 2001, p.19)

The crux of the recommendation was that clinical education should include the six aims of improving quality healthcare. To reiterate, the aims included that healthcare be safe, effective, patient-centered, timely, efficient, and equitable (IOM, 2001).

In response to the IOM’s call to overhaul clinical education for all providers of healthcare, a top level group of leaders gathered to consider the idea of reforming the education process for their particular disciplines. The report entitled Health Professions Education: A Bridge to Quality (IOM, 2003) was the result of discussions among participants at the summit. The shared vision of the group was that “all health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidenced-based practice, quality improvement approaches, and informatics” (IOM, 2003, p. 3). Born from the vision was the idea that the many disciplines within healthcare should share five core competencies. The first competency was concerned with the delivery of patient-centered care. It meant that the relationship between individuals and their providers of care should involve shared power and responsibility. Furthermore, communication should be open and individual values should be respected in the quest for illness prevention and health promotion. The second core competency, work in interdisciplinary teams, was based on the idea that all members of a team including physicians, nurses, pharmacists, and many others “coordinate, collaborate, and communicate with one another to optimize care for a patient or group of patients” (IOM, 2003, p. 54). In order to achieve the aforementioned competency, each member would be required to learn the role of other participants, be skilled in group dynamics, be able to resolve conflicts, and share a common language. Third of the five core competencies was to employ evidence-based practice. Incorporated in the competency was the ability to know where to find the best evidence and to determine how to integrate findings into practice. The measurement of quality, assessment of current practices, testing of interventions, identification of errors, and improvement of performances were integral to the fourth core competency, that of applying quality improvement. The fifth suggested core competency was to utilize informatics or in other words to “communicate, manage knowledge, mitigate error, and support decision making using information technology” (IOM, 2003, p. 4).

In reviewing the education, licensing, and certification of several of the major disciplines in healthcare, the committee found deficiencies in many of the core competencies deemed to be of critical importance to the health of the nation. Therefore, they recommended that a common language be developed, core competencies be considered in order to achieve accreditation, core competencies be taught and evaluated in the basic education of healthcare providers, skills concerning the core competencies be periodically tested, foundations fund learning centers to promulgate the five core competencies,
the government make available monies to support ongoing research related to the core competencies, and there be summits concerning the shared core competencies (IOM, 2003).

Improving the health of the nation through assuring safety, increasing the quality of care, and revising the education of providers were ideals that Katie considered to be important and with which she could not reasonably argue from the perspective of medical science. However, she remained somewhat confused about the link between the IOM reports and the push toward the DNP. Katie thought one possibility may be the desire of the profession of nursing to be considered an equal partner in the healthcare teams envisioned by the IOM. Members of the team would include physicians, nurses, pharmacists, and social workers and many of these disciplines have as their terminal degree a practice doctorate. Without the DNP nurses might once again be considered less than, in other words to go unrecognized. So, Katie continued her search for understanding by reading more about the reasons behind the quest for a DNP, the essentials of the DNP, the position statement on nursing research, and texts concerning the role of the DNP.

Reasons for the DNP

The article, “National Agenda for Advanced Practice Nursing: The Practice Doctorate” written by Clinton and Sperhac (2006), reiterated what Katie had found in the IOM reports and substantiated her notion of the desire for equality for the nursing profession. Clinton and Sperhac stated that the disciplines of audiology and physical therapy have practice doctorates which are the entry into practice for these groups of healthcare providers. It was their contention that “these practice doctorate programs provide skills necessary to synthesize and apply knowledge to clinical populations” (Clinton & Sperhac, 2006, p. 8). Furthermore, it was determined that acquiring new knowledge to provide care for individuals through the actions of collaboration and coordination would require additional hours for nurse practitioner programs. This would be prohibitive since many programs have already exceeded the number of credit hours requisite for a master’s degree. Clinton and Sperhac (2006) believed that “the practice doctorate in nursing would provide parity in credentialing with these disciplines and allow nurses to be recognized as full participants in health care decision making” (p. 8). Both of the authors not only wished for recognition within healthcare for nurse practitioners, but also for those involved in management and informatics.

Not only were parity and the number of educational credits among the factors in the push toward the DNP, but also the shortage of nurse faculty was seen as a reason for the practice doctorate in nursing. The American Association of Nurse Anesthetists (AANA) in their interim position statement on the DNP (Weisbrod, Horton, & Saavedra, 2006) brought to light the fact that the demand for healthcare in the future will rapidly increase and require more advanced practice nurses. However, the number of nurse faculty prepared at the doctoral level to educate nurses at the master’s level and beyond has not kept pace with the demand. Thus, if advanced practice nurses were required to obtain a DNP, as entry into advanced practice, the pool from which to draw nursing faculty would be substantially increased. The AANA also considered the DNP a way to “integrate current advanced clinical skills with the ability to recognize and adapt nursing practice and achieve an overall higher level of accountability and scope of practice comparable to other healthcare disciplines with doctoral education” (Weisbrod et al., 2006, p. 111).

So, Katie’s understanding of the push for the DNP centered on parity, mounting credits required for advanced practice nurses, faculty shortages, and increasing the scope of practice for the profession. Still, her question about the impact of the DNP on her future as a researcher had not been answered. Therefore, she continued her quest by reading the Essentials of Doctoral Education for Advanced Nursing Practice written by the American Association of Colleges of Nursing (AACN) in 2006b.

Essentials of the DNP

The backdrop for the creation of the aforementioned document was the IOM’s vision of safety and quality for the 21st century in healthcare. Furthermore, the AACN was concerned that not only were the disciplines of audiology and physical therapy requiring the practice doctorate as their terminal degree, but the professions of pharmacy and occupational therapy were doing so as well. Therefore, the AACN (2006b) declared that nursing needed the DNP and further stated “with the development of DNP programs, this new degree will become the preferred preparation for specialty nursing practice” (p. 6). According to this auspicious group of nursing leaders, the benefits of the DNP included the development of advanced competencies, increased knowledge and leadership skills, a means of attracting students especially those not interested in research as a focus, and a means to produce needed faculty (AACN, 2006b).

Moving forward the AACN developed eight core essentials for educating nurses desiring a practice doctorate. Included among the essentials was that the individual with a DNP must have a strong scientific foundation for practice. The AACN (2006b) determined that the foundation included:

- human biology, genomics, the science of therapeutics, the psychosocial sciences, as well as the science of complex organizational structures. In addition, philosophical, ethical, and historical issues inherent in the development of science create a context for the application of the natural and social sciences. Nursing science also created a significant body of knowledge to guide nursing practice and has expanded the scientific underpinnings of the discipline. (p. 9)
Another essential had as an outcome the ability of a nurse with the DNP to be able to develop and evaluate the delivery of care to individuals and populations. Furthermore, the DNP must be able to assure quality and safety by utilizing principles from business and ethics. Solving practice problems and improving health outcomes through the “translation of research into practice and the dissemination and integration of new knowledge” (AACN, 2006b, p.11) were inherent to the third essential of the standards of DNP education. Other essentials involved the use of information systems, creation of health policy, establishment of teams and leading such teams when appropriate, improvement in the health status of populations, and practice at an advanced level (AACN, 2006b).

From an examination of the essentials document, Katie gleaned that the DNP was a credential that would allow a nurse to work either as a nurse practitioner within a specialty or to affect patient outcomes through knowledge of various systems including healthcare administration, informatics, or governmental policy. She still did not understand the role of the PhD in nursing within the vision promulgated by the AACN (2006b). Therefore, Katie opened and began to read the AACN Position Statement on Nursing Research (AACN, 2006a).

Nursing Research

The article began with a description of nursing research as being a rigorous inquiry embarked upon to enhance nursing’s body of knowledge that in turn would advance practice, contribute to health policy, and influence the health and well-being of all populations worldwide. The factors influencing nursing research were deemed to be individual concerns, social issues, and national policies (AACN, 2006a).

The position statement also reported the scope of nursing research including clinical, outcomes, and educational research. According to the AACN (2006a), clinical research focuses on the concerns of nursing including providing care along the continuum of health and illness. Outcomes research has as its domain the delivery of healthcare including quality and cost. Finally, educational research concerns itself with teaching processes and creating new and better ways to promote lifelong learning and commitment to leadership. The document reported the manner in which research was to be strengthened by each academic level as it related to the education of nurses. Most important to Katie’s question about her role in the IOM’s vision of healthcare were the descriptions of the practice doctorate and the research doctorate. The AACN (2006a) defined practice doctoral programs as preparing graduates for the highest level of nursing practice beyond the initial preparation in the discipline. Graduates obtain the highest level of practice expertise integrated with the ability to translate scientific knowledge into complex clinical interventions tailored to meet individual and family and community health and illness needs. In addition, these professionals use advanced leadership knowledge and skills to evaluate the translation of research into practice and collaborate with scientists on new health policy research opportunities that evolve from translation and evaluation processes. They are prepared to focus on the evaluation and use of research rather than the conduct of research. (p. 6)

Whereas the AACN (2006a) defined research-focused doctoral programs as preparing graduates to pursue intellectual inquiry and conduct independent research for the purpose of extending knowledge. . . . Graduates are expected to plan and launch an independent program of research, seek needed support for initial phases of the research program, and begin to involve others (i.e., students, clinicians, and other researchers) in that work. (p. 6)

The idea of doctorates being focused either on practice or research was reiterated in The Essentials of Doctoral Education for Advanced Practice (AACN, 2006b). The end point of the DNP program was a final project that could concern itself with the outcomes of practice, a program evaluation, consulting, a pilot study, or an integrated literature review. The project was to be focused on the application of research findings in practice. On the other hand, the nurse pursuing a research doctorate was to be well-versed in theory, methodology, and statistics in order to produce new knowledge for the profession in the form of a dissertation (AACN, 2006a).

In Katie’s mind, there was not such a clear distinction between the research-focused doctorate and the practice-focused doctorate. She wondered just how and where one could arbitrarily uncouple the practice of nursing from nursing research. Exactly where were the lines to be drawn and what impact would such a demarcation have on her career and more importantly the discipline of nursing.

DNP Role in Research

More doubts began to creep into Katie’s thoughts as she perused The Doctorate of Nursing Practice: A Guidebook for Role Development and Professional Issues edited by Chism (2010). The text concerned itself with the various roles of the DNP but most worrisome was the chapter written by Morris Magnan on theory, research, and scholarship. In the chapter it was stated that “although it is recognized that the DNP is not a research degree, no universal law prohibits DNPs from conducting knowledge-generating research. If
the DNP is interested in serving as the sole principle investigator on the project, then a research consultant or mentor might be brought on board” (Magnan, 2010, p. 133). Presumably, the consultant would be a nurse with a PhD who could bring knowledge concerning the research process, funding, and manuscript development. Magnan (2010) went on to admonish the DNP to develop a relationship of trust with the research-focused nurse so that “their important research ideas would not be stolen by the PhD” (p. 133). The doubts that had arisen for Katie in her darkened office seemed to be coming to fruition and in fact caused her even more consternation. Not only did it seem as though she was destined to become just a consultant to the DNP, but she was not to be trusted and furthermore had no relevant ideas concerning nursing care.

Katie’s anxiety began to intensify as she read some of the studies actually conducted by nurses without expertise in research. One such study conducted by Loomis, Willard, and Cohen in 2007 concerning the difficult choice of deciding between a program focused on practice or one focused on research crystallized Katie’s fears. The study began with a review of the literature concerning the evolution of doctorates in nursing and proceeded to describe the sample, instrument, procedure, and findings. Lacking were several steps that researched-focused nurses would consider to be critical. There was no stated research question that a nurse with a PhD knows is central in the direction of any study. Furthermore, the instrument used had no stated psychometric properties and therefore its reliability and validity were to be questioned. Additionally, the absence of a methodology section left the reader wondering if the study was qualitative or quantitative, since the instrument used both multiple choice and open-ended questions. More disconcerting was the fact that the authors stated that one of the limitations of the study was that “there was no control group” (Loomis et al., 2007, p. 7). A control group for a non-experimental study? How was the discipline of nursing to expand its knowledge base and support the profession if research is to be conducted by those without even a rudimentary understanding of the process?

Even though Katie considered the lofty goals of the IOM related to patient safety and quality to have significance, she was disconcerted about the push toward the DNP as the entry in specialty practice. Katie concluded that the discipline and profession of nursing was being driven by outside forces toward the DNP, that the roles of the PhD and the DNP in regards to research were unclear at best, and that the uncoupling of theory, research, and practice would result in disastrous scholarship. Katie’s most poignant question concerned the diminishment of nursing theories and research born out of the phenomenological and existential movements whose purpose it is to understand and not to intervene. Katie’s questions have become my own and I am concerned.

**References**


