The Practice Doctorate in Nursing: Is It the Answer?

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Over the past few years, several national nursing and advanced practice nursing (APN) organizations have issued position statements regarding further development of the practice doctorate in nursing degree. Practice-oriented doctoral programs already exist at several schools of nursing, but they vary in terms of title granted, content, purpose, and outcome. In this article, we review the current state of practice doctoral programs, discuss the rationale for increasing the number of programs, and analyze the forces that are encouraging their expansion. We also aim to answer these questions: Is this the most appropriate direction to take in expanding nursing education? Do we need more practice doctorates? Or do we need to develop more effective strategies to solve the problems that these degrees are intended to fix?

What is the Practice Doctorate in Nursing?

The first difficulty in any discussion of practice doctorates is the confusion regarding the definition and the educational content. Various doctoral degrees in nursing, with "practice" either in the title or in the description of the degree to be granted, have emerged over the past 40 years. These degrees are the ultimate credentials that can be earned at programs starting with entry-level nursing programs and ranging up to APN programs and research doctoral programs that focus on practice-oriented research.

Doctor of Nursing Degree—Back in the 1970s, a doctor of nursing (ND) program was developed at Case Western Reserve University in Cleveland, Ohio, that offered an entry-level (prelicensure) nursing degree. This program did not originally include APN specialty preparation, but it expanded to include this as an option along with either baccalaureate or master's preparation. The Case ND program has been renamed; students now earn a doctor of nursing practice (DNP; see next section) degree. Fifteen years ago, the University of Colorado at Denver Health Sciences Center (UCDHSC) School of Nursing established another entry-level ND program that also prepared students to be certified in case management. UCDHSC recently approved conversion of the ND degree to a DNP degree.

Two other schools, Rush University in Chicago, Illinois, and the University of South Carolina, first offered an ND degree for post-baccalaureate entry. Rush originally offered an advanced practice clinical doctorate but has shifted its focus to leadership and business, which requires a practice-focused capstone project (a comprehensive project that is the summation of the degree; similar in concept to a dissertation in a research program). Schools of Nursing at both Rush and South Carolina have also shifted from the ND to the DNP degree. The programs at Case and at South Carolina prepare students for advanced practice and require a practice-related dissertation.

Doctor of Nursing Practice Degree—A second type of nursing doctorate, the DNP degree, is available at the programs described in the section above, as well as at the University of Kentucky, which offers specialty preparation in executive management and population-based clinical practice to nurses who already have a master's degree. The degree requires a capstone project on a practice problem instead of a dissertation.

Doctor of Nursing Science Degree—The University of Tennessee at Memphis offers a practice-focused doctor of nursing science degree (DNSc) at post-master's entry that allows students to develop their own area of specialization and requires a dissertation. The DNSc degree has historically been available in many universities as a practice-focused degree at the post-master's level. The American Association of Colleges of Nursing (AACN) Task Force on Quality Doctoral Education found little difference between DNSc and PhD programs in nursing in terms of curricula and graduation requirements, and suggested that these degrees be designated as research-focused degrees.

AACN Task Force—The AACN Task Force on the Professional Clinical Doctorate reviewed current programs and found that the practice doctorate differs from the PhD in that the former has less emphasis on theory and research and more emphasis on clinical practice, research utilization, and evaluation of practice and care delivery models. The task force's Position Statement on the Practice Doctorate in Nursing called for clarification of this confusion in titling by suggesting that the doctor of nursing practice—that is, the DNP—be the title for the practice doctorate and that other degrees be phased out. The task force also recommended that...
DNP programs include seven areas of content:
- scientific underpinnings for practice;
- advanced nursing practice;
- organization and system leadership/management, quality improvement, and system thinking;
- analytical methodologies related to the evaluation of practice and the application of evidence for practice;
- utilization of technology and information for the improvement and transformation of health care;
- health policy development, implementation, and evaluation; and
- interdisciplinary collaboration for improving patient and population health outcomes.

Rationale for a Practice Doctorate

Although practice-oriented nursing doctorates have been available at several institutions for many years, interest in these degrees has increased recently despite the lack of data regarding the value of the existing programs. Various forces have combined to generate a rationale for increased development of these programs.

Parity with Other Professions—One reason cited for the DNP degree is to enhance societal respect and promote parity with other healthcare professions. The assumption is that clinicians with a doctorate would face fewer barriers to practice than would master's-prepared APNs. Other healthcare professions, such as physical therapy, nutrition therapy, and pharmacology are increasingly developing doctoral programs for entry into their fields, and view the change as increasing the quality of the program and the prestige of the graduate. Furthermore, the medical profession has the doctorate as its first professional degree; it is argued that the DNP degree would create parity with medical doctors (MDs) in certain areas of practice.

The rationale for a DNP degree holds that nurses who earn it would gain increased access to reimbursement and credentialing, and would command greater respect from their peers. For example, NPs have been told by physicians, regulators, and legislators that they face barriers to independent practice because their education/training is not as lengthy and comprehensive as that of physicians. For NPs who earn it, the DNP degree would confer the legitimate right and potential legislative approval to practice independently. In addition, attainment of this degree could obviate the need for physician collaboration/supervision in state licensing laws and lead to equal status and privileges.

Need for Longer Programs—A second reason for development of a practice doctorate is the need to increase the length of APN programs to accommodate the breadth of information and technology available. Some experts have noted that APN programs are already longer than master's-degree programs in many other disciplines and are more similar in number of credits to doctoral degrees. The change would reflect a degree (ie, the doctorate) that fairly represents the amount of education needed for clinical practice.

Development of Clinical Leaders—A third reason cited for the creation of a practice doctorate is to allow clinical APNs to have parity in degree titling with their research-focused nursing colleagues, and to develop clinical leaders similar to elite nurse researchers. Over the past two decades, tens of thousands of APNs have been educated and trained to become knowledgeable, expert clinicians. Not surprisingly, many of these clinicians want to have doctoral degrees to designate their knowledge and skills (without needing to spend additional months or years performing scientific research).

Many APNs have spent several years in their formal preparation at the master's-degree level and some in post-master's education as well. Some of these clinicians would like to advance their clinical education, contribute to the development of the profession through writing and other scholarship, and be involved in teaching. The lack of a doctoral degree might prevent them from fully participating in these roles and in gaining the status of their research-active colleagues. Conversely, the availability of a practice doctorate would enable them to enhance their clinical knowledge and skills, and help them to achieve their career goals.

Increased Need for Nursing Faculty—Others have advocated for DNP degree programs in order to train clinically-skilled educators to fill gaps in the anticipated future shortage of nursing faculty. Development of these new programs would increase the number of doctorally-prepared nurses and create a cadre of faculty with expertise and interest in clinical nursing and in teaching. Although many master's-prepared nurses are involved in teaching, the lack of a terminal degree prevents them from having all the privileges of faculty with doctorates in most colleges and universities. Entrance into the tenure track most often requires the doctoral degree, and non-tenure-track appointments do not confer the same benefits and compensation in most non-academic medical centers.

Need for Doctoral Programs—The availability of a new type of program offers a new source of students for schools of nursing. As the
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Number of applicants to APN programs has stabilized over the past decade, new graduate programs that would attract students to enhance the stream of revenue to schools of nursing are needed. Some believe that many more nurses at the baccalaureate and master's levels would prefer to attend a DNP program than a PhD program in nursing. Many schools of nursing have not been able to obtain permission for the development of a PhD program because of a lack of research-active faculty or because of the perceived costs related to the small enrollments and higher faculty/student ratios in these programs.

Most non-research-intensive schools of nursing do not have doctoral programs. This lack not only decreases their enrollments but also their local and national reputations and their ability to attract expert faculty. Schools of nursing that are known for their ability to prepare expert clinicians at the baccalaureate level may receive less respect than do schools with doctoral programs, even though the former contribute significantly to the supply of nurses. Some people believe that the existence of a DNP program would enable these institutions to be equal in status to schools that offer a PhD degree in nursing. These institutions, many of which have large BSN programs, would also have a group of clinically-expert doctoral students to assist in the teaching of undergraduate students, as well as a pool of faculty candidates upon graduation.

Potential Problems with the Practice Doctorate

Although introducing additional DNP programs may have certain apparent benefits, at least on the surface, some unanticipated problems may arise. Before discussing potential problems, though, it is useful to determine the need for these programs, and to analyze the stated rationale for them. This exploration is important because no systematic evaluation of the impact of these programs on the healthcare workforce or on their graduates exists to assist in decision-making about future programs.

Parity with Other Professions—First, we want to explore the assumption that increasing the length and content of APN programs to enable students to obtain a doctoral degree will lead to increased independence and removal of barriers to nursing practice. As noted earlier, the need for physician collaboration and supervision of APNs has been based on APNs' "limited" education. However, many studies have shown that APNs in primary care function as well as do their physician counterparts.13 In fact, APN-physician teams have been shown to improve care14-16. This research suggests that further education is not necessary for APNs to provide quality care. Despite this evidence of APNs' competence, "organized medicine" has resisted efforts to change restrictive practice laws and has, in fact, convinced legislative bodies of their lack of competence.17

The mere attainment of additional advanced degrees by APNs is not likely to change organized medicine's resistance to APNs' greater independence. It is of particular interest that physicians have differentiated their practices without any formalized degrees or statutes; instead, they use advanced clinical education (residencies) and board certification as a means of determining which physicians can practice in certain specialties. The idea that additional degrees themselves would broaden the clinical arena for nurses does not hold up to scrutiny.

The assumption that increased education and the presence of a doctorate degree will lead to increased independence of NP practice also ignores the history of the power differentials in the healthcare system. The reality is that only those with the power—MDs in the current healthcare system—have had power and control. Although NPs have been able to make considerable strides in enhancing their status, restrictions still exist and organized medicine has been effective in blocking change through its political power. Even if nurses were to get further education and earn a doctoral degree, it is not clear that the degree would automatically confer on them the privileges of an MD, or that the political power dynamics would change. It can be argued that real change will only occur through collective political action within nursing and with the support of other non-physician groups and patients.

The belief that "if NPs had practice doctorates, then they would gain more independence and respect" may be flawed. This belief
may be influenced by the fact that nurses and APNs have been relatively powerless in "the system," and, as such, have acquired certain behaviors and ways of thinking that are common among powerless groups. An exploration of oppressed-group behavior theory that has been used to explain the behavior of nurses and APNs in the past may be helpful in understanding the flaw in the reasoning about the DNP degree.6,7

Oppressed-group behavior suggests that powerless groups develop impaired self-esteem and respect for members of their own group because of the devaluing of their characteristics by those in power. Over time, members of these groups internalize the belief that the powerful are superior, and they believe that "looking more like the powerful" will make them powerful as well. This belief leads to the lack of a solid identity and solidarity within the group because of their negative feelings about themselves and each other.

Many leaders and members of the powerless group who want to "get ahead" try hardest to look like the oppressor and, somewhat ironically, become "marginalized" within their own group because they do not share the same characteristics and behaviors. That is, they do not belong to either group because they are not legitimate members of the powerful group and they do not identify with their own group. Liberation does not come from looking like the oppressor but, rather, from developing a strong sense of identity and self-respect as a group. Pride and cohesiveness lead to political power and change in the power differential.

Acquiring a DNP degree may be an attempt on the part of some APNs to "look more like" physicians. Rather than increasing their independence and respect, this effort may have no effect whatsoever on the balance of power because it would not necessarily imbue nurses with the solidarity and political power they are striving for. Availability of the DNP degree might also sow further conflict and confusion by undermining the respect and pride that non-doctorate-credentialed APNs have worked so hard to build. During the past 30 years, nursing groups have been able to develop standards for practice and education, and they have enlightened patients and regulators about APNs' background and skills. An attempt to standardize APN regulations across the country has just begun. Mechanisms have been created for reimbursement of services and prescriptive authority. Although barriers still exist, in most states APNs are an integral part of the healthcare delivery system and are increasingly recognized as legitimate providers of care by the public. The current master's-degree curriculum has been highly successful in educating these professionals. Most APNs, like all professionals, use continuing education to maintain their practice skills in the face of new scientific and technological findings.

A change to doctoral preparation for APNs might be confusing at best; at worst, it would necessitate changes in all the standards, legislation, regulations, and certification requirements that have been developed over the years. The public and other professionals who have learned that the master's degree is the appropriate preparation level for specialization in nursing will once again be confused about what is considered adequate preparation.8 Preparation of APNs with multiple degrees sets back the effort for consistency that has taken almost 30 years to achieve, and may be used as an argument against professional autonomy for those who are not doctorate-credentialed.

This change to specialization of practice at the doctoral level may also increase conflict within nursing, and revive the divisiveness that was created in previous debates about entry into practice. Conflict between nurses, known as "horizontal violence" in oppressed-group theory, has frequently been described as a way of coping with powerlessness.9,10 The constant "battles" among nurses allow other groups to maintain control because the internal conflict within nursing decreases the professional unity necessary for successful political action. Development of the practice doctorate may pit the more "elite" in nursing against the more "traditional" nurse, and make APNs prepared at the master's level feel unnecessarily devalued.11 This change also favors the elite because they can afford to spend a longer time in school and makes it less possible for all nurses to pursue a specialty. This divisiveness is potentially destructive to the process of political advancement so
important to changing the power differential in health care.

Development of a practice doctorate might also increase conflict with physicians who already are worried about nurses competing against them in the healthcare marketplace. Over the past few years, organized medicine has increased its efforts to decrease APNs’ autonomy as a result of APNs’ success in this arena. Adding a doctoral degree might stoke fears that already exist among other professionals that nurses are trying to replace them. Regulatory and legislative changes to include this new category into existing practice laws might prove difficult to achieve in the setting of even greater resistance.

Need for Longer Programs—Although the concept of having more time to educate APNs is appealing, the cost and length of the program might make it prohibitive for many students. Most APNs do not gain a large increase in salary after completion of their specialty education, but they take on the role because of the autonomy and professional fulfillment it affords them. An increase in the length of the program would make it more expensive, and graduates would be unlikely to recoup their costs after graduation because it is unlikely that doctoral-prepared APNs would command higher salaries in the marketplace.

One of the reasons for NPs’ and other APNs’ success in the current healthcare system is the expertise that can be developed in a short time. As noted earlier, these clinicians have been found to function in their particular sphere at a level similar to that of their physician colleagues. One NP, when discussing the content and the length of the program for a DNP degree, remarked, “I might as well go to medical school—the length is about the same and I would make more money when I finish.” The cost-effectiveness of APNs to the healthcare system may diminish if it is more costly to educate and train them.

Development of Clinical Leaders—It may be appealing to think that a place for doctorally-prepared APNs in clinical practice arenas already exists, but this need has not been expressed by hospitals or agencies. Although these positions have been proposed, the lack of a needs assessment in care settings is problematic. Very recently, clinical nurse specialists, whose role is similar to that of APNs, were eliminated from many institutions because they were judged as being not cost effective. A major reason why APNs play their part in the healthcare system is because they fill a niche and meet a need. It is unclear whether graduates of DNP programs, as compared with current APNs, would find a greater number of advanced clinical positions and higher salaries.

One could argue that clinicians who have expertise in the realm of quality assurance research, outcomes research, or clinical research might be able to fill roles that could lead to interdisciplinary collaborations, external funding, and improvements in care. Clinicians with a PhD or DNSc degree are very successful in their roles as members of clinical research teams. Clinical leaders without research expertise would not be able to fulfill this role, however, which would, somewhat ironically, argue for the need for research training even in DNP programs.

Increased Need for Nursing Faculty—Development of a doctoral program that focuses on clinical practice and not on research is very appealing to many practicing clinicians. These potential applicants may think that this degree will increase the likelihood of securing a faculty position and of advancement in the clinical arena. These applicants may not know that most faculty positions outside of academic medical centers require research for promotion and tenure. These graduates may be able to obtain faculty positions but not be promoted and tenured because of their lack of research expertise. Although non-tenure-track faculty positions do exist, parity with other doctorally-prepared faculty is not likely because they do not have the qualifications for tenure. Earlier clinical doctoral programs that granted a DNSc degree have been changed over time to include a core of research training because it has been necessary for both faculty and clinical leaders. Recent evaluation suggests that most DNSc programs are similar to PhD programs in terms of being research intensive.

Many critics argue that the requirement for research and scholarly productivity is not useful for nursing faculty. They note that the
nursing profession needs clinicians, not researchers, to teach students. Many faculties, in fact, have non-tenure, primarily master's-prepared faculty who do the clinical teaching. This system may work well for students, but many of these faculty members feel like "second-class citizens" because they cannot attain tenure and do not have the same rights within the university. Graduates of practice doctoral programs could be admitted to a non-tenure track, but they would be in the same two-tiered system and would not have parity with their research-intensive colleagues. Therefore, the development of doctorally-prepared faculty who do not have the skills and knowledge to succeed seems unethical and not an improvement over using master's-prepared faculty.

Is the Practice Doctorate Really the Answer?
The question regarding whether the number of practice doctoral programs across the country should be increased may be the wrong question. Rather than focusing on the DNP degree to solve the problems that face nursing practice and education, NPs should focus on several other questions that need answers.

First, as noted earlier, the argument that the practice doctorate title will decrease barriers to independent nursing practice is based on a flawed assumption. The real barrier to independence of nursing practice is the control and monopoly of organized medicine. The history of advanced practice nursing suggests that despite evidence of APNs' having competence similar to that of physicians, MDs have been able to control nursing practice through political power. One of the major barriers to independent nursing practice has been the inability of nursing groups to organize and join together to work on the political front. Although this lack of cohesiveness is most likely a symptom of powerlessness, the development of ineffective strategies that lend themselves to further divisions among nurses leads only to less power. Persons who want to keep nursing powerless benefit from the confusion and lack of consistency within the profession. The first important question, then, is: How can we join together to provide a unified message to regulators and legislators? It is not clear that the practice doctorate answers this question.

Second, the length of APN programs has been a longstanding concern. Early APN programs were heavily supported by federal funding, were longer in duration, and frequently incorporated residencies. Residencies for specialty training in medicine have been and still are heavily subsidized by federal dollars. Faculty, APN students, and clinical faculties would embrace clinical residencies if funding were available to support them. The second question is: Why does nursing not share in the money that is available for medical residency training? A related question is: Why are APNs not working together to lobby legislators to support funded clinical residencies for graduate programs in nursing? Asking nurses to pay more tuition for longer practice doctoral programs may not be the answer.

Last, the shortage of nurses and nursing faculty is a national problem. The faculty shortage is partly due to an aging faculty, and it is particularly severe—again, somewhat ironically—because of the increased enrollment of basic nursing students to help alleviate the nursing shortage. Nursing needs to continue to argue that this crisis demands support for the development of new PhD programs. Rather than respond-
that may arise from broad implementation of the DNP degree. This analysis of the potential impact of the program suggests that this innovation may not be the answer to the problems that advanced practice nursing faces. Further exploration is needed to determine the benefits and potential problems. Evaluation of existing programs and their graduates, and the development and evaluation of pilot programs, are warranted to better understand the impact of these programs before their widespread adoption.

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