TRANSITIONING TO THE DOCTORATE OF NURSING PRACTICE

By

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Abstract

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On October 2004, the American Association of Colleges of Nursing called for doctoral preparation for all advance practice nurses by the year 2015. The decision for improved educational preparation is a response to address a complex health care system. Advanced practice nurses have the advantage of analyzing the educational transitions of other professions. This paper discusses the transitions of pharmacology, physical therapy, and audiology to practice doctorates. The focus is placed on the attitudes, obstacles, and methods of resolution. Findings will be evaluated for lessons that may be extrapolated and applicable to nursing as it transitions to the Doctorate of Nursing Practice.
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Transitioning to the Doctorate of Nursing Practice

Introduction

Research and planning for the transition to the Doctor of Nursing Practice (DNP) has been evolving for several years. In March 2002, the American Association of Colleges of Nursing (AACN) appointed a group to review and analyze clinical and practice doctoral programs in order to make recommendations for the future. In December 2003, the National Organization of Nurse Practitioner Faculties (NONPF) and AACN hosted a national forum on the practice doctorate in nursing. It was attended by over forty national nursing organizations and academic institutions.

In October 2004, the AACN released its *Position Statement on the Practice Doctorate in Nursing.* AACN recommended that the practice doctorate be the educational preparation for advanced practice nurses by the year 2015. In this position paper the AACN made thirteen recommendations for terminology related to the practice doctorate, implementing the DNP, and creating uniformity across educational programs for advanced practice nurses. The position statement was well received by many but also created controversy and concerns reaching far beyond the nursing profession.

Advanced practice nurses (APN) can benefit from examining the experiences of other health care professions as they transition to a practice doctorate degree. The desire to elevate the educational preparedness for entry level requirements into the profession has been shared by careers such as audiology, pharmacology, occupational therapy, psychology, and physical therapy. This article will discuss issues related to the transition to the DNP and compare this to the transitions to doctoral education made not only by pharmacists, but also physical therapists, and audiologists in an attempt to learn from their combined experiences.

Transition for Advance Practice Nurses

*Transition in Action*

The movement to adopt the practice doctorate degree for entry into advanced nursing practice and to outline its educational requirements is relatively recent. Altering the career pathway of a profession requires careful planning and deliberate action by the parties involved. AACN prepared the DNP
Roadmap and other documents such as the Essentials of Doctoral Education for Advanced Nursing Practice, and the National Organization of Nurse Practitioner Faculties (NONPF) introduced sample curriculum templates for DNP education and created the National Panel for NP Practice Doctorate Competencies in an attempt to further delineate the process. Throughout the United States, educational institutions have been planning and implementing DNP programs.

Despite adoption of the DNP by many institutions, transition to the DNP as entry into advanced practice may be difficult and require delay of the 2015 implementation date. The inability to adopt the baccalaureate degree as entry into nursing reflects the potential challenges, obstacles, and barriers for adoption of the DNP as the degree for entry into advanced nursing practice. In 1965 the American Nurses Association (ANA) recommended the Bachelor of Science in Nursing (BSN) as the entry degree for nurses. By 2006 there were still 850 associate degree and 70 diploma nursing programs. North Dakota was the only state to have required the BSN for entry into nursing. Approved by the state’s legislature in 1987, this requirement was overturned in 2003. Efforts continue to promote BSN education for all nurses throughout the country. In 2007, the Council for Nursing Education in Washington State proposed in the Master Plan for Nursing Education that by June 1, 2020 all newly licensed registered nurses must within 5 years have or attain a baccalaureate or higher degree in nursing to maintain licensure. This prolonged process underscores the difficulty and challenges involved in making an educational change within a profession.

Controversy within the Profession and Obstacles Facing Nursing

The decision to change the educational preparation for advanced practice nurses to the DNP has evoked strong emotions among those already in the profession. Opponents of the DNP argue that there are differences in the proposals for the practice doctorate by the AACN and NONPF, lacking clear competencies or outcomes for DNP programs. Many advanced practice nurses strongly question the applicability of the DNP and do not believe that the degree would enhance their skills or knowledge. Opponents contend that transition to the DNP distracts nursing from addressing more important issues at a time when there is a critical shortage of nurses and a health care crisis. Concerns for future APN
include the rising cost of doctoral education and the longer period of time required to complete a DNP rather than a master’s degree. Increasing the educational requirements and financial costs for advance practice nursing degrees might eliminate or discourage individuals who otherwise would have been expert practitioners. This transition could result in decreased enrollment in APN programs throughout the U.S., thereby worsening the health crisis.

One of the major challenges facing advanced practice nurses as they transition to the DNP is the preparedness of the nursing educational institutions. By August 2008, 78 educational institutions offered a DNP program with an additional 140 schools of nursing considering starting DNP programs. However, with more than 400 APN programs nationwide, this indicates that many programs are unable or unwilling to adopt DNP education for APNs. Many DNP schools and colleges only offer post-master’s programs with only about 30 offering post-baccalaureate DNPs. The number of post-baccalaureate DNP programs is far smaller than what is needed to implement the DNP as the entry degree for advanced nursing practice by the year 2015.

Other challenges facing nursing education is a faculty shortage and that increased educational requirements for students places additional stress on institutions with limited resources. Concerns regarding this issue in the transition include the increased need for nursing faculties overall and specifically DNP prepared educators. Another concern is whether DNP prepared faculty will be considered for tenured faculty positions and typically universities only allow tenured professors to be members of academic Senates. Some proponents for the DNP argue that faculty with practice doctorates would not seek tenure in academic institutions. Others argue that the action to not seek tenure would omit the DNP prepared faculty from collegial participation thereby creating further marginalization instead of closing the gap as proponents would suggest.

Despite the controversy, transition to the DNP as entry for advanced nursing practice has received unified published support from various credentialing and professional organizations. In addition, the prompt response by schools and colleges of nursing to the AACN 2004 Position Statement is remarkable, as evidenced by the large number of planned and implemented DNP programs throughout the
country. Leading APN organizations support the DNP as a method to better prepare APNs for a changing health care system, increase autonomy, and to be recognized in parity with other doctoral prepared health care professionals.23

There are many variables that will influence APN professional transition to the DNP. Analysis of how other healthcare professions transitioned to entry level doctorate degrees can provide nursing with insight on barriers, ways to avoid pitfalls, and methods to resolve the issues encountered.

Transitions by Other Health Professions

Pharmacology

History: Pharmacy education in the United States has continued to evolve since 1890 when the University of Michigan established the first program.24 Educational requirements for performing pharmaceutical tasks varied in length from three months to five years, variation in educational preparedness was largely due to the lack of a governing body that addressed degree uniformity until 1906.25 In 1948 as a result of the Pharmaceutical Survey, a study of pharmaceutical education, the recommendation was made to implement a six year curriculum for a Doctor of Pharmacy (PharmD) degree.25 This was a controversial recommendation. Not until 1954 was a compromise adopted by stakeholders and the American Association of Colleges of Pharmacy (AACP) to implement the requirement of a five year baccalaureate degree for all accredited pharmacology programs.25 Several universities and colleges, however, began to offer the Doctor of Pharmacology as an alternative to the baccalaureate degree. This was pioneered by the University of Southern California in 1950.26 The decision of universities to offer the doctorate degree before it was required demonstrated their acknowledgement for the need of a higher level of education.

In 1992, the AACP voted to implement the Doctor of Pharmacy degree for entry into the profession.25 This action was a direct result and in congruence with the report from the Commission to Implement Change in Pharmaceutical Education (CICPE) which had been released in 1989.27 In 1997 the American Council for Pharmacy Education (ACPE), the accrediting body for schools and colleges of pharmacy, initiated a timeline for transition to the PharmD. The timeline required the graduating class of
2005 to be the last with a baccalaureate degree.\(^{28}\) Since that time, the ACPE only accredits educational institutions offering the PharmD and all schools met the implementation deadline. Currently, the ACPE 2007 annual report indicates there are 106 accredited programs in the United States.\(^{29}\)

*Attitudes toward change.* As evident from the lengthy transition period to the PharmD, much controversy surrounded this movement since the introduction of clinical pharmacology in 1960.\(^{30}\) Arguments for and against the entry-level PharmD requirement related to: society’s needs, professional image, job satisfaction, self perception, roles, and responsibilities.\(^{31}\) Proponents of the PharmD listed the complexity of health issues and increasing demands on the profession, healthcare system, and society as evidence for change.\(^{30,32}\) Many felt that society would benefit from doctoral trained pharmacists, that it would enhance the professions image, and help create parity with other healthcare professionals. Opponents to the PharmD feared the transition would compound problems in the health care system related to the shortage of pharmacists. This fear was validated in a 2000 report submitted to Congress by the Bureau of Health Professions.\(^{33}\) It stated that transition to the PharmD had lengthened the educational program, required additional faculty and resources, reduced the number of graduates throughout the transition, and was associated with a decrease in applicants to pharmaceutical programs.

During the transition period, many within the profession who lacked doctorate degrees were concerned about how they would compete with PharmD graduates. Concerns were related to differences in professional image, roles, and responsibilities caused by two levels of pharmacists.\(^{34}\) Proponents for the PharmD argued that the degree would improve the practice of graduates.\(^{35}\) This perspective was perceived as threatening by many non-doctoral pharmacists. This issue was also exacerbated by graduates from PharmD programs having expanded clinical clerkships that improved preparation for clinical practice.\(^{30}\)

Questions on how the PharmD would impact patient care and salaries were posed by those inside and outside the profession. Benefits of improved patient outcomes with pharmacist collaboration in care include reduction in medication errors, hospitalizations, and health care costs.\(^{30,36,37,38}\) A direct association between the PharmD and improved patient outcomes has not been established.\(^{30,39}\)
research has established the impact of the PharmD implementation on pharmacists’ income.\textsuperscript{30} The fiscal impact of the PharmD is difficult to determine due to multiple variables and market changes.\textsuperscript{40,41}

Health professions outside of pharmacology have issued position statements about the PharmD as the educational requirement for pharmacists. In its position paper, \textit{Pharmacist Scope of Practice}\textsuperscript{42}, the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) supported the expansion of a complementary scope of practice and anticipated further research on the impacts of the PharmD. The ACP-ASIM, however, opposes independent prescriptive privileges and initiation of therapy by pharmacists.\textsuperscript{42} Proponents of the PharmD education endured criticism and opposition from other healthcare professionals.

\textit{Obstacles encountered.} Many of the barriers to the implementation of the PharmD were overcome. The issue of a pharmacist shortage was met with a unified approach by proponents of the PharmD. Credentialing and professional organizations have demonstrated support by uniformly emphasizing doctoral education as the appropriate preparation for graduates.\textsuperscript{27,28} Doctoral education provides pharmacists with the necessary tools and experience to meet the needs of an ever changing health care system.\textsuperscript{30,32}

Transition to the PharmD required restructuring the curricula of pharmacology programs with additional courses which extended most programs by one academic year.\textsuperscript{35} Curricular changes included: increased clinical activities, development of lifelong learning and study skills, leadership, and interpersonal and communication skills.\textsuperscript{31} Many opponents argued that the PharmD lacked consensus of goals and direction. In response, the ACPE published standards and guidelines for accreditation in an attempt to create uniformity amongst pharmacology programs.\textsuperscript{28} Recruitment and preparation of educational institutions for the transition to the PharmD were slowly and carefully organized. Many schools and colleges of pharmacy had already converted to the PharmD by the time that the ACPE implemented the timetable for accrediting only PharmD programs.\textsuperscript{28}
Physical Therapy

History. Plack\textsuperscript{43} chronicles the origin of the physical therapy profession in her article \textit{The Evolution of the Doctorate of Physical Therapy}. Physical therapy stems from two major tragic events that created a domestic health crisis. The first was the multiple poliomyelitis epidemics from 1894 to 1916, and the second was World War I from 1917 until 1919. Both these events left behind numerous individuals who were debilitated and wounded and in need of physical therapy.

In an attempt to cope with the impact of World War I, a 3 month emergency education program was utilized to prepare individuals to provide physical therapy. Subsequently, various educational programs for physical therapy were started throughout the United States. In 1960 the American Physical Therapy Association’s (APTA) House of Delegates (HOD) put forth a resolution making the baccalaureate degree the minimum qualification for physical therapists.

By the time the APTA endorsed the baccalaureate as the entry-level degree, many schools were already offering master’s degrees. As the profession progressed so did the demands on physical therapists. In order to meet the demands on the profession, the 1979 APTA-HOD passed a resolution that required an entry-level post-baccalaureate degree by 1990 for all physical therapists. This resolution was abandoned in 1988 due to lack of consensus on curriculum for educational preparation but in 1999 the resolution was revived.\textsuperscript{43} By the early 2000s, almost all of the baccalaureate programs had been phased out of the profession.\textsuperscript{44}

In 1992 the University of Southern California began the first post-professional transitional Doctorate of Physical Therapy (DPT) program. This action was followed by Creighton University which then offered the first entry-level DPT in 1993.\textsuperscript{45} The 2000 APTA-HOD issued a Vision Statement that by the year 2020 all physical therapy would be provided by DPTs.\textsuperscript{45} The Commission on Accreditation of Physical Therapy Education (CAPTE), the only nationally recognized accreditation agency for physical therapy programs, recognizes both the master’s and doctorate as professional entry-level degrees. In 2008 there were 210 accredited programs in the United States and 194 programs conferred the DPT and 16 the master’s degree.\textsuperscript{46}
Attitudes toward change. The transition to the practice doctorate has been slowly introduced to the profession. The concept was introduced in 1985 by Geneva R. Johnson\textsuperscript{47}, PhD, an associate professor from Baylor University, during the annual APTA lecture award. Dr. Johnson expressed her vision to make the doctorate of physical therapy the standard for entry-level education and to have by the year 2005 over half of practicing physical therapists with doctoral preparation. Not until 2001 did APTA’s Education Section take the position that the preferred professional degree for physical therapists was the DPT.\textsuperscript{45} As with pharmacology, the decision to advance physical therapy's entry-level to the doctorate degree created controversy.

Many within physical therapy question the motivation behind the change to the DPT. Some believe that the DPT is only an academic inflation of the degree in an attempt to create parity with other healthcare professionals and earn respect.\textsuperscript{48} A study evaluating the importance of professionalism for physical therapy students selection of degree, found no association between selection of the DPT and perceptions of professionalism within physical therapy in comparison to other health care professions.\textsuperscript{49}

The, lack of evidence on improved patient outcomes is frequently raised as an argument against the change.\textsuperscript{48} Many opponents of the DPT argue it does not provide added autonomy or clinically relevant skills and does not improve patient care.\textsuperscript{48, 50} The arguments against the DPT are related to its perceived lack of relevance to current issues in the profession. Physical therapists are troubled with the issues related to direct access and direct reimbursement.\textsuperscript{44, 48} Some in the profession are concerned that the DPT would create more confusion because currently physical therapy offers six to seven post-baccalaureate degrees.\textsuperscript{43} This confusion along with the extended program of study and lack of direct reimbursement may discourage individuals from entering the profession.

Supporters of the DPT present many arguments for the transition with an overwhelming theme for professionalism.\textsuperscript{43, 44, 47, 49} Since its birth early in the 20\textsuperscript{th} century, physical therapy has evolved from being providers of technical skills with little educational preparation to a nationally recognized profession with advance education that integrates applied knowledge and skills in an autonomous fashion. The APTA has listed the DPT as a crucial element in physical therapy’s quest to be a professionalized
Transition to the DNP

Proponents of the DPT argue that therapists are already practicing at professional levels. They feel that with added structure and slightly lengthened educational experience, the profession can finally be recognized for its many contributions and attain parity amongst other health care professions.

Obstacles encountered. As implicated from the attitudes against the DPT, there are several arguments opposing the transition. Some of the obstacles against the DPT have been presented by other professions who list issues regarding: patient safety, professional education, inability to diagnose, and increased risk to patients with direct access. Even within the physical therapy profession, many practitioners of various levels of education have expressed their opposition to the DPT. Acceptance and recognition of the DPT as a terminal degree by academic institutions creates an interesting challenge similar to that of other professions who are also transitioning to practice doctorates.

Still, physical therapy continues to make progress toward implementing the DPT. Major organizations within physical therapy have expressed a unified support for the DPT. An overwhelming support for the transition to the DPT has been demonstrated by educational institutions, with over 88 percent of the physical therapy programs conferring the DPT degree. The rapid response from the educational programs in response to the APTA task force recommendations, has superseded many expectations.

In preparation for the DPT, CAPTE, which is the accrediting agency for physical therapy education, stated the transition of educational requirements. This decision was reinforced by the APTA-HOD as it released its Vision Statement for Physical Therapy 2020, supporting the DPT. These unified actions have been instrumental in implementing the DPT across the profession. There still are some barriers to overcome in order to complete the transition. Currently CAPTE accredits both master’s and doctoral programs using the same criteria. This is an issue that must be addressed as the profession nears completion of the transition and seeks validation within and outside physical therapy.

Audiology

History. Harford describes the evolution of audiology in the book Audiology: Practice Management. The profession of audiology in the United States dates back to the 1940s during the time of
World War II. Interestingly, similar to physical therapy, audiology developed and progressed out of the needs created by war. At first audiology did not stand alone as its own profession but instead was grouped with other specialties. Initially, there as much overlap in the course work for a degree in audiology with that of speech pathology except for a stronger focus on audiology. Because audiology did not have its own professional degree and many practitioners earned either a master’s or PhD degree with educational requirements set forth by graduate schools. Specific requirements for the audiology PhD were formatted to prepare graduates as teachers or investigators. Graduate audiology program curriculum later came under the jurisdiction of the American Speech and Hearing Association (ASHA).

The initial degree in audiology was the Ph.D. which was research focused and its value was questioned in regards to adequate preparation for practice. In 1963, Bryce L. Crawford, PhD, chairman of the Council of Graduate Schools of the United States, addressed ASHA conference about the differences between professional and scholarly degrees. The idea of a professional doctorate was rejected at that time. Instead the Ed.D. was proposed as a less rigorous substitute for the PhD, in order to allow more clinical experience. Following a 1978 U.S. Supreme Court decision, audiologists were able to offer full services to patients in private practices.

In his 1981 ASHA presidential address, Alan S. Feldman, PhD, pointed out the flaws of a practice profession that only confers the research focused PhD. Boston University in 1985 began the first clinical doctoral program in audiology. In 1988 the American Academy of Audiology (AAA) was founded to implement change and gain control over the direction of the profession. The AAA pushed to implement a new practice doctoral degree for audiology. In 1989 the Audiology Foundation of America (AFA) was created to spearhead the Doctor of Audiology (AuD). The AFA conducted the 1995 “Standards and Equivalency Conference” to facilitate creation of standards for the AuD.

In 2002 a new accrediting body for Au.D programs, the Accreditation Council for Audiology Education (ACAE), was created. In January 1, 2007 the AuD became the entry-level degree for clinical practice of audiology. ASHS has also stipulated that by January 1, 2012 all audiologists seeking certification must possess a doctoral degree.
Attitudes toward change. Although the need for creating a practice doctoral degree for audiology has been a recurrent theme, the transition has invoked much emotion. ASHA which held much power over audiologists did not share the enthusiasm for the AuD. Unlike the other professions discussed where transition to the practice doctorate has been promoted by leadership, the AuD was born out of the ambition of practitioners. Taking an opposing stance to that of traditionally trained audiologists and going against the established PhDs was not easy. Even with support from a few in ASHA like Dr. Feldman and Dr. Crawford, stimulating this change was met with much opposition. Some of the arguments against the change involved specific educational requirements and movement away from elements of research that are fundamental to the PhD. There is some uncertainty as to how the AuD can be implemented as the required entry level degree. Many of the arguments against the Au.D including: possible limitation of employment opportunities, unwillingness of employers to pay increased AuD salaries thereby creating a demand for less expensive workers, and ambiguity on supervision of audiologists.\textsuperscript{64} Opponents of the AuD cite the lack of evidence that a clinical degree would better prepare audiologists. Malinoff\textsuperscript{65} identified from her findings that practitioners with PhD preparation did not feel lack of adequate preparation by their programs. She recommends the need for a study of PhD audiologists and whether they would have opted for the AuD were it available at the beginning of their careers. This would provide data needed for further discussion regarding adequate preparation.

Supporters of the AuD state that the required knowledge base to practice audiology while keeping up with advancements in science and improvements on technology require education beyond a master's degree.\textsuperscript{61} Deficits in the PhD preparation of audiologists have been pointed out by proponents. It does not prepare the practitioner for clinical practice but rather for academia or research.\textsuperscript{65}

Obstacles encountered. Challenges in the transition are evident from the long trajectory toward acceptance of the AuD as the professional entry-level degree. Transition to the Au.D met repeated opposition from ASHA.\textsuperscript{39,60,65} Many of the obstacles that audiology has faced stem from its roots of being grouped in a broad category of multiple professions and therefore being governed under the ASHA umbrella. Audiologist representation in ASHA is that of a minority. In 2007 the audiologists who were
members of ASHA were outnumbered by more than nine to one by speech pathologists. Nonetheless, as of 2008, 66 out of 68 programs listed in the United States confer the AuD degree for audiologists.

Discussion

Although the transition to practice doctorates for each profession is unique, there are shared characteristics that can be extrapolated from these experiences. According to Bridges transition is “the process of letting go of the way things used to be…, the way we come to terms with change”. As these professions developed and science advanced, it became evident that educational programs with structure and uniformity were required to adequately prepare practitioners. Each profession encountered their challenges but slowly continued to evolve into what they are today. There are three major themes regarding the transition of the health professions discussed above to doctoral education.

First, change is difficult and frequently creates controversy. This controversy impacts development immensely and comes both from within and from those outside the profession. Methods that were employed successfully by all of the professions studied included: having a vision of future practice for the profession, creating specific and common goals, unifying the efforts of proponents for change, and determining a pathway and evaluation process for achieving those goals.

The second theme involves implementation of the transitions. The barriers faced by the professions included financial costs, preparedness of educational systems, recruitment of those within the profession, agreement on educational requirements of doctoral degrees, and overcoming perceptions of those outside the profession. As requirements for entry into practice change, the professions are composed of individuals with varied educational backgrounds. At this time only pharmacology and audiology require a doctoral degree as entry-level preparation for practice, with physical therapy’s deadline 12 years away. But change takes time and in the case of these professions it took years of hard work. Common to the transition of all three professions is: a strong desire to have unified support for change from within the profession; an understanding that transitions take time; and careful planning to identify barriers and make modifications as needed through the transition.
The last theme identified is the effect of professional transition on patient outcomes. Because of the relatively recent transitions in all of the professions, there is no research regarding whether there is a link between educational preparation and improved patient outcomes. Studies that confirm doctoral education improves the quality of care can be used to inform individuals and organizations satisfied with the status quo that they are outdated and will be left behind.

Conclusion

Similar to the transitions of other health professions, adoption of the DNP for entry into advanced practice nursing has evoked many challenges. APNs can examine the transition of other professions and learn from their experiences. Unlike the BSN requirement, there is a strong support among various organizations of APNs for transition to the DNP. It is of great importance that the professional organizations for APNs: define clear goals and curricula, create unity among nursing, and follow a carefully delineated plan with patience as it transitions to the DNP. Unwavering commitment, flexibility of deadlines, and understanding that transition can be slow will be essential tools for APNs as they evaluate progress toward the DNP. Finally, it is of utmost importance that APNs clearly demonstrate to the profession and others that transitioning to the DNP is a decision based upon better meeting the needs of patients through added preparation, instead of a self serving action for added recognition.
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