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The Case Against the DNP: History, Timing, Substance, and Marginalization

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Abstract

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Keywords

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Doctor of Nursing Practice (DNP) or not? The answer is not! Within the historical context of our discipline, a doctorate degree should stand for advancing and translating knowledge. Clinical practice is the core of this knowledge. Separating the practice and research missions could undermine our ability to be equal partners in universities, as well as diminish our effectiveness in establishing the evidence for quality and safe health care.

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A new degree program leading to a Doctor of Nursing Practice (DNP) degree is currently being considered in a number of schools of nursing across the United States (US) (American Association of Colleges of Nursing, 2004). There are a number of compelling reasons why the DNP is not the right terminal degree in nursing. This article will focus on four of these reasons: history, timing, substance, and marginalization.

History

In the discipline of nursing, we have a long history of developing different types of doctorates that have evolved into the more mature doctoral programs that exist today. In our history of developing and granting doctoral degrees, we have offered the Doctor of Nursing Science (DNS or DNSc) degree, the Doctor of Science in Nursing (DSN) degree, the Doctor of Education (EdD) degree, and the Nursing Doctorate (ND) (Meleis, 1988). In many schools, such as the University of Pennsylvania and the University of California San Francisco, the rationale for offering the DNS was the lack of supported and sustainable faculty research programs, the limited number of faculty holding PhDs, and, most importantly, the resistance of those in power in university administration to grant nurses the privilege to study for and receive a PhD. It was a relief for leaders of university graduate programs, who controlled the development and implementation of doctoral degrees in the university, to be able to propose instead a professional degree other than the PhD. In most cases, that degree (such as DNS) was offered and administered by the school rather than by the university. When the school was able to prove that they had developed the critical mass of doctorally prepared faculty, and demonstrate that the faculty members had an appropriate research program trajectory, these schools submitted a new application to change their program and, therefore, grant a PhD degree (see entire NLN issues of 1986-87& 1989; Downs, 1989; Grace, 1983).

This history is particularly significant for those of us who participated painfully in attempting to justify, provide rationale for, and present evidence that growth in nursing science depends on providing a degree that equals other terminal degrees in the university. It was not only that we had to go through the long and arduous process of developing the PhD as a terminal degree, but also that many of us over the course of the last 30 years of evaluation of PhD programs also experienced the significant process of having nursing

faculty become equal partners in universities. Outcomes of such equity are not only the confidence and self-esteem of faculty members but, more importantly, the ability of nursing faculty to become part of the decision-making bodies of universities and affect policies, budget, and the future of universities. Examples of equality that resulted from having equal terminal education and equal faculty promotion processes are numerous. These include, faculty members being able to assume leadership positions in university-wide faculty senates and in universities' administrative structures, the development of joint-degree programs for nursing students, faculty members participating in and leading interdisciplinary research projects, and nursing faculty providing research mentorship for students from different schools and in related disciplines.

Having such history emerging out of academic marginalization, our ability to influence and affect other university programs, and to advance the discipline of nursing, was profoundly driven by achieving the ability to offer an equal terminal degree that is acknowledged and respected by all disciplines. While the MD may be a terminal degree, it is also an entrance degree to the profession of medicine. Increasingly, the PhD is sought by physicians for the purpose of advancing basic and clinical science in medicine. Furthermore, with a history of privilege, an MD degree holds a totally different level of valuation than a ND, DNS, or EdD degree. With such a history of struggle and marginalization, why repeat it?

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A colleague who is a proponent of the DNP, in attempting to advance the arguments for the degree, suggested that colleagues in medicine will support the development of the DNP. We agree. Our colleagues in health sciences have always supported such a terminal degree for nurses. Their rationale was that there is no such thing as nursing science, making it inappropriate for nurses to earn a PhD. No wonder they will support the DNP; they have always done so.

Timing

The diversion of nurse leaders to a dialogue, a debate, and a discourse about the logic of creating a new degree (whether it is or is not new is another subject for debate!) is very ill-timed. The crises in health care due to the critical shortage of nurses, the dialogues about environments in the health care system that undermine the retention of nurses, the threats to providing quality nursing care, and the well-documented disparities in health care are topics that are front and center in all major organizations and associations that deal with the goals of quality health care. Another major, well-documented crisis is unsafe hospital care. While these robust dialogues are ongoing at such leading organizations as the Institute of Medicine (IOM), the American Nurses Association (ANA), the Association of Academic Medical Centers (AAMC), the American Association of Colleges of Nursing (AACN), and the International Council of Nurses (ICN), among others, our nursing community is diverted to discussing the merits and disadvantages of yet another degree.

Nurses have had a history of focusing internally on our own professional development and academic preparation, rather than considering how our profession influences the quality of care provided. Recent research findings have linked nurses' educational levels and collaborative environments to patient morbidity and mortality, bringing the importance of nursing on the quality of patient care front and center (Aiken, Clarke, Cheung, Sloane, & Silber, 2003). Unfortunately, the refocus on our internal development with the DNP debate has diverted the dialogue back, to what appears to many outside the profession, to be the self-serving interests of nurses searching for parity among the health professions.

The unintended consequences of proposing a new degree involves debates within schools about the advisability of adopting the new degree and dialogues about the consequences of the new degree on existing graduate programs. Multiple committees are formed within AACN as well as other organizations to chart road maps of next steps to discuss certification, academic requirements, accreditation frameworks, and changes that may have to occur in other programs. Admission and graduation criteria and processes of

getting the new degree approved within universities require many hours of discussion and a trajectory of approval at many different levels.

The time involved in all these dialogues, debates, approvals, and changes is time taken away from the more vital discussion about the quality of care in the health care system. The timing for developing, implementing, and evaluating this degree is, in a nutshell, disastrous to the potential involvement of nurses to make a substantial difference in the safety and quality of health care. With the timely IOM reports on the critical need for cooperation between members of the health care team in order to provide quality and safe care, current dialogues should focus on ways to make that happen through interdisciplinary education, changes in health care environments, and enhancing information and communication between physicians and nurses (Greiner & Knebel, 2003; Institute of Medicine, 2001; Smedley, Stith, & Nelson, 2003). The proposal by IOM toward making the patient the center of care resonates with our profession's vision and provides an incredible opportunity to lead the health care system toward providing care driven by nurses' vision, education, and goals. However, the energy of those who could lead the way is drained by the endless discussions on the merits of the DNP and the processes by which it can be implemented.

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We consider the time required to consider a new degree to be wasted. Precious resources will be needed to mount this degree, resources that should be used in preparing nurse clinicians, scientists, and leaders to change the health care system. This is a turning point and a milestone in our history, and we are not sure that the DNP is a positive step toward a more responsive future.

Substance

Practice drives knowledge development in nursing. In fact, practice is the *essence* of the *discipline of nursing*. Therefore, advanced graduate education that does not address inquiry that reflects clinical practice, is likely to train researchers whose research progress may not readily advance nursing science. Similarly, nursing science is the body of evidence that answers significant questions that emanate from, or are about, the nursing profession. Receiving a PhD in nursing is predicated on the premise that the recipient has acquired advanced knowledge in some specific field in nursing. While it does not *presume* advanced practice beyond the Master of Science (MS) degree, it is built on the fundamental assumption that advanced practice, expertise, and knowledge acquired at the MS level drives the scientific inquiry and the goal for the development of the scientific knowledge of nursing (Whall, 2005). Therefore, practice knowledge is intricately connected to a scientific career. And all doctoral education must be designed to help define, generate, develop, translate, and test the substantive base of knowledge in nursing (McKenna, Cutcliffe, & McKenna, 2000).

In addition, just as we are encountering crises in shortages of clinical faculty and nurses, the discipline of nursing is facing a shortage in scientists. Nurse scientists advance the knowledge base that provides the evidence for advanced practice nurses. Why would we want to add to that severe shortage of nurse scientists by extending the education of nurses in advanced practice, thus extending the entire education trajectory of new nurse scientists? Will a DNP advance nurses' ability for scientific careers? We think not.

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Developing and supporting a cadre of advanced clinicians at the doctoral level without the research focus is supportive of a dichotomy that has thwarted knowledge development in nursing for decades. We believe that in our current master's and doctoral programs we have finally bridged the schism between research, practice, theory, and policy, only to reinstate it again by proposing a research doctorate and a practice

doctorate. Advancing nursing knowledge requires more integration and less compartmentalization and fragmentation.

Marginalization

It is a fair assumption to state that graduates with a DNP will seek teaching jobs as well as clinical jobs. We have major concerns related to the employment of DNP graduates in either of these career choices.

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Proponents of the DNP have argued that DNP graduates are needed for clinical teaching but will not seek tenure. It is fair to assume also that in programs where the DNP is offered, there will be a need for faculty who hold a similar degree, and are advanced practice clinicians, in order to provide the necessary role modeling and mentorship. If the DNP is the only degree option open to advanced practice nurses in a university, these faculty members should constitute the majority, if not all of the faculty body. They should be the ones leading the curriculum and the teaching mission of the school. How will this school then compare with others in the same university? Will it be the only school with a critical mass of faculty members, if not all of the faculty body, who are substantially different in education attainment and status than the rest of the university?

Let us then presume that some schools will have both options – a professional/practice doctorate and a research-focused doctorate. A professional and a research doctorate will require two different sets of faculty with different preparations, goals, senate membership, and tenure status. And here is the crux of one of the arguments against supporting the development of DNPs. In most U.S. universities, membership in the academic Senate is granted to faculty members who hold tenured professorial ranks with the requirement of a PhD. Many DNP-prepared faculty will be excluded from the "Senate" of universities, and thus will be excluded from having a voice and a vote in decision making pertaining to educational and faculty policies. Faculty members with the DNP, getting neither tenured positions nor Senate membership, will be barred from dialogues and discussions pertaining to their educational role. By developing a professional practice doctorate and a research doctorate, we are creating a second-class citizenship in universities and we are enhancing the potential of marginalization of one group by another group. One group of faculty will have voting rights, senate membership, the right to achieve tenure, and, in summary, the right for affecting university policy, while the other group will not.

Nursing has a long history of marginalization. The diploma graduates were superseded by the BS graduates. Doors were closed for the diploma graduates until we allowed them an educational ladder of opportunity to complete their BS degree. Are we intentionally creating the potential for another set of marginalizing credentials?

There is a presumption that graduates of the DNP will be appointed in clinical areas and eventually replace existing MS graduates (it is presumed we will eventually close MS programs). Where is the evidence that clinical institutions are poised to replace all MS graduates with DNP graduates? And herein lies another potential for devaluation of the MS-prepared advanced practice nurses who are slated to be obsolete and replaced by the new DNP graduates.

Conclusion

We have argued in this article that going ahead with the DNP is a major mistake for our profession of nursing as well as the discipline of nursing knowledge. The timing of the introduction of this initiative is detracting from other pressing matters related to quality and safe care. We seem to be reliving a history that we previously put behind us. It is "déjà vu all over again." We are derailing our efforts to become

equals in universities of higher learning, and we are setting the stage for developing second-class citizens who are marginalized. Also, the shortage in nursing scientists and agents of science makes it imperative to prepare and train those who can combine and integrate advanced nursing expertise with a scientific knowledge base to produce the evidence for improving the quality of care for our clients.

In addition to the above discussed reasons, we would like to end with another major issue and that is the global impact of adding another new title. In addition to the confusion created with the multiple routes to achieving a doctoral degree in nursing (Gennaro 2004), we have also created confusion internationally with our exporting of these multiple degrees. Our international students face many obstacles in having their U.S.-obtained degree credentialed in their countries. Master of Science and PhD degrees are known entities internationally, against which U.S.-acquired degrees are benchmarked. Having a new set of letters tends to make our graduates vulnerable to endless interrogations and possible rejection of the degrees with the suspect set of letters.

Finally, we have two graduate degrees that are well understood by our public and that have thrived – the MS and the PhD. Both of these degrees are based on science and driven by practice. Why are we creating yet another degree that requires certification and accreditation? We have the educational programs that create equal partners in the scientific arena. Let's make these programs stronger and our science more influential.

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Kathleen Dracup, RN, FNP, DNSc, FAAN, has held a university professorship for 30 years. At the University of California, Los Angeles she contributed to the proposal that ultimately led to the establishment of a PhD program in the School of Nursing and served for many years on the School's curriculum committee. She is currently Professor and Dean, School of Nursing at the University of California, San Francisco. She is a member of the Program Committee of the American Association of Colleges of Nursing and Chair of the Doctoral Program Subcommittee. She is an expert in cardiovascular nursing and has published over 300 articles, editorials, and book chapters, and is a member of the Institute of Medicine. Her outstanding mentorship of doctoral students was acknowledged in 2003 by the American Heart Association when she was awarded the Eugene Braunwald Academic Mentorship Award.

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