

I am the doctor: conflicts and tensions of a professional doctorate as a labour market qualification

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The aim of this paper is to identify tensions in the United States confronting the advanced practice nurse (APN) prepared with a doctorate of nursing practice (DNP) that propagate within the academic environment and unfurl into the clinical setting. As American educators struggle to determine educational pathways, role conflict and potential barriers to practice have been identified. Without clearly stated objectives and a command of the advanced practice nurse role domain, APN's with a doctoral education may be doomed to failure. Challenges associated with scholarship and scope of practice have emerged and placed APN's with a doctoral education at risk for marginalisation. For advanced practice nurses prepared with a doctoral education to have an impact on health care delivery, they must become stakeholders in the sustainability of their future and define themselves before other disciplines in practice define them.

Keywords: Advanced nurse practitioner, Doctor of Nursing Practice, professional doctoral education, controversy, marginalisation

Glossary of Terms:

In the United States there are two doctorate-level terminal degrees in the nursing profession: The Doctor of Nursing Practice (DNP), and the Doctor of Philosophy (PhD).

The Doctor of Nursing Practice (DNP) is a professional doctorate that focuses on the clinical aspects of nursing. The Doctor of Philosophy (PhD) in nursing focuses on academic research. Curriculum for the DNP degree generally includes leadership and application of clinical research,

Advanced Practice Nurse (APN) roles in nursing include the nurse practitioner (NP), certified registered nurse anesthetist (CRNA), certified nurse midwife (CNM), and the clinical nurse specialist (CNS) with graduate level education (NANN, 2006).

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Advanced Nurse Practitioner (ANP) or Nurse practitioners (NPs) are registered nurses that are clinically educated to provide health services to provide to all age group populations. In the United States, NPs complete graduate-level education and are authorised to diagnose and prescribe medication in 49 states (ACNP, n.d.).

Classroom tensions: to be or not to be...independent

***Composite case*²**

A Doctor of Nursing Practice student told a story about a meeting he had with a PhD-prepared public health professor to whom he reached out for discussion and guidance with his dissertation interest. The student was asked to invite his academic advisor. After formal introductions, the professor of public health asked the DNP student 'What is it you do? What do nurses do?' The student reported that he felt stunned by the question, and was unsure of how to answer. Consumed with the audacity of the question, he offered that he would be a doctor of clinical nursing practice. Fearful that the student felt intimidated by the question, his academic advisor compensated for the student's loss of words, explaining that there were several types of nurses: some worked in hospitals, some in research, and some as nurse educators. At the meeting, the student expressed ideas for a simple quantitative research design, albeit not related to his work. Shortly after the discussion began, he was directed toward a less fulfilling subject and told that neither the nursing nor the public health department would support the research of interest.

Upon listening to this story, it appeared that the advisors were probably right and the project was overly ambitious. As the student continued and explained his method of design and the details of his project interest, it became obvious that he was not merely disappointed about being denied his topic choice; he also felt voiceless during the meeting. A decision had been made for him.

The project seemed feasible. The only barrier to achieving success was that he would need another scientific discipline's support and guidance. I began to feel distressed about the matter.

² This case study is a composite of experiences reported by doctor of nursing practice students.

As a DNP student, I felt marginalised that a professor of public health at a robust university did not understand the different roles of nursing. I wondered if she found nursing to be generally unimportant. I am certain that the question of what doctors do would not have been posed to the DNP analog, the MD. Society questions neither the role nor authority of physicians. Moreover, physicians are not limited in their careers. Their competence unquestioned, they practice, perform and participate in research, or work in leadership positions. The esteem enjoyed by the medical doctor and doctor of osteopathic medicine even transcends that of the PhD prepared public health professional.

Do no harm

Stagnation in the doctoral curriculum and lack of interaction with other disciplines may lead to missed opportunities to transform theory and practice as well as attitudes about the nursing discipline. A process that does not involve curiosity, the questioning of assumptions, and analysis of alternatives serves only to sustain the status quo. Limiting scholarly discussion to an exchange of homogenous ideas is potentially harmful and may create further marginalisation of nursing efforts.

Essential to the implementation of critical thinking is the empowerment of the individual nurse to be an independent thinker. Working collaboratively with other disciplines with the authority to examine theory, reflect, and express views is essential in the development of improvement and should begin in the classroom (Cody & Kenney, 2006).

Advanced practice nursing refers to a range of nursing practice. The profession of the advanced practice nurse can be described as a pyramid. According to Styles and Lewis (as cited in Bryant-Lukosius et al., 2004) 'the base are environmental factors that support the apex or purpose of APN roles, which is advanced nursing practice. In this context, APN includes but is more than advanced nursing practice'. Despite the need for an increased higher level of nursing practice, challenges exist. The American Nursing Association describes three characteristics that distinguish advanced nursing practice:

1. Specialisation or provision of care for a specific population of patients with complex, unpredictable, and/or intensive health needs;
2. Expansion or acquisition of new knowledge; and
3. Skills and role autonomy extending beyond traditional scopes of nursing practice; and advancement, which includes specialisation and expansion (Bryant-Lukosius, et al. 2004).

All things equal: defending the dissertation

There is controversy stirring within the nursing doctoral community. Particularly worthy of discussion is the relevance of the dissertation to clinical doctorate education. Generally, DNP (the most predominant doctor of nursing practice degree in the U.S. and far more prevalent than the DrNP) candidates are required to develop an exhaustive and integrative practice capstone project. Such projects are often practice-related written assignments involving analysis and evaluation of a patient intervention, system analysis or business plan for a clinical project. The capstone must be defensible to peers and the review of other professionals (Lenz, 2005).

According to Marion and colleagues, the looming question in the nursing community is not whether the practice doctorate is 'future or fringe' but rather what must be accomplished to ensure quality in educational curriculums (Marion et al, 2003). The Task Force on the Professional Clinical Doctorate surveyed students, DNP graduates and administrators of existing clinical doctorate programs to determine how to apply research curriculum adaptations to DNP programs. While differentiation between research-focused and practice-focused doctoral programs remains a concern, broad variability in opinion exists (AACN, 2004b). In the American Association of Colleges of Nursing (AACN) *Position Statement on the Practice Doctorate in Nursing* it was concluded that there should be:

...less emphasis on theory and meta-theory, considerably less research methodology content, with the focus being on evaluation and use of research

rather than conduct of research, different dissertation requirements, ranging from no dissertation to theses or capstone projects (termed dissertations in some programs) that must be grounded in clinical practice and designed to solve practice problems or to apply to practice directly (AACN, 2004a)

Programs would maintain an 'emphasis on practice in any research requirement, clinical practica or residency requirements' (2) and concentrate 'on scholarly practice, practice improvement, innovation and testing of interventions and care delivery models, evaluation of health care outcomes, and expertise to inform health policy and leadership in establishing clinical excellence' (Marion et al, 2003).

To impact 'organisational and systems contexts for care and management; research and analytic methodologies needed to evaluate, apply, and generate evidence; informatics and the use of information technology; health policy analysis and evaluation; and interdisciplinary collaboration' (Lenz, 2005: 1) a poor grasp of theory, meta theory, and research methodology terminating with a capstone project seems insufficient.

The level of sophistication required for the clinical doctoral candidate to demonstrate competence transcends a capstone project. When the DNP education culminates with a capstone project it becomes impossible to distinguish between the masters degree in nursing science and the doctorate of nursing practice. Education for the doctorally prepared advanced nurse practitioner must be standardised to include a dissertation. The doctoral dissertation is pivotal to the value and esteem of the nursing clinical doctorate. If the DNP is to command and maintain respect in its status as the highest level of preparation for clinical practice, the educational curriculum must be rigorous for both the PhD and the DNP candidate.

Furthermore, it is paramount that the two nursing doctoral degrees unite and collaborate more to optimise healthcare delivery. The PhD and the DNP degree should not be at odds, but rather work in concert with one another and serve as complement of one another, each respecting

the other's function. Role confusion decreases as each domain recognises its function as separate with an academic purpose independent from the other, with the sole objective to create integral leadership and expertise in the development of fundamental health solutions for global populations. 'Society is served through scholarship of practice as community needs for expert nursing care are met by nurses who directly give, evaluate, and constantly improve evidence-based nursing care' (Fulton & Lyon, 2005: 1). To that end, it is essential that the PhD and DNP prepared nurse work cohesively and accept overlap in educational curriculums.

The clinical setting: (confronting the good ol' boys and girls)

In the United States advanced practice nurses have been providing primary and specialty patient care for over forty years. Preparation for these roles has been met in the past via masters degree programs, whilst nurses assuming these roles have practiced in most states under the supervision of medical or osteopathic doctors. Numerous studies have found that there is no difference in patients' outcomes between care managed by advanced practice nurses or medically trained providers (Mundinger, 2005).

The AACN has recommended that the practitioner role would be best provided by doctorally prepared nurses, acknowledging the degree of advanced study previously demanded of masters prepared practitioners, and the need for more educational preparation to keep pace with a challenging healthcare environment (AACN, 2005).

Resistance from the medical community towards recognition of nursing doctors as autonomous practitioners of primary healthcare has contributed increasing tensions. As the field of nursing continues to progress to advanced levels of educational preparedness, it will also need to challenge traditional roles and care models in order to realise its potential.

Many U.S. physicians express concern that as nurse practitioners acquire autonomy, the term 'doctor' may confuse patients and become a source of contention between care providers. They assert that the term 'doctor' should be applied to different types of doctors, but not to

Doctors of Nursing Practice. Other physician leaders are in protest of the doctor of nursing practice certification exam and worry that patients may be misled into believing nurses who pass the exam share the same qualifications as physicians (Bein, 2009; Mundinger, 2005).

In 2008, the National Board of Medical Examiners offered testing to a voluntary DNP cohort. The exam was based partially on the U.S. Medical Licensing Examination (USMLE). In January 2009, the Council for the Advancement of Comprehensive Care (CACC) contracted with the National Board of Medical Examiners to develop an exam for advanced nurse practitioners with clinical doctorates. Fifty percent of doctorally prepared advanced practitioners passed. The exam content was 'equivalent to medical exam content, and it measured the same set of competencies and administered similar performance qualifications as the USMLE (step 3)' that is applied to physicians as one component of qualifying for licensure (Bein, 2009: 1).

Physicians immediately complained that nursing organisations characterised the results of the certification exam inaccurately. The AMA House of Delegates and other specialty medical organisations resisted and asked that the NBME authorise nursing groups to clearly denote the differences between the DNP and physician exams and are expected to consider a 'resolution proposing to explore alternative physician licensing testing options. This resolution would call for the AMA to withdraw representation from the NBME if the testing organisation fails to act to safeguard the integrity of the physician licensure process' (Bein, 2009: 1).

The resolution further advised that the AMA would investigate physician licensure options to rival the NBME (Bein, 2009). Moreover, the resolution said 'If the NBME is unwilling to preserve the integrity of the physician licensure process, an AMA representation withdrawal to the NBME is recommended' (Bein, 2009: 1). In defense of this position, the CACC has stated that the test was designed to standardised credentialing 'to provide further evidence to the public that DNP certificants are qualified to provide comprehensive patient care' (Bein, 2009: 1).

Outraged, the AMA and other specialty medical organisations asked that the NBME mandate

that nursing groups clearly spell out the differences between the DNP and physician exams. The AMA House of Delegates called for a resolution to:

1. Explore alternative physician licensing testing options
2. Call for the AMA to withdraw representation from the NBME if the testing organisation fails to act to safeguard the integrity of the physician licensure process
3. Withdrawal from the NBME

'It's very important that delineation between nursing degrees and physician degrees is not obscured and patients aren't misled,' said Roger A. Moore, MD, president of the American Society of Anesthesiologists. He cited examples of DNP references to themselves as 'doctor' in the clinical setting. Nursing schools also have adopted terms such as 'residency' and 'fellowship' as part of their doctoral programs. Use of the USMLE Step 3 'appeared to be one more step in that direction for nurses to be able to claim they have the same credentials as physicians ... and that's a misrepresentation' (Sorrel, 2009: 2).

Physician groups maintain that there are significant differences in testing and training that should not be minimised, 'For patients to make an informed decision, they need to know who is caring for them, what their level of training is and in what field. To the extent those lines are blurred, that [decision-making] becomes even harder', William Hazel Jr., M.D., an orthopedic surgeon and a member of the AMA Board of Trustees (Sorrel, 2009: 2).

Nursing heal thyself

In an article published in the *Chronicle of Higher Education*, Munding, et al. (2000) articulates a more substantial tension. If advanced practice nurses demonstrate the same level of competency, they must be reimbursed at a competitive rate. Physician organisations fear that without NBME support, the perspective may gain strength (Sorrel, 2009).

In 2008, the AMA agreed to a resolution to limit the professional use of the term 'doctor' to physicians, osteopaths and podiatrists; although these resolutions are not enforceable. In response, nursing associations addressed three essential issues: the DNP, NP certification and use of the title 'doctor' and determined that the DNP degree more accurately reflects current clinical competencies and includes preparation for the changing health care system. Furthermore...the title 'doctor' is earned by many and should not be reserved for physicians alone (Guadagnino & Mundinger, 2008).

C. Fay Raines, PhD, RN, president of the American Association of Colleges of Nursing, argues that the clinical doctorate degree will not change the advanced practice nurse's scope of practice, which is mandated by American state legislatures. However, the nursing clinical doctorate is comparable to the medical degree and educational preparation involves advanced preparation. Many states are recognizing the value of the advanced practice nurse's ability to independently manage patients. In addition, many health disciplines are moving toward professional doctorates in response to primary care scarcities and a rapidly aging population. Furthermore, the NBME's certification is a voluntary credential, however professional acknowledgment in the form of certification in areas of expertise is essential (Sorrel, 2009).

The DNP certification exam uses the model developed for USMLE (United States Medical Licensing Exam) Step 3 as a basis for its competency testing. In addition, the NBME does not support the contention that health care management provided by nurse practitioners is inferior to similar clinical services provided by physicians (Bein, 2009).

The debate regarding nurse practitioner licensing examination continues despite development of several respected national psychometrical certification examinations available to advanced nurse clinicians. Relevant to the discussion is the question of whether or not the NBME is a valid measurement of advanced nurse competency. Is it appropriate to test DNP prepared practitioner competencies against that of physicians? Exam supporters believe if they can show that DNP's can pass that NBME exam, it will validate their knowledge and competency

equivalence to physicians, which AACN Executive Director, Polly Bednash, feels might inappropriately invite the perception that nurses are:

‘...trying to be a mini doctor. We are not reconceptualising the role of advanced practice nurses. We are reconceptualising the educational requirements to stay current with a complex health care environment. It is clear that changing demands of practice require taking more coursework to stay safe and current’ (Guadagnino & Mundinger, 2008, p.3).

Policy development for determining the scope of clinical practice and competency continues to be controversial despite outcome studies. Mundinger (2005) argues that outcome studies supporting primary care physicians are not incontrovertibly the ‘gold standard of quality against which to measure NPs’ outcomes’ (p. 2). ‘There is no national data that show how physicians impact quality of care, so half of the data haven’t been collected’ (Mundinger, 2005).

Physician groups maintain that there are significant differences in testing and training that should not be minimised, ‘For patients to make an informed decision, they need to know who is managing their care and their level of education and expertise’ (Bein, 2009: 2). Rigorous competency testing and outcome studies must take priority.

Attitudes are changing and there is variance among the community of physicians. The competency debate regarding autonomous practice is a diversion and the physician community must learn to adjust to the reshaping role of nurse clinical practitioners. Richard A. Cooper, M.D., professor of medicine at the University of Pennsylvania and senior fellow at the Leonard David Institute of Health Economics, contends that the ‘80-hour per week workload cap on residents has greatly intensified demand for NPs in hospital settings to fill the workforce gap. While a shortage of specialty physicians – such as urologists – has created a huge demand for NPs in physician specialty practices...’ (Guadagnino & Mundinger, 2008). That’s one reason the doctoral-level program is so important: to ratchet up the training level of nurse practitioners so they can work with more complex patients, not to be independent in a community clinic handling the common cold or checking blood pressure (Guadagnino & Mundinger, 2008).

Dissent among the ranks: just a little respect

The Institute of Medicine (2003) supported an increase in preparation for health care professionals. Specific to nursing, the IOM suggested a need for a clinical doctorate degree.

There have been unintended consequences in advancing the new degree. The controversy over who should be identified as 'doctor' has generated debate within schools of nursing and the profession. Does the professional practice doctorate create a 'second-class citizenship in universities and enhance the potential of marginalization' (Meleis & Dracup, 2005)?

Unfortunately, the internal DNP debate has slowed progression and energised disputation among the health professions. At the center of the nursing debate are valid questions. Consequentially, determining who is best qualified to educate in the academic arena? Advocates for the DNP argued that DNP graduates are critical to the application of both clinical practice and nursing education in the clinical setting, but should not seek tenure.

Pressing challenges have emerged regarding the future of clinical doctoral education, for example: Should DNP prepared nurses teach at the College or University level? With DNP enrollment increasing, will nurses continue to seek PhD education, or could there be a void in scholarly research- oriented nursing education? Who will be qualified as a role model and to offer mentorship? Is it fair to assume that DNP students should be taught by DNP faculty? Conversely, should universities and schools fail to hire DNP faculty, how would they qualify the degree's professionalism and legitimacy? Would acceptance of DNP's as tenured faculty illegitimise a nursing department and foster its marginalisation or strengthen the process by augmenting the professionalism that nursing has struggled to achieve (Meleis & Dracup, 2005)? Should the research-oriented doctorate and clinical doctorate require two different sets of faculty with separate sets objectives and preparation?

University faculty membership is generally reserved for tenured professorial ranks that are PhD prepared. DNP prepared doctors are excluded from upper level membership decisions that will

impact their ability to vote on educational and faculty policies and are barred from 'senate' university membership (Meleis & Dracup, 2005).

Some nursing scholars believe that by investing in the practice doctorate, nursing is 'creating a second-class citizenship' in teaching institutes with the possibility of marginalisation of the DNP by the PhD. Significantly, PhD faculty will continue to have voting rights, senate membership, tenure privileges, and most importantly, full authority to affect university policy, from which the DNP community would be excluded (Meleis & Dracup, 2005).

Another pivotal argument posed by DNP opponents is a question of utility and relevance of the doctorate practice degree. A fundamental question becomes 'Where is the evidence that clinical institutions are poised to replace all MS graduates with DNP graduates' (Meleis & Dracup, 2005: 5)?' And if they are prepared to replace master's programs, the salient question becomes, what will differentiate the DNP prepared nurse from the MSN in the clinical setting? A consequence of the discourse is the potential for marginalisation of the master's prepared nurse that may become obsolete with the advent of the DNP prepared nurse (Meleis & Dracup, 2005).

Finally, cost effectiveness must be examined. Nursing scholars have also questioned whether the nursing clinical doctorate may advance at an elevated cost to health care delivery. Meleis and Dracup (2005) suggest that DNP prepared practitioners would demand sharp increases in salary for which health corporations would compensate by hiring less skilled staff, thus creating a negative net effect on the quality of patient care. The scientific literature has yet to challenge the assumption that healthcare facilities would adjust hiring practices to compensate for larger salary demands. Furthermore, whereas physicians command salaries commensurate with their educational investment, the interplay of economic factors, not expectation alone, sets compensation levels. Nevertheless, attitudes that support compensation differentials between PhDs and DNPs may contribute to the marginalisation that the profession struggles to eliminate.

Lean forward: defining the doctor of nursing practice

In the 1990s, clinical doctorate programs began to explore capstone projects and a plan to put evidence into practice to improve patient care. As healthcare reform advances, tensions may continue to exist between physicians and doctorally prepared advanced practice nurses and even within the nursing community because ‘although each group is conceptually distinct, overlap exists within the realm of everyday practice’ (Ulrich, 2010: 10). Moreover, distinction among who delivers care to patients within our health care system is sometimes ambiguous to the public. Therefore, DNP’s must own their role and actively convey competency and authority to the community, in a way that is substantive (Ulrich, 2010).

There is a need, however to revisit the 1995 ANA definition to include the scope of practice for the DNP graduate. Dr. Loretta Ford, co-founder of the modern nurse practitioner movement in the 1960’s describes the advanced practice nurse with a DNP as ‘the next logical step toward clinical excellence, leadership and political acumen in advanced practice nursing’ (2009, p.1). Ford’s vision for the DNP- prepared practitioner includes complex clinical decision-making. According to Ford, the role of DNP-prepared practitioners will advance the nursing profession in the following manner:

1. Application of evidence-based science
2. Complex decision making processes
3. Technologies and informatics, new proposed paradigms
4. Assess population needs with focus on restorative and preventive health care.
5. Lead translational research, clinical teaching and institutional leadership
6. Possess a vision, knowledge, communication skills, political savvy and a sense of social justice beyond that required for the one-to-one relationship of patient care (Ford, 2009).

If these lofty objectives are to be achieved, the intellectual framework and infrastructure must be continually evaluated. It is also critical that doctoral advanced clinical practice does not

evolve in isolation from other role domains or health disciplines. With a push for more inter professional education, 'Acquisition of specialty or expanded clinical knowledge and skills is not indicative of advanced practice unless clinical practice directs and is guided by the knowledge and activities of other role domains and disciplines to improve patient care' (Bryant-Lukosius et al., 2004). In other words, doctoral advanced clinical practice must be guided by both practice-based knowledge and evidence-based knowledge and be interconnected to other health disciplines to best improve health (Dreher & Smith Glasgow, in press).

Summary: when the nurse becomes the 'dr.'

The overarching question becomes 'how do advanced practice nurses with practice doctorates equip themselves for the challenge?' Cartwright and Reed (2005), categorise the 'Doctorate in Nursing Practice... as the highest level of preparation for clinical nursing practice and must revolutionise nursing practice and education' (2005: 1). As in any revolution, there will be risk. Guidelines and strategies must be formulated as nursing schools contemplate critical decisions on how to advance opportunity and exceptionalism. To better define the role of the Advanced Practice Nurse prepared with a practice doctorate we must:

1. Maintain scholarly standards. The greatest contribution of the practice doctorate is that its practice-oriented research mission should support linkages between practice and research. In 2010, University College Cork in Ireland began offering a Doctor of Nursing Practice (DNP) degree program (the first outside the US), promoting it as the highest degree for nurse/midwives interested in a clinical focused doctorate. The university's literature maintains that the DNP is for nurses similar to the MD for physicians, suggesting that the DNP candidate will gain the opportunity to acquire competency as an autonomous independent researcher as necessary to a deeper understanding of theoretical frameworks underpinning nursing (University College Cork, n.d.).
2. Build a sound professional and academic infrastructure that supports doctoral level clinical practice. The practice doctorate should focus on building partnerships with PhD

prepared nurses and other disciplines and all doctoral graduates should be mentored to be stewards of their discipline.

3. Refrain from using language such as 'cost effective alternative,' as this language may suggest that doctoral prepared advanced practice nurses are inferior to other health care professionals and serve to undermine the practice.

4. Conduct outcomes studies on the impact of the doctor of nursing practice. Master's level APRN practice has a long history of cost effective, high quality care. A building body of knowledge to support doctoral level clinical practice is now needed.

5. Lastly, doctorates of nursing practice must define themselves, and not allow other disciplines to define them. As a first step to increasing autonomy, an organisation designed to support the advancement of doctoral level nursing practice could be developed.

Acknowledgements:

I would like to express my gratitude to Dr. H. Michael Dreher for modeling distinguished stewardship. His dynamic teaching approach, gracious and generous outlook extends to and inspires his students. And thank you to Dr. Barbara Posmontier for whom I have enormous respect. You awakened my spirit, challenged my ability and demanded my best.

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