I recently had the opportunity to read the American Medical Association (AMA) House of Delegates Resolution 211, which was introduced by the American Society of Anesthesiologists. The Resolution addresses concerns expressed by the AMA related to the Doctor of Nursing Practice and is as follows:

AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES
Resolution: 211
(A-06)
Subject: Need to Expose and Counter Nurse Doctoral Programs (NDP) Misrepresentation

Referred to: Reference Committee B
(John M. Zerwas, MD, Chair)

Whereas, The patient-physician relationship is the foundation of effective medical care; and Whereas, Patient trust is a cornerstone of good medical care delivery; and Whereas, Quality medical care requires appropriate education, skills, training and experience, as recognized and upheld in state laws; and Whereas, State-based regulation of medicine should be aggressively protected to ensure patient safety and optimal clinical outcomes; and Whereas, Confusion, injury and a breakdown of quality medical care would result from persons not trained as medical doctors and doctors of osteopathy misrepresenting themselves as “doctors” in clinical settings; and Whereas, The American Association of Colleges of Nursing plans to convert its advance nurse practice degree from master’s programs to “Doctor of Nursing Practice” (DNP) by the year 2015; and Whereas, Four such “doctoral” nurse anesthesia programs currently are offered in the United States and more are planned; and Whereas, The Nurse Anesthesia Accreditation Council has mandated doctoral training for all nurse anesthetists by the year 2015; and Whereas, At least one of the DNP programs is advertising its programs as “similar in concept to practice doctorates in other professions such as medicine (MD), law (JD), and dentistry (DDM)”;

Whereas, The quality of care rendered by individuals with a nurse doctoral degree is not equivalent to that of a physician (MD or DO); and Whereas, Nurses and other non-physician providers who hold doctoral degrees and identify themselves to patients as “doctors” will create confusion, jeopardize patient safety, and erode the trust inherent in the true patient-physician relationship; and Whereas, Patients led to believe that they are receiving care from a “doctor,” who is not a physician (MD or DO), but who is a DNP may put their health at risk; therefore be it

RESOLVED, That it shall be the policy of our American Medical Association that institutions offering advanced education in the healing arts and professions shall fully and accurately inform applicants and students of the educational programs and degrees offered by an institution and the limitations, if any, on the scope of practice under applicable state law for which the program prepares the student (New HOD Policy); and be it
further RESOLVED, That our AMA work jointly with state attorneys general to identify and prosecute those individuals who misrepresent themselves as physicians to their patients and mislead program applicants as to their future scope of practice (Directive to Take Action); and be it further RESOLVED, That our AMA pursue all other appropriate legislative, regulatory and legal actions through the Scope of Practice Partnership, as well as actions within hospital staff organizations, to counter misrepresentation by nurse doctoral programs and their students and graduates, particularly in clinical settings. (Directive to Take Action)

Fiscal Note: Implement accordingly at estimated staff cost of $10,836.1

So how can and should we respond to our medical colleagues? What is the intent of the doctor of nursing practice (DNP) degree? What are the benefits, and what real concerns should we address?

BACKGROUND ON THE DOCTOR OF NURSING PRACTICE

The American Association of Colleges of Nursing (AACN) in fall 2004 developed a white paper in support of the DNP as a terminal practice degree. The DNP was intended to be different from the research doctorate and to supplant the master of science degree for nurse practitioners and those in leadership roles by 2015. The rationale for moving in the direction of the DNP was to make nursing education similar to other health care disciplines, to acknowledge the large number of credits already required in advanced practice nursing education, to facilitate the development of faculty to fill the nursing faculty shortage, and to better educate nurses to address increasingly complicated clinical issues. In addition, the DNP embodies a higher level of overall knowledge and scope of practice and theoretically would mean that DNP graduates could assume greater responsibility and accountability for their patients. The ultimate goal of the DNP is to improve the care patients receive by providing a more expansive educational background to advanced practice nurses.

The exciting aspects of the DNP are that it will increase the time available in educational programs to provide graduate students with additional and advanced clinical experience. The DNP programs will also allow for more time to develop writing and documentation skills and for an increased focus on research and translating evidenced-based findings appropriately into practice.

The outcomes of DNP programs are yet to be demonstrated, however, and I appreciate and share some of the concerns expressed by the AMA. Specifically, I agree with the AMA about the potential confusion that patients may have and their concern that patients may mix up an academic “doctorate” with the doctor of medicine. For those of us teaching in DNP programs, we are responsible to educate students carefully on the importance of understanding this distinction. Moreover, it is critical that we teach the public about these differences. Having started my nurse practitioner career in 1981 when the role was new to the public, I used every patient interaction to explain that I was a nurse practitioner and what that meant in terms of my educational background and legal authority to diagnose and prescribe. I also used it to explain that I was not equal to their physician, with whom I worked closely. Rather, we would work together to provide them with optimal care in the diagnosis and management of their medical and psychosocial problems.

I disagree with the AMA, however, in their statement that the DNP will “jeopardize patient safety and erode the trust inherent in the true patient-physician relationship.” There are no data to support that patient safety is jeopardized when care is provided by a nurse practitioner. There are numerous studies, including randomized clinical trials, to compare nurse practitioners with physicians across a variety of clinical specialties (e.g., pediatrics, geriatrics) and in particular areas of practice such as management of asthma or congestive heart failure.2-9 A 2005 Cochrane Review of nurse practitioner practice published concluded that there were no appreciable differences between physicians and nurse practitioners related to patient health outcomes, processes of care, resource utilization, or cost of care. Consistently in these studies patient health outcomes were similar for physicians and nurse practitioners, but patient satisfaction was higher with nurse practitioner-directed care. Generally, the nurse practitioners tended to provide longer consultations, give more information to patients, and discuss treatments as well as social and emotional aspects of patients’ lives.5 Lastly, there is no indication that nurse
practitioners are more likely to be involved in litigation related to care activities. In terms of “eroding the trust inherent in the true patient-physician relationship,” I can find no data to support this suggestion and know of no clinical situation in which this has occurred. Patients often confuse health care providers, particularly male caregivers (nursing assistants and nurses, occupational or physical therapists), and will call them physicians. All of us as caregivers must, as I indicated, correct these misunderstandings. If anything, it has been my experience (albeit only in geriatrics) that the combined nurse practitioner and physician team improve the patient health care provider relationship(s) as well as the satisfaction of the patient and his or her family.

There continues to be some debate among the nursing community about the advantages and disadvantages of the DNP. I hold a level of excitement about the prospect and concern as indicated. I hope the majority of our physician colleagues can be as open about this new educational endeavor and consider this as a way to develop advanced practice nurses with additional education and clinical experience that will optimize practice. We in nursing education, I hope, will take on the challenge to assure our colleagues that we are not attempting to become the equivalent of physicians for we have chosen nursing for a reason. Our focus as nurses, whether working as registered nurses or advanced practice nurses, is not on disease from a diagnostic perspective. Rather, it is on helping that patient deal with the disease and diagnosis with which they are working. In geriatrics, this requires advanced clinical knowledge and experience and that we work together as an interdisciplinary team. I challenge us all to develop programs that will ensure clinically competent advanced practice providers who continue, as we always have, to explain to our older patients that they are nurse practitioners working among an interdisciplinary team (that includes physicians) to provide accessible, affordable care.

References


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National Conference of Gerontological Nurse Practitioners announces a new section editor. We welcome Kathleen Jett, PhD, ARNP, BC GNP. We want to thank Ann Schmidt Luggen, PHD, GNP, CNAA, for her many years of service as section editor.