The nursing profession has long recognized many pathways as an entrance to practice. In 1968, the Macy Foundation founded one of the first nurse practitioner master’s degree at Boston College (Pulcini & Wagner, 2005). The typical master’s preparation for advanced practice nurses (APNs) began in the late 1980’s with a major increase in graduate level preparation in the 1990’s (Fairman, 2009; O’Sullivan, Carter, Marion, Pohl, and Werner, 2005). In 2004, the American Association of College of Nursing (AACN) advocated that by 2015, entry into advanced practice roles should change from the master’s degree to the Doctor of Nursing Practice (DNP) degree. This position is concordant with The Future of Nursing, Transforming the Change (Institute of Medicine, 2011). The Institute of Medicine’s 2001 report entitled, Crossing the Quality Chasm: A New Health System for the 21st Century, stated that the field of nursing should move to higher education to participate in translating research to practice. The DNP is expected to create parity with other professional disciplines by assisting advanced practice registered nurses APRNs, with transforming nursing science and assuming leadership in clinical practice, clinical teaching and health...
policy. As DNP s assume positions in the academic arena, there continues to be unanswered questions regarding their preparation to assume tenured nurse faculty roles. At issue remains the determination of parity between the varied preparation and academic requirements of both the clinical and research doctorates in nursing. This article examines the cultural conflict inherent in the preparation of both research and clinical doctorates for graduate academic education roles.

**Cultural Dissonance in Academic Nursing**

Culture is defined as the “learned, shared, and transmitted values, beliefs, norms, and lifeways of a specific individual or group that guide their thinking, decisions, actions, and patterned ways of living” (Leininger & McFarland, 2002, p. 47). In the nursing culture, the values that are sustained in the clinical arena are sometimes incongruent with values that sustain the academic role. For example, the Advance Practice Registered Nurse (APRN) at the bedside engages in humanistic, personable, and individualized patient communication (Person & Finch, 2009). Quality is determined by concrete measures of improved biologic outcomes usually among a single patient, family, and/or community. In academia, demonstration of competence requires simultaneous assessment of large groups of nursing students while maintaining clinical expertise and engaging in research. Cultural dissonance is the conflict created by members of a culture undergoing change in their cultural surroundings (Duphily, 2011). For novice nurse faculty, the difference between clinical and academic values creates cultural dissonance (Duphilly, 2011; Schriner, 2007).

Academic educational roles traditionally balance the faculty roles of scholarship, teaching, service, and practice (Banks, 2012; Boyer, 1990; Schriner, 2007). Nursing education has evolved from nurses trained at the bedside to a formal academic structure. New faculty transition from clinical nursing roles to faculty roles with fewer than 50% possessing a doctoral degree (Duphilly, 2011; Schriner, 2007). The cultural dissonance between the clinical and faculty role is fostered by scant formal education in effective teaching pedagogies. Nurse practitioner faculty endure an increased source of cultural dissonance as they face the additional dilemma of balancing professional practice expectations mandated by their profession with research expectations mandated by university expectations.

An increasing factor that contributes to cultural dissonance among doctorally prepared faculty is tenure. Tenure is the gold standard reward that has long divided clinically based faculty from research faculty. In the past, clinical professors in graduate nursing were defined by the absence of a doctoral degree. Today, the distinction between possible tenure and non-tenured faculty is decided by the type of doctoral degree. Loomis, Williard, & Cohen (2006) reported academic career intentions were present in more than 55% of DNP student respondents (n=69). Therefore, clinical doctorally prepared nurses could be viable alternatives for the nurse faculty shortage. Yet, nursing is perpetuating the 6.9% nurse faculty vacancy rate by not utilizing tenure as a career trajectory strategy to retain DNP faculty. Approximately 56% of the vacancies were tenure track faculty positions preferring or requiring a doctoral degree (American Association of Colleges of Nursing, 2010b, 2012; Banks, 2012; Tracey & Fang, 2010). Nurses with a spirit of scholastic inquiry have a choice between doctoral degrees in translational and/or generational research. It could be asked if the decision to earn a PhD should be about the ability to obtain future tenure in the academic profession. Cultural dissonance may be improved through formal education, mentoring, adoption of mutual doctoral values, and socialization to the faculty role (Schriner, 2007). In order to reduce cultural dissonance, nurse faculty tenure should be determined by the Boyer (1990) model of scholarship to create parity between PhD-prepared and DNP-prepared faculty.
History of the “Professional” Doctorate in Nursing

The 21st century marks an intense cultural growth of doctorally prepared nurses whose historical and sociologic evolution began in the era of the Great Depression. The Goldmark Report of 1923 introduced the idea that nurses should be educated in a collegial and university setting (D’Antonio, 2007; Goldmark, 1923). In 1916, 16 university programs existed and quadrupled to 70 programs by 1936, and there were 138 programs by 1945 (D’Antonio, 2007).

In the 1940’s, as nursing education shifted from the bedside to the academic setting, nursing educators were introduced to cultural dissonance. Nurse educators were forced to value themselves by obtaining respect in academia, which resulted in spending more time validating research than focusing on clinical practice (Bosold & Darnell, 2012; Newland & Truligio-Londrigan, 2003). Little & Milliken (2007) suggest this disparity persists today, as academic competencies in research and scholarship are valued higher in tenure promotions than clinical practice competencies.

In 1933, Teacher’s College at Columbia University created the first doctorate in nursing; the EdD in nursing education. Dreher & Smith-Glasgow (2011) argue that this was the first professional or practice doctorate concentrating on education. For the purpose of this manuscript, the EdD is considered as a research doctorate because although it is practice-oriented, the EdD always completed a research dissertation. The first PhD in nursing started at New York University in 1934, and the next PhD program was not founded until 1954 at the University of Pittsburgh. Historically, as nursing science struggled with recognition as a “real” scientific discipline, the idea of the development of a clinical doctorate for the profession as an alternative to a research doctorate emerged. In 1960, Boston University created the Doctor of Nursing Science (DNSc) degree. In the mid 1970’s, the University of Alabama-Birmingham and Indiana University led the impetus for similar degrees; the Doctor of Science of Nursing (DSN) and the Doctor of Nursing Science (DNS). These early attempts at clinical doctorates were actually de facto PhD degrees with research intensive thesis components (AACN, 2006; Dreher & Smith-Glasgow, 2011).

The first professional doctorate in nursing to have a practice thesis component that was differentiated from the PhD research dissertation was the Doctor of Nursing (ND) degree. Founded in 1979 at Case Western Reserve University by Dean Rozella Sclotfeldt, the degree was developed as a professional nursing degree on parity with clinical degrees in other fields such as medicine (Cronenwett, Dracup, Grey, McCauley, Meleis, & Salmon, 2011; Dreher & Smith-Glasgow, 2011; Loomis et al., 2006; O’Sullivan et al., 2010). This degree has now currently been phased out and converted to the contemporary DNP degree.

In 2001, the first contemporary DNP degree arose at the University of Kentucky and focused on clinical executive management. In 2004, the AACN concluded that higher levels of advanced practice would require additional competencies and knowledge. The membership voted to adopt the DNP as the highest practice degree (AACN, 2006). The first advanced practice iteration of this doctoral degree that focused on translating evidence into practice was the Doctor of Nursing Practice (DrNP) at Columbia University in 2005. Other inaugural programs in 2005 included DNP degree programs at: Case Western University, Drexel University, Rush University, University of Tennessee-Memphis, University of South Carolina, University of Colorado-Denver and Tri-College University Nursing Consortium (Concordia College, Minnesota State University, Moorhead, and North Dakota State University).

Impetus for Change in NP Education

Societal Shifts

In our current era of healthcare reform, there
is an increasingly culturally diverse, aged population, with an increased burden of chronic illnesses. In order to meet the health needs of the United States, it is expected that one million nurses will be needed in the U.S. workforce (Dunphily, 2011). Nolte & McKee (2011) suggested 84,300 Americans under age 75 would not have died with proper access to effective health care. The 2010 Patient Protection and Affordable Care Act (PPACA) acknowledged the necessity for an increased workforce of family nurse practitioners to address the health care needs of 46 million uninsured Americans. Once fully implemented, approximately 68 million people will have access to care covered by the essential health benefit requirement (Kaiser Family Foundation, 2012). Moreover, during the past two decades, advanced practice nursing has become the dominant preparatory focus of graduate education to address access to primary care (Pulcini & Wagner, 2005; Pohl, Duderstadt, Tolve-Schoenberger, Uphold, & Thorman-Hartig, 2012). PPACA will provide federal funding for training of family nurse practitioners for primary health care. Therefore, clinical scholars who are experts in implementation and translational science are tremendous assets to the preparation of graduate nurses. It would seem that resurgence of the practice doctorate, in the current incarnation of the DNP, is a glimpse of the future of nursing faculty.

In 2008, the Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) launched a two-year initiative to transform nursing to respond to the rapidly evolving health care system. The resulting report was entitled The Future of Nursing, Transforming the Change (Institute of Medicine, 2011). The report stated that in response to complicated patient needs, mortality, and morbidity, nursing education must be improved. Specifically, nurses needed to attain improved competencies to ensure the delivery of safe, high-quality, patient-centered care across settings (IOM, 2011).

Four key messages applicable to this discussion were:

1. “Nurses should practice to the full extent of their training and education.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure.” (IOM, 2011, p.4).

The competencies specifically necessary to advance this challenge are currently best represented in the DNP practice doctorate. Nurses are currently expanding roles to master health technology and information management systems while collaborating and coordinating interdisciplinary health teams. DNP competencies include leadership, health policy, system improvement, mentorship, research and evidence-based practice, and interdisciplinary collaboration, as well as competency in specific clinical content areas, including primary and acute care disciplines (AACN, 2006; 2010b). The nursing faculty profession can honor the spirit of the IOM edict by creating full partnerships between all doctorally prepared nurses.

Effect of Nursing Faculty Shortage

The nursing profession has a shortage of nursing faculty due in part to the insufficient number of nurses with doctoral degrees. The U.S shortage of nurses has been projected to extend past the next decade (AACN, 2012; Buerhaus, 2008). AACN (2010) reported 52,115 qualified nursing applicants were delayed from enrolling in baccalaureate and graduate programs due to the shortage of faculty. In 2011, this number in-
increased to 75,587 qualified applicants (AACN, 2012). When focusing on doctoral applicants, 1156 qualified applicants were deferred enrollment (AACN, 2012).

In a survey of 662 nursing schools, a total of 1182 faculty vacancies were reported (AACN, 2012). To accommodate student demand, an additional 102 faculty positions were identified as necessary. AACN (2012) identified a national faculty vacancy rate as 7.6%, with a record 88.3% of those vacancies preferring or requiring a doctoral degree. One-third of survey participants cited the limited pool of doctorally prepared nurses as the reason for this vacancy rate (AACN, 2012). Clearly, doctoral programs are not producing a large enough pool of graduates to enter the educational arena. (to meet the current demand?)

An additional factor contributing to the nursing faculty shortage is the “graying” of doctorally prepared nursing faculty. The National Research Council (NRC) (2011) reports most nurses enter PhD programs substantially later than in other science and social science programs. The average age of PhD-prepared nurse faculty is 55 years of age (AACN, 2010a). The current trend of nursing education suggests that most nurses spend 8.3 to 15.9 years after obtaining a master’s degree to achieve a research doctorate (NRC, 2011). The next decade is expected to experience a wave of the retirement of 200-300 doctorally prepared nurses as they reach the average retirement age of 62.5 years (AACN, 2012). The DNP is projected to recruit younger faculty as it becomes the entrance to practice and advances undergraduate students directly into doctoral education. Loomis et al. (2007) showed that 27.5% of respondents (n= 69) entering a DNP program were 35 years of age or younger. NRC (2011) suggests two key recommendations to improve the “graying” dilemma in nursing:

- Streamlining the master’s degree to facilitate direct passage into the PhD at a younger age
- National Institute of Nursing Research should develop and support clinical training of DNPs who desires participation in clinical scientific research.

Diversity in the Philosphic Worldviews of Both Degrees

The suggested debate is that scientific inquiry in nursing is best performed by a research doctorate that is prepared to develop nursing theory. Mangan (2010) accurately describes that the aim of PhD programs is to train development of nursing theory, while DNP programs aim to prepare APNs to use theory in practice. DNPs are learning to apply nursing theory to diverse clinical situations. In addition, DNP programs are preparing APNs “to develop and evaluate new practice approaches based on nursing theories and theories from other disciplines” (AACN, 2006, p. 9). Thus, DNPs bridge multiple theories into practice and participate in translational research.

It is a valid argument that the practice doctorate does not place the same emphasis on generating research methodology that concludes in a controlled trial experiment. A research doctorate prepares its scholars to generate knowledge in writing, teaching, and dissemination to practice (AACN, 2010). Yet, to conclude that there is no methodology or statistical analysis among clinical doctorates would also be false. Systematic meta-analysis and integrative reviews require a solid curriculum of nursing research. In the current publication “Essentials of Doctoral Education for Advanced Nursing Practice” (AACN, 2006), competencies include foundation in ethics, research methodology, statistical analysis and critical appraisal of nursing research. The rigor necessary to conduct a quantitative or qualitative systematic review requires the same analytic foundation of critical appraisal to translate research as it does to generate research. The National Organization of Nurse Practitioner Faculties (NONPF) (2012) states that APRN “graduates of a practice doc-
torate program have knowledge, skills, and abilities that are important to clinical practice including complex decision-making; refined communication; scientific foundations; mentored patient care experience with emphasis on independent and inter-professional practice; analytic skills for evaluating and providing evidence-based, patient care across settings; and advanced knowledge of the health care delivery system” (p. 1). Specifically, NONPF (2012) outlines the following competencies that demonstrate that the clinical doctorate is also prepared to develop new nursing theory through a scientific foundation:

- “Critically analyzes data and evidence for improving advanced nursing practice.
- Integrates knowledge from the humanities and sciences within the context of nursing science.
- Translates research and other forms of knowledge to improve practice processes and outcomes.
- Develops new practice approaches based on the integration of research, theory, and practice knowledge” (NONPF, 2011, p.2).

This suggests that closing the gap between the developments of evidenced-based research to the implementation in practice requires appreciation of the potential for both the DNP and PhD to conduct rigorous scholarly research to improve patient care outcomes.

For doctorally prepared faculty, IOM (2011) includes two specific recommendations that can best be accomplished through partnership between clinical and research doctorally prepared nurses. First, it proposes that the number of nursing faculty should double by the year 2020. Considering the larger salaries for Nurse Practitioners (NP) in clinical practice, tenure tracks may offer an incentive to add a diverse nursing faculty to the cadre of nurse faculty. Over 30% of all DNPs are now teaching in academia but retention may prove difficult if they perceive a second class role (Dreher & Smith-Glasgow, 2011). Second, the IOM (2011) supports interdisciplinary collaboration and partnership with health care organizations to increase the proportion of nurses with bachelor’s degrees to 80% by 2020. DNP outcomes and skill sets may be more advantageous in the latter recommendation, as APRNs already collaborate and hold positions of leadership in health care organizations. Florczac (2010) reports that the emphasis of the DNP upon newer models of delivery in patient-centered care has created significant contributions by DNP clinicians including advances in policy development, evidence-based practice, quality improvement, program evaluation, and competency-based education. Nursing literature has begun to publish collaborative research projects that demonstrate the strength of the combined knowledge bases of both doctorates (Stein, 2011). Vincent, Johnson, Velasquez, & Rigney (2010) noted that the DNP is a valued partner in bridging the link between research and practice. In order to facilitate collaborative potentials between the two degrees, the cultural discrepancy in their independent definitions of scholarship must be explored.

Cultural Discrepancy in Scholarship: Expectation of Research versus Practice

The AACN (2010) defines the outcomes of scholarship among both the research and clinical doctorate as writing, teaching, and dissemination (of knowledge?) into clinical practice. The DNP program outcomes focuses on the utilization and application of evidence generated by researchers in practice while the PhD program outcomes focus on generating that knowledge (Edwardson, 2010). NONPF (2012) reveals that competencies demonstrating the theoretical underpinnings of both the DNP and PhD research outcomes are more concordant than discordant. The PhD may be research intensive while the DNP is practice intensive yet neither is devoid of research and practice.

A doctoral degree in nursing prepares grad-
uates for a scholarly trajectory in the discipline of nursing (AACN, 2010; Magnan, 2010). Scholarship is developed over the course of a career and cannot simply be conferred by earning a degree. Doctoral education differs from a masters’ education in that it requires critical thinking, appreciation of worldviews of philosophy and an exploration of causation that leads to new theories and interventions (Dreher & Smith-Glasgow, 2011). The goal of both the DNP and PhD is the appreciation of research design, nursing theory, and basic nursing science to improve health care outcomes. Translational research by definition should be interdisciplinary among the faculty. In theory, the DNP critically analyzes qualitative and quantitative research and focuses on applying those research findings to patient populations (i.e. evidenced based practice). In theory, the PhD proposes scientific qualitative or quantitative inquiry methods to develop, test, and hypothesize strategies to gain new knowledge (i.e. scientific process). The DNP may use implementation science to create evidence-based implementation projects and program evaluations, while the PhD may design a research protocol. Each clearly improve nursing practice by participating in clinical trials that engage in both implementation and generational nursing science. Clinical nursing science is based on similar ways of knowing, theoretical frameworks, and philosophy of science.

Many doctorally prepared APRNs have successfully obtained the PhD, and yet strongly identify themselves as clinicians and not academicians. In 1997, many PhD-prepared APRNs became academicians in response to the National Task Force on Quality NP Education, which recommended that the director/coordinator of all APN programs be doctorally prepared and certified in their teaching specialty (NONPF, 1997; Pohl et al., 2012). Similarly, we may see many DNP’s as academic scholars and program coordinators with a unique ability to integrate the knowledge of clinical practice with educational theory. The AACN (2004) anticipated this need when they indicated that the practice doctorate should include some coursework and practical training to prepare DNP graduates to teach as nurse educators. Marginalizing the DNP educator by not creating parity with APRNs with a PhD suggests a second-class citizen status in which DNP’s do not deserve to travel along the career trajectory already paved by their PhD-prepared APRN predecessors. Research collaborations and mentorships should be continued between the PhD faculty that are currently responsible for educating the highly trained DNP graduate faculty. Cronenwett et al. (2011) state “the optimal learning environment for DNP education is one in which doctorally prepared faculty members are actively engaged in teaching, clinical practice, translational science, and systems improvement, preferably within an environment characterized by robust inter-professional learning opportunities” (p. 14). Moreover, both the PhD and DNP faculty should collaborate to foster undergraduate and prospective doctoral students’ research and highlight differing applications of clinical problem-solving skills.

Tenure for the Clinical Doctorate

The AACN (2006) acknowledges that neither the basic DNP, nor PhD curriculum, prepares the graduate for a faculty teaching role. Both types of graduates planning a faculty career in nursing need preparation in educational pedagogies, methodologies, curriculum design and development, and program evaluation. The most convincing argument for tenure among advanced practice nurses lies in the stewardship of their mentors; PhD-prepared APRN’s who have educated them to accept a commitment of clinical scholarship. As the future of the degree is forecasted, DNP graduates will educate future DNP’s. It is culturally incongruent with best teaching practices to have future clinical doctorates trained by PhD graduates, whose program emphasis is on research, as is the suggestion that DNPs should not teach PhDs. Clearly, both
DNP and PhD faculty whose practice is “education” need to be part of the curriculum strategies for both doctorates.

Schriner (2007) utilized a qualitative study design focused on a phenomenological method of ethnographic inquiry to discuss the importance of understanding how cultural variations affect the transition of nurses into faculty roles. Transitioning from a clinical practice role to a faculty role surfaced as a stressful situation for all participants. However, the amount of stress related to transition varied among faculty members, with clinical faculty facing the greatest struggle for survival in their new role. Disparities were found to exist between what faculty members expected compared to what they actually experienced. A level of dissonance was identified, as cultural values of clinical proficiency rewards were not rewarded in academia in a similar manner. Tenure was perceived as a reward that enabled more “time off,” while clinical faculty considered themselves overloaded with courses (Schriner, 2007, p. ?). Schriner (2007) concluded that new faculty should be universally taught and mentored to be nurse educators. Moreover, the research proposed that graduate programs need to specifically address the education of future nurse faculty. The publication Essentials of Doctoral Education for Advanced Nursing Practice (AACN, 2006) proposes competencies in education for the DNP curriculum.

For the past four decades, the National Organization of Nurse Practitioner Faculties (NONPF) has established nurse practitioner curriculum through supporting the development of instructional skills and scientific investigation. Since 2001, NONPF endorsed that the DNP differed from the PhD, in that it did not prepare nurse scientists for research careers, but instead prepared expert clinicians to use research knowledge and methods to create, implement, and evaluate practice interventions. NONPF envisioned DNPs “establishing, implementing and testing national practice guidelines and collaboratively managing clinical trials,” as well as “clinical teaching with patients, students, families, communities, and professional colleagues” (O’Sullivan et al., 2005, p.?).

At the beginning of the 21st century, AACN and NONPF prepared position statements defining the scholarship of clinical practice as an essential component in promotion and tenure for nurse faculty (Edwards, Alichnie, Easley, Edwardson, Keating, & Stanley, 1999; Pohl et al., 2012). Scholarship in nursing “can be defined as those activities that systematically advance the teaching, research, and practice of nursing through rigorous inquiry that is significant to the profession, is creative, can be documented, can be replicated or elaborated, and can be peer-reviewed through various methods” (Edwards et al., 1999; Pohl et al., 2012, p.254). Both DNP and PhD-prepared nursing faculty scholarship exceedingly meet this expectation.

This definition of diversity of scholarship has been embraced by PhD-prepared nurse practitioner faculty since the Carnegie Foundation first published Scholarship, Reconsidered: Priorities of the Professoriate (Boyer, 1990). Boyer’s conceptualization of scholarship has four major tenets currently utilized to determine tenure among many clinical professions. Boyer recognized, as doctorally prepared faculty must now accept, that knowledge is not developed in a linear model. Practice and theory inform each other in both directions. Certainly, theory leads to practice change, and newer practices can lead to theory development. Boyer (1990) suggested that best teaching models shape both practice and research. Doctorally prepared faculty should view their work as four separate, overlapping scholarship functions: discovery, integration, application, and teaching.

The scholarship of discovery is traditionally considered research. Scholarly investigation generates new knowledge. The scholarship of integration is multidisciplinary and involves interpretation of research into larger intellectual patterns. Boyer (1990) distinguished discovery
from integration by analyzing the scholastic inquiry question. Discovery seeks what is known and yet to be found, while integration seeks the meaning of the findings. The third element of scholarship involves application of theory to practice. NP faculty identify their service to professional practice as a scholarship of application. During the process of application, real world issues are addressed. The final scholarship of teaching is a dynamic process of pedagogical processes whereby knowledge is transferred from the teacher and learned by the student.

When revisiting the definition of education “practice” within a Boyer framework model, both doctorally prepared degrees demonstrate all four overlapping components of scholarship. DNP’s translate nursing science using evidenced based research. A common application is the performance of a systematic review, or meta-analysis, such as found in the Cochrane Database. A systematic review is an analysis prompted by “a clearly formulated research question that uses systematic and explicit methods to identify, select and critically appraise relevant research, and to collect and analyze data from studies that are included in the review” (Melnyck & Fineout-Overholt, 2011, p. 409). A systematic review that integrates the findings of discrete studies informs clinical practice guidelines and can improve quality of healthcare outcomes and efficiency of the system. A systematic review can generate new knowledge as well as identify areas for future research. Therefore, DNP’s scholarship of discovery is conducting systematic reviews. They are also poised to integrate their findings into clinical practice (Velasquez, McArthur, & Johnson, 2011). The complexity of society and the health care system requires nursing to look at scholarship in a broader view (Reed & Scheerer, 2011). The practice doctorate was created to meet these challenges, and should be embraced for their unique nursing perspective.

Future Implications

We must dispel the myth that the current increase in practice doctorates will somehow diminish enrollments in the research doctorate. The existence of a DNP preserves and stimulates the integrity of the PhD as the research doctorate. Diverse bodies of nurses who have achieved the success of a clinical doctorate are now better prepared for the research doctorate. Moreover, the introduction of the practice doctorate has increased enrollment in the research doctorate (O’ Sullivan et al., 2005). The AACN (2010) reported the greatest growth in doctoral programs enrollment was seen in DNP by 25.6%, as a record number of 1,282 DNPs graduated that year. During this same time period, enrollment in research-focused doctoral programs (i.e., PhD, DNSc) also increased by 4.5 percent (AACN, 2010). In 2008, a national survey of registered nurses reported an estimated 28,369 nurses with a doctorate degree in nursing or a nursing-related field, which was an increase of 64.4 percent since 2000 (U.S. Department of Health and Human Services, 2010).

In addition, tenure serves to balance workload requirements of scholarship and practice. Hurtado & Sharkness (2008) suggest the essential value of tenure lies in providing a safe environment for the development of new knowledge and innovation utilizing a review process that adapts to changes in scholarship. Not acknowledging practice as scholarship means that many APRN faculty must meet the demands of clinical hours to maintain certification apart from their faculty workload. As a result, work-life balances are poor mentorship examples for aspiring future nurse faculty, as well as the populations they treat, with deleterious unhealthy lifestyles (Banks, 2012). DNP scholarly practice relates to their area of expertise and knowledge by providing evidence-based practice and implementing change within health systems. To suggest that these efforts are not tenure appropriate because they are not as demanding, requiring the same rigor of peer review and accountability associated with PhD research activities, is blatantly inconsistent with Boyer.
er’s model of scholarship. Therefore, scholarly clinical nurse faculty require more tenure opportunities to maintain and refine their clinical specialization (Pohl et al., 2012). The future will require the creation of creative curriculum that allow the development of dual PhD/DNP programs as well as research of DNP faculty outcomes. The AACN (2010c) recognizes that there will be an overlap in selected curricular areas and coursework, and supports efforts to streamline the process for student’s completion of both DNP and PhD degrees, whether this is in an integrated DNP/PhD program or in a sequential DNP to PhD program.

Summary
Preparation of the next generation of advanced practice nurses will require the appreciation of a complex health system that meets the needs of a diverse population. The educational system is already incorporating interdisciplinary strategies among individuals with doctorates in medicine, psychology, pharmacy, and other fields to educate nurses. Clearly, nursing will benefit from both doctorally prepared nurses in the educational preparation of nurse practitioners. Yet, to not create a parity of trajectory to tenure for clinical research doctorates is to potentiate a culture in which clinical knowledge and leadership only has academic and scientific value if it generates research. Research that is generated requires translation within the health care arena, and translational research development also requires scientific and academic rigor. Clinical doctorally prepared nurses are finally translating nursing research outcomes at health policy tables on parity with other professional doctors. The spirit of egalitarianism is necessary to diminish cultural dissonance among doctorally prepared faculty. It is time for nursing to discuss tenure parity at the academic table. To not begin this discussion is to academically marginalize a significant number of clinically educated, doctorally prepared nurses to address the complexities of our healthcare system.

References


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