DNP Role Development
for Doctoral Advanced Nursing Practice
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Mary Ellen Smith Glasgow, PhD, RN, ACNS-BC, ANEF, FAAN, is dean and professor, Duquesne University School of Nursing, Pittsburgh, Pennsylvania. An early driver and adopter of innovation, she has developed many innovative academic programs; incorporated the cooperative education model; envisioned and implemented the use of online courses and standardized patients, simulation, and various technologies in the nursing and undergraduate health profession curricula. She advanced online pedagogy, developing one of the largest online nursing programs in the country, utilizing asynchronous and synchronous creative teaching strategies. She recently developed the first dual undergraduate-degree program in nursing and biomedical engineering in the nation at Duquesne University. She was honored with the Villanova University College of Nursing Alumni Medallion for Distinguished Contribution to Nursing Education. She was the former associate editor for Oncology Nursing Forum, where she was responsible for the leadership and professional development feature. She was a trustee of Princeton HealthCare System and was selected as a 2009 Robert Wood Johnson Foundation Executive Nurse Fellow. She has more than 70 publications, 135 national and international presentations, and recently coauthored two books: Role Development for Doctoral Advanced Nursing Practice (2011, first edition), the recipient of the 2011 American Journal of Nursing Book-of-the-Year Award, and Legal Issues Confronting Today’s Nursing Faculty: A Case Study Approach (2012), the recipient of the 2012 AJN Book-of-the-Year Award. Her research interests include safety and interprofessional simulation and leadership development in nursing, for which she secured $2 million in funding. She was elected as a fellow of the American Academy of Nursing and the National League for Nursing Academy of Nursing Education.
DNP Role Development for Doctoral Advanced Nursing Practice

Second Edition

H. Michael Dreher, PhD, RN, FAAN
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Editors

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To Morris Traube and Albert S. Jung, who really saved my life, and Michael D. Dahnke, who enriches it every day. I am so sad to hear of the passing away of Miss Helen Burke, my dear, dear teacher. If she had not poked my head with science in high school at Hillcrest of Dalzell, South Carolina, I know I would not have become a registered nurse and had my wonderful career. She always beat her own drum, to hell if you didn’t like it, but with love. I beat my own drum with you dear teacher . . . rest in peace.

—HMD

To my husband, Thomas W. Glasgow, my partner in life, for making everything possible; and Kathy Smith Pickup, Frank Smith, and Mike Smith, who are great siblings and even better friends.

—MEG
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Foreword

I am most impressed with this second edition of DNP Role Development for Doctoral Advanced Nursing Practice, a notable winner of the American Journal of Nursing first-place award in the Advanced Practice Education category in its first edition. Drs. Dreher and Glasgow continue to provide insights in their work toward advancing the role of advanced practice nurses (APNs) by presenting a rich historical perspective on the evolution of the Doctor of Nursing Practice (DNP) degree and critical content on role development, and by promoting the progression of doctoral nursing roles within our complex health care system. When writing a foreword, it is important to respond to the following: distinguishing the credibility of the authors; determining the importance of the book relative to others; and describing the value of the book to the reader. Drs. Dreher and Glasgow are well-qualified authors who are educating and mentoring DNP students working in leadership and academic roles. Their involvement in the DNP degree and advancing nursing practice has been from the beginning very prominent in the national discourse, with their first text paving the way to greater discoveries and innovative insights. In this second edition, the many diverse contributors provide important perspectives that are unique and worth reading, given their extensive backgrounds in doctoral nursing education and advanced practice nursing.

As our health care systems become more complex (high-reliability organizations), we are charged with greater accountability to provide safe, quality value-added care. To not do so would be irresponsible. In September 2010, the American Association of Colleges of Nursing (AACN) reported 121 DNP programs and one DrNP program. In 2015, the AACN noted 264 DNP programs and 60 or more in development. The tipping point toward the DNP-degree model has been quick, with the National Organization of Nurse Practitioner Faculties (NONPF) supporting the position of the “DNP by 2015.” Although this position has yet to be realized, the NONPF continues to advance the notion, with other primary nursing specialty organizations (nurse anesthetists, nurse-midwives, and clinical nurse specialists), that the profession advance the DNP discussion as a replacement for the master’s degree for advanced practice registered nurses (APRNs). We know that by the year 2025, educating nurse anesthesia students will be done at the doctoral level. However, we still have far to go, as there have been no regulatory actions in any state that is requiring the DNP degree as a replacement for the master’s degree for APRNs. Although we struggle for consensus—and it is a slow process of modifying 50 individual State Nurse Practice Acts, changing regulatory requirements on the federal, state, accrediting organizational, and specialty practice levels—the passion for the DNP degree continues, particularly among nurse educators and DNP graduates. The true “proof of success” will be the DNPs’ influence in health systems as well as the value-added, data-driven outcomes of these graduates. Those working side
by side with these expert clinicians and clinical executives may be puzzled as to why seeking advanced education is necessary. We are, however, noting less discussion on the need and reasons for DNP education and greater attention focused on refinement of the degree and future implications and expectations. Specifically, the nature of the final project, initially recommended to be called a capstone project by the AACN (2006) and now a DNP project (2015) by the AACN in a new white paper, *The Doctor of Nursing Practice: Current Issues and Clarifying Recommendations*, remains a centerpiece for discussion with the degree.

Purposeful and intentional conversations about knowledge development occurring as the DNP degree evolves are critical, especially as many senior nurse scientists are retiring and PhD enrollments are remaining flat. This second edition is a “must read” and adds value to evolving DNP programs and education for APNs. The concept of DNPs generating practice-based evidence, although in many discussions it was related to what “deliverables” the degree should encompass, was not always first and foremost as an end goal. It is more evident now this was (and is) a critical concern, and that the profession was missing opportunities for practice-generated knowledge. The recent white paper (AACN, 2015) has made advances in this area, recognizing “that practice-focused graduates are prepared to generate new knowledge” (p. 2) and noting that “new knowledge generated through practice innovation, for example, could be of value to other practice settings” (pp. 2–3). We are at a critical juncture to discuss future considerations given our 10-year history with DNP education. The profession must not be complacent and lose precious time toward seeking understanding on what we agree on regarding outcomes and what might not be value-added in this still-new degree. The editors, contributors, and reflective commentators in this second edition provide ongoing discussions that are essential to the future development of DNP education. This is particularly important as the literature does not provide overwhelming evidence that the degree is “superior” and focuses more on what the role of the DNP graduate is with regard to knowledge development and how DNP graduates will be socialized to be more engaged stewards of the discipline than master’s graduates. Notable inclusions in this text focus on why doctorally educated clinicians and practitioners in particular need to enhance their emphasis on reflective practice; a distinctive way in which the delivery of patient-centered care cannot be overwhelmed by the forces of population-based care (Chapter 19) and important data from a very large comparative study on the state of doctoral nursing faculty (Chapter 11). One or more Reflective Responses accompany each chapter as commentaries on the content; these are written by recognized DNP leaders from diverse roles and reflect the experiences of educators, practitioners, and administrators from different DNP programs. Thought-provoking discussions are anticipated as faculty and students address the reflections of DNP leaders. The beauty of this second edition is the provocative nature of the content relevant to DNP education and unfolding role development. It will be a wonderful resource in DNP role development courses and courses covering contemporary DNP-degree issues.

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**REFERENCE**

Preface

Functioning as both a graduate textbook and a professional resource, *DNP Role Development for Doctoral Advanced Nursing Practice* explores the historical and evolving role of the doctoral advanced practice registered nurse, as well as describes Doctor of Nursing Practice (DNP)-educated nurse practitioners, nurse-midwives, nurse anesthetists, and clinical nurse specialists. Similarly, this text addresses roles for nurses engaged in doctoral advanced nursing practice, which describes the role of the clinical executive, faculty member with a clinical focus, quality officer, and the other diverse roles that the DNP graduate may assume. There is a growing literature on the domain of practice “beyond the MSN,” and this text specifically focuses on this emerging discussion. Because the role of the DNP graduate is still evolving, the primary authors and contributing authors of this text present positions and Reflective Responses that represent a wide range of current views on the DNP role and the diverse “ideals” of what the role of this graduate should be. This text also exclusively examines the evolving and expanding role functions of the DNP graduate.

Too often, nursing texts offer the sole view of the author. This text uniquely offers the views of many diverse faculty, executives, practitioners, and scholars. The distinctive feature of this text is the two-part chapter organization that presents the chapter content followed by one or more Reflective Responses, which provide commentaries that may counter or support the opinions of each chapter author or authors. Each Reflective Response is written by a well-known DNP leader or leaders representing the diverse roles and experiences of academics, administrators, and practitioners, including graduates from different DNP programs. This innovative chapter presentation is bound to enhance classroom discussion. The work in its entirety is hopefully stimulating and provocative, and a well-rounded presentation of issues germane to DNP education, core competencies, and unfolding role development. We believe this is a “must have” text in DNP role development courses and courses covering contemporary DNP-degree issues.

Each of the textbook’s sections thoroughly covers important aspects of role development:

- Section I provides background information on the evolution of the DNP degree, essential content on role theory, what nursing “roles” are and how they evolved, and a discussion of how master’s- versus doctoral-level advanced nursing practices differ.
- Section II focuses on the three basic roles of the DNP graduate that currently predominate: practitioner, clinical executive, and faculty member with a clinical focus. This section also addresses the role of the clinical scholar, something each graduate is expected to embrace as a steward of the discipline.

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Section III covers the diverse skills that comprise the doctoral advanced practice registered nurse (APRN) and doctoral advanced practice nurse (APN) role, including leadership content, negotiation skills, quality improvement, and leveraging technology to support doctoral advanced level practice; it includes doctoral global health competencies with mandatory study abroad and how the doctoral APRN or the DNP engaged in doctoral advanced practice nursing can use these new competencies to function at a higher level.

There always has been debate in nursing about the direction of the profession. We have witnessed the evolution of our practice-focused disciplinary trajectory from our earliest nursing curricula in the 19th century, to the predominance of the diploma-educated nurse, and now to current forces attempting to supplant the master of science in nursing (MSN) in favor of the DNP for entry-level advanced practice. Throughout the text, authors raise important questions about the current state of doctoral education, DNP outcomes, role satisfaction, and contributions to nursing practice and health. This text aims to honor our history of diverse discourse and add to the growing literature about the evolution of nursing “practice” emerging at the doctoral level. Qualified instructors may access a PowerPoint presentation that details the important aspects of this book by e-mailing testbook@springerpub.com.

H. Michael Dreher
Mary Ellen Smith Glasgow
CHAPTER FOUR

How Doctoral-Level Advanced Practice Roles Differ From Master’s-Level Advanced Practice Nursing Roles

Kym A. Montgomery and Sharon K. Byrne

Since the publication of the first edition of this book, two sentinel events have further transformed the landscape of nursing practice: the passage of the Patient Protection and Affordable Care Act (PPACA; U.S. Department of Labor, 2010) and the release of Institute of Medicine’s (IOM) report The Future of Nursing: Leading Change, Advancing Health (IOM, 2010). The PPACA has challenged the U.S. health care delivery system to provide care to 30 million previously uninsured Americans, improve the health of our society, and to reduce the overall health care costs by providing the necessary health care services in a most efficient way. The IOM (2010) report is a prescription for the future of nursing’s role in American health care through nursing leadership in decision making in a multidisciplinary arena, seamless academic advancement for all nurses, and the ability to achieve the maximum scope of nursing practice. The Doctor of Nursing Practice (DNP) graduate exemplifies the vision of the IOM report and is perfectly positioned to achieve the goals of the PPACA. In essence, the DNP is the answer to the future of nursing practice.

Globally, the ranks of advanced practice registered nurses (APRNs) have exploded over the past 50 years. Despite the number of APRNs in clinical practice, however, there has been a lack of consistency in education that is reflected in poor degree parity compared to other health care professions such as physical therapy, nutrition therapy, occupational therapy, and pharmacy that have successfully developed doctoral programs as entry into their fields of practice. Nursing’s first foray into doctoral nursing education began in 1932 at Teachers College of Columbia University with the awarding of the first doctor of education (EdD) degree in nursing education (Nichols & Chitty, 2005). Since that time, the profession has been persistently and unsuccessfully seeking a true clinical doctorate degree that showcases the true intellectual triad of the nursing profession. In the past, the profession’s support of the PhD, doctor of nursing science (DNSc), doctor of nursing science (DNS), and doctor of science in nursing (DSN), and lukewarm support of the EdD and doctor of nursing (ND) degrees, did not yield an appropriate pathway to the “clinical” doctorate. Is it possible that amid this chaos and ongoing scholarly debate about which is the right terminal degree for clinicians, opportunity knocks with
The development of the Doctor of Nursing Practice (DNP)? The authors of this chapter hopefully present a thought-provoking discussion regarding the roles of the long-standing and historically master of science in nursing (MSN)-prepared APRN, and contrast it with the newly heralded DNP-prepared APRN, as a new method of achieving a terminal degree that supports superior professional excellence.

THE EMERGENCE OF THE DNP DEGREE

The timeline leading up to the DNP degree for APRNs began with the call of the IOM (2001) for sweeping redesign of the entire health care system. The IOM outlined basic skills that all health care professionals should have and suggested that new educational options be developed to ensure the safety of patients and close the gap that impedes quality care. The IOM (2001) stated:

Forced with rapid changes in the healthcare system, the nation’s healthcare delivery system has fallen far short in its ability to translate knowledge into practice and to apply new technology safely and appropriately. And if the system cannot consistently deliver today’s science and technology, it is less prepared to respond to the extraordinary advances that surely will emerge during the coming decades. There is a dearth of clinical programs with the multidisciplinary infrastructure required to provide the full complement of services needed by people with common chronic conditions. The healthcare system is poorly organized to meet the challenges at hand. (IOM, 2001, p. 1)

IOM’s challenge ignited a series of responses by a myriad of organizations that called for better-prepared APRNs who could address the complexity of patient care requirements, improve the efficiency of health care environments, and provide for an increased knowledge base for practice and excellence in nursing leadership. Three years later in 2004, the American Association of Colleges of Nursing (AACN) adopted a position to move the level of preparation necessary for advanced practice roles from a master’s degree to a doctoral degree. Initially, the AACN (2004) anticipated that the DNP would become the requisite credential for entry into advanced practice nursing by 2015. Although there has been significant movement toward this goal over the past decade, the lack of clarity regarding the definition of “nursing practice,” the variety of curriculum existing among DNP programs, and the barriers inhibiting a school’s implementation of a DNP program have prompted further reconsideration when to initiate this requirement (AACN, 2015a). Through a national survey of nursing schools offering APRN programs by the RAND Corporation, the AACN found great support and rising demand for DNP programs from nursing schools and nursing academic leaders (AACN, 2015a). The RAND study also identified obstacles inhibiting DNP programs such as lack of faculty, financial concerns, lack of clinical sites, resource issues regarding DNP scholarly projects, and confusion of potential employers surrounding the difference between master’s-prepared and DNP-prepared APRNs. The Council on Accreditation of Nurse Anesthesia Educational Programs (American Association of Nurse Anesthetists [AANA], 2007) has mandated that all nurse anesthetists have doctoral education in order to practice by 2025. Could this possibly be the impetus for all APRN specialties to mandate the IOM’s recommendation for nursing’s seamless academic achievement (IOM, 2010)?

Similarly, the Commission on Collegiate Nursing Education (CCNE, 2005), the accrediting body of the AACN, decided that only practice doctorate degrees with the credential DNP would be considered for accreditation by the CCNE. At the time, this was a controversial stance since the initial 2004 vote was not unanimous (AACN, 2004).
Columbia University had proposed an older DNP degree model first, a DrNP, but there were concerns that multiple practice degrees might take the degree model down the path of the DNSc, DSN, DNS alphabet soup path again (AACN, 2004). As the first DNP degree founded at the University of Kentucky in 2001 did not prepare practitioners but only clinical executives, it is unclear why the Columbia degree model, which prepared advanced practitioners and clinicians, was not the preferred degree model.

Presently, CCNE continues to accredit master’s in nursing programs leading to advanced practice (CCNE, 2010). In 2006, the National Organization of Nurse Practitioner Faculties (NONPF) also issued a position statement supporting the practice doctorate in nursing. The NONPF (2006) statement highlighted core competencies expected of entry-level nurse practitioners (NPs) with DNP preparation. This work, along with The Essentials of Doctoral Education for Advanced Nursing Practice (AACN, 2006), identified the competencies and outcomes necessary for quality DNP educational programs (Exhibit 4.1).

The DNP Roadmap Task Force stipulated steps to be taken to achieve the 2015 goal relative to educational programs. Having now identified that the DNP will be the terminal clinical practice doctorate supported by the previously mentioned organizations, the two major questions still remain: How will the DNP-educated APRN differ from the traditional master’s-educated APRN? Can the health care system afford a workforce of exclusively doctoral-prepared APRNs, particularly in this economic climate?

THE MSN ADVANCED PRACTICE NURSE

The MSN-prepared APRN role as first outlined by the American Nurses Association (ANA) in 2004 has been historically restrictive and prescriptive. More recently, the ANA (2010) stated that an APRN is the regulatory title for one of the four advanced practice nursing direct care roles (e.g., certified nurse anesthetists, certified nurse-midwives, certified NPs, clinical nurse specialists). The requirements for licensure, accreditation, certification, and education for APRNs are outlined in the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education (2008). The authors of this chapter acknowledge that well-educated master’s-level APRNs provide safe, efficient, comprehensive, high-quality care to the population they serve. Mundinger and colleagues’ (2000) classic article in the Journal of the American Medical Association reported equivalent master’s APRN outcomes compared with physician primary care outcomes; these study findings were replicated 2 years later by Horrocks, Anderson, and Salisbury (2002) in the United Kingdom. These studies indicate the DNP degree was certainly not created because MSN APRN care was inferior. Unfortunately, the professional recognition of MSN-prepared APRNs outside of the nursing profession has been stunted because of numerous factors including “cookie cutter” educational training programs (e.g., overly restrictive, lacking innovation, or “designed for the past, not the future”) and inaccurate and derogatory perceptions of these providers as being simply physician extenders or mid-level providers. These are terms that the nursing profession has fiercely tried to negate. As NPs, what we do is not midlevel anything: We certainly do not provide just mid-level care, and we certainly do not practice at a midlevel, nor is it mediocre! We suspect you, as well the authors of this chapter, provide high-quality care to the best of your ability all of the time. To us, that is not midlevel. We would prefer to be called by our title or be identified by the role that we hold within the health care domain with an emphasis on maintaining our nursing identity as APRNs, advanced practice nurses, doctoral APRNs, board certified nurses, or the designation provided by respective State Boards of Nursing.
EXHIBIT 4.1  AACN’s The Essentials of Doctoral Education for Advanced Nursing Practice, With Commentary I

I. Scientific Underpinnings for Practice

The DNP program prepares the graduate to:

1. Integrate nursing science with knowledge from ethics, biophysical, psychosocial, analytical, and organizational sciences as the basis for the highest level of nursing practice

2. Use science-based theories and concepts to:
   - Determine the nature and significance of hearth and health care delivery phenomena; describe the actions and advanced strategies to enhance, alleviate, and ameliorate health and health care delivery phenomena as appropriate; and
   - Evaluate outcomes

3. Develop and evaluate new practice approaches based on nursing theories and theories from other disciplines

*Our View:* The MSN graduate should be aware of all current evidence and knowledge to provide quality patient care and remain current in practice.

*In Addition:* The DNP graduate should design, develop, implement, and publish scientific findings to improve patient care and health care systems; and utilize new scientific evidence to devise protocols and practice plans. Additionally, the DNP graduate should maintain an active professional development plan.

II. Organizational and Systems Leadership for Quality Improvement and Systems Thinking

The IDP program prepares the graduate to:

1. Develop and evaluate care delivery approaches that meet current and future needs of patient populations based on scientific findings in nursing and other clinical sciences, as well as organizational, political, and economic sciences

2. Ensure accountability for quality of health care and patient safety for populations with whom they work
   - Use advanced communication skills/processes to lead quality improvement and patient safety initiatives in health care systems
   - Employ principles of business, finance, economics, and health policy to develop and implement effective plans for practice-level and/or system-wide practice initiatives that will improve the quality of care delivery
   - Develop and/or monitor budgets for practice initiatives
   - Analyze the cost-effectiveness of practice initiatives accounting for risk and improvement of health care outcomes
   - Demonstrate sensitivity to diverse organizational cultures and populations including patients and providers

3. Develop and/or evaluate effective strategies for managing the ethical dilemmas inherent in patient care, the health care organization, and research

*Our View:* The MSN graduate should participate in professional organizations and lobby government officials for access to quality, cost-effective health care.

(continued)
EXHIBIT 4.1 AACN’s The Essentials of Doctoral Education for Advanced Nursing Practice, With Commentary I (continued)

In Addition: The DNP graduate should represent professional organizations at the table with government officials to ensure health care policy efficacy and quality. The DNP actively and prominently initiates and advances the health care agenda.

III. Clinical Scholarship and Analytical Methods for Evidence-Based Practice

The DNP program prepares the graduate to:

1. Use analytic methods to critically appraise existing literature and other evidence to determine and implement the best evidence for practice
2. Design and implement processes to evaluate outcomes of practice, practice patterns, and systems of care within a practice setting, health care organization, or community against national benchmarks to determine variances in practice outcomes and population trends
3. Design, direct, and evaluate quality improvement methodologies to promote safe, timely, effective, efficient, equitable, and patient-centered care.
4. Apply relevant findings to develop practice guidelines and improve practice and the practice environment
5. Use information technology and research methods appropriately to:
   • Collect appropriate and accurate data to generate evidence for nursing practice
   • Inform and guide the design of databases that generate meaningful evidence for nursing practice
   • Analyze data from practice
   • Design evidence-based interventions
   • Predict and analyze outcomes
   • Examine patterns of behavior and outcomes
   • Identify gaps in evidence for practice
6. Function as a practice specialist/consultant in collaborative knowledge-generating research
7. Disseminate findings from evidence-based practice and research to improve health care outcomes

Our View: The MSN graduate should understand the need for research to advance nursing science, actively participate in research agendas, and utilize current information to provide quality care.

In Addition: The DNP graduate should design, develop, implement, and evaluate clinical research to improve patient care and outcomes through the development of guidelines, protocols, and informed opinion. The DNP should ensure that organizational guidelines are congruent with current evidence-based practice, always with an open eye toward continuous improvement; and maintain a culture of excellence through continued scientific inquiry and personal and professional transformation.

(continued)
EXHIBIT 4.1  AACN’s The Essentials of Doctoral Education for Advanced Nursing Practice, With Commentary I  (continued)

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

The DNP program prepares the graduate to:

1. Design, select, use, and evaluate programs that evaluate and monitor outcomes of care, care systems, and quality improvement including consumer use of health care information systems
2. Analyze and communicate critical elements necessary to the selection, use, and evaluation of health care information systems and patient care technology
3. Demonstrate the conceptual ability and technical skills to develop and execute an evaluation plan involving data extraction from practice information systems and databases
4. Provide leadership in the evaluation and resolution of ethical and legal issues within health care systems relating to the use of information, information technology, communication networks, and patient care technology
5. Evaluate consumer health information sources for accuracy, timeliness, and appropriateness

Our View: The MSN graduate should have a clear understanding of current technological advances to improve patient care and patient outcomes; and have the ability to evaluate new systems and suggest updates to fulfill the needs of rapidly changing clinical environment.

In Addition: The DNP graduate should participate in the design, development, implementation, and evaluation technology to meet the current and future needs of health care teams nationally and internationally; design, develop, implement, and evaluate databases to improve health care informatics and communications; and lead activist groups to lobby for global electronic medical records to ensure the quality and continuity of patient care.

V. Health Care Policy for Advocacy in Health Care

The DNP program prepares the graduate to:

1. Critically analyze health policy proposals, health policies, and related issues from the perspective of consumers, nursing, other health professions, and other stakeholders in policy and public forums
2. Demonstrate leadership in the development and implementation of institutional, local, state, federal, and/or international health policy
3. Influence policy makers through active participation on committees, boards, or task forces at the institutional, local, state, regional, national, and/or international levels to improve health care delivery and outcomes
4. Educate others, including policy makers at all levels, regarding nursing, health policy, and patient care outcomes
5. Advocate for the nursing profession within the policy and health care communities
6. Develop, evaluate, and provide leadership for health care policy that shapes health care financing, regulation, and delivery
EXHIBIT 4.1  AACN’s The Essentials of Doctoral Education for Advanced Nursing Practice, With Commentary I  (continued)

7. Advocate for social justice, equity, and ethical policies within all health care arenas

Our View: The MSN graduate should have a deep-rooted understanding of financial aspects of quality care, diverse ways to access care, and how to advocate for legislative changes to influence health care delivery systems.

In Addition: The DNP graduate should identify problems within the health care delivery system and actively spearhead legislation to improve and/or change health care policy utilizing advanced negotiating, consensus building, and partnering skills, particularly across other health care disciplines.

VI. Interprofessional Collaboration for Improving Patient and Population Health Outcomes

The DNP program prepares the graduate to:

1. Employ effective communication and collaborative skills in the development and implementation of practice models, peer review, practice guidelines, health policy, standards of care, and/or other scholarly products
2. Lead interprofessional teams in the analysis of complex practice and organizational issues
3. Employ consultative and leadership skills with intraprofessional and interprofessional teams to create change in health care and complex health care delivery systems.

Our View: The MSN graduate should collaborate and consult with health care providers as well as participate as a member of the health care team to advocate for both quality health care for patients and for the advanced practice role of the nurse.

In Addition: The DNP graduate should create and provide leadership in an interprofessional environment to advance health care agendas and improve patient care by utilizing critical and reflective thinking, scientific foundations, and research in all disciplines.

VII. Clinical Prevention and Population Health for Improving the Nation’s Health

The DNP program prepares the graduate to:

1. Analyze epidemiological, bio-statistical, environmental, and other appropriate scientific data related to individual, aggregate, and population health
2. Synthesize concepts, including psychosocial dimensions and cultural diversity, related to clinical prevention and population health in developing, implementing, and evaluating interventions to address health promotion/disease prevention efforts, improve health status/access patterns, and/or address gaps in care of individuals, aggregates, or populations
3. Evaluate care delivery models and/or strategies using concepts related to community, environmental, and occupational health, and cultural and socioeconomic dimensions of health

(continued)
Our View: The MSN graduate should provide comprehensive, culturally diverse, and competent care to patients in their scope of practice. The practitioner should investigate all resources to ensure quality care for their population.

In Addition: The DNP graduate should utilize problem-solving skills to generate new knowledge that affects patients within and outside their population. The DNP utilizes clinical experience, advanced analytic skills, and leadership abilities to target health care GLOBAL health care issues.

VIII. Advanced Nursing Practice

The DNP program prepares the graduate to:

1. Conduct a comprehensive and systematic assessment of health and illness parameters in situations, incorporating diverse and culturally sensitive approaches
2. Design, implement, and evaluate therapeutic interventions based on nursing science and other sciences
3. Develop and sustain therapeutic relationships and partnerships with patients (individual, family, or group) and other professionals to facilitate optimal care and patient outcomes
4. Demonstrate advanced levels of clinical judgment, systems thinking, and accountability in designing, delivering, and evaluating evidence-based care to improve patient outcomes
5. Guide, mentor, and support other nurses to achieve excellence in nursing practice
6. Educate and guide individuals and groups through complex health and situational transitions
7. Use conceptual and analytical skills in evaluating the links among practice, organizational, population, fiscal, and policy issues

Our View: The MSN graduate should practice in a collaborative environment.

However: The DNP graduate should “create” the environment he or she practices in utilizing principles of autonomy and independence, while fostering an interdisciplinary climate. While some believe this is just a new degree with the same role, we disagree. We encourage more explicit development of doctoral advanced practice nursing competencies.

Conversely, the DNP degree is not prescriptive to the clinical specialty areas like master’s education. The DNP degree builds on the MSN level of education, and the student learns to branch out of standard roles in order to assume greater responsibility and accountability for his or her patients, ensuring care continuity that will infiltrate
through other disciplines (Mundinger, 2005). If the master’s-prepared nurse wants to achieve a practice doctorate simply to earn the respect and the “doctor” title, we urge the matriculating student to stop now or proceed with extreme caution! Doctoral education differs dramatically from MSN education. It commands an overwhelming amount of dedication and an unwavering intellectual curiosity to “pry the lid off” of the road map point of care pathways and to understand the “why”; to think outside the box, to question practice, and to be the conduit to explore causation that might lead to new interventions (Dreher & Montgomery, 2009).

Since the first edition of this book in 2010, the 330-plus master’s degree programs that have been accredited by the CCNE or by the National League for Nursing Commission for Nursing Education Accreditation (CNEA), which was established in 2013 and formerly known as the National League for Nursing Accrediting Commission (NLNAC), has grown to more than 450 master’s or post-master’s degree programs (CCNE, 2015; CNEA, 2013). Historically, master degree preparation for APRNs has existed with fairly standard and traditional curricula incorporating basic theoretical and conceptual aspects of nursing science, skills performance, research comprehension and application, and leadership proficiency to improve the health care system (AACN, 2006). The MSN graduate APRN is then molded within his or her practice environments to grow and mature in a specialty area. For many master’s-prepared clinicians, contentment is found in providing high-quality care to the patients or systems they serve. For others, they may feel they have reached their full potential or the boundary of their practice ability. Their professional contentment slowly dissipates and results in the quest for “more.” But just what exactly is more?

THE DNP-PREPARED APRN

The DNP is the answer to the prior resounding question! The emergence of this new title and its associated curricular structure may be just what the doctor ordered (no pun intended) to lead APRNs with a progressive thirst for knowledge and armed with the assimilation and integration of new DNP NONPF competencies to merge into a different world of lifelong engagement and satisfaction in doctoral advanced practice nursing. In Exhibit 4.1, we have included a very specific commentary where we highlight what the DNP graduate is educated and trained to practice beyond the MSN. It is noted however that there is still variation in the academic preparation and transition within the health care system of the DNP student that appears outside of the eight substantive areas listed in the DNP Essentials (AACN, 2006). These variations in curriculum and the “real-life” roles of DNP graduates are discussed at length by Melnyk (2013). Both of us having now “lived” the Essentials (AACN, 2006) feel our perspective is very valuable as the profession tries to define what exactly is the domain of practice that exists beyond the MSN. As the number of DNP programs soar to more than 260 programs in 48 states and the District of Columbia with 125 programs accredited by the CCNE, the debate over academic preparation and role development is sure to continue (AACN, 2015b). The following two scenarios provide cases in-point for readers interested in sharing the journey and personal insight of two DrNP graduates from the start to completion of their terminal degree. We offer our two personal stories openly and hope they may be valuable to current DNP students.
CASE STUDY I: A Women’s Health NP Who Continues to Want “More”

The first author of this chapter is a 50-year-old, well-seasoned practicing APRN. My 20-year practice, specializing in women’s health in both clinical and academic arenas, centered on achieving success at providing empathetic, comprehensive care to my patients and was focused on health promotion and disease prevention. Each office day was packed with a full complement of patients with an array of issues ranging from the normal annual well visit to the extremely complex and potentially life-threatening disease situations. Booking an appointment with me typically necessitated a 6-month wait. My collaborating physicians’ operating room schedules were also booked with referrals stemming from my robust practice. In addition, the number of my pregnant patients delivering with the collaborating physicians greatly contributed to the income of the practice. Needless to say, I successfully cultivated a large and loyal patient volume through dedication and hard work, and earned the respect of the medical community and my peers through my practice—my ideal clinical APRN professional career goal attainment.

However, as the years passed and as each professional milestone was attained, my office hours began to get longer and more mundane. Challenges were fewer and farther between. I did not feel as though I had to put much thought into providing high-quality, effective, and efficient care. I did, however, become more frequently frustrated by existing policies that were incongruent with high-quality health care options. Somehow, invisible to my patients and initially without my own complete self-awareness, I was intellectually stunted. But what grew out of this discomfiture was a gnawing desire to seek the unknown—to find “more,” whatever that was. I thought about taking the Law School Admission Test (LSAT) for law school admission, but my unwavering self-identification and dedication as a nurse clinician halted that option. I also explored avenues in forensic nursing, defense law expert for nurses, and even medical school. However, my zest for my specialty and my profession continued to overpower my “wandering eye” into other career areas, until I found the practice doctorate, the DrNP.

In response to another IOM report (2003), Health Professions Education: A Bridge to Quality, the AACN interpreted the document’s policy recommendations as supportive of more advanced nursing education, and thus the early planning and politicking toward a practice doctorate degree alternative to the PhD was underway. Many master’s-level nursing programs had revamped their existing curricula by requiring an expansion of the already challenging and complex credit loads to deal with the IOM’s requests. Some thought the MSN degree already conferred this advancement and was almost equal to similar entry-level health profession doctorates. Was nursing about to abandon its history of failed clinical doctorate models in favor of a new practice doctorate degree? The AACN ultimately indicated the new DNP degree was created to meet the demands of the present-day fragmentation of services and system failures in health care by preparing nurse clinicians (and later clinical executives) for practice with interdisciplinary, information systems, quality improvement,
and patient safety expertise (AACN, 2006). Practically simultaneously, Mary O’Neil Mundinger, dean of the Columbia School of Nursing, pioneered the first DrNP program to revolutionize the nursing profession and prepare the nurse clinician for more sophisticated and complex advance nursing practices (Yox, 2005). At this juncture, a debate ensued that has really not abated. If the master’s degree is still filled with rigor and produces capable and competent APRNs, why are some left asking for “more?” Why go for the DNP?

Before the DNP/DrNP degrees evolved, many passionate APRNs found themselves in PhD programs, not exactly certain what their role would be if they completed the PhD. Typically, APRNs who seek a doctoral nursing terminal academic degree still identify strongly with the clinician role (Bloch, 2005; Chism, 2009). The DNP program “requires competence in translating research in practice, evaluating evidence, applying research in decision-making, and implementing viable clinical innovations to change practice” (AACN, 2006, p. 6). In addition, a strong DNP curriculum should prepare the APRN clinician to become an integral part of a research team. In our program, and perhaps in some DNP programs, the graduate is also prepared to competently spearhead research initiatives, especially those deeply grounded in practice.

The expert APRN’s journey into the DNP curricula is definitely not an easy one. Then again, is any doctoral program designed to be navigated effortlessly? For the clinician accustomed to being “on top of her game” in the clinical world, rejoining a very different academic world will often result in frustration. Being a doctoral student mentally means experiencing challenging workloads designed to reprogram the APRN’s view of the world, the very same view that was accustomed to confidence and security in both judgment and performance (with a master’s degree). In order for the APRN to attain the DNP, an extremely challenging metamorphosis needs to occur. These programs are designed to infuse a deep-rooted understanding of the multifaceted aspects of evidence-based practice, research skills, leadership, administration, and policy into the polished practitioner. The lens from which clinical practice was previously viewed is reinforced, but also changed so that a new broader landscape perspective is seen. The DNP clinician possesses newly acquired skills, which fortify critical thinking about the care provided and empower the nurse to authoritatively and credibly question the standard of care and to participate actively in the revision of current standards to improve patient care.

In my case, my quest to find something “more” and stay true to my clinical roots allowed me to build on my master’s-level training. I was truly at the point in my professional career where I was no longer satisfied with doing the “how to,” but I craved the “why” and the “why not” in order to improve “how to” learning. In this quest, my doctoral education encouraged and challenged me to find novel and creative ways to improve the care I deliver and enable me to make a greater impact on the lives of not only the patients I encounter but also the future generations of patients and providers through the dissemination of my clinical scholarship.

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Despite an economy in turmoil, the overall number of nursing students enrolled in doctoral programs continues to increase. There are currently 269 nursing schools in 48 states plus the District of Columbia accepting students into a DNP program with an additional 60 schools contemplating offering a DNP program (AACN, 2015b). Student enrollment in DNP programs has increased by 26.2% (14,688 in 2013 to 18,352 students nationwide) in 2014. Of particular interest, in research-focused doctoral programs, enrollments increased by only 3.2% from 2013 to 2014 with 5,290 students currently enrolled (AACN). As a critical mass of DNP clinicians accrues, their additional education, greater depth and breadth of knowledge, more refined leadership abilities, and enhanced skill set will propel graduates to exert more influence on patient care and demand equivalent input into joint decision making for their patients. At the same time, the DNP will “profoundly improve the nation’s image of nursing” (Mundinger, 2005, p. 174). Mundinger also acknowledges that DNP’s, based on their intense advanced education, coupled with their passion for patient care, are raising intriguing questions, offering resolutions, and stepping in with welcome wisdom to improve the care in the systems in which they work. The saga continues.

With the attainment of my DrNP, coupled with my scholarship productivity and expert clinical practice, I am no longer doing the same thing I was doing when I walked into my first doctoral seminar. I now have a joint appointment in both a prestigious nursing school and medical school, and published nine journal articles (three research related) in respected peer-reviewed journals in my first year of postgraduation. My clinical scholarship focuses on helping to raise public awareness concerning the issues of human papillomavirus (HPV) in women’s health care, both nationally and internationally. I continue to be active in promoting optimal women’s health care and I really believe my primary care has improved because of my enhanced abilities at formal clinical inquiry. My doctoral education (and the specific coursework I took) has given me (a clinician!) the tools to evaluate and strengthen women’s health NP curricula and now educate future “foot soldiers” in women’s health advanced practice nursing. I truly believe my doctoral education has enabled me to accept the challenge of the IOM (2001) to help close the gap that impedes the quality of care we give to patients. I also do not see practice on one side of the road and research on the other. Instead, my own degree has helped me professionally build a bridge between the two. I have been successful in writing and receiving funding for transdisciplinary education grants that combine diverse expert faculty instruction, multilevel simulation, and collaborative case study learning formats to educate OB/GYN medical students and resident physicians, women’s health NP students, physician assistant students, and nurse anesthesia students together in a collaborative setting.

The focus of my work is to enhance knowledge of roles and responsibilities within the health care system, foster development of team-building skills, improve health care team communication, reduce medical errors, and improve the quality of patient care through simulation in a transdisciplinary environment.
Coupled with my achievements of becoming a Fellow of Sigma Theta Tau’s Nurse Faculty Leadership Academy (NFLA) and the American Association of Nurse Practitioners (FAANP), I am now the chair of a very large and successful NP program. My education and experience empowers me to mold the future of nursing practice! Had I kept my head to the grindstone in my clinical practice and never decided to continue on to get my DrNP, I do not believe I would have ever dreamed such issues existed in health care, or that I could be part of a solution. I feel as though the lenses of my clouded glasses were cleaned, and now I can see farther and more clearly than ever before. My DNP education has satisfied my desire for additional education, but my quest for “more” continues. I now see a new world of endless possibilities that will continue to assist me in my own personal and professional development, as well as help me be a better steward of my profession and discipline.

CASE STUDY II: Transitioning in Academia, Practice, and Scholarship: One DrNP’s (DNP) Story

The second author is an APRN who, after 30-plus years of practice evolving from a diploma-prepared registered nurse followed by a bachelor of science in nursing (BSN) degree and master’s-level preparation as a clinical nurse specialist, sought and achieved post-master’s certification as a family NP. After 3 years of competent practice in this role, at both a primary care setting and university medical center outpatient clinic setting, I had the personal drive to “do more.” At first this urge was satisfied with supplemental adjunct faculty responsibilities in the clinical arena. This role, however, only fueled my desire to be both an expert practitioner and educator in my own realm. After exploring both PhD and DNP programs for more than a year, I knew that my future quest was doctoral education in nursing practice. As opposed to a PhD in nursing program, which emphasizes the philosophy of science, nursing science, and research, or the standard DNP, I chose a hybrid DrNP program as my educational pathway due to the ability to declare a dual track as a scholar in both nursing practice and nursing education. Coursework in the program appealed to the practitioner within me, as it included both a clinical and role practicum that could be tailored to expand my knowledge and translation of evidence-based practice. Specific to the ever growing discipline of oncology nursing advanced practice, this included such areas as genetics, multimodal treatment using a multidisciplinary team approach, and taking an active role in prevention and early detection of disease and cancer survivorship issues often overlooked by physician peers in their efforts to provide the latest technology based medical care. In addition to the chance to be an active participant in coordinating my education and securing...
CASE STUDY II: Transitioning in Academia, Practice, and Scholarship: One DNP’s Story  (continued)

expert mentorship, the program I choose included core courses in nursing science, leadership, legal issues in advanced practice, research methods, as well as cognates focused on nursing education. A major draw to this program was the ability to connect with international nursing scholars during a 2-week “DrNP-in-London” study abroad program.

The philosophy and tenets of the practice-oriented terminal degree program I chose coincided with my personal interests and ability to achieve subjective satisfaction and purposefulness in my professional role as a NP with dual national certification in both family practice and advanced oncology nursing. I felt strongly that on completion of the DrNP program, I would be prepared at the highest level, practice with the admiration of peers both inside and outside the discipline of nursing, and develop skills that were crucial to becoming a valued nursing faculty member and empowered nurse leader. The latter two skills have been found to be determinative in students’ choosing a practice doctorate rather than a research-focused doctorate, and to support those who desire to focus their careers on clinical practice and nursing education (Loomis, Willard, & Cohen, 2007). Likewise, Brar, Boschma, and McCuaig (2010) stated the DNP is the most recent credential and source of preparation of new nursing knowledge that has a strong emphasis on advanced leadership in clinical practice.

Following my coursework related to the terminal degree and successful defense of a clinical dissertation based on my practice and interest in breast cancer disparities in minority populations, I am pleased to say I was offered a full-time appointment as an assistant clinical professor in a College of Nursing and Health Professions within a large urban university. As noted in a discussion by Agger, Oermann, and Lynn (2014) related to the perceptions of deans’ and directors’ regarding hiring and utilization of new DNP prepared faculty, my main role was that of teaching across the curriculum at the baccalaureate and master’s level. Within a short time frame, my clinical and leadership expertise were recognized by the department chair and I was offered and accepted the position of track coordinator for the MSN family NP program. It was in this position that I was able to apply many of the skills gained and mentorship given to me in the cognate educational courses within the terminal degree program to revamp the curriculum and transition the program from on-campus to on-line delivery.

Two years ago, I choose to move to a public collegiate institution that focused on the teacher–scholar model and offered the opportunity to join the tenure track. It is at this current setting that I have flourished beyond the initial intention of the DNP role and have realized my potential for shaping not only future nursing professionals but also have realized opportunities for shaping the health care system, a sentiment shared in the literature by Dunbar-Jacob, Nativio, and Khalil (2013). Within my current academic setting, I am up for promotion to associate professor as I am now 5 years out of my terminal degree and hold an appointment as cochair of the Department of Nursing. Over the past 2 years I have also had the distinct pleasure of giving back to the profession by serving as a mentor and/or preceptor to both master’s-level advanced practice

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nursing students as well as doctoral level DNP and PhD students. I have served on both capstone and dissertation committees, and am faculty for research and evidence-based practice coursework at the graduate level.

Dunbar-Jacob et al. (2013) feel that DNP prepared faculty foster scholarship in nursing. My own scholarship related to academia post DrNP continues on an active path with such activities as being a participant in one of the NLN’s Scholarly Writing Retreat, being a primary author of manuscripts published in journals and certification review books, serving as a peer reviewer for specialty nursing practice, nursing education, and a nationally recognized public health journal, being principal investigator (PI) on a Health Resources and Services Administration (HRSA) grant submission focused on advanced nursing practice academic–practice partnerships, being awarded a 2-year Support of Scholarly Activities (SOSA) grant to engage in my program of research. I also fill the office of president of a chapter of Sigma Theta Tau.

Competency and engagement in clinical practice and providing high-quality care to underserved populations is what gives me the greatest satisfaction in my professional life. I feel strongly that my expertise as an advanced practice nurse (NP) was fostered by the application of evidence-based practice in my focused terminal degree program.

Currently, I am credentialed and practice within a university-based cancer center. In addition to serving as a provider, and as one of a half dozen APRNs (and the only one doctorally prepared) in an outpatient setting within the center, I have taken the lead in designing and developing educational outreach projects based on gaming strategies to increase participation of women in cancer screening and increase early access to services. These programs are the result of funding that was secured through grants from a nationally recognized cancer foundations and organization. This year I was chosen as coordinator-elect of the Prevention/Detection Special Interest Group within the Oncology Nursing Society and participated in 2015 Annual Congress by presenting a poster abstract at a session specifically focusing on research outcomes.

Dunbar-Jacob et al. (2013) described what they termed “the short-term impact in other areas” related to DNP education (p. 426). For me, the other area is one that I am growing ever more passionate about global health. I will soon embark on my fourth health outreach in Haiti where I serve as a primary care provider in the family NP role delivering care across the life span to individuals and families living in an extremely resource-poor environment. I also have had the opportunity to mentor nursing students at both the undergraduate and graduate level that have been involved in service learning within the area. Involvement with a nongovernmental organization (NGO) that provides sustainable health care and health education services in this country has strengthened my practice from one based on cultural competency to one of cultural humility. Although being involved in some type of international outreach effort was always in the back of my mind as a nurse or master’s-prepared NP, the confidence and leadership skills related to capacity building gained throughout my doctoral education gave me the impetus to “jump in” and “round out” my role-development journey from a registered nurse to a doctoral advanced practice nurse.
APRN DNPs: SEE ONE, DO ONE, TEACH ONE?

As demonstrated in the case studies previously, both authors are expert clinicians, doctor nursing practice graduates, recognized leaders, and nurse educators. However, neither received formal training as a nurse educator (beyond one doctoral nursing education course each elected to take) during their doctoral program, necessitating independent study to attain the certified nurse educator (CNE) certificates. In contrast, other nursing terminal degree programs do include formal nurse educator curricula built into the program of study, but lack the advanced clinical component that provides the credibility for a clinical doctorate. Some nursing leaders postulate that one of the goals in the creation of the DNP was to help alleviate the nursing faculty shortage (Minnick, Norman, & Donaghey, 2013). In fact, more than 30% of DNP graduates do go into academia (Zungolo, 2009) and it makes perfect sense that APRN-DNP clinicians teach in all levels of nursing education, particularly in NP and DNP programs. Nursing accreditation bodies further require that the director of an NP program hold a doctoral degree (CCNE, 2013). The AACN as well as most state boards of nursing require directors of NP programs to be, at the minimum, master’s-prepared. A survey of 220 nursing deans and directors identified the top five desired characteristics of novice faculty (Penn, Wilson, & Rosseter (2008):

- Teaching skills
- Knowledge, experience, and preparation for the faculty role
- Curriculum/course development skills
- Evaluation and testing skills
- Personal attributes

Ironically, formal education in the majority of these skills is specifically prohibited by the accreditation body to be included in DNP curriculum! Fortunately, many educational conferences, continuing nursing education programs, and faculty development agendas provide content to foster teaching excellence for clinician educators.

A quandary still exists. APRN DNP’s are both needed in practice to further develop and improve the national health care agenda and needed in the educational settings to prepare the future nursing work force to provide the highest quality, safe, and efficient health care. As we envision the future of nursing as delineated in the IOM report (2010), is it time to reconsider a DNP clinical educator track as a solution to do more than “see one, do one, teach one?” The DNP graduate is being recruited to fill vacancies not only in practice and administrative roles within health care settings but also in academia particularly in programs that prepare master’s-level advanced practice nurses, offer the DNP terminal degree, or are experiencing a shortage of PhD-prepared faculty.

The DNP prepared advanced practice nurse is also gaining more popularity in clinical practice. According to the DNP Fact Sheet (AACN, 2015b), employers are recognizing the contributions the DNP-prepared nurse bring to practice settings. It also appears that with this change many issues and questions arise, some of which have already been discussed previously. Questions that still linger include but are not limited to: What are the benefits of DNP versus MSN preparation of APRNs? Are practice settings recognizing the difference between doctoral-level advanced practice and master’s-level advanced practice with respect to salary? When will the impetus for the DNP becoming the entry level for advanced practice actually occur?

For the most part, it appears the benefits of the DNP verses MSN are both personal and professional. Seeking and obtaining the DNP is both personally challenging and rewarding. It is the practitioner who does not accept the status quo that seems to be driven to obtain a terminal degree before it is actually formally mandated. In the ever-changing
health care landscape, the DNP can assist advance practice nurses to increase their respective knowledge and skills in many areas already noted within this chapter. Having a DNP seems to “level the playing field” or create parity with other practice disciplines when working on multidisciplinary projects within health care settings. It is also a degree that is embraced by administrators as in many instances the DNP-prepared APRN has knowledge of organizational and systems thinking that can be applied to quality improvement projects or evidence-based practice initiatives that ultimately lead to improved patient care outcomes. Thus, in many instances the DNP-prepared APRN makes the institution, department, or program “look good” in the eyes of accreditors, patients, and other stakeholders. There has been concern raised about who will hire NPs with a practice doctorate and whether the pay they receive would be worth the additional education. A most recent 2014 salary survey conducted by Advance Healthcare Network (2015) estimated that NPs with a DNP are receiving an average salary of $113,618. This is approximately $13,000 more than the average salary of a master’s-prepared NP. This is also close to a $4,500 gain since the same organization’s 2011 salary survey. What will happen in the future across a larger geographic landscape, increased number of DNP-prepared graduates entering the profession and an influx health care system remain to be seen.

SUMMARY

The evolution of APRN education from the master’s to the doctorate level appears to be here to stay. As Dreher (2005) stated: “Has this train left the station? If so, just where is it going?” (p. 17). The issues surrounding this transition will most likely continue to be debated for some time, and the ultimate direction of the DNP degree is still unfolding. We think that active, practicing DNP graduates can actually shape the future of this degree with our critical mass. We absolutely want more outcome data on what these graduates are accomplishing. We even welcome any constructive criticism, especially if there are DNP programs that proliferate that are not rigorous or that aim to create an easy path to the title “Dr.” Weak DNP programs will harm us all and not advance the nation’s health. We also call for the DNP graduate to advance “practice knowledge development” as has been advocated by Dreher (2010) who also contends the DNP graduate should be the leader in creating practice-based evidence for the discipline. DNP-prepared APRNs have quickly positioned themselves to become an integral part of our discipline’s future. They not only carry with them a unique preparation for diverse health care roles, but a plethora of opportunities for advancement in the arenas of practice, leadership, education, and applied research awaits them.

So, exactly how is the MSN different from the DNP? Why take the leap into obtaining a practice doctorate in nursing? The answers to these questions will be different for every nurse practicing in the clinical arena. You will decide if you want more. However, one fact is clear: The MSN degree allows you to be part of the change to improve the quality of patient care you provide, while the DNP equips you to collaborate more inter-professionally (and with more confidence) to be the change and advance the discipline. This degree opens your professional world to a myriad of new lenses, new options, and new agendas with which to advance nursing and make a true impact on the patients you serve and to the larger aggregate through your disseminated clinical scholarship. To reiterate our warning at the beginning of the chapter, proceed with caution! When you obtain the DNP, you will be different. Your professional eyes will be open more widely to many more challenges. Your metamorphosis, we attest, will be profound.
CRITICAL THINKING QUESTIONS

1. After review of the chapter, has your individual thoughts or views on the AACN’s position to move the level of preparation necessary for advance practice roles from a master’s degree to doctoral level as requisite credential for entry into advanced practice nursing changed? Why or why not?

2. If the DNP is mandated by regulatory bodies (licensure, accreditation, certification, and education), will it be held to the same prescriptive expectations as the master’s-prepared ARPN?

3. Is there a need for a standardized, designated title to signify the educational preparation and national credentialing of DNPs? Explain.

4. Do you feel that the DNP degree will support the triad of academia, practice, and research related to the nursing profession? Discuss.

5. Will the DNP degree better prepare nurses to deal with the complexity of patient care environments, expand the knowledge base for practice, initiate and evaluate evidence-based practice through clinical research, and meet the need for nursing leadership in education and administration beyond that currently found within master’s-level programs?

6. Can preparation at the DNP level contribute to and sustain the perfect balance between teaching and clinical practice competencies within the nursing profession? In other words, do you feel the DNP may lessen the “theory–practice gap” as discussed by Little and Milliken (2007)?

7. Based on the experience of these two DrNP graduates from the start to the completion of their terminal degree, can you see how the DNP supported a diverse perspective of roles and myriad of opportunities that may have not been otherwise fulfilled with traditional master’s-level advanced practice nursing education?

8. Can the health care industry afford a workforce made up of exclusively doctoral-prepared ARPNs (DNPs)? Discuss.

9. The debate on how doctoral-level advanced practice nursing roles differ from master’s-level advanced practice nursing roles is far from over. What areas of systematic evaluation related to the impact of the DNP on the advanced practice workforce do you see as most pressing?

10. The rationale for the shift in academic preparation of nurses in advanced practice has focused on several issues including how the transition to clinical doctoral preparation for APRNs can be conducted so that master’s-prepared APRNs will not be disenfranchised in any way. Based on your knowledge and the information provided within this chapter, can this transition be handled smoothly? How should it proceed?

NOTES

1. Both initials DNP and DrNP stand for doctor of nursing practice, although all programs now use DNP initials, except some doctoral programs in nurse anesthesia. Because the DrNP degree is termed a hybrid professional doctorate and emphasizes both advanced practice and the conduct of practical clinical research, it used different initials.

2. On a serious note, however, we highly discourage the use of the word doctor to describe one who is actually a physician. There are lots of doctors in health care, including DNPs who complete the doctorate. By using the proper title physician, we are describing their role and their profession. Even to a patient we recommend saying for example, “What did your physician prescribe for you?”

3. In nursing, a practice-focused doctorate is akin to the DNP while a research-focused doctorate is akin to the PhD.
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CHAPTER FOUR

Reflective Response 1

Connie L. Zak

The question of how doctoral-level education versus MS education impacts the role of advanced practice nurses (APNs) is asked by many nursing faculty and APNs nationally. The authors have eloquently presented their own experiences and impetus for pursuing the Doctor of Nursing Practice (DNP). The authors started their discourse with a historical recapitulation of doctoral education in nursing, leading up to the practice doctorate, and going on to give their personal journeys from seasoned practitioner to doctoral student and graduate.

It is important to understand that the inception of a practice doctorate in nursing is not a new concept, but one that has been around for 30 years. Nursing has been debating the need for a practice doctorate for a very long time. Unfortunately, the early practice doctorates, such as the doctor of nursing (ND) degree, were not generally accepted. Schools of nursing offering such degrees for nurse practitioners (NPs) lost students to MS programs and in the end had to phase out such programs.

Subsequently, with the position statement from American Association of Colleges of Nursing (AACN) in 2004 came the era of agreement (for the most part) within the nursing profession of the importance for APNs, and especially NPs, to have doctoral education as entry into advanced practice, as noted by the authors (AACN, 2004). This shift in nursing education is timely, given the changes in health care occurring in our nation today, which started with the Institute of Medicine’s (IOM, 2001) report, outlining the skills needed for improving health care. It is important to highlight that translating research into practice, testing new models of care, and working in transdisciplinary teams, are the essentials of the role of DNP-prepared practitioners. Furthermore, the IOM emphasized the need for all health professions programs to educate students to be able to deliver patient-centered care as members of interdisciplinary teams that emphasize evidence-based practice, quality improvement, and informatics.

It is also important for the reader to understand that the DNP is a degree and not a role. The practice doctorate is not just role oriented, but it is advanced education that gives “added value” to the practitioner to better serve their patients and populations. One must keep in mind the AACN definition of advanced nursing practice as conceptualized in the DNP Essentials document refers to:

any form of nursing intervention that influences health care outcomes for individuals or populations, including the direct care of individual patients,
management of care for individuals and populations, administration of nursing and health care organizations, and the development and implementation of health policy. (AACN, 2006, p. 4)

Although the authors point out that the DNP builds on MSN-level education, it should be understood that the DNP replaces MSN-level education for advanced practice with comprehensive and in-depth knowledge that is necessary to manage the complexities not only for individual patient care but also for populations and health care systems.

As outlined in Case Study I, A Women’s Health NP Who Continues to Want “More,” the DNP degree provides the education that practitioners need for responding to the health needs of the nation by being the bridge between research and practice. I would differ in opinion with this author who stated that this degree is for the NP who wants more, but I declare it is for the NP who needs more to continue to be effective in facing the challenges of taking care of patients in the ever-changing and expanding health care system. This is not to say that MS-prepared APNs are ineffective in their roles, but it is to say that continuing their education to the DNP will allow them to be even more effective, not only in their roles but also in improving the care they deliver. In doing so, it will be instrumental in changing practice to better serve their patients.

In Case Study II, Transitioning in Academia, Practice, and Scholarship: One DrNP’s Story, the author highlights the importance of the DNP-prepared educator. Colleges of Nursing educate practitioners, and what better-prepared faculty is there than the “Practice Expert?” There is a national shortage of qualified nursing faculty that is further contributing to the nursing shortage nationally. The increasing number of DNP programs opening across the nation is one answer to the faculty shortage as it increases the number of faculty who can train nurses at both the entry and advanced levels. I agree with this author that it is very important to choose a DNP program that will fulfill the candidate’s future career goals.

Finally, it is important to point out the importance of the DNP-prepared APN as a member of a research team, even as the leader of clinical research endeavors. This important point is still not appreciated in the AACN’s revised White Paper on the DNP published August 2015, which attempts to clarify the scholarly role of the DNP student and graduate. When it comes to evidence-based practice, it is important to understand that there is not a linear pathway to improving patient care. Rather, it is a circular path that always feeds back into primary research. Without measuring outcomes of evidence-based changes in practice, there is no way to ascertain that such change has actually improved patient care and outcomes. It is imperative that DNP-prepared APNs are able to not only synthesize science, but also to apply it to practice and measure the impact of such change. The question here is, At what point is the generation of evidence-based practice knowledge considered ‘research’ and how do they differ? DNP-prepared practitioners are able to and should be prepared to measure the impact of their practice, whether by measuring the process of a program or practice change or by measuring individual patient outcomes. If this is considered “research,” one can comfortably say that it is not primary knowledge generating research, but evidence-based practice that will actually benefit the health care system. Dreher (2016) has labeled this “practice knowledge” derived from practice evidence and Melynk and Fineout-Overholt (2014) label this “internal evidence” (p. 11) that is practice-generated. Webber (2008) raised an important question regarding the decision of DNP programs not to prepare graduates to be principal investigators of clinical research. She argues that such action “will limit the creation of a broader, more inclusive research environment and thus perpetuates marginalization of research for many faculty, students, and practicing nurses” (p. 466). Webber points out
how NPs rely on medical research to support their practice. She urges the conduct of more practice-focused research based on phenomena unique to the nursing experience which will not happen if DNPs are marginalized from the research enterprise.

In conclusion, the authors have made a very important statement regarding the “added value” that DNP education gives to APNs. With the exciting changes going on in health care today, the road has been paved for DNPs to make their mark by advancing nursing practice, improving health care, and educating the future nursing workforce.

REFERENCES

CHAPTER FOUR

Reflective Response 2

Karen Kaufman

Drs. Montgomery and Byrne provide a thought-provoking analysis of the differences between doctoral-level and master’s-level practice roles. The personal stories and experiences they relate are powerful reminders that nurses with practice doctorates, with their advanced knowledge and strong commitment, are making enormous contributions to the nursing field and to health care in general. Most importantly, the authors point to the distinction between the MSN degree, which “allows you to be part of the change,” and the Doctor of Nursing Practice (DNP), which equips you “to be [sic] the change.” In other words, MSNs are qualified to carry out important, necessary changes in the practice of health care, while DNPs are the people with the knowledge and responsibility for actually driving that change.

The gulf between these two roles is vast. Our experience working with Drexel DNP students suggests that no book, seminar, or dissertation is sufficient to transform the DNP candidate from a nursing practitioner into a health care leader. Indeed, two highly respected former Drexel professors, Smith Glasgow and Lachman (2010) documented that at least half of the DNP candidates in the Drexel DNP program did not truly see themselves as future leaders, nor did they understand the connection between their unique personality preferences and the role requirements of a leader.

Effecting such a transformation does indeed require advanced knowledge, skills, and experiences, and it also requires a significant change in one’s self-image—which is the first and most important step in persuading others to see you differently as well. Even the best doctoral programs, because of their academic nature, have difficulty affecting this kind of personal transformation in their students. As a result, most DNPs do graduate with the knowledge to address complex patient care challenges and to improve the efficiency of health care delivery. Where they often have difficulty, though, is in mastering the leadership skills required to enlist others in the effort—to implement real and lasting improvement in the nursing profession and health care in general. In short, to be the change—which, after all, is the key reason for obtaining a DNP degree in the first place. As one second year Drexel doctoral residency student said, “Karen’s ability to empower us into transformational leadership is very valuable. We need to transform and elevate our role. We have had the role of clinicians for years. Now we are moving to the executive level which requires a different type of training.”
In my years of designing and leading professional development programs, I have noted that doctoral nursing students are not the only ones in need of more comprehensive leadership training, but leadership skills are especially critical in nursing, a field still dominated by women, most of whom have been socialized to cede leadership authority to men. To be sure, male DNP's need leadership skills too, but as more and more women earn DNP's, their ability to lead will have an outsized effect on the profession as a whole—how it is viewed by other health care professionals and by the general public.

I have had the privilege of working with Drexel DNP students to enhance their leadership abilities. Like Professors Smith Glasgow and Lachman, I have observed that the typical female student does not see a “disconnect” between her own personality preferences—such as the desire to be liked and avoid confrontation—and the more active role requirements of a leader. Effective leadership depends on a variety of factors, from vision and assembling the right team of people, to the integrity of personal actions and behaviors. However, developing leadership skills has to begin with self-image. We need to think of ourselves as leaders in order to have others see us as leaders.

Impression management (Kaufman & Kaufman, 2010) is the term our firm uses to describe the distinctions and tools for building and expanding the key relationships required to meet complex leadership challenges. It is the art and science of making a favorable, role-appropriate impression on others, both personally and professionally. In our work at Drexel, we discuss and dissect these tools in a classroom setting. We are confident that much more could be accomplished with one-on-one consultations.

Our recommendation for all forward-thinking DNP programs—is to treat DNP candidates as we do our executive coaching clients. To help prepare these students for leadership roles, DNP programs would do well to offer a few individualized sessions in which each candidate is profiled according to his or her unique combination of perceptual, cognitive, behavioral, and emotional traits. That analysis can then become the foundation of a customized development plan in which students identify and optimize their strengths while also focusing on areas of improvement to maximize role performance.

DNP programs would benefit by including impression management for nursing leadership into the curriculum. This will provide a proactive approach toward transforming nursing practitioners who are enrolled in DNP programs into health care leaders through detailed analysis and behavioral focus. Such an approach, when consistent with the student’s professional goals and advanced knowledge, is the best possible way of transforming nursing practitioners into the leaders that our health care system so urgently needs.

REFERENCES


The maturity of the nursing discipline and the challenges created by the market-driven environment that we live in today make clinical scholarship more important than ever before. The professional roles of nurses today require that nursing practice be consistent with the emerging knowledge. The roles and responsibilities of nurses will continue to expand, as they become the key health care providers of the next decades. The health care system continues in its transformation, and along with it, new challenges for health care professionals to justify and validate the care they provide. Nurse leaders are increasingly expected to provide the direction and management of the outcomes of the evaluation process. To improve outcomes, clinical decision must be grounded in clinical inquiry where nurses who practice in a scholarly manner work directly and collegially with other health care providers in other settings, both in the discovery and the application of new knowledge. The integration of knowledge across disciplines and the application of knowledge to solve practice problems and improve health outcomes are alternative ways that new phenomena and knowledge are generated in nursing practice other than through research (DePalma & McGuire, 2005; Rolfe & Davies, 2009; Sigma Theta Tau International [STTI], 1999). This chapter addresses the kind of clinical scholarship that is continuing to evolve as advanced practice nurses (APNs) with practice-focused doctorates generate evidence/knowledge to guide improvements in practice and outcomes of care.

HOW IS CLINICAL SCHOLARSHIP DEFINED?

The scholarly practice of nurses can be traced to Florence Nightingale’s work (1860/1992) during the Crimean War, in which data and statistical methods were used for clinical decision making. For several decades, nursing leaders have discussed the scholarship of practice (Benner, Tanner, & Chesla, 1996; Dickoff & James, 1968; Diers, 1995). Although discovery is central to expanding knowledge, linking discovery with application is an essential underpinning for practice disciplines (Riley, Beal, Levi, & McCausland, 2002). Therefore, the traditional belief that scholarship is primarily for the conduct of original research is a serious limitation in a practice discipline such as nursing.
Boyer (1990) inspired most disciplines to engage in robust dialogues about the meaning of scholarship in modern times. Various nurse scholars have shared opinions on what a scholar and clinical scholarship means. In writing about clinical scholarship, Diers (1995) argued that while clinical research in nursing is an accepted form of scholarly activity, clinical research and clinical scholarship are not the same. According to Diers, clinical scholarship offers an alternative way of extending knowledge about nursing practice. She conceptualized clinical scholarship in a practice profession as an intellectual activity that creates a new understanding for the practice. Clinical scholarship examines the practice itself and offers rich descriptions of the practice. Through clinical scholarship, the practitioner synthesizes practice knowledge and challenges the theories and procedures that we have learned and practiced.

Wright and Leahey (2000) argued that clinical scholarship requires an immersion in clinical practice while simultaneously finding ways to articulate, describe, and analyze what is occurring within clinical practice. Using a framework to describe the fundamental building blocks of clinical scholarship, they differentiated perceptual, conceptual, and executive skills related to the nursing of families. According to Wright and Leahey (2000), perceptual skills focus on what the nurse observes, and conceptual skills involve how the nurse makes sense of what is observed, relying on his or her conceptual grounding and personal experience. In addition, there are executive skills that include what the nurse does. Specifically, how the nurse responds (communication skills) is based on how he or she conceptually makes sense of what is happening within the individual, family, and larger systems, as well as between himself or herself and these systems. Clinical scholarship is refined through many hours of observation and participation in therapeutic conversations between nurse clinicians and families using written documentation that requires analysis of these conversations. Clinical scholarship requires intellectual maturity that comes from expertise and repeated experiences, which is reflected in careful analyses of situations and critical assessment of responses. The explanations and reflections offered by the clinical scholar are contextualized in his or her personal history and are enhanced by his or her well-supported interpretations.

Melanie Dreher (1999) argued that clinical scholarship is a value orientation about inquiry and implies a willingness to scrutinize nursing practice. Clinical scholarship is an intellectual process grounded in curiosity about why our clients respond the way they do and why we, as nurses, do the things that we do. It includes challenging traditional nursing interventions, testing our ideas, predicting outcomes, and explaining both patterns and expectations. Clinical scholarship is rooted in observation on ways in which clients respond to their problems and to their treatments. Unfortunately, the observations nurses typically have documented often have not been for the purpose of improving patient outcomes, but rather for limiting liability. It is not sufficient to observe phenomena. Observations must be interpreted by comparing them with similar phenomena (whether or not those comparisons are drawn from personal clinical experience). Comparisons can also be accomplished by using what is known based on the literature. Synthesis builds on the analysis to create an understanding of why these patterns and/or exceptions exist. Synthesis in clinical scholarship is the process of explaining or attaching meaning to the observations and the use of comparisons in examining events or situations. Clinical scholars generate an interpretation of their observations through the process of discussion with colleagues within the nursing community and with other disciplines. Another example is the review of literature and the conduct of integrative reviews of nursing research that incorporate the informed and expert clinical knowledge of the clinician (Ganong, 1987). At another level, understanding meta-analyses of the science literature provides stronger evidence of practice phenomena under consideration.
In addition to observation, analysis, and synthesis, clinical scholarship includes application and dissemination—all of which result in a new understanding of nursing phenomena. With the current explosion of knowledge, there is an expectation that relevant knowledge must be translated to benefit societies. Various nurse scholars argued that clinical scholarship requires the ability to engage in critical theoretical discourse and discern gaps in knowledge related to clinical practice (Dracup, Cronenwett, Meleis, & Benner, 2005). Knowledge of different theoretical frameworks with various assumptions and theoretical propositions is critical for clinical scholars when choosing different types of evidence and in translating evidence into clinical practice. The Doctor of Nursing Practice (DNP)-prepared nurse can discover new ways of refining or transforming practice by using or adapting constructs and concepts in existing theoretical frameworks to solve everyday problems.

The scholarship of application encompasses translation of the knowledge to solve problems for individuals, families, or society. This type of scholarship requires integration of the knowledge of best practices in achieving the best outcomes. Building on Boyer’s (1990) perspective on scholarship, Palmer (1986) described the scholarship of application as a complex activity and synthesis of observations of clients and patients “a complex activity that has as its purpose, the discovery, organization, analysis, synthesis, and transmission of knowledge resulting from client-centered nursing practice” (p. 318).

According to the American Association of Colleges of Nursing (AACN, 2015), clinical scholarship is focused on generating new knowledge through innovation of practice change, the translation of evidence, and the implementation of quality improvement processes in specific practice settings, systems, or with specific populations to improve health or health outcomes. New knowledge generated by the DNP graduate can be transferred to other population or systems but is not considered generalizable (AACN, 2015).

Clinical scholarship requires that the desired outcomes are identified and systematic observation and scientifically based methods are used to identify and solve clinical problems. Additionally, scientific principles, current research, consensus-based guidelines, quality improvement data, and other forms of evidence are used to support clinical practice and clinical decisions. Evidence-based practice stresses the use of research findings as well as other sources of reliable data from quality improvements, consensus of recognized experts, and affirmed clinical experience (Stetler et al., 1998). The movement in nursing toward “evidence-based practice” has been articulated by the leaders like Melnyk and Fineout-Overholt (2005), and has been widely adopted by the DNP program. For example, the faculty at the University of Washington have developed a practice-focused doctorate that includes practice inquiry in the curriculum, addressing the appraisal and translation of evidence into practice, and evaluation with the potential for collaborative clinical research endeavors (Magyary, Whitney, & Brown, 2006). Both evidence-based practice and practice inquiry are likely to impact DNP clinical scholarship now and in the future.

The clinical scholar with a practice-focused doctorate will provide leadership for evidence-based practice with skills in translational research. Clinical scholarship is achieved by reading, by thinking, by discussing with colleagues (interdisciplinary efforts), and by mentoring to generate possible explanations on a clinical problem. Clinical scholars seek validation with fellow clinicians on their documented observations regarding patients’ goal-related progress. Interdisciplinary efforts are necessary skills for the translation of research findings. The value of shared reflections on practice and experience is critical. These reflections can be developed formally through written clinical narratives (Benner, 1984). Reflection, self-scrutiny, and subsequent dialogue form the basis for personal growth and mutual learning among peers.
Despite the variations in the definition of what scholarship means, the following are common themes that describe a scholar. Clinical scholars are characterized by a high level of curiosity, critical thinking, continuous learning, reflection, and the ability to seek and use a spectrum of resources and evidence to improve the effectiveness of clinical interventions. They consistently bring a spirit of inquiry and creativity to their practice to solve clinical problems and improve outcomes (STTI, 1999).

**HOW IS CLINICAL SCHOLARSHIP DEMONSTRATED IN DNP GRADUATES?**

In an era of unprecedented accountability for the delivery of quality, cost-managed health care, the nurses are being challenged to demonstrate effective and efficient care. Well-informed consumers are demanding greater access to quality health care. Rising patient acuity, escalating complexity in health care needs, and the increasing infusion of technology in health care systems are creating daunting challenges for nurses. Additionally, nurses are practicing in environments with limited financial resources. As these challenges increase, nurses can no longer rely on traditional nursing practices or base their clinical decisions on intuition and years of clinical experience to plan and implement care required in today’s patients. Responding to this challenge requires collective knowledge, clinical expertise, and commitment to base patient-care decisions on evidence and involvement of patients. Clinical scholarship is particularly important for APNs with practice-focused doctorates to provide leadership in establishing clinical excellence and informed health care policy.

The master of science in nursing (MSN) degree historically has been the degree for specialized advanced nursing practice. With the development of DNP programs, a practice-focused doctorate, the DNP degree will become the preferred preparation for specialty nursing practice. According to the National Organization of Nurse Practitioner Faculties (2006), the competencies for the DNP are similar to the MSN (with mastery of an advanced specialty within nursing practice), but the DNP competencies are formulated with more emphasis on leadership, quality improvement, health care delivery systems, and health care policy. The implementation of a model for evidence-based practice has been documented to promote clinical scholarship among clinical nurse specialists in various institutions such as Baystate Medical Center in Massachusetts, the University of Texas Medical Branch, Kaiser Permanente and California Pacific Medical Center, and the University of Iowa Hospitals and Clinics and College of Nursing (STTI, 1999). Clinical scholarship among nurse specialists provides opportunities to generate reflective thinking for improved clinical practice and heightened awareness for a new standard for evidence-based thinking (STTI, 1999). Clinical scholarship for the practice-focused doctorate should build on what has been started by clinical scholars with the MSN degree to provide leadership for evidence-based practice. This requires the application of knowledge to solve clinical problems and generate evidence through their practice to guide improvements in practice, outcomes of care, and participation in collaborative research (DePalma & McGuire, 2005; Magary et al., 2006). Evidence-based practice should result in better outcomes leading to a better quality of life for all citizens.

DNP graduates engage in advanced nursing practice and provide leadership for evidence-based practice. This requires competence in knowledge application activities: the translation of research into practice, the evaluation of practice, improvement of the reliability of health care practice and outcomes, and participation in collaborative research (DePalma & McGuire, 2005).
The DNP Essentials (AACN, 2006) articulate the competence of the graduate in terms of clinical scholarship. Graduates of the program are trained to use analytic methods to determine and implement the best evidence for practice. They do so in order to design and implement processes to evaluate outcomes of practice, practice patterns, and systems of care against national benchmarks to determine variances in practice outcomes and population trends. In addition, they design, direct, and evaluate quality improvement methodologies and apply relevant findings to develop practice guidelines and improve practice and the practice environment. They are trained in the use of information technology and research methods to accomplish these. The DNP clinical scholar functions as a practice specialist/consultant in collaborative knowledge-generating research, and disseminates findings from evidence-based practice and research to improve health care outcomes (AACN, 2006).

HOW IS EXPERTISE IN THE USE OF EVIDENCE-BASED PRACTICE ACHIEVED?

In practice, the utilization of research evidence does not occur in vacuum. Multiple contextual factors influence the diffusion of practices that carry the weight of evidence borne of scientific inquiry. Funk, Tornquist, and Champagne (1995) identified four categories of barriers perceived by nurses to the utilization of research in clinical practice: those related to nurses’ research values and skills, those related to limitations in the setting, those related to how the research is communicated, and those related to the quality of the research itself. The DNP role’s impact on facilitating evidence-based practice needs to be conceived as that of successfully overcoming those barriers. Because DNP competencies are formulated at a higher level with more emphasis on leadership, quality improvement, health care delivery systems, and health care policy, the DNP-prepared nurse will be expected to provide leadership in creating working environments for evidence-based practice, with the expectation necessitating a certain level of skills and competency in translating science into practice.

In terms of nurses’ research values and skills, the DNP nurse can become a role model for change and transformation not only for the workplace environment, but also for the individual nurses working in that environment. This can occur at two levels by: (a) increasing the nurse’s confidence in evaluating the quality of the research evidence and (b) changing perceptions regarding the benefits of changing practice with the use of research evidence. The nurse leader who is prepared at the doctoral level can actively participate in formal or informal discussions on evaluating interventions reported in the research literature using the opportunity to increase nurses’ knowledge and ability to evaluate research findings more wisely and logically. By taking on the role of an innovator, as an early adopter, the DNP nurse can create the climate for changing perceptions to one of increased respect and value for the scientific process and its outcomes.

As a leader in clinical practice, the DNP nurse can overcome limitations within the setting for practice. By allowing implementation of innovations through active support and provision of the needed structure and processes, the DNP administrator brings authority and accountability in facilitating the workplace environment for these innovations. This includes focusing on overcoming the limitations in how research is communicated. By providing the resources needed for the nurses and health care team to develop skills in reading, understanding, and evaluating research reports accurately and efficiently, the DNP administrator can promote, sustain, and maintain the
implementation of evidence-based practice. In terms of barriers related to the quality of the research evidence, the DNP nurse can lead the effort to contribute further to the knowledge base by replicating investigations that evaluate the effectiveness of interventions. This requires a step beyond simply implementing and measuring the outcomes of interventions, to formally testing hypotheses regarding the impact of such interventions on nursing and health care. In effect, it requires the DNP-prepared nurse to be skilled in the conduct, use, and dissemination of translational research.

In various leadership roles, the DNP-prepared nurse is uniquely positioned to innovate and experiment with various models for increasing the utilization of research in practice settings. With administrative authority that comes with these leadership roles, the DNP-prepared nurse should have multiple options available for integrating research into the workplace environment. Whether it is increased and more effective use of existing resources or the deployment of external support and expertise, the DNP nurse can raise the organization to higher levels of application of translational science into practice. Particularly in promoting the translation of science into practice, the DNP nurse can engage in action research, which leads to the solution of everyday practical, as well as clinical, problems.

■ IS ACTION RESEARCH ORIENTED FOR DNP CLINICAL SCHOLARSHIP?

Methods to increase the quality and rate of research translation are increasingly becoming the focus of clinical practice. Leadership in clinical practice requires recognition that evidence-based practice is central to the achievement of effective and efficient health care delivery and to obtaining positive client outcomes (Mohide & Coker, 2005). Traditional approaches to building the evidence predominate in the current research enterprise. Nevertheless, there is increasing pressure upon the scientific community to look at alternative paradigms to increase the uptake of research evidence into community- and population-wide practice. Action research, one such alternative paradigm, is science designed to obtain practical results to solve a specific challenge. Engagement in action research is one in which the DNP nurse is optimally positioned, with the strong leadership skills in community-based initiatives that is one of the hallmarks of the education and preparation for DNP practice. In addition to the basic steps in traditional research of design, data collection, analysis, and communication, this alternative paradigm requires action, which is developmental in nature and has a wide range of applications in health care. This showcases the strengths and talents of the DNP nurse; it highlights the natural skills of the practitioner for practical solutions to real and actual problems in the clinical setting as they occur. In addition to skills and competencies in the application of multidimensional and multifaceted designs of participatory action research, the DNP nurse is prepared to lead communities to form collaborative partnerships with the academic scientists in community-based initiatives that aim to solve problems facing vulnerable populations (Stringer, 2007).

■ WHAT IS THE ROLE OF THE DNP CLINICAL SCHOLAR IN DISSEMINATION?

The role of the DNP nurse as clinical scholar has within it an inherent obligation and responsibility to disseminate knowledge and expertise gained from practice to various
audiences. There are many reasons for engaging in the dissemination process. These include the sharing of ideas and new knowledge for the improvement of health care delivery to influencing outcomes of health care. In addition, for practical purposes, dissemination activities are essential job requirements, including requirements for promotion and tenure in any work setting. Thus, DNP preparation includes experiences aimed at developing and increasing skills in manuscript writing as well as in oral presentations in the dissemination of ideas. In leadership roles, the DNP nurse can create the climate for scholarship for those with whom she or he works. Increasingly, the endeavor to produce manuscripts for publication is carried on by writing teams that are engaged in common activities in health care delivery. Likewise, the tasks of preparing and delivering oral as well as poster presentations become less daunting and onerous if undertaken by teams of colleagues engaged in similar activities of dissemination. The DNP nurse provides the needed leadership to get the initiative started, to provide the resources for people to engage in these activities, and to encourage the work of continued and active scholarship. This also provides opportunities for mentoring and mentorship among nurses and other health care professionals who work together to achieve health care goals for groups of patients.

**SUMMARY: THE FUTURE OF THE DNP CLINICAL SCHOLAR**

Whether the creation of this degree enhances the progress of the clinical scholarship for the profession of nursing and furthers the quality of patient care depends entirely on the nursing profession’s willingness to address the critical issues related to educational quality, outcomes, and standards. Focusing on the issue of the preparation of the DNP as a clinical scholar is of particular importance. At the current time, when standards of DNP education are continuing to evolve, it is critically important that the skills and competencies that have been articulated to prepare the DNP for this role be coupled with specific parameters for identifying the outcomes of this preparation relative to this role. Learning experiences in the educational and training curricula must emphasize increasing skills in the application of translational research, while at the same time the development of higher levels of competencies in the conduct of evaluation research and dissemination of critical findings must be facilitated and monitored before the DNP is granted the degree. The DNP graduate should be educated and trained for the increasingly interprofessional nature of practice within a transformed health care system. To prepare the DNP for the increased and enhanced roles in leadership, communication, and team practice, there must be opportunities for inter- and intra-professional collaboration, both between DNP and PhD nursing students as well as between DNP students and other health professions’ students. Increasingly, many DNP students have found opportunities to work with students in other fields such as engineering, public health, health care administration, and business (AACN, 2015).

Nursing leaders and state and national organizations have spent considerable time and finances ensuring the public, legislators, and other members of the health care community that the educational level that nurses currently possess results in high quality care. Although it is intuitively appealing that educational requirements and standards will address the Institute of Medicine’s (IOM’s) concerns about patient safety and health care quality (IOM, 2000, 2001, 2003), there are inconsistencies in the educational preparation of DNP nurses that may not fulfill the promise on the quality of patient care and progress in the nursing profession. Studies relating educational preparation and quality at the entry level do support that more and different education results in higher quality...
(Stanley, 2005). However, these data are not generalizable to advanced practice, and the suggestion that better patient care will result from this preparation, although intuitively appealing, must be documented based on evidence. These challenges must encourage continuous dialogue about the best educational preparation for doctorally prepared APNs who will assume the role of clinical scholars. This is critical as changes in technology, health care delivery systems, science, and changing and evolving roles for nurses all require that the nurse of tomorrow be prepared to participate in the health care system as it evolves. Additionally, employers and professional organizations should provide mechanisms for exercising leadership that support activities for clinical scholarship for DNPs. It is imperative that professional nursing groups and organizations endorse a call for more prolific clinical scholarship in this new cadre of DNPs as central to their mission and philosophy and as a rationale for a practice-focused doctorate. Furthermore, the workplace also needs to state its commitment through tangible means of support to enhance clinical scholarship.

## CRITICAL THINKING QUESTIONS

1. Explain the differences in the clinical scholarship of a practice-focused doctorate from a research-focused doctorate.
2. Describe the kind of clinical scholarship you believe is most appropriate for the practice-focused doctorate.
3. Explain why knowledge in theoretical frameworks is critical for clinical scholars with a practice-focused doctorate.
4. Why is clinical scholarship for APNs with practice-focused doctorates important?
5. How should clinical scholarship differ in advanced practice MSN from the DNP APN?
6. How does a DNP APN achieve expertise in use of evidence-based practice?
7. Explain the importance of action research for a clinical nursing scholar.
8. Explain how dissemination activities could be achieved by the DNP clinical scholar.
9. Discuss issues/barriers in the development of a DNP clinical scholar.
10. Explain the role of administrators in supporting DNP clinical scholars.

## REFERENCES


CHAPTER NINE

Reflective Response 1

Bernadette Mazurek Melnyk

The chapter by Gonzalez and Esperat clearly describes the role of the Doctor of Nursing Practice (DNP)-prepared nurse as providing leadership for evidence-based practice (EBP). This description is congruent with the American Association of Colleges of Nursing (AACN) and the DNP essentials, which have always been clear that the DNP should produce clinicians who are not researchers, but leaders in EBP (AACN, 2004, 2006). This DNP leadership role requires competency in translating research findings into practice, critically appraising a body of evidence, evaluating outcomes of practice changes, applying research in decision making, and implementing viable clinical innovations to change practice (Melnyk, 2016). Although it was never the intent of the DNP degree to prepare nurse researchers, there remains confusion in academic curricula across the United States about how to prepare the students enrolled in these programs. Many DNP programs continue to require original research for DNP capstone projects when it was never the intent for the DNP prepared nurse to conduct rigorous research as is expected for PhD graduates. One reason for this research expectation is that many faculty teaching in DNP programs are excellent PhD-prepared researchers, yet they have never developed strong knowledge and skills in EBP. As faculty cannot teach what they themselves do not know, they must be given the opportunity to develop these skills if they will be mentoring DNP students to be EBP experts (Melnyk, 2013). Unfortunately, publications have even contended that the role of DNPs should be practitioner-researchers (Vincent, Johnson, Velasquez, & Rigney, 2010).

Because DNP programs do not incorporate all of the research methodology and statistics courses required in PhD programs, DNP graduates are not sufficiently prepared to conduct rigorous original research. As a result, the research being produced by DNPs may have inherent limitations that could eventually weaken the body of nursing science. DNP programs should prepare EBP experts who can generate internal evidence through outcomes management and conduct evidence-based quality improvement initiatives. In addition, DNP graduates should be outstanding EBP mentors who facilitate system-wide cultures and environments that sustain evidence-based care. Instead of a research dissertation, DNP programs should require an EBP change project or evidence-based quality improvement project as the program’s capstone requirement. However, DNPs can be valuable members of research teams, specifically in identifying gaps in EBP, bringing important clinical questions to the table for study, and assisting PhD researchers in conducting studies in real-world practice settings. They also can be
instrumental in helping PhD researchers to develop interventions that will be relevant and scalable in clinical settings and key in rapidly translating research-based programs into practice once their efficacy has been established through research.

As a result of continued variability in the preparation of DNP graduates, health care systems also are confused about the role that DNP graduates should assume (Melnyk, 2013). Hospitals and health care systems who hire DNP graduates should expect that they are the best translators of research evidence into practice to enhance quality of care, improve population health outcomes and reduce health care costs. In their chapter, Gonzalez and Esperat mention that DNs should conduct translational research. However, translational research should not be confused with EBP. Translational research is rigorous research that studies the barriers and facilitators of EBP and how best to translate research findings into practice whereas EBP is a seven step problem-solving approach to the delivery of health care that integrates the findings from well-designed studies with a clinician’s expertise and a patient’s preferences and values (Melnyk & Fineout-Overholt, 2015; Melnyk & Morrison-Beedy, 2012). It is only when clinicians deliver evidence-based care in an EBP culture and environment that it will sustain. Therefore, the DNP prepared nurse must not only be an expert in EBP, but they must have advanced knowledge and skills in facilitating individual behavior and organizational system change as many practicing clinicians do not consistently deliver evidence-based care and they must learn these new skills.

The DNP prepared nurse also must meet the new research-based EBP competencies for practice nurses and advanced practice nurses. These advanced practice competencies include:

1. Systematically conduct an exhaustive search for external evidence to answer clinical questions
2. Critically appraise relevant pre-appraised evidence and primary studies, including evaluation and synthesis
3. Integrate a body of external evidence from nursing and related fields with internal evidence in making decisions about patient care
4. Lead transdisciplinary teams in applying synthesized evidence to initiate clinical decisions and practice changes to improve the health of individuals, groups and populations
5. Generate internal evidence through outcomes management and EBP implementation projects for the purpose of integrating best practices
6. Measure processes and outcomes of evidence-based clinical decisions
7. Formulate evidence-based policies and procedures
8. Participate in the generation of external evidence with other health care professionals
9. Mentor others in evidence-based decision making and the EBP process
10. Implement strategies to sustain an EBP culture
11. Communicate best evidence to individuals, groups, colleagues, and policy makers (Melnyk, Gallagher-Ford, Long, & Fineout-Overholt, 2014). Mentoring registered nurses and advanced practice nurses to meet the new research-based EBP competencies also should be inherent in the DNP role.

Both PhD prepared researchers and DNP prepared clinical scholars fulfill key roles in our health care system, but it is imperative that academic programs prepare each for the role they were intended to assume in our health care systems. Together, new evidence will be generated and quickly translated into practice and policy to improve the quality of health care and population health outcomes.
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Chapter Nine

Reflective Response 2

DeAnne Zwicker

As the beginning of my doctorate of nursing practice degree in 2007 with nearly 30 years of experience, I chose a research-based practice doctorate (DNP) program at Drexel University to better understand the research behind evidence-based practice (EBP). My review of the chapter “The Clinical Scholar Role in Doctoral Advanced Nursing Practice” by Elizabeth W. Gonzalez and M. Christina R. Esperat, was enlightening. When I started the DNP degree, EBP was rapidly becoming the norm. The Drexel program encompassed primarily research courses such as Qualitative and Quantitative Methods in Research, Philosophy, and a Dissertation. This was in contrast to the current Doctor of Nursing Practice (DNP) curriculum. The DrNP focused on understanding research principles, including limitations of research, levels of evidence, and translation of research evidence into practice. There were and still are a variety ways in which universities implement the DNP standards, many adding at least two more research-based courses and EBP. The DNP is rapidly becoming a requirement, especially for senior nursing role in practice. The DNP curriculum builds on prior research experience allowing nurses to lead the way in translation of evidence into practice. Building on that experience, the DNP is directed toward scholarship in clinical practice, testing delivery models, and practice improvement in health outcomes (AACN, 2004).

The concept of practice-based clinical scholarship has evolved over time as depicted by the authors in this chapter. Nurses are grounded in observation and gain perceptual and other necessary skills over many years of practice that enable them to grow and gain a higher level of knowledge and skills to analyze, synthesize, and interpret patient findings. This occurs at the graduate level. Also essential are critical thinking skills for the appropriate application of knowledge. Most experienced graduate level advanced practice registered nurses (APRNs) have learned how to learn to think critically and can apply their skills when complex problems occur in a fast-paced clinical setting. Accuracy in judgment using reasoning and problem-solving skills become well honed. Ultimately, clinical experience enables nurses to generalize knowledge and apply it to different situations (Grose, 2013). Building on the graduate knowledge is the next level of the DNP. Graduate nurses are inherently able to move to a higher level of implementation and facilitation of translation science.

The authors’ discussion on interprofessional teams (IPT) is key. Rounds with other disciplines (medicine, psychology, social work, case manager, and others) can enhance the learning of the team members and address a holistic approach to care prioritizing
needs of patients and family. This method is especially important in patients with complex needs. One study showed that an IPT managing vulnerable older adults (mean age: 80.9 years) were able to reduce the expected length of stay by 1.03 days and the incidence of complications, lower than the control group (Borenstein et al., 2015). Further research is greatly needed to evaluate the outcomes using IPT to demonstrate the effectiveness and cost saving of the collaboration.

The significant challenge, as noted in this chapter, seems unsurmountable. An example experienced in practice is a large hospice group has two different software systems, one for inpatients and a different system for outpatients in the same organization. These systems do not communicate. This creates repetitive, time-consuming extra work that results in not only information errors that may lead to an adverse event but also takes away time with patients and families. Finally, we now have had many graduates of DNP programs across the country. A presentation of what our DNP clinical scholars have achieved thus far would be welcome information of nursing’s clinical scholarship success, to date, and the implications for the future. According to a RAND faculty survey (2014) the DNP has shown value added to practice and the Institute of Medicine agrees (Auerbach et al., 2014). Future research needs to focus not only on the outcomes of DNP scholars but also the value added.

REFERENCES


In Chapter 9, the authors frame the discussion of the clinical scholar role in doctoral advanced nursing practice in the context of the external forces that are driving evidence-based responses to improve the delivery and outcomes of care and an evolving view of how Doctor of Nursing Practice (DNP)-prepared nurses can lead evidence-based practice (EBP) efforts. It has been well established that the reinvigorated efforts to launch a practice doctorate in nursing nearly 15 years ago were significantly influenced by the increasing complexity of the health care environment, clear evidence that the status quo in health care was no longer sustainable, and a strong sense that nurses could more fully leverage their clinical expertise and disciplinary perspective to accelerate health care transformation (American Association of Colleges of Nursing [AACN], 2006). Ten years after the publication of *The Essentials of Doctoral Education for Advanced Nursing Practice*, however, the nascent role of the DNP scholar continues to hold considerable unrealized potential. While the demand for scholarly output related to outcomes of DNP practice has dominated professional discourse, the equally compelling need for nurses with practice doctorates to explore the theoretical knowledge embedded in practice remains largely unaddressed.

The authors emphasize that increasingly, the generation and utilization of valid evidence in practice will be the cornerstone of transformational care that is patient-centered, high quality, and cost-effective. In this changing health care milieu, the term clinical scholarship has become synonymous with a form of practice inquiry that seeks opportunities to improve care, develops solutions to clinical problems, generates new understandings from clinical practice, and identifies new areas of practice inquiry (AACN, 2006, 2015). As the authors emphasize, clinical scholarship is inextricably enmeshed in clinical practice and they call on DNP-prepared nurses to provide leadership in driving clinical excellence and informing health care policy.

Gonzalez and Esperat’s in-depth discussion of the definition of clinical scholarship reflects the pluralistic nature of nursing knowledge. Building on Nightingale’s empirical work during the Crimean War, the authors provide an overview of the contributions of leading nurse scholars in recent decades that also recognize personal and experiential sources. In addition, the authors emphasize the fundamental connection between the discovery and application of knowledge that is crucial for practice disciplines. Their inclusion of Boyer’s (1990) seminal work challenging traditional orthodoxy of knowledge development affirms the scholarly contributions of DNP practice
that is evidence-based and context specific. The importance of contextualizing care as a hallmark of DNP scholarship cannot be overstated in an ever-increasing EBP health care culture. The authors stress the vital role that DNP-prepared nurses play in addressing contextual factors that impede practice innovation and research utilization in health care systems. In addition, Jutel (2008) contends that “[i]t is not that science does not have the ability to ask questions, rather it is unable to contextualize its answers at either the individual or social level. Science explains disease; it does not treat patients” (p. 418). Thus, as clinical scholars, DNPs have an opportunity to fill the research–practice gap by adapting interventions to meet patient needs and to develop new practice-centered models of knowledge production in nursing.

While the authors acknowledge the importance of theoretical discourse in clinical practice, conceptualizing the scholarly role of the DNP-prepared nurse as theorist is not discussed. This crucial aspect of clinical scholarship deserves further deliberation and debate in both practice and academe. The critical question remains. How will DNP-prepared nurses generate disciplinary knowledge? In AACN’s (2015) recent publication on the practice doctorate, scholarship is defined as the process of knowledge development within a discipline. The report also states that graduates of both research and practice-focused doctoral programs are prepared to produce new disciplinary knowledge (AACN, 2015). Importantly, this more capacious view offers an unprecedented opportunity to significantly increase the scholarly productivity of all doctorally prepared nurses (less than 1% of all nurses). Exclusive focus on the role of DNP as knowledge translator, facilitator, and evaluator perpetuates a constraining paradigm that marginalizes nursing knowledge and undermines professional jurisdiction over practice (Jutel, 2008; Reed & Lawrence, 2008).

The pursuit of innovative approaches to developing theory-based practice knowledge by DNP-prepared clinical scholars will be critical to advancing a more unified worldview of clinical scholarship in nursing. Exposition of the “knowing practitioner” for whom theory and practice are inseparable could be an important area of DNP scholarly inquiry (Doane & Varcoe, 2005). Exploration of the mechanisms of knowledge generation in practice or the explication of practice inquiry methods that examine the unique interaction between nurse and patient could also be rich sources of DNP clinical scholarship (Reed, 2006; Rolfe, 2006). Finally, continued development of conceptual models that identify the distinct and shared contributions of nurse clinicians and nurse scientists to advance disciplinary knowledge will also be needed to further cultivate DNP scholarship (Velasquez, McArthur, & Johnson, 2011).

The authors provide a timely and relevant discussion of the clinical scholarship role of doctoral advanced nursing practice. With over 4,200 DNP graduates and more than 22,000 currently enrolled in DNP programs (Trautman, 2016), it is imperative that the scholarly contributions of doctoral-prepared advanced practice nurses to innovate and improve care be demonstrated and disseminated. Within the discipline, the emergence of the practice doctorate also provides exciting opportunities for scholarship through exploration of new epistemological approaches to knowledge production in nursing practice.

**REFERENCES**


