The Doctor of Nursing Practice: Defining the Next Steps

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ABSTRACT
The purpose of this article is to summarize the previous articles in this special issue of the Journal of Nursing Education that are based on the Committee on Institutional Cooperation’s Dean’s Conference on the Doctor of Nursing Practice (DNP) and to identify areas of consensus, as well as areas of controversy. Areas of consensus include the high level of interest in DNP programs and the intent to expand the role of the advanced practice nurse to population health, policy, and leadership. Areas of controversy include the nature of the DNP product, the definition of clinical experiences, the nature of the capstone project, the outcomes of these new practitioners, and the impact on schools. Suggestions for achieving higher levels of consensus, including the need for respective, inclusive dialogue, are provided. [J Nurs Educ. 2013;52(8):462-465.]

In 2004, the American Association of Colleges of Nursing (AACN) adopted a position statement in support of moving education for advanced nursing practice to the doctoral level by 2015 (AACN, 2004). In the ensuing 8 years, Doctor of Nursing Practice (DNP) programs have proliferated, with a variety of curricula, objectives, and outcomes. As the target date of 2015 looms closer, it is important to review the developmental status of this new degree, which was the purpose of the conference on the DNP, sponsored by the Committee on Institutional Collaboration (CIC) nursing school deans in August 2012. In this article, conclusions are drawn from the conference and from the literature, resulting in areas of both consistency and disagreement. Further, this article provides recommendations about the next steps in ensuring that the product and outcomes of DNP programs will forward the goals of the movement to the practice doctorate.

The original goal of the DNP, as contained in the AACN position statement, was to prepare “experts in population-based practice,” moving advanced practice education to the level of the practice doctorate (AACN, 2004, p. 9). Partly driven by Master of Science in Nursing (MSN) curricula that often required more credits than a doctoral degree, but without evidence that the current preparation was inadequate, the AACN voted to approve moving to the DNP as the entry into advanced practice (Cronenwett et al., 2011). At the time of the CIC conference, more than 200 DNP programs existed in the United States. The papers presented at the CIC conference document that more than half of these programs are post-master’s programs with a wide range of credits and requirements. For example, post-master’s DNP programs range from as few as 5 courses to as many as 20 courses. As the number of programs grows, so has enrollment in programs grown to 9,094 in 2011, compared with a stable number of PhD enrollees at 4,000 (AACN, 2012b). The majority of these DNP students are in programs that focus on advanced clinical practice, but a substantial number are in programs that focus on administration, policy, or education.

Approximately 1,600 people have graduated from DNP programs. The majority are working in hospital administration and nursing education and as advanced practice nurses primarily in inpatient settings (Dennison, Payne, & Farrell, 2012). Data on the impact of these new providers are limited. Anecdotal data suggest...
that they provide leadership in acute care and focus on quality improvement. DNP graduates who are in faculty roles may provide leadership in practice or education. Transformational leadership in primary care is less frequently cited as an outcome.

As reported by Broome, Riner, and Allam (2013) in this issue of the Journal of Nursing Education, DNP graduates are publishing material with increasing frequency. The publications cover a broad range of topics and appear primarily in journals focusing on practice and administration. Slightly more than 30% of these papers are data-based, and many are quality improvement projects.

**AREAS OF CONSENSUS**

These papers presented at the CIC conference and the summary above suggest a few areas where there is clear (or near clear) consensus. There is no question that interest in the DNP is high. Some of this interest is driven by the 2015 target, which led many MSN-prepared nurse practitioners (NPs) to believe they would not be able to be licensed without holding the DNP degree (Loomis, Willard, & Cohen, 2006). Thus, the majority of DNP programs focus on post-master’s education and fewer focus on entry into advanced practice. Such post-master’s programs emphasize content on administration, policy, and leadership so as to not repeat the clinical education provided in MSN programs. Also, there is consensus that the intent of DNP preparation is to expand the role of the advanced practice nurse (APN) to address population health, health policy, and leadership. Despite these areas of agreement, the rapid proliferation of these programs of various lengths and objectives has also led to areas of controversy, which are detailed below.

**AREAS OF CONTROVERSY**

The areas of controversy brought to light by the literature and the papers presented at the CIC conference include questions about what the product is. Programs are preparing either APNs or leaders, making it unclear exactly what a DNP degree means. Clinical hours in programs vary from traditional patient care to leadership experiences in varying amounts. In addition, there is little consistency in the capstone experience and product. Finally, it is important to assess the outcomes of this new degree program on multiple constituencies. Each of these areas of controversy is described in detail below.

**What Is the Product?**

As noted above, the original intent of the professional DNP was to educate APNs for population-based care. The experience to date suggests that this objective is carried out less consistently than originally planned. Bachelor of Science in Nursing (BSN)-to-DNP programs are more likely to have as their objective the education of new, entry-level APNs. MSN-to-DNP programs have more variability but emphasize what has been termed “advanced, advanced practice” (Cronenwett et al., 2011, p. 9). Although leadership, policy, education, and management are part of the essentials of the DNP (AACN, 2006), these components comprise most of the content in post-master’s DNP programs. Obviously, for experienced APNs, revisiting content mastered in years past is not very useful and certainly would not lead to differences in practice. Many of these graduates do not go back to practice, but take on other roles as educators, administrators, or policy leaders. If DNP graduates are not going into practice, it is unclear whether they are fulfilling the original intent of the degree.

This dichotomy creates an interesting question: Is a DNP a DNP? The objectives of most BSN-to-DNP programs are focused on creating a safe, effective clinician, but the DNP graduate of a post-master’s program is expected to assume leadership roles in practice or education. As DNP programs proliferate, there must be consensus about what the degree means and what capabilities can be expected by those who would hire DNP graduates. This discussion needs to go beyond creating class warfare between those who hold an MSN and those with a DNP (e.g., “MSN-prepared NPs are really mini-docs, but DNs are real advanced practice nurses,” as was stated by one person at the CIC conference). This kind of statement creates problems not only because there are no data to support it but also because it is a classic example of nursing turning against itself, rather than addressing the larger problem.

**What Are Clinical Practica in a DNP Program?**

There appears to be little consistency in the clinical requirements across programs, with the exception of a requirement in the Essentials for a minimum of 1,000 hours (AACN, 2006). Because of the variable content in DNP programs, it is not surprising there is little consistency in clinical requirements. Such experiences might include traditional APN practice in clinical settings, health policy and leadership experiences, and teaching experiences (Wolf, Budd, & Bhattacharya, 2011). With the range of expected outcomes across various DNP programs, this variability might be expected. As consensus is built around what the DNP curriculum is preparing—much like the consensus that the PhD prepares traditional academic nurse scientists—more clarity might be reached.

An additional concern regarding clinical experiences relates to the need for appropriate sites and preceptors. Many DNP programs rely on a few doctorally prepared faculty members, but clinical preceptors, especially in primary care, are usually not DNP or PhD prepared. This gap is a developmental phenomenon, but it is critical that students are participating in clinical experiences that reflect the higher level, population-based model that guided the AACN’s (2004) position statement.

**What Is the Capstone?**

The purpose of the capstone project is to provide students with an educational experience that allows them to put various facets of their education to use in a scholarly project of some kind. Data presented in the paper by Kirkpatrick and Weaver (2013) at the CIC conference (and their article in this issue of the Journal) show that these projects range from an independent research project (in 50% of programs) to evidence-based change projects, leadership projects, evidence synthesis, and translational research. A random survey of online curricular patterns in DNP programs conducted by this author (M.G.) for this article shows that most programs have one research methods course and one statistics course, much like the original MSN programs.
When a thesis was still required by the majority of programs. Thus, the expectation that a DNP student can conduct an independent research project seems unjustified. Although masters’ theses did offer an educational opportunity, the projects were often small studies that were not published. Current ethical standards suggest that such projects are inappropriate given that participants should not be asked to participate in projects that do not advance science (Lo, 2009). Furthermore, our profession runs the risk of suggesting that the rigorous research training that is expected of our PhD students is not necessary for a research career, especially as DNP graduates are seeking research postdoctoral fellowships (Fagin, 2011).

Evidence synthesis, leadership projects, and evidence-based change projects would appear to be more appropriate to the goals of the DNP, as noted by Melnyk (2013) in her article in this issue of the Journal. However, these skills are less well known to many faculty, creating a gap between faculty expertise and appropriate capstone requirements. This is equally the case with regard to translational research. There are few experts in nursing in translational research, and most are not involved with DNP capstone projects. More consensus on the objectives for the capstone, as well as the types of faculty support necessary, is needed.

Other issues related to the capstone also exist. Some programs encourage students to work on group projects. Group projects have several advantages, including mimicking how projects are accomplished outside of an educational project. The difficulty lies in assuring that each member of the group has made appropriate contributions to the final product and that each member achieved the objectives of the capstone.

Some have raised the question of whether a capstone scholarly project is necessary at all. The answer to this question is likely to rest on the answer to the question, “What is the product we are trying to achieve?” If the purpose of the DNP program is to prepare APNs for population-based practice, then a capstone project that focuses on the clinical and leadership experiences or case studies may be appropriate. If the purpose relates more to “advanced, advanced practice,” then evidence synthesis projects may be indicated.

**What Are the Outcomes?**

The data presented in the other articles in this issue of the Journal suggest that the majority of DNP graduates have moved into faculty and administrative roles, not traditional APN practice roles. This finding raises the question of whether the original goals of the DNP are being reached. Further, the expectations for BSN-to-DNP graduates are different from those of the DNP program movement will depend on the type and quality of programs and graduates. As we have learned from other educational efforts, the lack of consistency in expectations may lead to negative perceptions both within and outside of our profession. A recent search of the literature revealed that there is a dearth of information about the impact on schools of the addition of DNP programs. Many programs have several specialties, creating the need for a large faculty to support the programs. In addition, many schools do not have DNP-prepared faculty to support these programs. Many programs are large, with most students attending part time. Further, this growth in DNP programs is occurring in an era of decreased resources (Cronenwett et al., 2011).

As was true for a time with APN programs, especially part-time programs, it is often the assumption that DNP programs will be a fruitful source of revenue. Ignored in this assumption is that mounting a new DNP program requires investments that may or may not result in a substantial return on that investment. Expenses include the development of faculty to teach in DNP programs, the investment in instructional technology, and the personnel to support high-quality online and hybrid offerings. Collection of such data and the sharing of various experiences would help schools considering the addition of a DNP program with their decision making. An additional impact on schools may be the potential impact on PhD programs. If, for example, DNP students are conducting research projects for the capstone, faculty may be taken away from their own programs of research and that of PhD students.

**DISCUSSION: DEFINING BEST PRACTICES**

The data presented at the CIC conference and in this issue of the Journal suggest that the adage “If you have seen one DNP program, you have seen one DNP program” may still be true. It is critically important that we begin a serious, respectful dialogue about these controversies. Ultimately, the acceptance and impact of the DNP program movement will depend on the type and quality of programs and graduates. As we have learned from other educational efforts, the lack of consistency in expectations may lead to negative perceptions both within and outside of our profession.

The product of DNP education needs to be defined. We need clarity about the product of the program and the roles we expect graduates to fulfill when they complete the program. At present,
DNP graduates appear not to be moving into population-based primary care, as initially proposed. It needs to be clear that the competencies of a BSN-to-DNP graduate are at least equivalent to those of an MSN-to-DNP graduate. The degree should mean the same thing regardless of level of entry, just as the objective of a MSN program is the same whether one enters as a BSN graduate or with a degree in another field.

After the DNP product has been defined, we need to examine our curricula and ensure that our programs are actually preparing DNP graduates to fill these roles (e.g., educator and clinician). If we expect the DNP graduates to help solve the faculty shortage, then we need to be sure they have the requisite coursework and clinical experiences to help them be successful. Although it should be expected that programs will evolve over time and that flexibility may be important, we need to ensure that we all know what we mean by the DNP degree.

One element that is crucial to the practice of DNP graduates is the ability to work in interprofessional teams. A review of curricula online from a random sample of schools offering the DNP seems to indicate that the majority of class and clinical work is focused on intraprofessional collaboration. Just as team science is the expectation in research careers, collaborative team care should be the expectation in advanced practice programs. Curricula vary in length and depth, even within BSN-to-DNP or MSN-to-DNP programs. The standards for DNP curricula should be determined by nurse educators, not by certification or other bodies (e.g., physician groups).

Similarly, we need to define the link of clinical practice across the range of the essentials of DNP education. These standards state that 1,000 hours are required (AACN, 2006), but that assumption was not based on data, nor does it clearly define clinical experiences in teaching, leadership, and policy. After consensus is obtained on the product of the DNP education, then the appropriate clinical experiences can be determined. If programs have differing emphases, these may be flexible. An important consideration going forward is the movement toward competency-based education, which makes determination of the clinical objectives more important than the number of hours.

The capstone project also must be defined more consistently. A focus on evidence-based practice would seem to be appropriate to the practice doctorate, rather than traditional empirical research. Again, such decisions need to be made in the context of the product, not what we think we already know how to do (e.g., conducting research versus evidence-based practice projects).

Serious discussion of the real impact—both positive and negative—of DNP implementation is needed. These discussions need to focus on faculty and staff costs, as well as socialization of the faculty, for educating for the roles for which graduates are being prepared.

Data are critically needed on the impact of the DNP on patients and on the profession. We need inclusive, respectful dialogue, not dialogue that is dismissive of people who have other views. It is also important that we embrace interprofessional collaboration in the service of better health outcomes for people and populations.

Finally, we must consider the impact of the DNP on society. Advancing the educational level of the profession is likely to be good for nursing (Institute of Medicine, 2011), but it is too early to know whether moving to the DNP is good for society in terms of better health for the population. The target date of 2015 for all APNs to be educated at the DNP level is less than 2 years away, and we are still years from reaching this goal, if that goal is good for the public (Cronenwett et al., 2011). Before we implement major changes in accreditation and licensure for APNs, we need to be assured that we are on the correct road for the better health of the public.

**CONCLUSIONS**

DNP programs have the potential to advance nursing and health care, but this potential has yet to be clearly demonstrated. To do so will require consensus about the objectives of the programs and consistency in their implementation across programs. It is time to hold a summit on the DNP degree to discuss these important questions and make recommendations. Ideally, such a summit will be hosted by organizations whose sole interest is in solving the issues, not in furthering their own agenda. The dialogue alone may be critical.

**REFERENCES**


