The Essentials of the Doctor of Nursing Practice: A Philosophical Perspective

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Introduction

The Doctor of Nursing Practice (DNP) degree has been recommended by the American Association of Colleges of Nursing (AACN) as the terminal practice-focused degree in nursing (AACN, 2004). Since its inception, the DNP degree has been met with both support and criticism (Burman, Hart, & McCabe, 2005; Chase & Pruitt, 2006; Dracup & Bryan-Brown, 2005; Hathaway, Jacob, Stegbauer, Thompson, & Graff, 2006). Despite the controversy associated with this innovative degree, approximately 184 DNP programs exist, with over 100 more currently in development (AACN, 2012). Because of the recommendations of the AACN (2004), as well as the growth in programs devoted to awarding this degree, it is necessary that graduate nursing students understand the definition and competencies of the DNP degree.

This chapter provides a definition of the DNP degree. This definition may be more easily understood from a historical perspective of nursing education; therefore, the history of doctoral education in nursing leading up to the development of the DNP degree is reviewed. The AACN's *Essentials of Doctoral Education for Advanced Nursing Practice* defines the competencies of the DNP degree (AACN, 2006a) and is also discussed. *Essential I, Scientific Underpinnings for Practice,* is extensively explored, with particular attention being paid to philosophical inquiry regarding the nature of the discipline of nursing and nursing science. The chapter concludes with a description of this author's development of a middle-range theory to exemplify bridging theory with practice.

Overview of the Doctor of Nursing Practice Degree

The DNP degree is defined as a practice-focused, terminal degree in nursing practice (AACN, 2004). Nursing practice is defined as follows:

> Any form of nursing intervention that influences healthcare outcomes for individuals or populations, including the direct care of individual patients, management of care for individuals and populations, administration of nursing and healthcare organizations, and the development and implementation of health policy. (AACN, 2004, p. 1)

Historically, nursing has been concerned with care of the individual. This more contemporary definition accurately describes care that focuses on the healthcare outcomes of populations from an organizational perspective, as well as nursing's impact on healthcare policy (Chism, 2013). These themes remain consistent throughout the competencies of DNP curricula as well and are reflected in *Essentials of Doctoral Education for Advanced Nursing Practice* (see **Table 3–1**).

It should be noted that the DNP degree differs from the traditional PhD in both focus and content (see **Table 3–2**). The DNP degree is a *practice-focused degree,* whereas the doctor of philosophy (PhD) is a *research-focused* degree. Both degrees share a common goal regarding a "scholarly approach to the discipline and commitment to the advancement of the profession" (AACN, 2006a, p. 3). However, the DNP degree emphasizes practice, while the PhD degree emphasizes theory and research methodology (AACN, 2004, 2006a). The DNP graduate is expected to demonstrate scholarly activity through a theory-driven research project, often termed a capstone project. This project may be guided by middle-range

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TABLE 3–1   AACN's *Essentials of Doctoral Education for Advanced Nursing Practice*

Essential I	Scientific Underpinnings for Practice
Essential II	Organizational and Systems Leadership for Quality Improvement and Systems Thinking
Essential III	Clinical Scholarship and Analytical Methods for Evidenced-Based Practice
Essential IV	Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care
Essential V	Healthcare Policy for Advocacy in Health Care
Essential VI	Interprofessional Collaboration for Improving Patient and Population Health Outcomes
Essential VII	Clinical Prevention and Population Health for Improving the Nation's Health
Essential VIII	Advanced Nursing Practice

Source: American Association of Colleges of Nursing (AACN). (2006a). Essentials of doctoral education for advanced nursing practice. Reprinted by permission of American Association of Colleges of Nursing.

TABLE 3–2   Key Differences Between DNP and PhD/DNS/DNSc Programs

	DNP	PhD/DNS/DNSc
Program of study	**Objectives** Prepare nurse specialists at the highest level of advanced practice	**Objectives** Prepare nurse researchers
	Competencies Based on AACN essentials of the DNP degree	**Content** Based on indicators of quality in research-focused doctoral programs in nursing (AACN, 2001)
Students	Commitment to a practice career	Commitment to a research career
	Oriented toward improving outcomes of care	Oriented toward developing new knowledge
Program faculty	Practice doctorate and/or experience in the area in which teaching	Research doctorate in nursing or a related field
	Leadership experience in the area of specialty practice	Leadership experience in the area of sustained research funding
	High level of expertise in specialty practice congruent with the focus of the academic program	High level of expertise in research congruent with the focus of the academic program
Resources	Mentors/preceptors in leadership positions across a variety of practice settings	Mentors/preceptors in research settings
	Access to diverse practice settings with appropriate resources for areas of practice	Access to research settings with appropriate resources
	Access to financial aid	Access to dissertation support dollars
	Access to information and patient care technology resources congruent with the areas of study	Access to information and research technology resources congruent with the program of research

(*Continues*)

TABLE 3–2   Key Differences Between DNP and PhD/DNS/DNSc Programs (*Continued*)

	DNP	PhD/DNS/DNSc
Program assessment and evaluation	**Program Outcome** Healthcare improvements and contributions via practice, policy change, and practice scholarship	**Program Outcome** Contributes to healthcare improvements via the development of new knowledge and other scholarly projects that provide the foundation for the advancement of nursing science
	Oversight by the institution's authorized bodies (i.e., graduate school) and regional accreditors Receives accreditation from a specialized nursing accreditor Graduates are eligible for the national certification exam	Oversight by the institution's authorized bodies (i.e., graduate school) and regional accreditors

Source: AACN DNP Roadmap Taskforce Report, October 20, 2006 (b). Reprinted by permission of American Association of Colleges of Nursing.

nursing theory and demonstrate ways in which research affects practice. Middle-range nursing theory and the DNP degree are discussed later in this chapter.

Historical Perspectives

Doctoral education in nursing has, indeed, evolved over the past 40 years. In the 1960s, nurses' choices for doctoral education included a PhD in the basic sciences such as biology, anatomy, or physiology or an education doctorate (EdD; Carpenter & Hudacek, 1996; Marriner-Tomey, 1990). As doctoral education in nursing evolved, more nursing-related doctoral degrees emerged.

The first nursing-related doctorate degree originated at Teacher's College, Columbia University, in 1924. This degree was an EdD that was designed to prepare nurses to teach at the college level. It was unique in that it was the first doctoral degree in nursing to emphasize both nursing education and the needs of the profession (Carpenter & Hudacek, 1996). Later, in 1934, the first PhD in nursing was offered at New York University, followed by introduction of a maternal–child nursing PhD program in the 1950s at the University of Pittsburgh (Carpenter & Hudacek, 1996). Importantly, the latter PhD program was the first to recognize the importance of clinical research for the development of the discipline of nursing (Carpenter & Hudacek, 1996). Throughout the United States, other PhDs continued to focus on sociological fields such as psychology,

sociology, and anthropology. Actual nursing PhDs did not become popular until the 1970s (Grace, 1978).

According to Murphy (1981), doctoral education in nursing developed in three phases. The focus of these phases included nursing doctorates that emphasized the development of (1) functional specialists, (2) nurse scientists, and (3) doctorates that were "in and of nursing" (p. 646). The first phase, which emphasized the development of functional specialists, focused on preparing nurses as teachers or administrators. Throughout the second phase—the development of nurse scientists—relevant questions emerged that directly affected the third and final phase of nursing doctoral education:

- What is the essential nature of professional nursing?
- What is the substantive knowledge base of professional nursing?
- What kind of research is important for nursing? As a knowledge discipline? As a field of practice?
- How can the scientific base of nursing knowledge be identified and expanded? (p. 646)

These questions led to the development of nursing doctorates that were "in and of nursing" (p. 646), and they continue to influence nursing doctoral education today.

More recently, a fourth phase of doctoral education in nursing has evolved. This phase emphasizes nursing practice and initially began with the development of the Doctor of Nursing Science (DNS). The first DNS degree was developed at Boston University and "focused on the development of nursing theory for a practice discipline" (Marriner-Tomey, 1990, p. 135). The DNS was perceived as the first practice-focused doctorate. Cleland (1976) noted that the research doctorate should focus on contributions to nursing science and the practice doctorate should focus on expertise in clinical practice. Grace (1978) suggested that nurses be prepared as "social engineers," with attention being given to the clinical field (p. 26). Finally, Newman (1975) indicated that a practice doctorate would prepare nurses as "professional practitioners" for entry into practice (p. 705).

Although the DNS was developed to prepare nurses as practice experts, over time curricula in these programs began to resemble the PhD in nursing (AACN, 2006b; Apold, 2008; Marriner-Tomey, 1990). Given this development, the AACN has designated all DNS degrees as research-focused degrees (AACN, 2004). Hence, the challenge to develop a true practice doctorate remained.

Rozella Schlottfeldt pioneered the development of a Doctorate of Nursing (ND) degree in 1979 at Case Western Reserve University in Cleveland, Ohio. Schlottfeldt posited that nursing needed a practice doctorate to address several needs of nursing education:

- The need to reorient the existing system of health care toward services that enhance the health status of all people, while maintaining the existing services that focus primarily on detection and treatment of disease

- The need to reorient the nursing community in ways to hasten the emergence of nursing as a scholarly discipline and a fully autonomous practice profession
- The need to reorient nursing's approach to preparing professionals with a view toward promptly augmenting the cadre of competent, independent, accountable nursing practitioners (Schlottfeldt, 1978, p. 302)

Unfortunately, ND programs did not have the same popularity as DNS or PhD degrees. It was also noted that the curricula for these programs lacked the uniformity needed to establish their credibility as practice doctorate programs (Marion et al., 2003). Interestingly, the needs outlined by Schlottfeldt are reflected in the curricula of present DNP programs.

Development of the Doctor of Nursing Practice

In 2002, a task force was formed by the AACN to evaluate the current status of practice doctorates in nursing. The task force was charged with developing recommendations for a practice doctorate in nursing, as well as proposing practice doctorate curriculum models. This work led to the development of the AACN's *Position Statement on the Practice Doctorate in Nursing,* which was published in 2004. The position statement recommended that the DNP degree become the terminal practice-focused degree for nursing by 2015 (AACN, 2004).

The University of Kentucky's School of Nursing was the first to admit students to this program in 2001. Dr. Carolyn Williams, President of AACN (2000–2002) and Dean Emeritus of the University of Kentucky's School of Nursing, was an early proponent of the practice doctorate in nursing and, along with others, helped to facilitate the development of the DNP degree. Currently, more than 184 DNP programs exist in the United States, with more than 100 in development (AACN, 2012).

Doctor of Nursing Practice Competencies

In 2006, the AACN developed the *Essentials of Doctoral Education for Advanced Nursing Practice*. The *Essentials* "address the foundational competencies that are core to all advanced nursing practice roles" (AACN, 2006a, p. 8). Also in 2006, the National Organization of Nurse Practitioner Faculties developed the *Practice Doctorate Nurse Practitioner Entry-Level Competencies,* and in 2008, the National Association of Clinical Nurse Specialists developed the *Core Practice Doctorate Clinical Nurse Specialist Competencies*. Together, these documents provide the curriculum standards for all DNP programs. The following is a summary of the *Essentials of Doctoral Education for Advanced Nursing Practice.*

Essential I: Scientific Underpinnings for Practice

Essential I describes the scientific foundations for nursing practice. These scientific foundations are derived from the natural and social sciences and may include human biology, physiology, and psychology. This foundation also includes nursing science, which adds to the discipline of nursing. Within the discipline of

nursing, specific nursing middle-range theories that guide practice are also part of the foundation for nursing practice (AACN, 2006a). *Essential I* provides the scientific basis necessary for advanced nursing practice. Because of the importance of understanding the foundations for nursing practice, *Essential I* will be discussed in more depth later in this chapter.

Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking

Essential II describes preparation in organizational and systems leadership that affects subsequent healthcare delivery and patient care outcomes. Preparation in this area provides DNP graduates with expertise in "assessing organizations, identifying systems' issues, and facilitating organization-wide changes in practice delivery" (AACN, 2006a, p. 10). The DNP graduate is prepared to assume roles in leadership at every level, from informal leadership in the clinical setting to more formal leadership at an executive level (Chism, 2013).

Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice

Essential III describes competencies related to the evaluation, integration, translation, and application of evidence-based practice. DNP graduates are unique in that their practice perspective allows them to merge nursing science, practice, human needs, and human caring (AACN, 2006a). Additionally, because of their practice perspective, DNP graduates are well positioned to apply research to practice, as well as to ask pertinent questions related to practice (Chism, 2013). Potential roles related to *Essential III* include partnering with research colleges and participating in clinical research, evaluating and developing practice guidelines, critically evaluating existing literature to determine best practices, and designing and evaluating methodologies that improve patient care (AACN, 2006a).

Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care

Essential IV prepares the DNP graduate to use information technologies in ways that improve patient care outcomes. Additionally, DNP graduates develop expertise in information technologies to support leadership and clinical decision making. Examples of information technologies important for improvement of healthcare outcomes include web-based communications, online documentation, telemedicine, and data mining. DNP graduates may employ their expertise in information technologies when evaluating programs for online documentation or data from large systems or databases as part of a search for practice outcome patterns. Graduates may also use information technologies to communicate and evaluate the accuracy, timeliness, and appropriateness of healthcare consumer information (AACN, 2006a). Finally, DNP graduates have a role in attending to the ethical and legal issues related to information technologies (AACN, 2006a).

Essential V: Healthcare Policy for Advocacy in Health Care

Essential V describes the importance of nurses' involvement in healthcare policy and advocacy. As leaders in the practice setting, it is imperative that DNP graduates understand the relationship between practice and policy. Such graduates may be called on to analyze health policies and proposals from multiple points of view; provide leadership in the development of healthcare policies on different levels; actively participate on committees, boards, or task forces; and act as advocates for the nursing profession through organizational leadership (AACN, 2006a).

Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes

Essential VI prepares the DNP graduate to understand the importance of interprofessional collaboration within a multitiered healthcare environment. Nurses frequently function as collaborators with members of other professions. This essential skill expands on the collaboration that naturally occurs among professionals by ensuring that DNP graduates will develop the expertise needed to assume leadership roles when collaborating with teams, as well as participate in the work of the team. Graduates must also be prepared to act as consultants during times of change (AACN, 2006a).

Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health

Essential VII prepares DNP graduates to "analyze epidemiological, biostatistical, occupational, and environmental data in the development, implementation, and evaluation of clinical prevention and population health" (AACN, 2006a, p. 15). Nursing has traditionally been involved in health promotion and risk reduction/illness prevention. The DNP graduate is prepared to assume roles that improve health promotion and reduce risk from an advanced nursing practice perspective.

Essential VIII: Advanced Nursing Practice

Essential VIII describes the clinical specialization content from a specific domain of advanced nursing practice. Post-baccalaureate DNP degree programs "provide preparation within distinct specialties that require expertise, advanced nursing knowledge, and mastery in one area of nursing practice" (AACN, 2006a, p. 16). The DNP graduate is prepared to develop therapeutic relationships with patients and other healthcare professionals to improve patient outcomes, assess health and illness parameters, utilize advanced clinical decision-making skills and critical thinking, serve as mentor to others in the nursing profession, and educate patients (AACN, 2006a).

Focus on *Essential I: Scientific Underpinnings for Practice*

The scientific underpinnings of practice provide the basis of knowledge for advanced nursing practice. These scientific underpinnings include sciences such as biology, physiology, psychology, ethics, and nursing. Although the basic sciences

are often accepted as the basis of knowledge for nursing practice, the role of nursing science may not be as readily understood. Nursing science has expanded the discipline of nursing to include the development of middle-range nursing theories and concepts to guide practice (AACN, 2006b). Graduates of DNP programs have a pertinent role in the implementation of middle-range nursing theories to guide nursing practice. Hence, understanding the scientific underpinnings for nursing practice is essential for all DNP graduates.

Basic Sciences

It is often accepted that advanced nursing practice borrows from the social and basic sciences—much as medicine does—to build a scientific basis for practice. These sciences frequently include biology, physiology, psychology, and ethics. According to Webber (2008), nurse practitioners "rely on medical research to support their practice because not enough advanced practice research and researchers exist" (p. 466). Concerns have been raised that advanced nursing practitioners "adopt the practice values of medicine rather than identifying and adopting knowledge, skills, values, meanings and experiences unique to this nursing specialty" (p. 466). This point may be well taken; however, without the basic understanding of disease, how will nursing develop an understanding of the human responses to disease? Gortner (1980) noted this paradox also and suggested that if nursing rejects the medical model, it rejects the body of knowledge that describes and explains the pathology that leads patients to nurses' care. Through development of an understanding of the fundamentals of the sciences that predict and explain disease processes, nursing can build a basis for understanding how best to care for those affected by disease. Donaldson and Crowley (1978) described professional disciplines such as nursing as "emerging *along with* rather than *from* academic disciplines" (p. 116).

The Discipline of Nursing

A discipline is characterized by a "unique perspective, a distinct way of viewing all phenomena, which ultimately defines the limits and nature of its inquiry" (Donaldson & Crowley, 1978, p. 113). The discipline of nursing has been defined as the body of knowledge concerned with the following aspects of care:

- The principles and laws that govern all life processes, well-being, and optimal functioning of human beings, sick or well
- The patterning of human behavior in interaction with the environment in normal life events and critical life situations
- The processes by which positive changes in health status are effected
- The wholeness of health of human beings, recognizing that they are in continuous interaction with their environments (adapted from AACN, 2006a; Donaldson & Crowley, 1978; Fawcett, 2005; Gortner, 1980)

Nursing is concerned "with the whole human, with lifestyles and with health behavior" (Gortner, 1980, p. 181) and looks beyond the biological and physiological perspectives on disease. In doing so, nursing seeks to explain and predict responses to therapy, improvement in health status, and wellness (Gortner, 1980).

Nursing Science

The definition of nursing science may be somewhat more difficult to elucidate. Nursing science has been described as both a body of theoretical knowledge and the methods of reproducible modes of inquiry (Gortner, 1980; Jacobs & Huether, 1978; Jacox, 1974). Gortner (1980) defined it as "the base of knowledge underlying human behavior and social interaction under normal and stressful conditions across the lifespan" (p. 180). Interestingly, Jacobs and Huether (1978) defined nursing science as "the process, and the result, of ordering and patterning the events and phenomena of concern to nursing" (p. 65). Thus nursing science may be understood as both the "methods of inquiry specific to the discipline of nursing—the process—as well as the outcomes of that inquiry—the result" (Jacobs & Huether, 1978, p. 65). Nursing research has been differentiated from nursing science as "the systematic inquiry into problems associated with illness, health, and care" (Gortner, 1980, p. 180).

Nursing Theory

Nursing theory has been described as the product of nursing science (Jacobs & Huether, 1978; Kerlinger, 1973). Specifically, Jacobs and Huether (1978) described the dual purposes of nursing science as "to define common goals and guide the practice of nursing" (p. 64)—hence, the development of nursing theory. A *theory* is defined as a relationship between two or more concepts, whereas the term *concept* describes objects, properties, or events, and indicates the subject matter of the theory (Jacox, 1974). The concepts within a theory are related by propositions that describe the relationships between two or more concepts (Jacox, 1974). In essence, then, nursing theory attempts to describe, predict, or explain phenomena consistent with nursing's perspective (Donaldson & Crowley, 1978).

Middle-Range Theory

Nursing's body of knowledge, or discipline, includes both grand and middle-range theories (Fawcett, 2005). Grand theories are more abstract and are broader in type, whereas middle-range theories are more concrete and are narrower in type (Fawcett, 2005). For this reason, middle-range theories are more applicable to clinical practice (Lenz, 1998). Further, clinicians may use middle-range theory "situationally," or to help "direct their assessment, decision-making, and nursing interventions when cued by a particular kind of situation rather than practicing consistently according to the tenets of a given theory" (Lenz, 1998, p. 63).

Doctor of Nursing Practice Graduates and Nursing Theory

Nursing has traditionally struggled to close the theory–practice gap (i.e., the lack of use of theory in practice or the inability of nurses to use theory in practice; Kenney, 2006). Reasons for this shortcoming include lack of knowledge, understanding, belief, or applicability of nursing theory as a guide for practice (McKenna, 1997).

Further, the use of medical knowledge, especially in advanced practice nursing roles, has prevailed as a guide for nursing practice (Meleis, 1993).

Because of the limited, narrower, and more applicable scope of middle-range theories, the understanding and application of such theories may be vital to closing the theory–practice gap. As a practice discipline, when nursing theories prove useful in the real world and are "logical and consistent with other validated theories, they may provide a rationale for nursing actions that lead to predictable client outcomes" (Kenney, 2006, p. 297). For this reason, DNP graduates must have an understanding of middle-range theories, as well as the skills necessary to apply those theories in practice.

In a book chapter entitled "Expectations for Theory, Research, and Scholarship," Magnan (2013) suggested that it was more important for DNP students to acquire the skills needed to apply theory to practice than to simply be exposed to a number of middle-range theories. Further, Magnan noted that these skills should be "transferable" and apply to the application of other middle-range theories to practice (p. 110). To achieve this goal, DNP students will need to meet the following criteria:

- Have a foundation in the language of theory (e.g., concepts, relational statements)
- Learn how to distinguish modifiable from nonmodifiable predictors and understand the meaning they have for planning theory-based interventions
- Understand how to interpret the research literature to determine the level of empirical support for relationships between theoretical concepts (Magnan, 2013, pp. 110–111)

As experts in the application of theory, and specifically in middle-range theory, DNP graduates are well positioned to close the theory–practice gap (Magnan, 2013). Such nurses are practice experts who combine their clinical expertise with a doctoral-level understanding of nursing science and theory. This combination prepares the DNP graduate to clearly articulate for others the importance of theory in practice. DNP graduates are ideal role models to increase the use and understanding of theory-guided practice.

Doctor of Nursing Practice Graduates and Use of Other Theories

Essential I of the AACN's *Essentials of Doctoral Education for Advanced Nursing Practice* clearly recommends that DNP graduates garner an understanding of the scientific underpinnings of nursing practice (AACN, 2006a). It is well understood that these scientific underpinnings include other sciences such as biology, physiology, psychology, and ethics. *Essential I* reaffirms the notion that DNP graduates must apply other middle-range theories to practice in an effort to provide patient-centered care. As Meleis (1997) noted, because nurses study many disciplines as a foundation for practice, nursing theory tends to reflect a broad range of perspectives and premises.

Donaldson and Crowley (1978) asserted that nursing is—importantly—a practice-oriented discipline. In a book chapter entitled "Nursing Science for Nursing Practice," Donaldson (1995) thoughtfully emphasized the point that nursing practice, as well as society's need for nursing services, has shaped the discipline of nursing. Because of nursing's interest in societal needs and desired patient outcomes, the discipline of nursing may include many theories, and the most appropriate theory selection will depend on the patient or societal situation. Donaldson (1995) described the nurse pragmatist as a nurse who will use the most pragmatic theory to accomplish the desired patient outcome. Further, nursing science will be a source of theory to the nurse pragmatist only if that theory "fits" the desired patient outcome (Donaldson, 1995).

DNP graduates, therefore, not only have a responsibility to exemplify the application of nursing theory to practice, but they must also be "nurse pragmatists" (Donaldson, 1995) and apply various theories from other sciences to practice. The role of the DNP graduate in theory evaluation and selection may well be one of the most valuable roles that such a person fills. Hence, DNP graduates become the knowledge appliers and exhibit expertise in evaluating, applying, and supporting theory-based interventions to ensure patient-centered care.

Dilution of the Discipline of Nursing: Philosophical Considerations for Doctor of Nursing Practice Graduates

Although applying and integrating theories from various disciplines may add to the knowledge base considered to be part of the discipline of nursing, some practitioners have expressed concerns that this trend dilutes the discipline of nursing (Cody, 1996; McKenna, 1997). McKenna (1997) expressed concerns that combining other theories with nursing theories compromises the context of the original nursing concepts. Additionally, if theories are constantly borrowed and incorporated into the discipline, it may become difficult to differentiate nursing as its own discipline (Cody, 1996). Johnson (1968) pointedly discussed this dilemma, stating that if nursing "continues to observe behavior from the perspective of the sciences such as sociology and psychology, if we continue to study disease with the aim of elucidating etiologies, properties, or life cycles, . . . we may be serving the cause of science, but not necessarily the cause of nursing" (Johnson, 1968, pp. 207–208).

The dilemma ensues upon reviewing *Essential I* of the AACN's *Essentials* document. DNP graduates are frequently advanced practice nurses. Many people who fill advanced practice nursing roles identify very closely with a medical model and may be viewed as "junior doctors" (Meleis, 1993). According to Fawcett (1997), nurses are often unaware of their discrete knowledge and instead glean fragmented information from a medical model. Moreover, DNP graduates are expected to understand the scientific underpinnings of practice, including the basic sciences—sciences that are traditionally associated with the medical model. An interesting question then arises: How do DNP graduates understand and

contribute to the discipline of nursing through application of knowledge if this knowledge base has been infused with theories borrowed from other disciplines, specifically the basic sciences?

This dilemma may be resolved by DNP graduates developing a good understanding of nursing as a profession, a science, and a discipline. Nursing is a practice profession whose science and body of knowledge depend on its perspective. Further, if this understanding is developed, DNP graduates will integrate the necessary knowledge from a nursing perspective, understanding what nursing is and what it is not. While the basis of knowledge may include knowledge borrowed from various sciences to explain and predict disease, nursing is concerned with the laws and principles that govern the life processes, well-being, and optimal functioning of human beings; the human behavioral responses to disease; and the processes by which positive health status is effected (Donaldson & Crowley, 1978). The ability to elucidate what defines nursing practice, while employing various "pragmatic" (Donaldson, 1995, p. 6) scientific underpinnings from a nursing perspective, may be what truly differentiates the DNP-prepared nurse.

Summary

The AACN recommended that the DNP degree become the terminal practice-focused degree for nursing by 2015 (AACN, 2004). Adoption of this recommendation has implications for the advancement of nursing as a profession, a science, and a discipline. Expanding their understanding of the scientific underpinnings for practice is perhaps the most essential expectation for DNP graduates. Through the process of gaining this understanding, DNP graduates will garner expertise in the differentiation and application of nursing knowledge. Moreover, as the practice experts and knowledge appliers, DNP graduates will be in an ideal position to bridge the theory–practice gap, an enduring ambition of nursing.

Exemplar

The following discussion is a case scenario in which this author developed, tested, and applied a nursing middle-range theory, thereby bridging theory and practice.

> During my doctoral study at Oakland University in Rochester, Michigan, Dr. Morris Magnan charged the advanced theory class with writing a middle-range theory paper. I had only recently been introduced to middle-range theory and was struggling to develop an understanding of nursing as a science and a discipline. However, applying middle-range theory to an actual patient scenario helped me to develop a broader understanding of nursing.
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> Dr. Magnan and I were having a telephone meeting one evening to discuss which middle-range theory I would use for my theory paper.

My research interest was spiritual care in nursing. I was drawn to Olson's empathic process theory (Olson, 1995) as the theoretical guide for my ideas. Dr. Magnan urged me to describe in more detail why I believed that this middle-range theory applied to spiritual care in nursing.

I explained that I had recently cared for a patient whose son had attempted suicide and was now in an intensive care unit (ICU) clinging to life. My patient was struggling with what to pray for: death or healing. She was disturbed also by how she was approached by a rabbi in the ICU who whispered to her in Hebrew and touched her knee when he spoke to her. She related, "Just because I am Jewish, it doesn't mean that I speak Hebrew. And furthermore, I don't want anybody whispering to me and touching me. I will pray in my own way and on my own terms." I replied to my patient, "So, you felt that instead of the rabbi asking you how you pray, or what your spiritual need was, he assumed what you needed and made you even more anxious." She immediately relaxed in the chair and exclaimed, "Yes! That's exactly how I feel." Her body language clearly exhibited an openness to further spiritual discussion. I added, "Why don't you pray for peace?" She agreed: "Yes, that's what I will pray for—peace."

I will never forget the night I shared this story with Dr. Magnan. When I had finished, he replied, "Well, I believe you have a middle-range theory here."

With Dr. Magnan's guidance, we developed my ideas into Chism's middle-range theory of spiritual empathy (MTSE; Chism, 2007). The MTSE was deductively derived from Olson's empathic process theory (1995; middle-range theory) and Orlando's dynamic nursing process theory (1990; grand theory). The MTSE purports that nurses' spiritual care perspectives—that is, nurses' attitudes and beliefs about spiritual care (Taylor, 2002)—will influence nurses' expression of spiritual empathy—that is, the nurse's expression of verbal understanding of a patient's spiritual concern (Chism, 2007; Chism & Magnan, 2009; Olson, 1995). Expression of spiritual empathy will then increase the patient's perception of empathy—patients feeling that they are understood by nurses (Olson, 1995). Spiritual distress—impairments in a sense of connectedness to self and others, faith and belief system, sense of purpose, inner peace, and inner strength (Villagomeza, 2005)—will then decrease. The final concept, spiritual well-being—a sense of inner peace and contentment resulting from one's perceived sense of connection to self or others (Chism, 2007)—is purported to increase at this point.

One portion of the MTSE was tested as my capstone project: the relationship between nurses' spiritual care perspectives and their expressions of spiritual empathy. The MTSE has been presented in two poster

presentations, and findings from the theory testing study have been published (Chism & Magnan, 2009).

The development and testing of the MTSE during doctoral study in a DNP program was somewhat industrious and not a customary expectation of a DNP research project. This rewarding experience not only challenged me to develop my scholarship, but it also exemplified the use of theory (specifically, middle-range theory) to guide practice. As a DNP graduate and advanced practice nurse, I have a responsibility to understand, from a nursing perspective, the scientific underpinnings of disease processes and the care of my patients. Moreover, the development and testing of the MTSE reinforced for me the idea that the discipline of nursing truly guides nursing practice.

Acknowledgment

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