

Section Editor

Deborah Callender, MS, CPNP
Potomac Hospital
Woodbridge, Virginia

The DNP and Unintended Consequences: An Opportunity for Dialogue

Patricia Clinton, PhD, RN, CPNP,
& Arlene M. Sperhac, PhD, RN, CPNP, FAAN

At the Annual Conference of the National Association of Pediatric Nurse Practitioners held March 19-22, 2009, in San Diego, California, Drs. Arlene Sperhac and Patricia Clinton presented a session, "The DNP and Unintended Consequences: An Opportunity for Dialogue," to address issues that have emerged as a result of the shift in advanced practice education and the opening of Doctor of Nursing Practice (DNP) programs across the United States. The main objective of the presentation was to describe the unintended consequences resulting from implementation of the educational mandate to move the educational preparation of nurse practitioners (NPs) from the master's level to the DNP. Three main topics were focused on, including: (a) the changes in regulation that may result with adoption of the Advanced Practice Registered Nurse (APRN) model of regulation by individual states; (b) the implications and/or concerns raised by the option of a DNP certification examination; and (c) the impact of the DNP on

key stakeholders such as medical associations, employers, insurers, and the public. At the close of the formal part of the presentation, the authors facilitated a discussion with participants and offered to answer other questions in a follow-up article in the *Journal of Pediatric Health Care*. We received several questions and have combined them into topical areas to address the issues raised. Two important questions underlie basic assumptions that appear to be major sources of concern and will be described.

The first concern is that the practice doctorate (DNP) is a threat to traditional doctoral (PhD) education. There is no intent to discard the research degree (PhD) in favor of the DNP. The two are complementary and in fact overlap. The research mission is to generate knowledge, and the practice mission is to apply that knowledge. The interaction between the two should bolster both degrees; in other words, research questions often are generated through clinical practice, and those questions

Patricia Clinton, Clinical Professor,
Director Masters & DNP Programs,
University of Iowa College of Nursing, Iowa
City, IA.

Arlene M. Sperhac, Professor, Coordinator
Pediatric Nurse Practitioner Program,
Rush University College of Nursing,
Chicago, IL.

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Correspondence: Patricia Clinton, PhD
RN, CPNP, University of Iowa College of
Nursing, Iowa City, IA 52242; e-mail:
patricia-clinton@uiowa.edu.

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become the focus of research programs. The findings from the research programs return to the practice environment for application and further exploration and evaluation. Or it could be a reverse process; that is, a nurse researcher with a specific clinical interest looks at the clinical environment to validate hypotheses, the clinicians help define and frame the context of the research, and then a research project is born. The results of that project are then applied to practice, where evaluation and refinement occurs.

Second, some NPs question the value of the DNP degree given the time and expense required to attain the DNP degree versus the Medical Doctor (MD) degree and the ability to recoup educational costs through increased compensation. Some NPs believe that for the additional educational time to degree and expense associated with the DNP, one would be better served by enrolling in medical school. The first question to ask is: What are your core values and beliefs? While the medical and nursing scopes of practice may overlap, fundamental differences exist in how the two professions approach delivery of care. If you believe the nursing model matches your vision of practice, that is the path you should take. Compensation is an individual value; with a median salary of almost \$82,000, NPs earn approximately 38% more than the median household income in the United States of \$51,000 (Salary Wizard, 2009).

CLINICAL EXPERIENCE AND EDUCATION

Several questions were raised as to clinical experience in programs, residencies, and prior experience and prior degree held if entering post-master's DNP programs. Clinical residencies, unlike clinical practica or management courses that normally are found in MSN programs, may be required in some programs in which the entire

program focus is based on a clinical model. Generally these residencies provide the student with a mentored experience that is intended to assist them in acquiring the DNP competencies. Most post-master's DNP programs do not

clinical sites and preceptors to support their learning and mastery of clinical decision making and clinical skills. More clinical practice time does not necessarily translate into competence in clinical practice.

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have a clinical residency; they require clinical hours that support the student's career goals and capstone project.

Standards for DNP programs require post-master's NP students who are nationally certified to demonstrate achievement of DNP essential content and competencies. Master's-level competencies focus on acquiring clinical competence in treating the individual patient. At the DNP level, these competencies shift to more of a population focus with emphasis on independent and interprofessional practice; analytic skills for evaluating and providing evidence-based patient care across settings; and advanced knowledge of the health care delivery system (National Organization of Nurse Practitioner Faculties, 2006).

There has been a debate about clinical experience needed prior to admission in an NP program and the number of clinical hours needed for programs. In the past, most programs required clinical experience (1 to 2 years) prior to admission or enrollment in clinical courses. However, there is no good evidence to support that clinical experience prior to admission into a NP program improves student outcomes. Rather than the accumulation of clinical hours in DNP programs, the focus of national discussions is about achievement of competencies. Students should be matched to

One issue that continues to recur is comparison of roles, licensure, and scope of practice between advance practice nurses, physician assistants, and physicians. It would seem that the core of the issue is scope of practice. Clinical skills or activities overlap between professions, and the critical concern should be whether the practitioner has the education and competence to deliver care (Changes in Healthcare Professions' Scope of Practice; Legislative Considerations, 2007). Licensure for all professions occurs after completion of accredited programs and, in most states, after some type of certification of competency examination. Overlap of scopes of practice is inevitable. Practicing within one's scope does not occur in isolation but considers the needs of the client and the education and training of the NP. The ultimate goal is that the NP has the knowledge and skill to deliver safe quality care and actively assumes that responsibility.

Lastly, many NPs in practice hold a master's degree in another discipline such as public health. While programs differ in their admission requirements, accredited programs must meet the DNP competencies. Ways to meet the standards and competencies are not prescriptive and are not outlined and vary amongst programs. This factor is helpful because NPs with different backgrounds and educations who

have specific goals can find programs to meet their needs.

In the future, two educational levels (pre-licensure programs and doctoral programs) may become the accepted standard for nursing education. However, the master's degree will be with us for some time to address curriculum needs of specialties, for example, school health nursing, occupational health, or community health.

CAPSTONE PROJECT

Questions regarding specialty practice and how to accommodate that within a DNP program can be answered by describing the capstone or scholarly project required in DNP programs. Most programs encourage students to identify career goals that will be realized in their capstone project. Thus, if a student is interested in international health, the student might select additional courses, such as epidemiology or global studies, that will assist him or her in planning and implementing their capstone project, whereas students interested in being entrepreneurs may choose electives in business, finance, and/or business law to achieve their academic and career goals.

Primary care has been defined as care that is accessible, comprehensive, coordinated, continuous, and accountable. This definition includes and accommodates practitioners who work in specialty practices. NPs in practices such as dermatology or orthopedics are recognized by the new APRN regulatory model as specialists beyond the role (NP) or population focus (e.g., pediatrics). Licensure is at the role and population level, and the specialties build on that base.

ROLE

Several people had questions about the role of the DNP—the title, the future for non-DNP-prepared practitioners, and certification. Education, certification, and practice should match. For example, a graduate of a PNP program would sit for the PNP examination and practice

in the PNP role. The certification examinations that are required in many states for licensure are based on the role (NP, clinical nurse specialist, nurse midwife, or nurse anesthetist) and the population being cared for, such as pediatrics, adult, family, or neonatal. The Pedi-

third-year medical students. Also, most faculty believe that it is not logical to assess generalist content after a NP has demonstrated competence with a certification examination in a specialty.

While the DNP has caused some NPs to be concerned about their

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atric Nursing Certification Board (PNCB) or American Nurses Credentialing Center (ANCC) certification examinations for PNPs that are currently offered are for MSN and DNP graduates. When there are sufficient number of DNP-prepared PNPs, if there is a change in the role, the examination will be

continued legitimacy to practice, the shift from the MSN to the DNP as the preparation for advanced practice is an education-driven initiative. The role of the PNP is outlined in the scope and standards for practice. No state currently requires a DNP for licensure. If states require the DNP in

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changed to reflect the difference in practice; certification is based on the expectations of the role.

Additional certification for the DNP is not required and is not considered to be the entry-level certification examination. The Council for the Advancement of Comprehensive Care has developed a general examination for persons who are already certified and who have completed a DNP program. A few faculty believe that this generalist examination, with content on pathophysiology and other basic content, provides added evidence of abilities. Many DNP program directors do not advise their graduates to take this examination because it is based on generalist content found in examinations for

the future, current licensure and certification would continue to be recognized in that state. Licensure is a property right; as long as the licensure in the state and certification are maintained, the NP may practice. If the PNP were to relocate to another state, however, this right to practice may not apply.

REGULATORY ISSUES

Some questions focused on regulatory issues, such as grandfathering MSN-prepared NPs and how portable one's license is in other states. The primary issue here is that each state is regulated by its own Board of Nursing. Each board determines the rules and regulations under which advanced practice nurses

may practice. Occasionally, other regulatory boards (such as medicine or pharmacy) within a state may impose additional measures. The nurse licensure compact for registered nurses and licensed practical nurses currently is applied in 22 states that have adopted it, but it has yet to gain ground in advanced practice. Portability across state lines, many believe, would be very helpful. This issue will have to be lobbied for state by state.

An MSN-prepared NP may continue to practice within the state where he or she initially was licensed as an advanced practice nurse. That right, however, does not travel across state lines. Therefore, it is important for NPs to consider closely their future and decide if mobility is important, as well as how long they wish to practice. For someone with 10 or more years ahead of them, it may prove advantageous to consider a post-master's DNP program. An additional con-

sideration may be employers who seek DNP-prepared practitioners and whether you, as an individual, can make the case for experience outweighing a degree.

CONCLUSION

Without question, the move to DNP programs has expanded rapidly. Currently 92 programs are enrolling students and there are 102 DNP programs in various stages of development. Most states (34) have at least one DNP program and some states, such as Florida, Minnesota, New York, Pennsylvania, and Texas, boast five or more. Although the number of graduates of these programs is relatively small (361 through 2008), this number will rapidly grow with more than 3400 students enrolled through the 2008 academic year (AACN, 2009). Our presentation on unintended consequences of the DNP at the Annual NAPNAP Conference discussed several

issues and raised many questions. As more programs emerge and curricula evolve, we anticipate that new issues and questions will arise. We hope we can continue this dialogue in other forums in the future.

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