

Overview of the Doctor of Nursing Practice Degree

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What exactly is a doctor of nursing practice (DNP) degree? As enrollment to this innovative practice doctorate program continues to increase, this question is frequently posed by nurses, patients, and other healthcare professionals both in and out of the healthcare setting. Providing an explanation to this question requires not only defining the DNP degree, but also reflecting on the rich history of doctoral education in nursing. Doctoral education in nursing is connected to our past and influences the directions we may take in the future (Carpenter & Hudacek, 1996). The development of the DNP degree is a tribute to where nursing has been and where we hope to be in the future of doctoral education in nursing.

Understanding the DNP degree requires developing an awareness of the rationale for a practice doctorate. This rationale illustrates the motivation behind the evolution of doctoral education in nursing and provides further explanation of this contemporary degree. The need for parity across

the healthcare team, the Institute of Medicine's call for safer healthcare practices, and the need for increased preparation of advanced-practice registered nurses to meet the changing demands of health care are all contributing antecedents of the development of the practice doctorate in nursing (American Association of Colleges of Nursing [AACN], 2006a, 2006b; Apold, 2008; Dracup, Cronenwett, Meleis, & Benner, 2005; Roberts & Glod, 2005). Becoming familiar with the motivating factors behind the DNP degree will aid understanding of the development of this innovative degree.

This chapter provides a definition of the DNP degree and a discussion of the evolution of doctoral education in nursing. The rationale for a practice doctorate is also described. The recipe for the DNP degree, which includes the *Essentials of Doctoral Education for Advanced Nursing Practice* by the AACN (2006b) and the *Practice Doctorate Nurse Practitioner Entry-Level Competencies* by the National Organization of Nurse

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Practitioner Faculties (NONPF, 2006), is provided in this chapter as well. The pathway to the DNP degree is also discussed. Providing a discussion of these topics will equip one with the information necessary to become familiar with this innovative degree.

RESEARCH-FOCUSED DOCTORATE AND PRACTICE-FOCUSED DOCTORATE DEFINED

The question, What is a DNP degree? is often followed by the question, What is the difference between a doctor of philosophy (PhD) and a DNP degree? Nurses now can choose between a practice-focused or research-focused doctorate as a terminal degree. Although the academic or research degree, once the only terminal preparation in nursing, has traditionally been the PhD, the AACN now includes the doctor of nursing science (DNS, DNSc, DSN) as a research-focused degree (AACN, 2004). Further, the AACN Task Force on the Practice Doctorate in Nursing has recommended that the practice doctorate be the DNP degree, which will replace the traditional nursing doctorate (ND) degree (AACN, 2006a). Currently ND programs are taking the necessary steps to adjust their programs to fit the curriculum criteria of DNP degree programs.

The practice- and research-focused doctorates in nursing share a common goal regarding a “scholarly approach to the discipline and a commitment to the advancement of the profession” (AACN, 2006b, p. 3). The differences in these programs include differences in preparation and expertise. The practice doctorate curriculum places more emphasis on practice and less on theory and research methodology (AACN, 2004, 2006b). The final scholarly project differs in that a dissertation required for a PhD degree should document development of new knowledge, and a final scholarly project required for a DNP degree should be grounded in clinical practice and demonstrate ways in which research has an impact on practice.

The focus of the DNP degree is expertise in clinical practice. Additional foci include the *Essentials of Doctoral Education for Advanced Nursing Practice* by the AACN (2006b), which include leadership, health policy and advocacy, and information technology. The focus of a research degree is the generation of new knowledge for the discipline and expertise as a principal investigator. Although the research degree prepares the expert researcher, it should be noted that frequently DNP research projects will also contribute to the discipline by generating new knowledge related to clinical practice and demonstrate the use of evidence-based practice. Please refer to **Table 1-1** for AACN’s comparison of a DNP program and PhD, DNS, and DNSc programs.

EVOLUTION OF DOCTORAL EDUCATION IN NURSING

To appreciate the development of doctoral education in nursing, one must understand where nursing has been with regard to education at the doctoral level. Indeed, nursing has been unique in its approach to doctoral preparation since nurses began to earn doctoral degrees. Even today nurses are prepared at the doctoral level through various degrees, including doctor of education (EdD), PhD, DNS, and now DNP. Prior to the development of the DNP degree, the ND was also offered as a choice for nursing doctoral education.

Examining the chronological development of doctoral education in nursing is somewhat complicated because early doctorates were offered outside nursing. These included the EdD degree and the PhD degree in basic science fields, such as anatomy and physiology (Carpenter & Hudacek, 1996; Marriner-Tomey, 1990). The first nursing-related doctoral program was originated in 1924 at Teachers College, Columbia University, and was an EdD designed to prepare nurses to teach at the college level (Carpenter & Hudacek, 1996). Teachers College was unique in that its program was the first to combine

TABLE 1-1

AACN Contrast Grid of the Key Differences Between DNP and PhD/DNS/DNSc Programs

	DNP	PhD/DNS/DNSc
Program of study	<p>Objectives: Prepare nurse specialists at the highest level of advanced practice</p> <p>Competencies: Based on <i>Essentials of Doctoral Education for Advanced Nursing Practice</i> (AACN, 2006b)*</p>	<p>Objectives: Prepare nurse researchers</p> <p>Content: Based on <i>Indicators of Quality in Research-Focused Doctoral Programs in Nursing</i> (AACN, 2001)**</p>
Students	<p>Commitment to a practice career</p> <p>Oriented toward improving outcomes of care</p>	<p>Commitment to a research career</p> <p>Oriented toward developing new knowledge</p>
Program faculty	<p>Practice doctorate and/or experience in area in which teaching</p> <p>Leadership experience in area of specialty practice</p> <p>High level of expertise in specialty practice congruent with focus of academic program</p>	<p>Research doctorate in nursing or related field</p> <p>Leadership experience in area of sustained research funding</p> <p>High level of expertise in research congruent with focus of academic program</p>
Resources	<p>Mentors and/or preceptors in leadership positions across a variety of practice settings</p> <p>Access to diverse practice settings with appropriate resources for areas of practice</p> <p>Access to financial aid</p> <p>Access to information and patient-care technology resources congruent with areas of study</p>	<p>Mentors/preceptor in research settings</p> <p>Access to research settings with appropriate resources</p> <p>Access to dissertation support dollars</p> <p>Access to information and research technology resources congruent with program of research</p>
Program assessment and evaluation	<p>Program outcome: Healthcare improvements and contributions via practice, policy change, and practice scholarship</p>	<p>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</p>

(continues)

TABLE 1-1 AACN Contrast Grid of the Key Differences Between DNP and PhD/DNS/DNSc Programs (*continued*)

DNP	PhD/DNS/DNSc
Oversight by the institution's authorized bodies (i.e., graduate school) and regional accreditors	Oversight by the institution's authorized bodies (i.e., graduate school) and regional accreditor
Receives accreditation by specialized nursing accreditor	
Graduates are eligible for national certification exam	

*American Association of Colleges of Nursing. (2006). *Essentials of doctoral education for advanced nursing practice*. <http://www.aacn.nche.edu/publications/position/DNPEssentials.pdf>

**American Association of Colleges of Nursing. (2001). *Indicators of Quality in Research-Focused Doctoral Programs in Nursing*. <http://www.aacn.nche.edu/publications/position/quality-indicators>

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both the “nursing and education needs of leaders in the profession” (Carpenter & Hudacek, 1996, p. 5). EdD degrees continued well into the 1960s to be the mainstay of doctoral education for nursing (Marriner-Tomey, 1990).

The first PhD in nursing was offered in 1934 at New York University. Unfortunately, the next PhD in nursing was not offered until the 1950s at the University of Pittsburgh and focused on maternal and child nursing. Incidentally, this degree was the first to recognize the importance of clinical research for the development of the nursing discipline (Carpenter & Hudacek, 1996). The PhD degrees earned elsewhere continued to be in nursing-related fields, such as psychology, sociology, and anthropology. This trend continued until nursing PhD degrees became more popular in the 1970s (Grace, 1978).

Grace (1978) summarized the progression of nursing education over time. Between 1924 and 1959 doctoral education in nursing focused on preparing nurses for “functional specialty” (p. 22). In other words, nurses were prepared to fulfill functional roles as teachers

and administrators to lead the field of nursing toward advancement as a profession. The problem with these programs was that they lacked the substantive content necessary to develop nursing as a discipline and a profession. The next shift in doctoral education attempted to fulfill this need and took place between 1960 and 1969. Within this time period, popularity increased for doctoral programs that were nursing related. This included doctorates (PhDs) that were related to disciplines such as sociology, psychology, and anthropology. Grace (1978) noted that the development of these types of programs provided the basic science and research input necessary for the development of future ND programs. Murphy concurred that this stage in the development of doctoral education in nursing led to pertinent questions for the discipline of nursing, such as “(1) What is the essential nature of professional nursing? (2) What is the substantive knowledge base of professional nursing? (3) What kind of research is important for nursing as a knowledge discipline? As a field of practice? (4) How can the scientific

base of nursing knowledge be identified and expanded?" (1981, p. 646).

In response to these questions, nursing doctoral education again progressed in the 1970s to include doctorate degrees that are actually in nursing (Grace, 1978). This stage also supported the growth of nursing's substantive structure, hence, the growth of the discipline of nursing. This is where nursing's history of doctoral education becomes more complex. In 1960 the DNS degree originated at Boston University and "focused on the development of nursing theory for a practice discipline" (Marriner-Tomey, 1990, p. 135), hence, the development of the first practice doctorate. The notion of a practice-focused doctorate in nursing is not new. Even as early as the 1970s, it was proposed that the research doctorate (PhD) should focus on preparing nurses to contribute to nursing science, and the practice (or professional) doctorate (DNS) should focus on expertise in clinical practice (Cleland, 1976). Newman also suggested a practice doctorate as the preparation of "professional practitioners" (1975, p. 705) for entry into practice. Grace (1978) noted that it was not sufficient to have a core of nursing researchers building the knowledge base (discipline) without also giving attention to the clinical field. It was also suggested by Grace that nurses prepared through a practice doctorate be titled "social engineers" (1978, p. 26). This seems appropriate given what expert clinicians in nursing are called upon to do.

Although the DNS degree was initially proposed as a practice or professional doctorate, over time the curriculum requirements have become very similar to those for a PhD degree (AACN, 2006a; Apold, 2008; Marriner-Tomey, 1990). Research requirements for this degree have eventually become indistinguishable from that of a PhD in nursing. Because of this, it is not surprising that the AACN has characterized all DNS degrees as research degrees (2004). With the DNS and PhD degrees so similar in content and focus, the challenge to develop a

true practice doctorate remained. An attempt toward this was made in 1979 when the ND originated at Case Western Reserve University, followed by the University of Colorado, Rush University, and South Carolina University. The first ND program was developed by Rozella M. Schlotfeldt, PhD, RN. The ND was different in that the research component was not the general focus of the degree. This degree was designed to be a "pre-service nursing education which would orient nursing's approach to preparing professionals toward competent, independent, accountable nursing practice" (Carpenter & Hudacek, 1996, p. 42). This general theme for a practice doctorate remains consistent even today. Unfortunately, this program did not share the same popularity of DNS or PhD degrees in nursing, and it was less common to find a clinician with this preparation. Further, the curricula in these programs were varied and lacked a uniform approach toward a practice doctorate (Marion et al., 2003).

In 2002 the AACN board of directors formed a task force to examine the current progress of practice doctorates in nursing. Their objective also included comparing proposed curriculum models and discussing recommendations for the future of a practice doctorate (AACN, 2004). To accomplish their mission, the AACN task force (2004) took part in the following activities:

- Reviewed the literature regarding practice doctorates in nursing and other disciplines.
- Established a collaborative relationship with NONPF.
- Interviewed key informants (deans, program directors, graduates, and current students) at the eight current or planned practice-focused doctoral programs in the United States.
- Held open discussions regarding issues surrounding practice-focused doctoral education at AACN's Doctoral Education Conference (January 2003 and February 2004).

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- Participated in an open discussion with NONPF along with representatives from key nursing organizations and schools of nursing that were offering or planning a practice doctorate.
- Invited an External Reaction Panel, which involved participation from 10 individuals from various disciplines outside nursing. This panel responded to the draft of the *AACN Position Statement on the Practice Doctorate in Nursing*.

In 2004 the AACN published the *AACN Position Statement on the Practice Doctorate in Nursing* and recommended that the DNP degree would be the terminal degree for nursing practice by 2015. According to NONPF, the purpose of the DNP degree is to prepare nurses to meet the changing demands of health care today by becoming proficient at the following (Marion et al., 2003):

- Evaluating evidence-based practices for care
- Delivering care
- Developing healthcare policy
- Leading and managing clinical care and healthcare systems
- Developing interdisciplinary standards
- Solving healthcare dilemmas
- Reducing disparities in health care

Not only is the development of the DNP degree a culmination of today's emerging healthcare demands; the degree also provides a choice for nurses who wish to focus their doctoral education on nursing practice.

Since its inception the growth of this degree has been astonishing. The University of Kentucky's College of Nursing was the pioneer for this innovative degree and admitted the first DNP class in 2001. In spring 2005, eight DNP programs were offered, and more than 60 were in development. By summer 2005, 80 DNP programs were being considered. In fall 2005, 20 programs offered DNP degrees,

and 140 programs were in development. Today there are 243 DNP programs in the United States (AACN, 2014).

It should also be mentioned that in 1999, Columbia University's School of Nursing was formulating plans for a doctor of nursing practice (DrNP) degree that would build on a model of "full-scope, cross-site primary care that Columbia had developed and evaluated over the past ten years" (Goldenberg, 2004, p. 25). This degree was spearheaded by Mary O. Mundinger, DrPH, RN, dean of Columbia University's School of Nursing. The curriculum of a DrNP program is clinically focused with advanced preparation designed to teach "cross-site, full-scope care with content in advanced differential diagnosis skills, advanced pathophysiology and microbiology, selected issues of compliance, management of health care delivery and reimbursement, advanced emergency triage and management, and professional role collaboration and referrals" (Goldenberg, 2004, p. 25). This expanded clinical component is what seems to differentiate a DrNP degree from a DNP degree. The first DrNP class graduated from Columbia University in 2003.

Since the development of the DrNP degree, the Commission on Collegiate Nursing Education (CCNE), the autonomous accrediting body of the AACN, has decided that only practice ND degrees with the doctor of nursing practice title will be eligible for CCNE accreditation (AACN, 2005). This decision was reached unanimously by the CCNE Board of Directors on September 29, 2005 in an effort to develop a process for accrediting only clinically focused NDs (AACN, 2005). The CCNE's decision is consistent with accrediting organizations for other healthcare professions and helps to ensure consistency with degree titling and criteria. Specific criteria for the DNP degree, including the AACN's *Essentials of Doctoral Education for Advanced Nursing Practice* (2006b) and the *Practice Doctorate Nurse Practitioner Entry-Level Competencies* (NONPF, 2006), are discussed later in this chapter.

WHY A PRACTICE DOCTORATE IN NURSING NOW?

It has already been mentioned that the notion of a practice doctorate is not new, so why the development of the DNP degree now? It has been noted that the development of the DNP is “more than a mere interruption but rather a response to the need within the healthcare system for expert clinical teachers and clinicians” (Marion, O’Sullivan, Crabtree, Price, & Fontana, 2005, para. 1). Health care needs are not new, yet the growth of this program has been escalating. The question is therefore posed, What are the drivers of this DNP degree, and why is there such urgency?

The Institute of Medicine’s Report and Nursing’s Response

In 2000 the Institute of Medicine (IOM) published a report titled *To Err Is Human: Building a Safer Health System* (Kohn, Corrigan, & Donaldson, 2000). This report summarized information regarding errors made in health care and offered recommendations to improve the overall quality of care. It was found that “preventable adverse events are a leading cause of death in the United States” (p. 26). In more than 33.6 million admissions to U.S. hospitals in 1997, 44,000 to 98,000 people died as a result of medical-related errors (American Hospital Association, 1999). It was estimated that deaths in hospitals by preventable adverse events exceed the amount attributable to the eighth leading cause of death in America (Centers for Disease Control and Prevention [CDC], 1999b). These numbers also exceed the number of deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297), and AIDS (16,516) (CDC, 1999a). The total cost of health care is greatly affected by these errors as well, with estimated total national costs (lost income, lost household production, disability, healthcare costs) reported as being between \$29 billion and \$36 billion for adverse events

and between \$17 billion and \$29 billion for preventable adverse events (Thomas et al., 1999).

As a follow-up to the *To Err Is Human* report, in 2001 the IOM published *Crossing the Quality Chasm: A New Health System for the 21st Century*. In an effort to improve health care in the 21st century, the IOM proposed six specific aims for improvement. According to the IOM (2001), these six aims deem that health care should be:

1. Safe in avoiding injuries to patients from the care they receive
2. Effective in providing services based on scientific knowledge to those who could benefit, but services should not be provided to those who may not benefit
3. Patient centered in that provided care is respectful and responsive to individual patient preferences, needs, and values; all patient values should guide all clinical decisions
4. Timely in that wait time and sometimes harmful delays are reduced for those who give and receive care
5. Efficient in that waste is avoided, particularly waste of equipment, supplies, ideas, and energy
6. Equitable in that high-quality care is provided to all regardless of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status

The IOM (2001) emphasized that to achieve these aims, additional skills may be required on the healthcare team. This includes all individuals who care for patients. The new skills needed to improve health care and reduce errors are, ironically, many skills that nurses have long been known to exemplify. Some examples of these skills include using electronic communications, synthesizing evidence-based practice information, communicating with patients in an open manner to enable their decision making, understanding the course of illness that specifically relates to the patient’s experience

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outside the hospital, working collaboratively in teams, and understanding the link between health care and healthy populations (IOM, 2001). Developing expertise in these areas required curriculum changes in healthcare education as well as addressing how healthcare education is approached, organized, and funded (IOM, 2001).

In 2003 the Health Professions Education Committee responded to the IOM's *Crossing the Quality Chasm* report (IOM, 2001) by publishing *Health Professions Education: A Bridge to Quality* (Greiner & Knebel, 2003). The committee recommended that "all health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics" (Greiner & Knebel, 2003, p. 45). To meet this goal, the committee proposed a set of competencies to be met by all healthcare clinicians, regardless of discipline. These competencies include the following: provide patient-centered care, function in interdisciplinary teams, employ evidence-based practice, integrate quality improvement standards, and utilize various information systems (Greiner & Knebel, 2003).

As part of the continued effort to advance the education of healthcare professionals, the Robert Wood Johnson Foundation (RWJF) and the IOM specifically addressed advancing nursing education. In 2008 the RWJF and the IOM "launched a two-year initiative to respond to the need to access and transform the nursing profession" (IOM, 2010a, p. 1). The IOM appointed the Committee on the RWJF Initiative on the Future of Nursing. This committee published a report titled *The Future of Nursing: Focus on Education* (IOM, 2010a). In this report, the IOM concluded that "the ways in which nurses were educated during the 20th century are no longer adequate for dealing with the realities of healthcare in the 21st century" (2010a, p. 2). The IOM reiterated the need for the aforementioned competencies, such as leadership, health policy,

system improvement, research and evidence-based practice, and teamwork and collaboration. In response to the increasing demands of a complex healthcare environment, the IOM recommended higher levels of education for nurses and new ways to educate nurses to better meet the needs of this population.

The IOM included recommendations in the report that specifically address the number of nurses with doctorate degrees. It was noted that although 13% of nurses hold a graduate degree, fewer than 1% hold doctoral degrees (IOM, 2010a). The IOM concluded that "nurses with doctorates are needed to teach future generations of nurses and to conduct research that becomes the basis for improvements in nursing science and practice" (2010a, p. 4). Therefore, recommendation 5 states that "schools of nursing, with support from private and public funders, academic administrators and university trustees, and accreditation bodies, should double the number of nurses with a doctorate by 2020 to add to the cadre of nurse faculty and researchers, with attention to increasing diversity" (IOM, 2010b, p. 4).

The development of the DNP degree is one of the answers to the call proposed by both the IOM's Health Professions Education Committee and the IOM's and the RWJF's Initiative on the Future of Nursing Committee to redefine how healthcare professionals are educated. Nursing has always had a vested interest in improving quality of care and patient outcomes. Since Florence Nightingale, "nursing education has been directed toward the individualized, personalized care of the patient, not the disease" (Newman, 1975, p. 704). To further illustrate nursing's commitment to improve quality of care and patient outcomes, the competencies described by the Health Professions Education Committee are reflected in the AACN's *Essentials of Doctoral Education for Advanced Nursing Practice* (2006b) and NONPF's *Practice Doctorate Nurse Practitioner Entry-Level Competencies* (2006). Preparing nurses at the

practice doctorate level who are experts at using information technology, synthesizing and integrating evidence-based practices, and collaborating across healthcare disciplines will further enable nursing to meet the challenges of health care in the 21st century.

Additional Drivers for a Practice Doctorate in Nursing

In a 2005 report, titled *Advancing the Nation's Health Needs: NIH Research Training Programs*, the National Academy of Sciences (2005) recommended that nursing develop a non-research doctorate. The rationale for this initiative included increasing the numbers of expert practitioners who can also fulfill clinical nursing faculty needs (AACN, 2011). The report specifically states that “the need for doctorally prepared practitioners and clinical faculty would be met if nursing could develop a new non-research clinical doctorate, similar to the MD and PharmD in Medicine and Pharmacy, respectively” (National Academy of Sciences, 2005, p. 74). The initiatives of the National Academy of Sciences regarding doctoral education in nursing are reflected in the AACN’s development of the DNP degree.

An additional rationale for a practice doctorate is reflected in nursing’s educational history when the practice doctorate was first proposed. Newman noted that “nursing lacked the recognition for what it has to offer and authority for putting that knowledge into practice” (1975, p. 704). Starck, Duffy, and Vogler stated that “for nursing to be accountable to the social mandate, the numbers as well as the type of doctorally prepared nurses need attention” (1993, p. 214). The NONPF Practice Doctorate Task Force summarized the most frequently cited additional drivers for a practice doctorate in nursing (Marion et al., 2005):

- Parity with other professionals who are prepared with a practice doctorate. Disciplines such as audiology, dentistry, medicine,

pharmacy, psychology, and physical therapy require a practice doctorate for entry into practice.

- A need for longer programs that both reflect the credit hours invested in master’s degrees and accommodate additional information needed to prepare nurses for the demands of health care. Most master’s degrees require a similar number of credit hours for completion as the number required for practice doctoral degrees.
- Remedy the current nursing faculty shortages. The development of a practice doctorate will help meet the needs for clinical teaching in schools of nursing.
- The increasing complexity of healthcare systems requires additional information to be included in current graduate nursing programs. Rather than further burden the amount of information needed to prepare nurses at the graduate level for a master’s degree, a practice doctorate allows for additional information to be provided and affords a practice doctorate to prepare nurses for the changing demands of society and health care.

WHAT IS A DNP DEGREE MADE OF? THE RECIPE FOR CURRICULUM STANDARDS

The standards of a DNP program have been formulated through a collaborative effort among various consensus-based standards. These standards reflect collaborative efforts among the AACN as the *Essentials of Doctoral Education for Advanced Nursing Practice* (2006b), NONPF as the *Practice Doctorate Nurse Practitioner Entry-Level Competencies* (2006), and more recently the National Association of Clinical Nurse Specialists (NACNS) as *Core Practice Doctorate Clinical Nurse Specialist Competencies* (2009). These organizations’ strategies for setting the standards of a practice doctorate in nursing demonstrate interrelated criteria that are congruent with all rationales for a

practice doctorate in nursing. It should be noted, however, that while maintaining these consensus-based standards, there may be some variability in content within DNP curricula.

AACN Essentials of Doctoral Education for Advanced Nursing Practice

In 2006 the AACN published the *Essentials of Doctoral Education for Advanced Nursing Practice*. These essentials are the “foundational outcome competencies deemed essential for all graduates of a DNP program regardless of specialty or functional focus” (AACN, 2006b, p. 8). Nursing faculties have the freedom to creatively design course work to meet these essentials, which are summarized in the following sections.

Essential I: Scientific Underpinnings for Practice

This essential describes the scientific foundations of nursing practice, which are based on the natural and social sciences. These sciences may include human biology, physiology, and psychology. In addition, nursing science has provided nursing with a body of knowledge to contribute to the discipline of nursing. This body of knowledge or discipline is focused on the following (adapted from AACN, 2006b; Donaldson & Crowley, 1978; Fawcett, 2005; Gortner, 1980):

- The principles and laws that govern the life process, 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 affected
- The wholeness of health of human beings, recognizing that they are in continuous interaction with their environments

Nursing science has expanded the discipline of nursing and includes the development of

middle-range nursing theories and concepts to guide practice. Understanding the practice of nursing includes developing an understanding of scientific underpinnings for practice (the science and discipline of nursing). Specifically, the DNP degree prepares the graduate to do the following (adapted from AACN, 2006b):

- Integrate nursing science with knowledge from the organizational, biophysical, psychological, and analytical sciences, as well as ethics, as the basis for the highest level of nursing practice.
- Develop and evaluate new practice approaches based on nursing theories and theories from other disciplines.
- Utilize science-based concepts and theories to determine the significance and nature of health and healthcare delivery phenomena, describe strategies used to enhance healthcare delivery, and evaluate outcomes.

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

Preparation in organizational and systems leadership at every level is imperative for DNP graduates to have an impact on and improve healthcare delivery and patient care outcomes. DNP graduates are distinguished by their ability to focus on new healthcare delivery methods that are based on nursing science. Preparation in this area will provide DNP graduates with expertise in “assessing organizations, identifying systems’ issues, and facilitating organization-wide changes in practice delivery” (AACN, 2006b, p. 10). Specifically, the DNP graduate will be prepared to do the following (adapted from AACN, 2006b):

- Utilize scientific findings in nursing and other disciplines to develop and evaluate care delivery approaches that meet the current and future needs of patient populations.

- Guarantee accountability for the safety and quality of care for the patients they care for.
- Manage ethical dilemmas within patient care, healthcare organizations, and research, including developing and evaluating appropriate strategies.

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

DNP graduates are unique in that their contributions to nursing science involve the “translation of research into practice and the dissemination and integration of new knowledge” (AACN, 2006b, p. 11). Further, DNP graduates are in a distinctive position to merge nursing science, nursing practice, human needs, and human caring. Specifically, the DNP graduate is expected to be an expert in the evaluation, integration, translation, and application of evidence-based practices. Additionally, DNP graduates are actively involved in nursing practice, which allows for practical, applicable research questions to arise from the practice environment. Working collaboratively with experts in research investigation, DNP graduates can also assist in the generation of new knowledge and affect evidence-based practice from the practice arena. To achieve these goals, the DNP program prepares the graduate to do the following (adapted from AACN, 2006b):

- Analytically and critically evaluate existing literature and other research to determine the best evidence for practice.
- Evaluate practice outcomes within populations in various arenas, such as healthcare organizations, communities, or practice settings.
- Design and evaluate methodologies that improve quality in an effort to promote “safe, effective, efficient, equitable, and patient-centered care” (AACN, 2006b, p. 12).
- Develop practice guidelines that are based on relevant, best-practice findings.

- Utilize informatics and research methodologies to collect and analyze data, design databases, interpret findings to design evidence-based interventions, evaluate outcomes, and identify gaps within evidence-based practice, which will improve the practice environment.
- Work collaboratively with research specialists and act as a “practice consultant” (AACN, 2006b, p. 12).

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

DNP graduates have cutting-edge abilities to use information technology to improve patient care and outcomes. Knowledge regarding the design and implementation of information systems to evaluate programs and outcomes of care is essential for preparation as a DNP graduate. Expertise is garnered in information technology, such as web-based communications, telemedicine, online documentation, and other unique healthcare delivery methods. DNP graduates must also develop expertise in utilizing information technologies to support practice leadership and clinical decision making. Specific to information systems, DNP graduates are prepared to do the following (adapted from AACN, 2006b):

- Evaluate and monitor outcomes of care and quality of care improvement by designing, selecting, using, and evaluating programs related to information technologies.
- Become proficient at the skills necessary to evaluate data extraction from practice information systems and databases.
- Attend to ethical and legal issues related to information technologies within the healthcare setting by providing leadership to evaluate and resolve these issues.
- Communicate and evaluate the accuracy, timeliness, and appropriateness of healthcare consumer information.

Essential V: Healthcare Policy for Advocacy in Health Care

Becoming involved in healthcare policy and advocacy has the potential to affect the delivery of health care across all settings. Thus, knowledge and skills related to healthcare policy are central to nursing practice and are therefore essential to the DNP graduate. Further, “health policy influences multiple care delivery issues, including health disparities, cultural sensitivity, ethics, the internalization of health care concerns, access to care, quality of care, health care financing, and issues of equity and social justice in the delivery of health care” (AACN, 2006b, p. 13). DNP graduates are uniquely positioned to be powerful advocates for healthcare policy through their practice experiences. These practice experiences provide rich influences for the development of policy. Nursing’s interest in social justice and equality requires that DNP graduates become involved in and develop expertise in healthcare policy and advocacy.

Additionally, DNP graduates need to be prepared in leadership roles with regard to public policy. As leaders in the practice setting, DNP graduates frequently assimilate research, practice, and policy. Therefore, DNP preparation should include experience in recognizing the factors that influence the development of policy across various settings. The DNP graduate is prepared to do the following (adapted from AACN, 2006b):

- Decisively analyze health policies and proposals from the points of view of consumers, nurses, and other healthcare professionals.
- Provide leadership in the development and implementation of healthcare policy at the institutional, local, state, federal, and international levels.
- Actively participate on committees, boards, or task forces at the institutional, local, state, federal, and international levels.

- Participate in the education of other healthcare professionals, patients, or other stakeholders regarding healthcare policy issues.
- Act as an advocate for the nursing profession through activities related to healthcare policy.
- Influence healthcare financing, regulation, and delivery through the development of leadership in healthcare policy.
- Act as an advocate for ethical, equitable, and social justice policies across all healthcare settings.

Essential VI: Inter professional Collaboration for Improving Patient and Population Health Outcomes

This essential specifically relates to the IOM’s mandate to provide safe, timely, equitable, effective, efficient, and patient-centered care. In a multitiered, complex healthcare environment, collaboration among all healthcare disciplines must exist to achieve the IOM’s and nursing’s goals. Nurses are experts at functioning as collaborators among multiple disciplines. Therefore, as nursing practice experts, DNP graduates must be prepared to facilitate collaboration and team building. This may include both participating in the work of the team and assuming leadership roles when necessary.

With regard to inter professional collaboration, the DNP graduate must be prepared to do the following (adapted from AACN, 2006b):

- Participate in effective communication and collaboration throughout the development of “practice models, peer review, practice guidelines, health policy, standards of care, and/or other scholarly products” (AACN, 2006b, p. 15).
- Analyze complex practice or organizational issues through leadership of inter professional teams.

- Act as a consultant to inter professional teams to implement change in healthcare delivery systems.

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

Clinical prevention is defined as health promotion and risk reduction–illness prevention for individuals and families, and population health is defined as including all community, environmental, cultural, and socioeconomic aspects of health (Allan et al., 2004; AACN, 2006b). Nursing has foundations in health promotion and risk reduction and is therefore positioned to have an impact on the health status of people in multiple settings. The further preparation included in the DNP curriculum will prepare graduates to “analyze epidemiological, biostatistical, occupational, and environmental data in the development, implementation, and evaluation of clinical prevention and population health” (AACN, 2006b, p. 15). In other words, DNP graduates are in an ideal position to participate in health promotion and risk reduction activities from a nursing perspective with additional preparation in evaluating and interpreting data that are pertinent to improving the health status of individuals (adapted from AACN, 2006b).

Essential VIII: Advanced Nursing Practice

Because one cannot become proficient in all areas of specialization, DNP degree programs “provide preparation within distinct specialties that require expertise, advanced knowledge, and mastery in one area of nursing practice” (AACN, 2006b, p. 16). This specialization is defined by a specialty practice area within the domain of nursing and is a requisite of the DNP degree. Although the DNP graduate may function in a variety of roles, role preparation within the practice specialty, including legal and regulatory issues, is part of every DNP curriculum. With regard to

advanced nursing practice, the DNP graduate is prepared to do the following (adapted from AACN, 2006b):

- Comprehensively assess health and illness parameters while incorporating diverse and culturally sensitive approaches.
- Implement and evaluate therapeutic interventions based on nursing and other sciences.
- Participate in therapeutic relationships with patients and other healthcare professionals to ensure optimal patient care and improve patient outcomes.
- Utilize advanced clinical decision-making skills and critical thinking, and deliver and evaluate evidence-based care to improve patient outcomes.
- Serve as a mentor to others in the nursing profession in an effort to maintain excellence in nursing practice.
- Participate in the education of patients, especially those in complex health situations.

A Note About Specialty-Focused Competencies According to the AACN

The purpose of specialty preparation within the DNP curricula is to prepare graduates to fulfill specific roles within health care. Specialty preparation and the eight DNP essentials equip DNP graduates to serve in roles within two different domains. The first domain includes specialization as advanced-practice registered nurses who care for individuals (including, but not limited to, clinical nurse specialist (CNS), nurse practitioner, nurse anesthetist, nurse–midwife). The second domain includes specialization in advanced practice at an organizational or systems level. Because of this variability, specialization content within DNP programs may differ (AACN, 2006b). It should also be noted that postmaster’s degree DNP preparation includes doctoral-level content exclusively; however, postbaccalaureate DNP preparation includes both advanced-practice specialty content that

was previously covered in master's preparation and doctoral-level content.

NONPF Practice Doctorate Nurse Practitioner Entry-Level Competencies

NONPF published *Practice Doctorate Nurse Practitioner Entry-Level Competencies* for nurse practitioner and DNP graduates (2006). These competencies differ somewhat from the AACN's essentials in that they are particular to nurse practitioner roles. However, these competencies are also reflective of the AACN's essentials. The competencies are as follows:

- I. Competency Area: Independent Practice
Practices independently by assessing, diagnosing, treating, and managing undifferentiated patients.
Assumes full accountability for actions as a licensed practitioner.
- II. Competency Area: Scientific Foundation
Critically analyzes data for practice by integrating knowledge from arts and sciences within the context of nursing's philosophical framework and scientific foundation.
Translates research and data to anticipate, predict, and explain variations in practice.
- III. Competency Area: Leadership
Assumes increasingly complex leadership roles.
Provides leadership to foster intercollaboration.
Demonstrates a leadership style that uses critical and reflective thinking.
- IV. Competency Area: Quality
Uses best-available evidence to enhance quality in clinical practice.
Evaluates how organizational, structural, financial, marketing, and policy decisions affect cost, quality, and accessibility of health care.

Demonstrates skills in peer review that promote a culture of excellence.

- V. Competency Area: Practice Inquiry
Applies clinical investigative skills for evaluation of health outcomes at the patient, family, population, clinical unit, systems, or community levels.
Provides leadership in the translation of new knowledge into practice.
Disseminates evidence from inquiry to diverse audiences using multiple methods.
- VI. Competency Area: Technology and Information Literacy
Demonstrates information literacy in complex decision making.
Translates technical and scientific health information appropriate for user need.
- VII. Competency Area: Policy
Analyzes ethical, legal, and social factors in policy development.
Influences health policy.
Evaluates the impact of globalization on healthcare policy.
- VIII. Competency Area: Health Delivery System
Applies knowledge of organizational behavior and systems.
Demonstrates skills in negotiating, consensus building, and partnering.
Manages risks to individuals, families, populations, and healthcare systems.
Facilitates development of culturally relevant healthcare systems.
- IX. Competency Area: Ethics
Applies ethically sound solutions to complex issues.

NACNS Core Practice Doctorate Clinical Nurse Specialist Competencies

In 2006 the NACNS consulted with various nursing organizations and nursing accrediting entities regarding the implications of the DNP degree for CNS practice and education (NACNS, 2009). A formal task force, including

representatives from NACNS and 19 other nursing organizations, was charged with developing competencies for the CNS at the doctoral level (NACNS, 2009). Because traditional CNS education has included a master's degree, "the *Core Practice Doctorate Clinical Nurse Specialist Competencies* should be used with the National CNS Competency Task Force's *Organizing Framework and Core Competencies* (2008) and the AACN *Essentials of Doctoral Education for Advanced Nursing Practice* (2006b) to inform educational programs and employer expectations" (NACNS, 2009, p. 10).

The foci of the *Core Practice Doctorate Clinical Nurse Specialist Competencies* are congruent with the AACN's *Essentials of Doctoral Education for Advanced Nursing Practice* and NONPF's *Practice Doctorate Nurse Practitioner Entry-Level Competencies* (Figure 1-1). Specifically, graduates of CNS-focused DNP programs should be prepared beyond traditional CNS competencies to "strengthen the already significant contribution that CNSs make in ensuring quality

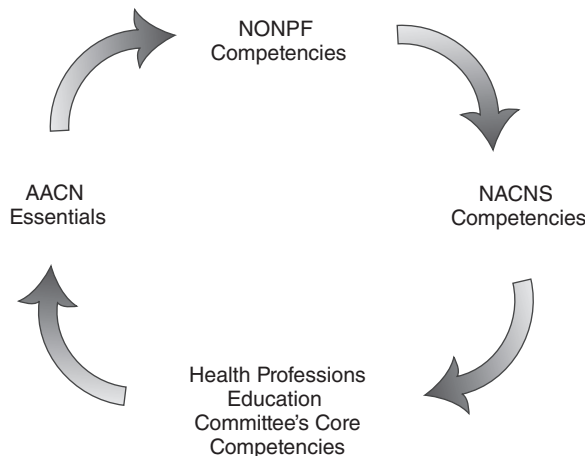
patient outcomes through establishing a practice foundation based on advanced scientific, theoretical, ethical, and economic principles" (NACNS, 2009, p. 11). These competencies ensure that doctoral-prepared CNS graduates are prepared to do the following (adapted from NACNS, 2009):

- Generate and disseminate new knowledge
- Evaluate and translate evidence into practice
- Employ a broad range of theories from nursing and related disciplines
- Design and evaluate innovative strategies to improve quality of care and safety in all settings
- Improve systems of care
- Provide leadership that promotes inter professional collaboration
- Influence and shape health policy

Certified Registered Nurse Anesthetists
As advanced-practice nursing moves toward doctoral preparation for entry into practice, certified registered nurse anesthetists (CRNAs)

FIGURE 1-1

Relationship among the DNP Essentials, the NONPF Competencies, the NACNS Competencies, and the Core Competencies Needed for Healthcare Professionals per the Committee on Health Professions Education.



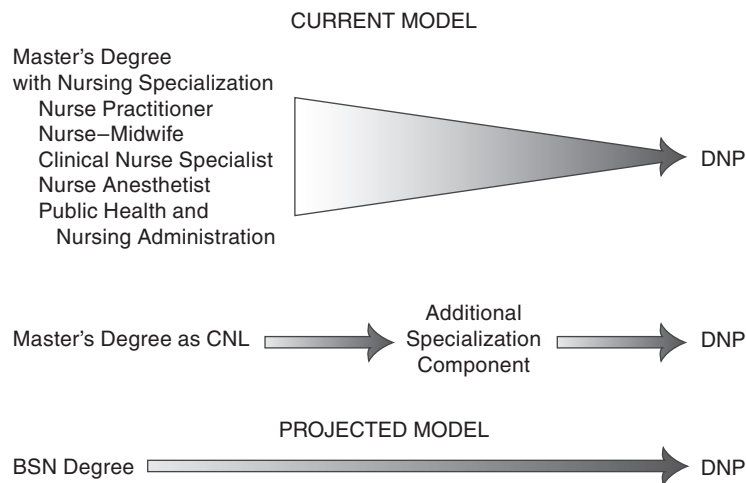
have debated if this progression is appropriate for this advanced-practice specialty. In 2005 the American Association of Nurse Anesthetists (AANA) Summit on Doctoral Preparation for Nurse Anesthetists convened to discuss and identify potential implications of adopting doctoral preparation (Martin-Sheridan, Ouellette, & Horton, 2006). The summit participants concluded that in the future CRNAs may need additional knowledge and skills that include doctoral preparation. Following the summit, the Task Force on Doctoral Preparation of Nurse Anesthetists was formed to develop recommendations regarding doctoral preparation for CRNAs. In 2007 a decision was made by AANA to transition from master’s-level education to doctoral-level education by 2025 (AANA, 2007). To date, the *Standards for Accreditation of Nurse Anesthesia Programs Practice Doctorate* state that “students accepted into accredited entry-level programs on or after January 1, 2022, must graduate with doctoral degrees” (Council on Accreditation of Nurse Anesthesia Programs, 2013, p. 2).

The Path to the DNP Degree: Follow the Academic Road

The path to the DNP degree is currently in transition. Previously DNP preparation included exclusively postmaster’s degree preparation. Many postmaster’s degree students will have already fulfilled several of the criteria listed in the *Essentials of Doctoral Education for Advanced Nursing Practice* and the *Practice Doctorate Nurse Practitioner Entry-Level Competencies* in their master’s degree curricula. Further, as mentioned earlier, the specialization content included in the DNP degree curriculum is currently being fulfilled within the master’s degree curriculum. However, a shift is occurring to include postbaccalaureate DNP preparation. This option presents many new challenges for both students and schools of nursing.

Each individual’s path to the DNP degree may be unique. Prospective students’ program content may be individualized to include the learning experiences necessary to incorporate the described requirements for the DNP degree. Please refer to **Figure 1-2** for an illustration of the pathways to the DNP degree.

FIGURE 1-2 Pathways to the DNP degree.



ROLE TRANSITION INTRODUCED

As explained earlier in the chapter, the doctoral-level content of the DNP degree is not intended to provide specialization in nursing practice. The doctoral-level content instead builds on advanced nursing practice specialization and provides additional preparation in the formulation, interpretation, and utilization of evidence-based practices, health policy, information technology, and leadership. Although DNP graduates may function as evaluators and translators of research, health policy advocates, nursing leaders, educators, information specialists, or clinicians,

it is entirely likely that these roles will be integrated as well. One DNP graduate may participate in research in addition to practicing as a nurse anesthetist. Another DNP graduate may be a nurse executive in addition to developing health policy. Nursing has always been a profession that involves juggling multiple roles (Dudley-Brown, 2006; Jennings & Rogers, 1988; Spherac & Strodtbeck, 1997). Within these multiple roles, the fundamental goal of the DNP graduate remains the development of expertise in the delivery of high-quality, patient-centered care, and the graduate utilizes the necessary avenues to provide that care.

Interview with a DNP Cofounder: Then and Now



Carolyn A. Williams, PhD, RN, FAAN, is professor and dean emeritus of the University of Kentucky. She was president of the American Association of Colleges of Nursing from 2000 to 2002 and scholar-in-residence at the Institute of Medicine from 2007 to 2008.

THEN ... 2008

Dr. Williams, could you please describe your background and current position?

I began my nursing career as a public health nurse at a public health department in a rural area and practiced for 2 years before returning to graduate school. I then received my master's degree in public health nursing. This was a joint master's degree from both the School of Nursing and the School of Public Health from the University of North Carolina at Chapel Hill (UNC, CH). I then went on to earn a PhD in epide-

miology from the School of Public Health at UNC, CH. This was met with some controversy in that I did not have a large amount of nursing experience before returning to graduate school. Interestingly, the School of Public Health was supportive of my doctoral studies whereas the School of Nursing seemed to think I needed more nursing experience. This is what I call a "pernicious pattern" in nursing education. I actually had to talk faculty [in nursing] into supporting me to earn a doctorate. However, faculty from other disciplines, e.g., medicine, psychology, and sociology in the School of Public Health, were very supportive. This is where nursing differs from medicine: we don't build in the experience into our educational programs.

Upon finishing my PhD in epidemiology, I took a faculty position at Emory University's School of Nursing. From there, I was asked to return to Chapel Hill to participate in the development and evaluation of a family nurse practitioner program in the School of Nursing and to teach epidemiology in the School of Public Health. The program in the School of Nursing was one of the first six federally funded family nurse practitioner programs in the country. I remained at

(continues)

Interview with a DNP Cofounder: Then and Now (*continued*)

Chapel Hill for 13 years before accepting an appointment as dean of the College of Nursing at the University of Kentucky. Last year I retired as dean after 22 years in that position and remained as a faculty member.

This year [2007 to 2008] I am a scholar-in-residence at the Institute of Medicine in Washington, DC. My role here includes development of a project, which happens to be inter professional collaboration. This stems from the view that improvement in quality care depends on people working together in inter professional teams. Inter professional collaboration is happening around the margins of education for health care instead of in the mainstream, particularly core clinical components of undergraduate and graduate education for health care. It may be picked up in passing, but frequently it is not a formal part of the curriculum. Part of my project involves identifying the policy changes [that] are needed at the university level to integrate inter professional collaboration as part [of] an integral component of education in the health professions. Inter professional collaboration is a necessary part of practice and therefore needs to be integrated into the preparation of healthcare professionals. This leads me to an issue I have always struggled with: too few clinical faculty in nursing actually practice. This is a problem due to the fact that a practice culture is not as visible as I believe it needs to be in most schools of nursing. Some progress in having nursing faculty engaged in practice was achieved with the nurse practitioner movement that started in the 1970s, but it is still a struggle for nursing faculty to engage in practice as part of their faculty role in a manner similar to what happens in medical education. Some faculty attempt to practice on their own, not as a part of their faculty role, and usually faculty practice is not viewed as a priority in schools of nursing. I feel if we want nursing faculty to provide leadership in practice and develop leaders for practice, each school of nurs-

ing needs to have a core group of faculty who actually engage in practice as part of their faculty role.

Dr. Williams, could you please describe how your vision for a doctor of nursing practice became a reality?

While on the faculty at the University of North Carolina at Chapel Hill and consulting with a number of individuals in practice settings, I developed some ideas of what nursing education to prepare nurse leaders needs to be. Initially, I viewed the degree as what public health nurses could earn to prepare them to face the challenges of public health nursing. I didn't feel that the master's degrees in nursing offered at that time [1970s through early 1980s] were sufficient for the kind of leadership roles nurses were moving in to. I felt a true practice degree at the doctoral level was needed.

When I went to the University of Kentucky as the dean of nursing, I was charged with developing a PhD in nursing program. While at Chapel Hill I had been very involved in research activity, doctoral education in epidemiology, and was active nationally in research development and advocacy in nursing as chair of the American Nurses Association's Commission on Nursing Research and as the president of the American Academy of Nursing. I proceeded to work with the faculty at the University of Kentucky, and we developed the PhD program in nursing. However, I was still interested in the concept of a practice doctorate and promoting stronger partnerships between nursing practice and nursing education.

As time went on it became clearer and clearer to me that to prepare nurses for leadership in practice, something more in tune with preparing nurses to utilize knowledge, not necessarily generate new knowledge, which was expected in PhD programs, was needed. Thus, I began to talk with and work with my faculty colleagues on the concept of a new practice

 Interview with a DNP Cofounder: Then and Now (*continued*)

degree for nurses to prepare for leadership in practice, not in education or research.

I saw practice as the focus with this degree, not research. Working with my University of Kentucky faculty colleagues, particularly Dr. Marcia K. Stanhope and Dr. Julie G. Sebastian, we developed the initial conceptualization of the degree. These foci included four themes that I feel should be central to a practice doctorate in nursing:

- 1. Leadership in practice, which included leadership at the point of care. This also includes leadership at the policy level to impact care.*
- 2. A population approach and perspective. This involves a broader view of health care, which recognizes the importance of populations when planning and evaluating care processes.*
- 3. Integration of evidence-based practice to make informed decisions regarding care.*
- 4. The ability to understand change processes and institute positive changes in health care.*

These four themes guided the development of the curriculum of the first DNP program at the University of Kentucky, which when we instituted it was the first in the United States. These themes also influenced and are incorporated in what became the AACN's Essentials of Doctoral Education for Advanced Nursing Practice.

To expand on the development of the DNP program at University of Kentucky, the following is the time line:

- 1994–1998 Informal conversations among faculty, people in practice, and others regarding a practice doctorate in nursing*
- 1998 Professional Doctorate Task Force Committee formed*

May 1999 Approval of DNP program by total college faculty

July 1999 Medical Center Academic Council approval

January 2000 University of Kentucky Board of Trustees approved the program

May 2000 Approval by the Kentucky Council of Postsecondary Education

January 2001 The first national paper on the DNP degree at the AACN's National Doctoral Education Conference (Williams, Stanhope, & Sebastian, 2001)

Fall 2001 Students admitted to the first DNP program in the country.

In 1998, when the University of Kentucky's DNP task force was created, we decided we didn't want this degree to look like anything else currently in nursing education. We also decided on the name of this degree in this committee. We wanted the degree and the name to focus on nursing practice, and we did not want the degree to be limited to preparing for only one particular type of nursing practice. We decided on the doctor of nursing practice because that describes what the degree is: a practice degree in nursing.

One of the most important things that happened during my presidency of the American Association of Colleges of Nursing was the appointment [of] a task force to look at the issue of a practice doctorate. The task force committee was carefully planned. I wanted to have a positive group of people as well as major stakeholders represented. These stakeholders were credible individuals who had an interest in the development of a practice doctorate. Members of the committee included representatives from Columbia University, the University of Kentucky, a representative from an ND program, as well as a representative

(continues)

Interview with a DNP Cofounder: Then and Now (*continued*)

from schools that did not have nursing doctoral programs. This committee was chaired by Dr. Elizabeth Lentz, who has written extensively on doctoral education in nursing. As this task force began sorting out the issues, it became the goal that by 2015, the DNP would become the terminal degree for specialization in nursing.

From this point, a group to develop both the essentials of doctoral education in nursing and a roadmap task force were formed. These committees worked together, and we presented together nationally in a series of regional forums. We invited others to engage in discourse regarding the essentials as well as ask questions about the DNP degree. As our presentations across the country came to a conclusion, we noticed an obvious transformation. The DNP degree was beginning to gain more acceptance. By the time we were done, the argument of whether to adopt a practice doctorate in nursing had given rise to how to put this degree in place.

Dr. Williams, are you surprised by the acceptance of the degree and speed with which programs are being developed?

Yes, I am surprised. I thought the DNP degree would be an important development for the field of nursing, and I thought some would adopt a practice doctorate. I certainly did not think things would move so fast. The idea of a DNP really struck a chord with many people.

Dr. Williams, do you think the history of doctoral education in nursing has influenced the development of a practice doctorate in nursing?

Well, we need to have scientists in our field. However, we also need to come to grips with the fact that we are a practice discipline. Over the years, since the late 1970s, many of the leading academic settings in nursing have become increasingly research intensive

and [have] not spent as much effort on developing a complementary practice focus. I feel the development of a practice doctorate has more to do with our development as a discipline than the history of doctoral nursing education. Attraction and credibility from the university setting stem from involvement in research. Therefore, it becomes a struggle when handling this practice piece. If nursing wants acceptance as a discipline, we must have research. But we are a practice discipline, and all practice disciplines struggle to some extent in research-intensive university environments.

Dr. Williams, do you agree that nursing should have both a research- and a practice-focused doctorate?

Of course. The ratio between research-focused and practice-focused doctorates may be tipped toward the practice focus due to the practice focus of our discipline.

Dr. Williams, could you describe what you feel is the future of doctoral education in nursing? *Down the pike, some people may move into DNP programs and then discover they want to be researchers and end up also getting a PhD. This would be very healthy for our profession. Essentially, we have lost talented folks due to offering only a research-focused terminal degree. The DNP allows us to accommodate those folks who don't want a research-focused degree. I also feel we need a more intensive clinical component integrated into the degree. This may be in the form of residency programs integrated within nursing degrees or as a postdoctorate option.*

Dr. Williams, could you expand on the grandfathering of advanced-practice registered nurses (APRNs) who don't wish to pursue a DNP degree?

The DNP degree will not be required to practice anytime soon. It took a while to require a master's degree

 Interview with a DNP Cofounder: Then and Now (*continued*)

to practice as an APRN. There will be a similar transition regarding the DNP degree. If someone is certified and successful as an APRN without a DNP, they should continue to be successful.

Dr. Williams, do you believe the DNP will continue to flourish as a degree option for nursing? If so, what would your advice be regarding nurses earning a DNP degree?

Yes, I do. My advice regarding nurses earning a DNP degree is that it depends on their career choice. Some have been looking for this option for a long time. This may be the right degree for some no matter where they are in practice.

NOW ... 2014

Dr. Williams, we discussed your nursing background and education the last time we spoke. Could you please describe your current position and what types of projects you are currently involved in?

Since I left the deanship of the College of Nursing at the University of Kentucky in the fall of 2006 I have remained on the faculty as a professor in the college and teach in both our DNP and PhD programs. I spent the 2007–2008 academic year at the Institute of Medicine in DC as the American Academy of Nursing–American Nurses’ Foundation’s scholar-in-residence. During that year I had the opportunity to be a part of the Health Policy seminars designed for the Robert Wood Johnson Foundation’s Health Policy Fellows. It was a unique experience to interact with health policy makers and experts in the national arena.

I continue to teach at the University of Kentucky in the areas of health policy, leadership, and ethics, and I work with students on DNP Clinical Projects and Dissertations. I also continue to serve as a consultant and mentor on issues related to graduate education in nursing and leadership in the field.

Dr. Williams, what is your impression of the current progress of the DNP degree? How does the current progress of the DNP degree compare to your original vision of the DNP degree? *The original vision that my colleagues and I at the University of Kentucky’s College of Nursing had for the DNP when we opened the first program of study leading to the DNP in the fall of 2001 was that it would be a postmaster’s program for those interested in leadership in nursing practice. Further we saw the DNP as a program of study for clinical nurse specialists, nurse practitioners, and nurse administrators. We conceptualized four key areas that we felt were necessary for leadership in practice and which we felt were not sufficiently dealt with in the master’s programs at that time. Those four pillars were: a population approach; the use of the best evidence possible in clinical decision making; understanding how to guide sustainable changes in practice based on the best evidence possible; and leadership at the unit and system level. Our original program was built around those concepts, and I am pleased that those concepts are clearly evident in the DNP essentials developed by the American Association of Colleges of Nursing (AACN, 2006b). For a program to receive accreditation by the Commission on Collegiate Nursing Education (CCNE) all of the essentials have to be evident in the curriculum. However, one issue that we need to continue to keep in focus and work on, particularly in the emerging BSN to DNP programs preparing nurse practitioners, is how to integrate those concepts into the manner in which the nurse practitioner student conceptualizes their practice. This is tricky since students in such programs focus so much of their efforts on getting comfortable with the assessment and management of individual patients, and time in many programs is limited.*

The overall growth of DNP programs has been far more rapid than I expected. The latest data from

(continues)

 Interview with a DNP Cofounder: Then and Now (*continued*)

AACN obtained during the fall of 2013 is that there are now 243 DNP programs in the United States (AACN, 2014). The good news is that access to a DNP program for those interested in such preparation has markedly increased. For those seeking a program, the challenge is to look carefully at what a given program can provide in terms of faculty expertise in key areas—doctoral education, relevant and current practice, and clinical scholarship. Given the national shortage of faculty with the necessary expertise, the very rapid increase in the number of programs makes it imperative that all involved in approving programs and providing them do all that is possible to ensure the quality of DNP programs.

Dr. Williams, why do you think the DNP degree continues to gain acceptance and momentum?

I believe some of the initial momentum for the DNP, particularly among nurse practitioners, was stimulated by AACN's 2015 target. However, I think much of it stems from the recognition that better-prepared nurses can be key players in improving patient outcomes at various levels of care and that the focus of DNP programs is on target with regard to the knowledge base and skills necessary for leadership in improving the quality of patient care and patient outcomes. Finally, the Institute of Medicine's report, The Future of Nursing (IOM, 2010b), which in recommendation 5 calls for doubling the number of nurses with a doctorate by 2020, has probably added to the momentum.

Dr. Williams, when we last spoke, you agreed that nursing needed both a research- and practice-focused doctorate. Do you still agree that a research and practice-focused doctorate are beneficial to the profession?

Absolutely. Until the emergence of the DNP the consensus among academic and research leaders in

nursing was that the PhD was the route to prepare for leadership in both the academic and practice arena. However, that was an unsustainable course for several reasons. First, too few nurses were seeking PhDs, and too few were being produced. Secondly, most of the PhD programs did not provide content or learning opportunities that directly addressed leadership in the practice arena. Finally, leaders in the field were increasingly recognizing that to be competitive in obtaining grant monies to sustain a viable program of research requires a concentrated focus on research; thus the strongest doctoral programs put their emphasis on how to prepare their graduates to be successful in doing research and obtaining grant support for their work. There was little or no time for preparing for leadership in practice.

In a presentation to the Advisory Council of the National Institute for Nursing Research in 2006 I argued that unless we had practice leaders in nursing who appreciated the need for the best evidence to inform clinical decisions and who knew how to guide evidence-based changes designed to improve nursing practice, the successful efforts of National Institute for Nursing research researchers would not have much impact on the quality of care provided to patients (Williams, 2006). I still hold that view.

Dr. Williams, do you believe that a partnership continues to form between PhD and DNP graduates?

I have been happy to observe some of those partnerships, and I look forward to more. I think all of us concerned about increasing the positive impact that nursing can have on patient outcomes need to encourage and foster such collaboration. I believe those who are faculty in schools and have both a DNP program and a PhD program have a special opportunity and an obligation to work on modeling such behavior by developing collaborative endeavors between DNP and PhD faculty

Interview with a DNP Cofounder: Then and Now (continued)

and having students in both programs work with them in their collaborative efforts.

Dr. Williams, are you noticing a transition of roles in nursing as more students graduate from DNP degrees and begin their careers? Are there any specific roles you see evolving as more nurses earn their DNP degree?

I have noticed that a year or two after completing a DNP a number of our graduates have moved into roles that involve assuming more responsibility and demand more organizational leadership. These include moving from providing care as a nurse practitioner to developing a new clinic in a rural area and moving from having responsibility as the nurse leading several clinical programs to becoming the vice president of nursing for a hospital. In addition to gaining more recognition as expert practitioners and clinical consultants, in the future I think we will see more of our graduates moving into leadership roles traditionally held by individuals with preparation in other fields, such as medicine and management. These include clinic directors, directors of clinical services, directors of quality assurance programs for various types of healthcare organizations and systems, health officers in large health departments, directors of practice initiatives in large healthcare organizations, and chief operating officers in healthcare organizations.

Dr. Williams, what do you think are the most significant contributions the DNP degree has made to nursing education?

I think it has helped to refocus many of our academic leaders in nursing on the essence of our discipline, which is practice, and realistic ways in which we can prepare graduates to provide leadership in improving nursing practice.

Dr. Williams, how would you recommend we continue to move forward with AACN's recommended target date of the DNP for entry into practice by 2015?

The target date was really an aspiration and it has done its work of fostering momentum. Now I think the emphasis should shift to more attention on continuous efforts to ensure program quality and the competence of the graduates in each of the DNP essential areas. Examples of such initiatives include faculty development related to clinical scholarship and partnerships between schools of nursing and practice settings that provide more opportunities for nursing faculty to have meaningful engagement in practice as a part of their faculty role. The DNP will continue to evolve, but for it to continue to be relevant and cutting edge, core DNP faculty who lead in curriculum development and implementation need to be in touch with and understand practice realities and possibilities.

SUMMARY

- The DNP degree is defined as a practice-focused doctorate that prepares graduates as experts in nursing practice.
- Nursing practice is defined by the AACN as “any form of nursing intervention that influences health care outcomes for individuals or populations, including direct care of individual patients, administration of nursing and health care organizations, and the implementation of health policy” (AACN, 2004, p. 3).
- According to the AACN's (2004) position statement, the DNP degree is proposed to be the terminal degree for nursing practice by 2015.

24 ■ Chapter 3 Overview of the Doctor of Nursing Practice Degree

- A nursing PhD degree is a research-focused degree, and a DNP degree is a practice-focused degree.
- The evolution of doctoral education in nursing illustrates where we have been in doctoral education and the direction nursing is taking in the development of doctoral education.
- The concept of a practice doctorate is not new. The idea began in the 1970s with the development of the DNS degree.
- The AACN now designates the DNS and PhD degrees as research-focused degrees, and the DNP and DrNP degrees are designated as practice-focused degrees.
- In 2002 the AACN board of directors formed a task force to examine the current progress of proposed doctorates in nursing.
- In 2000 the IOM published a report titled *To Err Is Human: Building a Safer Health System*, which summarized errors made in the healthcare system and proposed recommendations to improve the overall quality of care.
- In 2003 the Health Professions Education Committee published *Health Professions Education: A Bridge to Quality*, which outlined a specific set of competencies that should be met by all clinicians.
- In 2008 the IOM appointed the Committee on the RWJF Initiative on the Future of Nursing. This committee published a report in 2010 titled *The Future of Nursing: Focus on Education*, which concluded that “the ways in which nurses were educated during the 20th century are no longer adequate for dealing with the realities of healthcare in the 21st century” (IOM, 2010a, p. 2). This committee also recommended doubling the number of nurses with doctorates by 2020.
- In 2004 the AACN published a position statement regarding a practice doctorate in nursing and recommended that by 2015 all nurses pursuing advanced-practice degrees will be prepared as DNP graduates.
- In 2005 the National Academy of Sciences recommended that a nonresearch ND be developed to meet nursing faculty needs.
- In 2006 the AACN described the *Essentials of Doctoral Education for Advanced Nursing Practice*, which represents the standards for DNP curricula.
- NONPF outlined the *Practice Doctorate Nurse Practitioner Entry-Level Competencies* as standards for DNP curricula.
- In 2009 the NACNS developed *Core Practice Doctorate Clinical Nurse Specialist Competencies*.
- In 2007 the AANA stated that nurse anesthetist education would adopt doctoral education as preparation to enter into practice by 2025.
- The DNP degree includes postmaster’s degree programs and postbaccalaureate degree programs.
- Graduate students may follow an individualized path to the DNP degree, depending on their current degree preparation.
- DNP graduates may be involved in many different roles that may include, but are not limited to, research evaluator and translator, leader, healthcare policy advocate, educator, information technology specialist, and clinician.

DISCUSSION QUESTIONS _____

1. How do you think nursing’s history has contributed to the development of the DNP degree?
2. How do you think the IOM report *To Err Is Human: Building a Safer Health System*, along with the follow-up report *Crossing the Quality Chasm: A New Health System for the 21st Century*, contributed to the development of the DNP degree?
3. Explain why you think the IOM and the RWJF concluded, in their report *The Future*

of Nursing: Focus on Education, that nurses need improvement in their educational preparation.

4. Do you think a struggle still exists within nursing today regarding whether doctoral education should be research or practice focused?
5. Do you think nursing doctoral education should be research focused, practice focused, or both?
6. Do you think a DNP degree is the right degree for you?

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