

The Practice Doctorate: Perspectives of Early Adopters

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ABSTRACT

The emergence of the Doctor of Nursing Practice (DNP) degree is being described as a disruptive innovation that is altering the landscape of nursing and health care and creating a great deal of controversy within and beyond the profession of nursing. This article proposes that the DNP is actually the natural evolution of a larger disruptive innovation begun in the late 1960s with the advent of nurse practitioner programs. As expected with disruptive innovations, many challenges face those who are early adopters and who forge ahead during the early phase of innovation and later during the upmarketing phase. As faculty and administrators of one of the early, second-generation DNP programs, the authors are fully aware of ongoing discussion and issues related to the practice doctorate. This article shares the experiences of this group of early adopters and their insights into controversies surrounding the DNP movement.

There exists a fleeting and deliriously exciting moment in the life of an idea when it teeters between what one person suspects and what everyone accepts. In that moment, months or years before it exerts any practical influence, the idea holds the greatest potential to inspire and incite. Opportunities, implications, and related discoveries open up from it in all directions like a hall of mirrors. (Buchanan et al., 2005, p. 17)

The introduction of the Doctor of Nursing Practice (DNP) degree has certainly inspired and incited debate and is opening up new opportunities, implications, and discoveries. It has been decades since nursing has experienced such great debate, and the current debate is likened to the controversy stimulated by the creation of nurse practitioner (NP) programs in the late 1960s. Although intense debate continues, it occurs as a result of the nursing profession's sustained response to a crisis in health care.

Early response to the need for nurses with doctoral-level preparation for practice occurred in 1979 when Case Western Reserve University opened the first Nursing Doctorate (ND) program. Although three ND programs were subsequently opened, these first-generation practice doctoral programs were the only ones until 1999 when a second-generation practice doctoral program was opened at the University of Tennessee Health Science Center. Programs at the University of Kentucky and Columbia University quickly followed. During this time, the American Association of Colleges of Nursing (AACN) charged a task force with examining issues surrounding these emerging practice doctoral programs.

Following the AACN *Position Statement on the Practice Doctorate in Nursing* (2004), interest in and controversy regarding the DNP exploded. As faculty and administrators of one of the early second-generation DNP programs,

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the authors are fully aware of the issues and discussion surrounding the DNP movement. This article shares the experiences of this group of early adopters and their insights into the controversies surrounding the DNP movement, particularly to those raised in a series of questions posed by Chase and Pruitt (2006).

THE PRACTICE DOCTORATE AS A DISRUPTIVE INNOVATION

The early ND programs of the 1970s were struggling to forge the way for doctoral-level preparation for practice at the same time NP programs were emerging with great tenacity. Evolving regulatory requirements and clear standards for NP education helped move that nursing role into the mainstream, whereas similar standardization did not evolve for the ND. Although the journey of the NP movement was not an easy one, this movement serves as an exemplar of Christensen, Bohmer, and Kenagy's (2000) disruptive innovation framework, which is now being applied to the DNP movement (Chase & Pruitt, 2006).

Advances in health care and nursing have created new demands for nurses with even greater knowledge and skills than were required in the early 1970s. These new demands propelled the natural evolution of the original disruptive innovation associated with NP and early ND programs and ultimately contributed to the creation of the DNP. As early adopters of both NP and DNP programs, the authors' experiences with and perceptions of the application of Christensen et al.'s (2000) framework differs from those previously proposed (Chase & Pruitt, 2006).

The Natural Course of Disruptive Innovations

Chase and Pruitt (2006) misinterpreted Christensen et al.'s (2000) work in disruptive innovation, believing that innovation is positive and disruption is negative, separating them in a polar fashion. On the contrary, innovation, by its nature, is disruptive, occurring as an unmet need is addressed and continuing beyond the mere creation of a new innovation. In addition, Christensen et al. (2000) proposed an evolutionary path whereby the disruptive innovation moves upmarket to fill a gap created by additional unmet demands. At this phase in the evolution of an innovation, Christensen et al. (2000) cautioned that:

Inviting them [primary care providers] to move incompetently upmarket is a recipe for disaster. Disruptive technologies...will enable these caregivers to move *competently* upward. [Christensen et al.'s italics] (p. 110)

Given this observation, the emergence of DNP programs was predictable. Just as master's degree programs enabled early NPs to move competently upmarket from certificate programs, DNP degree programs enable nurses to move competently upmarket in today's complex practice environment.

The increasing complexity of health care and the demand for nurses with the ability to engage in problem solving and critical thinking and to meet the demands of today's complex patients are major forces in creating the

unmet need characteristic of the upmarketing phase of disruptive innovations. The nursing profession has begun to respond to these needs, as demonstrated by the growing number of master's degree programs and nurses acquiring master's degrees. An additional response is evidenced by the increasing content and length of existing master's degree programs; however, nursing education must continue to evolve to keep pace with emergent needs.

Similar to the initial NP movement, upmarketing of advanced practice nursing through DNP preparation was a grassroots effort and a natural evolution of the same disruptive innovation. Three schools opened DNP programs in 1999, 2001, and 2005 in response to nurses' pleas for formal, practice-centered education beyond the master's degree. These nurses wanted additional knowledge and skills to competently respond to the issues and challenges they were facing in practice. The programs created by these pioneering schools ultimately prompted the AACN to study the movement and resulted in a position paper (AACN, 2004) and subsequent debate about the DNP degree.

Christensen et al. (2000) also characterized the debate associated with disruptive innovations noting that:

[Leaders are often] incapable of embracing disruptive approaches because the profitability of the institutions they lead has been so eroded. Typically, not only do they ignore the potential disruptions, they actively work to discredit and oppose them. (p. 112)

These observations hold true for the DNP degree about which a number of questions and objections have been posed. Many questions have been answered, more are being addressed as DNP graduates enter the workforce, and some will go unanswered for many years, as is the case with any innovation. This does not mean the DNP movement should not continue forward. Only in recent years have there been data supporting the contention that patient outcomes improve when care is provided by baccalaureate-prepared nurses (Aiken, Clarke, Cheung, Sloane, & Silber, 2003). Society must recognize that world-changing innovations cannot always be built around quantitative science. The NP movement of the 1970s was built on a qualitative framework through participatory observation via faculty practice, interview, and focus group approaches. Only after NP practice blossomed did quantitative data become available to validate the efficacy and continued evolution of the role (Mundinger et al., 2000).

The New Unmet Need

The number of nurses with master's degrees has increased dramatically. During a 10-year period, there was a 36% increase in master's degree graduates (8,930 in 1995; 12,099 in 2005), despite the lengthening of existing master's degree programs (AACN, 1996, 2001, 2006a). These data are consistent with the increase in graduates of NP programs reported in the 2004 National Sample Survey of Registered Nurses, which reported a 35.5% increase in the number of NPs from 102,649 in 2000 to 141,209 in 2004 (Health Resources and Services Administration, 2004).

In their study of nursing students enrolled in nursing education programs, Norman, Buerhaus, Donelan, McCloskey, and Dittus (2005) reported that approximately one fourth of these students expect to enroll in graduate school immediately after graduation. Of these, 52% were interested in becoming NPs and 23% were interested in becoming nurse anesthetists. Only 5% planned to pursue doctoral education. Those interested in attending graduate school immediately after graduation tended to be younger and minority students. That 75% of students expecting to enroll in graduate school are interested in advanced practice provides additional support for increasing the number of DNP programs.

It is interesting that although the number of nurses with master's degrees continues to increase, the number of nurses acquiring doctoral degrees remains stagnant. In 1995, 65 doctoral programs reported 421 graduates; in 2005, despite a 55% increase in the number of doctoral programs ($n = 101$), the number of doctoral graduates increased only 20% to 506 (AACN, 2001, 2006a). More disturbing is the observation that from 2000 to 2005, the number of PhD graduates increased by only 0.3%, whereas program growth continued at a rate of 24.5% (AACN, 2001, 2006a).

Within this growing number of master's prepared nurses who choose not to pursue research-focused PhD study despite its accessibility, an unmet need exists. Indeed, many master's prepared nurses are seeking additional study, but not in PhD programs. Instead, they are earning a second master's degree or a post-master's certificate (AACN, 2006a). These data are testament to the fact that individuals *are* interested in attending educational programs with more credit hours and a greater investment of time, and they are willing to pay for it. They are not reluctant to invest time or money to advance their knowledge and skills but may not view current doctoral programs as offering the preparation needed for the challenges they face in practice. This unmet need gave rise to the grassroots development of DNP programs (Figure).

Nevertheless, the experience of existing DNP programs has had an interesting effect on PhD programs. Having an alternate route to doctoral preparation provides an opportunity to engage more individuals in discussion about doctoral study, and these discussions recruit more students to doctoral study in general, both DNP and PhD. Two universities actually reported increases of 35.7% and 30.8% in their nursing PhD enrollment from 2000 to 2005 following implementation of their DNP programs (Williams & Hathaway, 2006). Therefore, the establishment of DNP programs is helping increase the overall number of nurses with doctoral degrees and may serve to generate more interest in the PhD.

Because innovation is driven by an unmet need, it is no surprise that schools are not the real drivers of the DNP movement. The real drivers of the DNP movement are practicing nurses who experience new demands in their practice and recognize a need for additional education to respond more effectively to those demands. Although the

academic community is preparing excellent graduates, it must respond to pleas to provide nurses with knowledge and skills required for the demands of today's constantly changing practice environment. If academia fails to do so, another disruptive innovation will arise to address this unmet need and will likely displace nursing.

ALIGNMENT WITH THE ACADEMIC COMMUNITY

A second category of objections and questions surrounding the emergence of DNP programs concerns its place in the broader academic community. Many of these issues are grounded in perceptions related to professional versus academic degrees and the meaning of these degree designations related to issues such as existing degree articulation models, return on investment, and tenure.

Professional Versus Academic Degrees

The professional degree individuals earn with the acquisition of a DNP degree is in alignment with the academic community, will serve them well, and will open additional doors appropriate for their professional status. A professional degree is a post-baccalaureate degree, either at the master's or doctoral level, which is designed to prepare individuals for a particular career or profession. Most individuals who hold these degrees are not primarily engaged in scholarly research and academic activities, but rather are engaged in a profession, such as education, engineering, law, medicine, or religious ministry.

Terminal professional doctoral degrees are not academic research doctorates. The minimum term for a terminal professional degree is 3 years post baccalaureate, and the degree entitles the holder to pursue academic careers on par with holders of academic research doctoral degrees. Actual practice, and legal recognition, within the applicable professional field usually requires that the holders of professional doctoral degrees also become licensed by the appropriate professional body. In contrast, academic doctoral degrees are awarded in recognition of research of a publishable standard and that represents a contribution to human knowledge (Wikipedia, n.d.).

The pairing of professional and academic degrees within a discipline is common in the academic community, both within and outside of the health sciences. Generally, these are discipline-specific professional and academic degrees, as exemplified by the PharmD and PhD in Pharmacology, the MD and PhD in a basic science, or the EdD and PhD in education. In many ways, the pairing of professional and academic doctoral degrees in nursing is a better fit than is the current system in which, unlike other disciplines, both professional (MSN) and academic (MS) degrees in nursing are offered at the master's level but halt professional preparation beyond this point.

Despite the absence of a parallel professional doctoral degree in nursing, the nursing profession has a long history of valuing individuals with professional degrees; this is evidenced by some schools granting MSN degrees and others granting an MS with nursing as a focus. Nursing

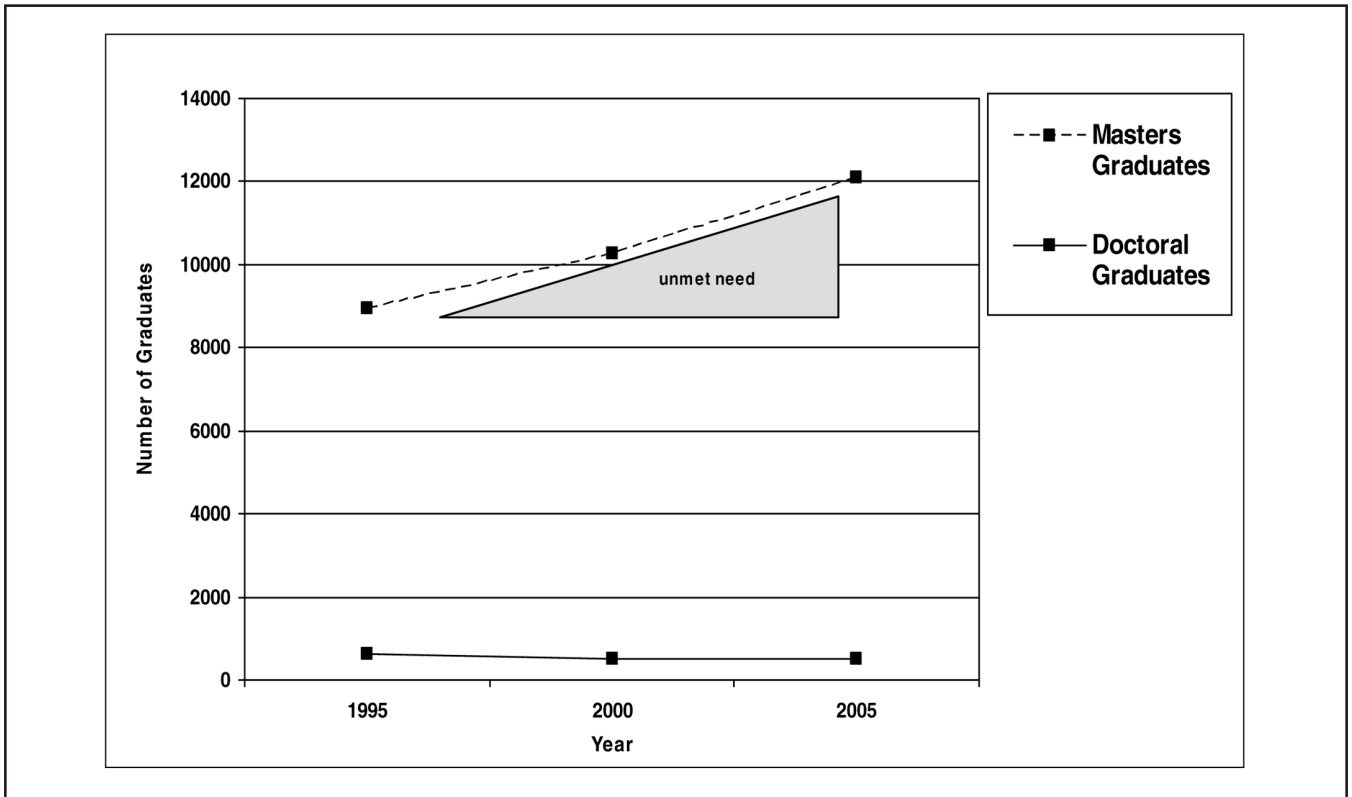


Figure. Number of graduates from master’s and doctoral nursing programs, 1995 to 2005.

faculty may hold the professional education doctorate (EdD), which differs from the PhD in education. These individuals have played an immensely critical role, especially in the early days of collegiate nursing education, which nursing evolved as an academic discipline. Although the number of nurses who hold an EdD has declined as nursing science has matured and emphasis moved to graduate preparation, many of these individuals continue to make valued contributions to nursing education.

Chase and Pruitt (2006) criticized the DNP degree as a professional doctorate, noting that “To now support a degree that allows graduates to be recognized as doctorally prepared when the same level of rigor in their preparation has not been required risks dismantling the hard work of doctoral educators over the past 50 years” (p.159). This claim discredits all individuals who hold professional degrees. In addition, this elitist stance asserts that doctoral degrees that are not steeped in the research enterprise fail the “rigor test” but are nevertheless powerful enough to topple the fragile pillars of nursing science. Nursing science is strong enough to survive, but it is recognized that the current model for preparing nurse-scientists requires attention.

The distinction between the professional and academic degrees in nursing is not one of rigor, but rather one that relates to the focus of study and subsequent scientific enterprise. The discipline of nursing, like other health science disciplines, needs both research-scientists and

practitioner-scientists. The DNP, like practice doctorates in other disciplines, builds on science generated by research, translates it into practice, and provides feedback, thereby putting the theory-research-practice feedback loop that has been advocated for years into action (Fawcett, 2005; Fawcett, Watson, Neuman, Walker, & Fitzpatrick, 2001; Neuman & Fawcett, 2001). Having practitioners with a level of knowledge and expertise in the practice realm equal to that of professionals in the theory and research realms will advance nursing science more rapidly and soundly.

Articulation of Degrees and the Economic Issue

The emergence of the DNP degree has stimulated the examination of existing nursing degree trajectories. Although Chase and Pruitt (2006) proposed that “With university degrees, graduates enjoy a smooth articulation between undergraduate, master’s, and doctoral programs across the country” (p. 157), many who have traveled this path would challenge this assertion. The many routes to the nursing doctorate begin with professional entry programs, which have alternative options from the associate through the master’s, and even doctoral, degree. This initial branching at the entry level is compounded as graduates of these programs seek additional educational preparation. One has only to attempt to explain this career path to the parent of a high school senior to recognize that it is neither a smooth nor logical system.

This complicated career path has been recognized by the National Academy of Science, which reports that few individuals proceed smoothly and efficiently from undergraduate to master's and doctoral study, and that graduate education in nursing occurs over a protracted period. In addition, the National Academy of Science (2005) has called for a change in doctoral preparation of nurses that includes a parallel practice-focused doctoral degree.

The DNP degree enables the nursing profession to establish a clear distinction between academic and professional degrees at the upper end of the educational continuum. In doing so, the profession accomplishes what it has been unable to do at the entry level of the continuum, where there has been a proliferation of routes for entry into professional practice. The lack of clarity among various entry-level nursing degrees has not served the profession well and is a mistake that can be avoided at the other end of the educational continuum. Rather than placing an educational glass ceiling on advanced practice nurses, these individuals have the ability to earn the degree and accompanying rights many of them are already earning and to which others should have access.

Return on Investment

The cost of a lengthy doctoral program is often cited as an obstacle that will dissuade individuals from pursuing preparation through a DNP program. The cost of education is never cheap, and the current, often convoluted path many nurses take makes the journey even more costly. Today, even the most efficient journey to a post-baccalaureate master's degree involves 1 to 3 years of full-time study. Following acquisition of a master's degree, doctoral study involves an additional 3 or more years of full-time study. Therefore, the current system generally requires at least 5 years of study to acquire a doctoral degree, typically more. The DNP degree is envisioned to involve 3 years of full-time post-baccalaureate study or 1 to 2 years of full-time post-master's study. In addition, many programs conceptualize the final year of study as incorporating a clinical immersion experience in which students may receive compensation from the institution where they will be practicing. Thus, the direct road to the doctoral degree through a DNP program will likely be much less costly for students and will also enable more efficient use of limited faculty resources.

The Tenure Issue

Tenure originated from the tradition that academics must have the ability to express their views and opinions, without fear of retribution, to advance science (Brand, 1999; Chemerinsky, 1998). In democratic societies today, the original intent has been replaced, to a great extent, with the use of tenure as a symbol of individuals' status in the academic community and the promise of continued reappointment. The tradition of and status placed on the acquisition of tenure is currently under close scrutiny, as options are being created for nontenure-track positions and university boards of trustees consider abolish-

ing tenure (Kirkpatrick et al., 2001; Pohl, Duderstadt, Tolve-Schoeneberger, Uphold, & Hartig, 2002). Regardless of what the future may hold for tenure, at least for the present, most schools of nursing reside in institutions that continue to have a tenure system in place.

Tenure is an institutional prerogative, and as such, each institution has the right and privilege to decide who shall be eligible for tenure and what standards must be met to be granted tenure. Within that context, it is common to find institutional policies that enable granting tenure to individuals with a professional doctoral degree (e.g., MD, JD, PharmD, EdD). If such a policy exists within an institution, it is only equitable that individuals who have earned a DNP degree should also be considered for tenure.

Actually earning tenure is a separate issue from being eligible for tenure. The ability to earn tenure as the holder of a professional doctoral degree will likely depend on institutional recognition of the scholarship of application described by Boyer (1990). Original research and publication should remain the key criteria by which research faculty performance is assessed. That the integration and application of knowledge through practice should also be valued is congruent with Boyer's model (1990). Boyer's definition of scholarship legitimates and places value on nonresearch enterprises, contending that the application of knowledge engages scholars who must ask how knowledge can be applied to problems, how it can be helpful to individuals outside of the institution, and how social or clinical problems can define an agenda for scholarly investigation. It must be realized that new intellectual understandings often arise from the act of application, whether in diagnosing conditions, serving clients in psychotherapy, or establishing processes for using health information systems (Boyer, 1990). In clinical activities such as these, theory and practice interact, and each renews the other. Therefore, according to Boyer (1990), if the institution values clinical practice, the scholarship of application must be considered in tenure decisions.

As value is placed on the scholarship of application, one could argue that having the ability to acquire a practice doctorate will actually enhance many faculty members' scholarship and their ability to earn tenure. There continue to be many highly valuable master's prepared nursing faculty who are critical to the educational mission of their schools yet are greatly disadvantaged when it comes to scholarly productivity and their ability to earn tenure. Although some of these individuals ultimately seek and obtain PhD degrees, many remain devoted to clinical practice and choose not to pursue doctoral education or make limited use of the research preparation they received during PhD study. This is evidenced by data indicating that only 11% of nurses with doctoral degrees are working in research-intensive institutions (AACN, 2006b; HRSA, 2004). Earning a DNP degree will enhance clinically focused faculty members' knowledge and skills, as well as contribute to their ability to earn tenure.

THE DNP CURRICULUM: LESSONS LEARNED

As evidence of an innovation gaining momentum, the number of schools planning DNP programs has increased rapidly, spurring another set of pragmatic questions about program implementation and curricula. Applying lessons learned from the experiences of early adopters of the DNP degree can provide insight into many of these issues and may help those schools developing new DNP programs.

The Nursing Discipline as a Foundation

In the 1960s, the nursing profession struggled with establishing its identity as a discipline (Chinn & Kramer, 1999; Reed, Shearer, & Nicoll, 2003). That time of inward focus fostered a view that nurses should teach nurses and only nursing theory should direct nursing practice. Questions of knowledge of or for nursing permeated the literature.

Nursing has matured as a profession and become more secure in its position as a distinct discipline and the understanding that knowledge is available to everyone (American Nurses Association [ANA], 1965; Doran et al., 2006; Irvine, Sidani, & McGills-Hall, 1998; National Quality Forum, 2004). Therefore, nursing no longer needs science courses designed only for nurses, as each discipline has its own unique lens through which knowledge is interpreted and integrated. It is through this foundational lens that competencies for practice are identified. Although specific competencies often overlap disciplines, taken together, the competencies help distinguish the discipline.

As health care and knowledge provision change, the view through the discipline lens changes; so must the competencies for practice. Advanced practice nursing is now in this state, calling for elevation of practice competencies to the doctoral level. In this context, knowledge from philosophy, economics, and epidemiology have applications for nursing practice. The application of knowledge gleaned from these disciplines is apparent to those who have progressed through baccalaureate to master's and then doctoral degrees and note that the manner in which they think about and perform the same general task (e.g., respiratory assessment) becomes more sophisticated with the acquisition of each degree.

This does not mean that the discipline of nursing has grown in isolation, but rather that it has better defined what it is and its unique contributions as a discipline (Fawcett, 2005). The nursing profession now more clearly recognizes the value that knowledge from other disciplines contributes to nursing science, and that knowledge is being used to enhance nursing science and advance it more rapidly (Reed et al., 2003). In this sense, the application of knowledge from other disciplines is no different than what pioneering nurse-theorists did when they borrowed from other disciplines to develop the 1960s-era nursing theories.

Further, the nursing profession understands that "...many of the most profound discoveries in science, technology and other branches of learning are occurring at the

boundaries between disciplines" (Spanier, 2001, Crossing Boundaries section). For it is at the boundaries of a discipline's interactions with another discipline that its members are challenged to justify their actions through evidence and even to ask new questions that would not likely have been generated otherwise. It is important that nursing professionals, particularly at the doctoral level, do not isolate themselves from, but integrate and "rub shoulders" with, professionals in other disciplines. This is reflected in the interprofessional nature of practice and the titles of some DNP courses.

DNP graduates with the nursing discipline as a foundation must be prepared to practice at the boundary of disciplines, making nursing contributions to other disciplines and using knowledge from those disciplines in the practice of nursing. The curricula being developed for DNP programs reflect this level of nursing practice. Coursework that incorporates knowledge of policy, economics, information systems, and similar topics provides nurses with tools that are critical for their survival in today's health care environment and enables them to lead change and improve health care.

Emphasis on Practice

The ANA (2003) defined advanced practice broadly as being:

distinguished by autonomy to practice at the edges of the expanding boundaries of nursing's scope of practice.... [It] is characterized by a complexity of clinical decision making and a skill in managing organization and environments greater than that required for the practice of nursing at the basic level. (p. 79)

The details of what defines advanced practice at the frontline of nursing are left to the individual. Therefore, the words *practice*, and especially *nursing practice*, evoke diverse images among individuals (Reed et al., 2003). Nurses have faced similar differences of perspective regarding what constitutes nursing research and have evolved their views over time, accommodating differing views and emerging science, yet remaining dedicated to nursing science. The same is true regarding nursing practice: Differing views and emerging science are being accommodated, yet the dedication to nursing practice remains intact.

The emphasis on practice is reflected throughout the DNP curriculum, embedded in every didactic course and addressed more practically by clinical experiences throughout the curriculum and finally in the culminating clinical immersion. The clinical immersion is not just a clinical experience; it provides the opportunity for students to synthesize and apply knowledge acquired across the program of study by practicing at a greater level of competence. As part of this clinical immersion, each student completes a project with a deliverable product that makes a contribution to practice at a level expected of doctoral graduates.

Debates continue regarding whether the final culminating clinical experience should be called a residency, practicum, clinical experience, or some other designation. Reasonable arguments can be made for all sides. In the

short term, resolution of this debate may hinge on institutional policy. In the long term, the resolution will probably depend on how DNP graduates are incorporated structurally and by policy into health care and academic communities (e.g., whether paid residencies become the norm for DNP students). Regardless, the final culminating clinical immersion provides an opportunity for DNP students to demonstrate the ability to synthesize the knowledge acquired throughout the program of study and, more important, apply that synthesized knowledge in practice in a highly sophisticated manner.

The Challenge of Program Transition

Transitioning master's degree advanced practice nursing programs to the doctoral level will challenge existing nursing programs. The challenges will come from several directions—from within programs that have resource deficiencies to overcome, from institutions that have policy and regulatory issues to contend with, and from other stakeholders—as partnerships are established and regulatory bodies are navigated. In many ways, these new challenges are dwarfed by the complexity of articulation and partnership arrangements the nursing profession has faced and overcome in the past. For example, current baccalaureate programs provide articulation for licensed practical nursing, associate degree nursing, and second-degree nursing students, and some include formal partnerships across institutions. Several pathways have similarly been designed for the master's and PhD degrees, which may or may not include having earned a baccalaureate or master's degree that may or may not be in nursing. Despite these multiple pathways, nursing accrediting bodies have assimilated the variety of degree options and program variations. Given nurses' collective wisdom and the profession's history of overcoming complex challenges, transitioning advanced nursing practice programs to the doctoral level should not be an insurmountable task.

It should be acknowledged that the future will not necessarily resemble what currently exists in master's degree education. That is, one should not expect that every existing master's program will become a DNP program. Again, the nursing profession can learn lessons from its past, where the profession has proven its ability to establish partnerships and offer unique programs that increase access to educational opportunities and facilitate students' acquisition of higher education. The creation of partnerships will not only increase nurses' access to doctoral education, but also will potentially enable more efficient use of limited faculty resources by better leveraging regional faculty talents, rather than competing among schools for limited faculty resources.

We, as nurses, have shown ourselves to be resourceful, creative, and persistent in our past efforts, and we will be just as resourceful, creative, and persistent as we move forward with implementation of the DNP. We can take courage from several of our colleagues who have already faced and overcome many great obstacles, paving the way for those who follow. As more DNP programs are estab-

lished and more solutions to the obstacles are devised, the path will become smoother.

The Time and Credit Issue

Most universities only require 30 semester hours for master's degrees, yet many advanced practice nursing programs require 45 to 50 credit hours, and some programs, such as anesthesia, require more. Credit hours do not reflect the entire story, however, because embedded in these credits are more clock hours than exist in other master's degree programs. For example, AACN data show that didactic and clinical hours for NP programs have increased by 72 and 36 hours, respectively, from 1995 to 2000 (AACN, 2002).

Current DNP programs and those in the planning stages are preparing post-baccalaureate curricula that are 3 years in length. The argument that programs will dramatically increase the time it takes for students to complete the requirements to acquire advanced practice credentials does not reflect the reality of most programs, if the actual course and clock hours required by various curricula are examined. Data described above in the "Articulation of Degrees and the Economic Issue" section of this article further dispel the belief that DNP programs will greatly expand the length of time and cost of advanced nursing education. Among the great opportunities provided by DNP programs are the possibilities for acknowledging the true investment of time required to prepare for advanced nursing practice and addressing the great variability in these programs.

Preparation for the Educator Role

It is widely recognized that doctoral education, whether in nursing, the health professions, or the broader academy, has not adequately addressed the need to prepare graduates for teaching responsibilities (Armstrong, Mannheimer, & Stanton, 2005; Greenberg, 2006; Pickoff-White, 2005; Siler & Kleiner, 2001). It is also widely known that doctoral education is grounded within the discipline, and as such, the coursework and learning that occurs during doctoral study are focused on the discipline (Kenny, 2003). Consequently, preparation for teaching, although important, must take a secondary position in any doctoral program.

Just as the acquisition of research skills by PhD students does not prepare graduates for all aspects of the faculty role, the acquisition of practice skills does not prepare DNP graduates for all aspects of the faculty role (Storch, 2007). However, DNP programs do offer a greater opportunity to address the faculty shortage than do traditional, research-intensive PhD programs. Although graduates of PhD programs are essential to build the science on which the discipline is built, DNP graduates are essential to facilitate the translation of scientific research into practice. This translational role places DNP graduates in an optimal position to help address the faculty shortage.

Most nursing students today are being prepared at the professional entry or advanced practice level, which means

their faculty must be exemplary clinical role models and have exceptional clinical knowledge and skills, which are characteristics of DNP graduates. Firm grounding in practice and high levels of clinical knowledge and skill are the first requirements for nursing faculty and are the principle foci of DNP education. Faculty who are steeped in practice will ultimately make the best faculty for professional entry and advanced practice nursing students. DNP graduates may well comprise the majority of nursing faculty in the future (Fitzpatrick, 2002).

Because discipline-specific knowledge is the core of professional doctoral education, creation of education tracks or options in DNP programs are not appropriate. Therefore, complementary opportunities should be made readily available for DNP students, just as they are for PhD students, to acquire basic teaching methods and strategies and foundational knowledge about teaching-learning theory. These opportunities could take the form of teaching assistantships, electives, or directed study. The Preparing Future Faculty program, a joint project of the Council of Graduate Schools and the Association of American Colleges and Universities (n.d.) can serve as a resource. In addition, just as health care institutions have a responsibility to orient staff and provide staff development to newly hired graduates, academic institutions have a responsibility to orient and provide for the development of new faculty.

EXPERIENCE AND SUCCESSES OF EARLY INNOVATION

The NP programs of the early 1970s were a disruptive innovation that has borne the test of time. Nurse practitioners have changed the face of health care and nursing education. The authors disagree with Chase and Pruitt's (2006) statement that, "Having an advanced practice credential, [was] once considered a detriment..." (p. 157). Rather, as early adopters of both master's level advanced practice and DNP programs, it has been the authors' experience and perception that advanced practice credentials have consistently brought added value and that the DNP program further recognizes the level of knowledge and expertise accompanying this credential.

Nurse practitioner programs have kept pace with changing demands in health care and have increased program content and length as knowledge and care requirements expanded. Today's programs continue to face the need to add content to the curricula in order to meet the expanding demands of practice. The nursing profession has clearly reached an educational tipping point, at which credit earned pushes one over the boundary of the master's degree into the realm of the doctoral degree. The upmarket phenomenon described by Christensen et al. (2000) is now propelling the NP movement to the next phase of disruptive innovation.

Graduates of DNP programs are already practicing upmarket and making important contributions. Their coursework and practical experiences acquired through doctoral

study help prepare them for this phase of practice. For example, the study of policy and economics enables DNP graduates to knowledgeable and effectively represent the interests of nursing before regulatory agencies and legislative bodies. Epidemiology and advanced evidence-based practice courses help position DNP graduates for leadership in the burgeoning quality improvement movement. These are only two of the many opportunities that exist and contributions that may be made by DNP graduates; more will emerge as the health care system undergoes dramatic change in the coming years. This cohort of doctorally prepared nurses enables the profession to be at the frontline, helping shape the landscape of the health care system.

Although many opportunities lie before DNP graduates, questions still arise such as, "Who is going to hire these graduates and pay the salaries they will demand?" Given today's nursing shortage, no nurse nor DNP graduate need go without employment. However, it is true, with few exceptions, that health care institutions do not pay nurses differentially for any earned degree. Expecting differential pay for a DNP degree, when it does not exist for a baccalaureate, master's, or PhD degree, is unrealistic. Still, nurses returning to school for graduate degrees do anticipate that their earning power will be enhanced, and ultimately, whether as a practitioner, educator, or administrator, graduate degree holders earn higher salaries. However, higher salaries are not earned because of the degree held per se, but rather as a result of the knowledge and skill acquired through graduate study.

As nurses and other health professionals with doctoral degrees and various kinds of certifications permeate the practice environment, some believe the public will be confused or misled by their degrees, credentials, and titles. There are two facets to this issue. The first relates to use of the title *Dr.*, which is a long-standing area of controversy with medical physicians, who often lead efforts to limit use of the title (American Medical Association, 2006). A second issue lies closer to home, with some nurse leaders believing the DNP degree designation implies all of its holders are NPs (Gennaro, 2004).

The belief that the public does not understand all of the degrees, credentials, and job titles associated with the various health professions is likely correct, and likely unimportant to most. Patients who routinely see NPs know who they are and what they do, and they know NPs are not physicians. Those who do not routinely see NPs do not know who they are or what they do. We are naïve if we believe otherwise. When exposed to the care provided by health professionals from any discipline, with any credentials, patients learn who those professionals are, what they do, and how they are different from other professionals. The roles of individual professionals, not the professional's degrees, make the difference to patients. The public just wants good health care. The degree is merely a mechanism that allows professionals to fulfill specific roles. Whenever health professionals introduce themselves to patients, they should use the title they have earned and

explain their role in the health care team. For example, "I am Dr. _____, the nurse anesthetist who will be administering the anesthesia for your surgery."

THE FUTURE IS NOW

The NP movement begun in the early 1970s has changed the landscape of nursing and health care. The DNP movement, a natural evolution of this earlier disruptive innovation, is occurring in response to the demands being placed on today's practicing nurses. Yet, such disruption generates fear of the unknown and can threaten those who perceive themselves as being displaced. Christensen et al. (2000) described predictable efforts to block innovative disruptions, explaining that "...the people and institutions whose livelihoods they [disruptive innovations] threaten often resist them" (p. 107).

Just as one heard strong voices from those who were comfortable with the status quo and adamantly opposed establishing NPs programs in the 1970s, one hears similar voices today. These voices represent individuals who are making valuable contributions to patient care and nursing education and will continue to do so. They perceive the changing landscape as a threat to the status quo, which is true regardless of the DNP movement. To thwart the rapidly growing DNP movement is a risk the nursing profession should avoid. If nurses fail to respond to the needs of consumers (e.g., potential students and patients), then others will respond to these needs, and their solutions will not likely be favorable to nursing.

Change of this magnitude does not occur without strategic effort, even if it is the right thing to do. A lesson can be learned from the ANA's 1965 *A Position Paper*, proposing the baccalaureate as the degree for entry into professional nursing. No implementation goal or strategies were designed to accompany this proposal, and baccalaureate entry was not achieved. Given recent evidence that mortality rates decline as the percentage of nurses with baccalaureate and higher degrees increases (Aiken et al., 2003), it is difficult to imagine how many lives would have been saved if the nursing profession had responded to the 1965 ANA proposal the way it is responding to the DNP proposal today, with specific goals for implementation.

The AACN's goal to transition advanced practice nursing preparation to the doctoral level by 2015 is ambitious, but it is essential to set a goal, and significant efforts toward achieving it are being made. If the nursing profession is to maintain a position of influence in shaping the health care system and delivering the highest level of nursing care, it is imperative that it strive to achieve the 2015 goal.

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