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**THE ROLE OF HIGHER EDUCATION IN ADVANCING NURSE PRACTITIONERS:
A LOOK AT THE INSTITUTIONAL DECISION CALCULUS OF
A HEALTH SCIENCES UNIVERSITY**

By

DEBRA J. JOHNSON

A dissertation submitted in partial fulfillment
of the requirements for the degree of

Doctor of Philosophy
University of San Diego

May 2010

Dissertation Committee

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ABSTRACT

In 2004, professional nursing joined the ranks of other health professions by altering accreditation standards for nurse practitioners, which now mandate that their terminal degree advance beyond the master's degree currently required for the doctor of nursing practice (DNP). This research examines the decision-making process involved in implementing a web-based DNP program in 2008 at a college of graduate nursing embedded in a health sciences university. Findings from two case studies, one of faculty and one of administrators, provide a narrative description of the institution, the decision process, and then describe how institutional and external factors influenced the process. Institutional influences aligned with the decision, while external influences aligned mostly with the process and slowed regional accreditation approval. Findings also revealed that DNP curriculum design did not specifically address nurse practitioners, but instead offered doctoral-level education to master's level nurses in general.

Currently, nurse practitioner credentialing requires master's level education; DNP accreditation change for nurse practitioners will eventually lead to degree changes for credentialing. Advancing doctoral education for nursing at large is the overarching goal of professional nursing and underlies this particular university's curricular design. As such, transferability of the findings of this research is limited to health science colleges of graduate nursing with web-based DNP programs; however, the importance of aligning both institutional and external resources with the process cannot be underestimated. In addition, findings support the recommendation by the Council of Graduate Schools for developing professional doctorate national standards and taken together, add to the body of academic literature about nursing education that can assist higher education stakeholders in evaluating future DNP programs.

DEDICATION

I dedicate this dissertation to my father, Joseph M. Leta, and to my mother, Gwentyth Ann Leta. Although my mother, Gwentyth, began as a stay at home mom who could not drive a car, and was wholly dependent upon my father and the good will of other people, she aspired to growth and change in her life and through out her life. Her example of stubbornness in the face of adversity served me well during this doctoral journey. My father, Joseph, is a quiet man who believes in service to his country, his community, and to his faith. His work ethic and persistence set standards for excellence early on in my life and facilitated my progress in my work and for my life. Quietly, my father led by example. Both of my parents have lived strong values, and instilled a deep love for the Lord in me. My parents steadfastly supported me not only on this journey, but also in every aspect of my life. Their love is strong and enduring.

ACKNOWLEDGEMENTS

My heart is full of gratitude for the people who have joined with me along my doctoral journey. I am very blessed to be so supported, guided, and cheered on by the wealth of humanity in my life. As I trod this path, I grew to value community with new eyes and greater understanding than I had known previously. Words alone are insufficient to express the appreciation I have in my heart for each and every one of you.

Bryan: I shared my academic struggles with you, as you often did with me. As my son you are my never-ending joy, but you also became my rock. You witnessed both the highest and lowest moments in this process, and those experiences only served to strengthen our bond. You've always believed in me as I believe in you. Thank you for the gift of your unconditional love and support.

Athena, Fred, and Karen: Thank you for your thought filled words, your hard work, and your support. Each of you mentored me differently, but in precisely the manner I required. I have enormous respect for each of you; you are truly talented people. For your efforts on my behalf I am most grateful. Your wisdom and guidance are irreplaceable in my life.

My colleagues: For those of you who have already transcended this process, and for those of you yet to transcend, I thank you. You are true leaders trail blazing the future, becoming the world leaders of tomorrow. Your kindnesses and support have kept me grounded and assisted my success in ways I can't adequately express. You have shared your intellect, your examples, your struggles, and your friendship. I am so very proud to call you my colleagues.

Dr. Thomas N. Sims: You are my lifetime mentor and an amazing example of excellence. Your example is not just in education, but is found in the smallest pieces of the way you live your life. You respect intellect and support its growth. You've always been surprising, and your influence upon my life unexpected. Thank you for coaching me to the finish. The

steps made all the difference.

Kesa Hopkins: You are a true support, my friend. Thank you for the much-needed distractions of travel, dinners, cycling, hiking, walking, phone calls, emails, and everything in between. In the end, you made it possible for me to move away from teaching so I could focus on completing this degree. Thank you.

My family: Dad, Mom, Dave, Barb, R.J., Samantha, Barry, and Linda, I thank you for understanding and for your support. But, most of all, thank you for all of your traveling, for letting me travel to you, and for staying away when I needed to work in the face of holidays and birthdays. Thank you for the regular phone calls, and for letting me know how proud you are of me, and the work that I was doing.

Southwestern College Dental Hygiene faculty and friends: Your interest and enthusiasm for my journey buoyed my spirits, and your belief in me carried me forward. Your support and hard work with students during my absence in the final year of this process made my success possible. Thank you.

Drs. John E. Lofthus and John S. Sottosanti and staff: Thank you for your understanding and support for my education, but also for assisting and tolerating the inevitable schedule changes and work interruptions imposed by this process. You are family, not just employers and fellow employees. I thank you from the very depths of my heart.

To my patients: You are deserving of a very special word of thanks. There are too many of you to name individually, but I thank you from the bottom of my heart for asking me to share with you my dissertation every week for the last three years. The many conversations and diatribes shared between us facilitated my process, my understanding, deepened my knowledge, and most importantly assisted with Fred Galloway's one minute summaries. Thank you. You

are the best!

To both my students and my former students: You are my cheerleaders at school, at meetings, in email, and on facebook. For your interest and enthusiasm I am eternally grateful, and humbled by all of you. Thank you for blessing my life.

St. Brigid Church parish: You are my faith community. You taught me the strength of faith through this process and where God belongs in my life. The greatest gifts come from God, and each of you is a gift in my life. Thank you.

To my very spoiled golden retriever family: Although Oliver passed away two years ago, he was my loyal and faithful golden companion as I began this journey in 2003. Annie continues to share my daily walks, interrupt my writing for treats, dinners, and potty breaks ... and provides ample displays of affection so I don't feel unloved. I love you both with all my heart!

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CHAPTER ONE

Introduction

Over the past fifty years, considerable change has occurred within the healthcare delivery system across the United States; not surprisingly, much of this change has been driven by technological innovation in the way that patients are initially diagnosed, treated, and ultimately, maintained. The medical system in this country, originally designed to function largely through hierarchical roles where generalist physicians diagnose and prescribe treatment, has increasingly moved toward physician specialization and the utilization of technologies for diagnostic and therapeutic work. Unfortunately, this trend towards specialization has not been well-supported by the existing health care infrastructure and has led the Institute of Medicine (1999, 2001, 2003) on several occasions to recommend reform of healthcare education and a redesign of our healthcare infrastructure into one that addresses the demands created by this technological shift.

Of course, this technological change has powerful implications in the way that health care providers need to be trained, and not surprisingly, the last few decades have seen increased educational requirements for a number of different health care professions, including masters' degrees for physician assistants and clinical doctorates for physical therapists. In the past few years, nursing has also decided to upgrade their degree requirements for advanced nurse practitioners to the clinical doctorate; the American Association of Colleges of Nursing (AACN) recommended this change in 2004. Four years later, 78 schools of nursing have developed their own doctor of nurse practitioner (DNP) degree, 60 schools are in the process of adding the degree program, and the rest must quickly decide how to respond (AACN, 2008b).

While the AACN (2004) positions this degree change for advanced nurse practitioners as

a recommendation, the accrediting body of the AACN, the Commission on Collegiate Nursing Education (CCNE), has determined that only “practice doctoral degrees with the Doctor of Nursing Practice (DNP) title will be eligible for CCNE accreditation” (AACN, 2005, ¶ 1). Program accreditation is a primary driver for determining education standards in the health professions. Since the CCNE is nursing’s autonomous accrediting body, the AACN recommendation is actually more of a mandate than a recommendation for education change. Most health care accrediting boards are tolerant of programs incompletely transitioned as long as they demonstrate some level of compliance with new standards; however, non-compliance is typically not an option. If graduate schools of nursing fail to alter curriculum to accommodate these changes in education standards, then their advanced practice nursing programs will no longer receive formal accreditation, and would likely cease to exist. Thus, the rapid proliferation of DNP programs is nursing’s response, at least in part, to the required changes in standards and degree.

As nursing schools react to the AACN (2004) recommendation, a substantial dedication of resources will likely be invested (Brown, Draye, Zimmer, Magyary, Woods, Whitney, et al., 2006). Many schools offer an array of nursing programs and will undoubtedly divert existing resources from ongoing programs. For these reasons, central for determining the value of a DNP program is first assessing stakeholder demand, interest, and support for the DNP. On the other hand, when contemplating institutional change, albeit great or small, Shaw (2005) recommends considering “the interrelatedness of the entire system” (Section 12.3, ¶ 20). At higher education institutions, the most important elements influencing the system and the programs it serves include institutional “mission/vision/goals, systems, policies and practices, structure, processes, infrastructure, and governance and culture” (Shaw, Section 12.3, ¶ 20).

Evaluating these factors and their relationship to the change process uncovered decision congruency with the institution's overarching mission. Other pressures driving education change include accreditation boards, the economy, and the state of the healthcare system overall; each factor acts upon the institution, generally, as well as healthcare programs, specifically, (El-Khawas, 1998; Harvey, 2004; Institute of Medicine (IOM), 2003). Perhaps, the biggest driver for nursing advancement is the current state of the U.S. healthcare system. Some forces propelling nurse advancement include: interdisciplinary care as the future of healthcare practice, *current trends* among mid-level healthcare fields to move toward the clinical doctorate, nurses as *extenders of healthcare* in present day practice, *scope of practice concerns*, and *the role of the institution*. Direct reimbursement, licensure regulation, and prescriptive privileges are also significant forces, but will be discussed under the heading of *scope of practice concerns* as these influences are reviewed in the background section.

Across graduate education, the clinical or practice doctorate has become a popular and fast growing degree (Bourner, Bowden, Laing, 2001; The Higher Learning Task Force (THLTF), 2006). While the recent decision of the AACN (2004) is driving a career entry degree change for nursing, little if any research has evaluated the process of curriculum and degree change (Gruba et al., 2004). Although accrediting bodies determine academic standards, curriculum design is generally left to the institution to resolve in accordance with their mission and goals. To what extent DNP web-based curriculum is a factor is not known. The purpose of this study was to look at the curriculum and degree change process for one healthcare university. This investigation sought to uncover the factors underlying the institutional decision as well as the forces driving choice of a web-based program.

Background

Interdisciplinary care is the future of healthcare (IOM, 2003). Physicians alone can no longer administer the demands of a broadly expanded managed-care medical system shaped by advancing technology, an aging population, and consumerism (IOM, 2003). As a result, the current medical system has evolved well beyond the traditional physician led practice (IOM, 2003). Over time, as both internal and external pressures were increasingly imposed on our medical system, a mid-level healthcare workforce surfaced, expanded, filled gaps in the system, and extended healthcare to patients in shortage areas. Now, this expanded workforce is altering longstanding traditions of leadership for healthcare, which include changing career entry degrees for certain health professions.

Current Education Trends

A number of education trends are evident across the healthcare community and are creating change among most professions to some degree and for nursing specifically. Understanding how these trends influenced the nursing profession, nursing education, and the future of the health care system was essential to the investigation of nurse advancement. In this section, the most significant trends affecting nursing education will be reviewed.

In healthcare, various lengths and levels of education persist across the health professions. These variations exist both within and between fields. For example, a number of mid-level healthcare fields including occupational therapists, nurse practitioners, physical therapists, physician assistants, and speech language pathologists have moved their career-entry education programs from certificate or baccalaureate degree to graduate degrees (Bureau of Labor Statistics (BLS), 2008-09b; K.O. Skaff, personal communication, April 17, 2008). For example, physical therapists and nurse practitioners are currently moving their entry-level

degrees from masters to the clinical or practice doctorate (American Association of Colleges of Nursing (AACN), 2008a; American Physical Therapy Association (APTA), 2008). This propensity for field advancement sometimes involves changes in program placement, as well as education length and level, the degree awarded, and scope of practice (BLS, 2008-09b; Council of Graduate Schools, 2007; Nelson, 2002). Yet, often, such changes are inconsistent across educational settings as a result of variations between institution missions and goals, as well as varied program curriculum even within the same field.

Increasingly evident is the trend for health professions to require graduate education; as a result, master's degrees have become the minimum career entry degree for many fields (Council of Graduate Schools, 2007). Examples of fields that have moved from lesser degrees to graduate school education include nursing, physician assistants, and physical therapists (Marion, O'Sullivan, Crabtree, Price, Fontana, 2005; Siler and Randolph, 2006; Sperhac and Clinton, 2004). Historically these professions began with on-the-job training, and then moved their programs to two-year, then to four-year or other program length variations (Byrd, 2002; Sperhac and Clinton). While many fields either phase out lesser degrees or grandfather in new career entry degrees for the profession at large, nursing persists in maintaining a number of practice degrees while still advancing their highest degrees (Byrd; Siler and Randolph).

Across healthcare fields, nursing contains the most varied levels and lengths of education, and has long pursued professional advancement through education and specialization (Daly and Carnwell, 2003; Joel, 2002; Mahaffey, 2002; U.S. Department of Health and Human Services Health Resources and Service Administration Bureau of Health Professions Division of Nursing, 2000). While the trend for field advancement is fundamental to nursing education, so is maintenance of basic nurse training to the field at large (Gosnell, 2002; Nancarrow and

Borthwick, 2005; Nelson, 2002). In an historical review of nursing's advancement through education beginning with the mid 20th century, Nelson, reports "Nursing leaders believed that the future of nursing depended on moving nursing education into higher education and their first objective was the phasing out of the hospital-based diploma program" (§ 6). Eliminating diploma programs would effectively situate nursing education in postsecondary institutions and could potentially open doors for further field advancement through education change. Although this rationale seemed quite sound, social and economic forces also drive education. The junior/community college movement from the early 1900s through the mid-twentieth century in combination with the vocational education act of 1963 proved to be an egregious stumbling block for nurse advancement (Andrist, Nicholas, Wolf, 2006; Pederson, 2008). Despite education change and advancement for the field over time, nursing's entry-level degree for the RN remains at the associate level.

Nursing career ladders was a subject of some discussion in 1971 by Bullough & Bullough when specialization for nursing was early in its development. At that time, efforts to eliminate hospital diploma programs were underway, and baccalaureate education for the RN was just being suggested for entry-level (Bullough & Bullough). Much has changed since that time and widely varied program curricula have been developed across nursing education to capture students with diverse needs. Career ladders for aspiring nurses have been created at several entry portals. Lesser fields such as Licensed Practical Nurses (LPN) are trained in one-year community college programs or even in high school vocational or technical schools and can advance their degree "through numerous LPN-to-RN training programs" (BLS, 2008-09c). Two-year and four-year RN programs (BSN) co-exist in relative harmony, although controversy persists over the required degree for career entry (AACN, 2000; Daly & Carnwell, 2003; Long,

2004). Despite greater opportunity for career advancement for BSN graduates, entry-level education for the RN degree is largely embedded in community colleges where student demand is greatest for such programs (BLS, 2008-09c, Joel, 2002; Nelson, 2002). Professional nursing's efforts to promote the baccalaureate degree (BSN) as the point of entry for the profession have been hindered by consumer resistance, and until very recently caused the AACN to abandon the entry-level argument for RNs and, instead, focus on nursing's highest degrees. Recent research supporting increased education for RNs has refueled the controversy (Aiken, Clarke, Cheung, Sloane, Silber, 2003).

Another popular field with varied education and one that also includes nursing is the field of midwifery. While all U.S. midwives have some formal education, direct entry midwives are not nurses, but they are licensed (Natural Healers, 2008). Certified nurse midwives (CNM) require an RN, as well as licensing, and additional midwife training, many at the master's level (AACN, 1996; Natural Healers). CNM programs were successfully introduced to the U.S. from England in the late 1930s, and continue today as a viable field in U.S. healthcare (Andrist et al. 2006). Meanwhile, advanced nurse practitioners evolved out of pediatric medicine in the mid-1960s, becoming so successful that many nurse specialization tracts closed at schools of nursing (SON) around the country (Andrist et al.). Nursing schools chose to replace specialization tracts with advanced nurse practitioner programs; however, advanced practice nursing is nurse specialization, only it is achieved through education at the master's level.

Alternative nurse curriculum is also available for students educated in other disciplines. Currently, there are 24 programs in fifteen U.S. states where school of nursing (SON) curriculum is now offered for entry-level nurse training beginning at the master's level; these programs are known as direct entry master's of science nursing (MSN) (All Nursing Schools, 2008). A

baccalaureate degree from another discipline is prerequisite for program entry. While much could be speculated about the design of such programs, adding more time to healthcare education, and nursing specifically, has become a consistent trend. Many healthcare fields currently graduate students with master's degrees as the entry-level degree, but that, too, is changing. Meanwhile, as nurse practitioners advance their career entry degree to the practice doctorate, the terminal degree for the nursing field remains the Ph.D.

Healthcare Extenders

Just as education trends influence change for the professions, so, too, does the shifting nature of professional roles. Role alterations often impact the health care system in many unintended ways. Although the professionalism literature is replete with ardent discourse on definitions and refinement of the professionalization process, much of that research presumed traditional patient/doctor roles and dispensing of healthcare (Krause, 1996). Patient/doctor roles and relationships changed significantly during the last half of the twentieth century, as did the manner in which healthcare is provided (Krause). For example, during this time the numbers of available generalist physicians grew at a slower rate while a corresponding rise occurred in physician specialization (Shi and Singh, 2005). Managed care, advancing technology, and physician overspecialization altered the manner in which healthcare services are provided, and failed to address physician and nurse shortages despite rising patient needs and increased demand for services (Krause, Shi and Singh). Without sufficient numbers of generalist physicians, responsibility for managing, monitoring, and treating the whole patient was ignored. As medical specialization evolved, patient treatment was increasingly dispensed from cocoons of isolated ivory tower medicine.

In medicine, the generalist physician is no longer prevalent in our healthcare system as he

once was in the early 20th century (Shi & Singh, 2005). Physician specialization overtook healthcare by the end of the 20th century, leaving behind a physician shortage (Shi & Singh). Although chronic disease in our aging population is the most prevalent health concern for the United States, the generalist or primary care physician, those MDs accountable for treating this patient population failed to increase in number. Instead, physician education coupled with advancing technology and innovation created an unprecedented rise in physician specialists (Shi & Singh). Drawn to specialization's greater financial rewards, prestige, and recognition, physicians chose specialization over generalist education by more than 9:1 (Shi & Singh). In the wake of this education shift, nursing, along with other mid-level healthcare fields, attempted to fill the chasm left behind by the loss of the physician generalist.

As a result, and over time, the U.S. developed a greatly expanded midlevel healthcare work force ready and waiting to attend to the needs of an aging population. Expansion of the workforce emerged from a system struggling to meet the healthcare needs of our nation, but, in some ways, this same workforce only served to complicate an already overburdened system. Professional roles and scope of practice for midlevel fields shifted and changed to fit emerging system needs; while a general blurring of field definitions and distinctions occurred within and between fields (IOM, 1999; National Center for Health Workforce Analysis Bureau of Health Professions Health Resources and Services Administration (HRSA), n.d.). Physician assistants, nurse practitioners, and nurse midwives, as examples, share overlapping roles and serve the public by dispensing the same services, often to the same populations of people (American Academy of Pediatrics, 1999; HRSA; Hooker and Berlin, 2002). Issues of scope of practice domain emerged, adding more pressure to the system.

Nurses, and other midlevel healthcare fields became known as extenders of healthcare,

charged with filling gaps where physicians were in short supply (Cooper, Henderson, Dietrich, 1998; Curren, 2007; Hooker, 2006). While midlevel field changes assisted in alleviating problems with physician shortfalls, they also produced problems. For example, the quality of healthcare provided was often diminished and disputes commonly arose between fields for scope of practice domain (Daly and Carnwell, 2003; Shi and Singh). Across the healthcare workforce, most providers were interested in dispensing quality patient care, but instead, found themselves struggling to meet patient wants and needs in a system lacking adequate structure. As a result of a broadly changing medical system, healthcare services fractured, creating communication disconnects between healthcare professionals and facilities (IOM, 1999, 2003). Limited access to patient information, failure to share records, or even investigate other ongoing and simultaneous therapeutic interventions, contributed to an overall breakdown in the quality of care being provided. These circumstances frequently resulted in both inadequate and often downright harmful care to patients (IOM, 1999). Currently, healthcare fields continue to practice in a broken medical system, and the work force vacillates between clinging to traditional roles and moving toward field redefinition to better fit the system, as it presently exists (IOM, 2003). The U.S. healthcare system, like a ship completely lacking a navigational system, blindly moved into uncharted waters. Just as the Institute of Medicine (2003) reports, our medical system is indeed broken and requires reform.

Scope of Practice

As mid-level fields worked diligently to fulfill their new roles as health care extenders, scope of practice began to shift for many health professions; for example, more healthcare fields are now included under the designation of professional than was once true. Physicians, dentists, veterinarians, chiropractors, lawyers, optometrists, osteopaths, podiatrists, and pharmacists have

all acquired the designation of “first professional” degree (Council of Graduate Schools, 2007, p. 10). These degrees, also known as clinical doctorates, are awarded “upon completion of a program providing the knowledge and skills for recognition, credential, or license required for professional practice” (CGS, p. 10). Until recently, pharmacy was the last field to make a career entry degree shift to the clinical or professional doctorate. Prior to 1997, the degree awarded in pharmacy was a baccalaureate; however, on June 14, 1997, the American Association of Colleges of Pharmacy (AACCP) changed pharmacy’s accreditation standards and guidelines and recommended the pharmacy degree become a clinical doctorate requiring six years of education (Meyer, 1998). Now, nursing and physical therapists are recommending similar changes for their fields.

For nursing, this new degree is expected to mean higher levels of autonomous practice, increased prescriptive authority, greater access to third party payment systems, and equity with regard to professional respect and recognition (Marion, et al. 2005). Currently, advanced nurse practitioners are educated at the master’s level, and already possess most of these scope-of-practice stipulations; however, many of these practice conditions are also shared by physician assistants (PA), and certified nurse midwives (CNM) with some variation (Cooper et al., 1998; HRSA, 2000). Despite sharing similar scope-of-practice services among these three fields, nursing is quick to point out that physician assistants do not have autonomous practice, and require physician supervision, a specific difference between the two fields (Cooper et al., HRSA). Nursing seeks to distinguish its field beyond the role and scope of practice held by physician assistants.

Scope of practice is not only influenced by supervision, but also by the level of provider reimbursement. Support for expanded practice and unsupervised services have experienced an

observable increase over an eight-year period from 1992 to 2000 (HRSA, 2000). Advanced nurse practitioners, physician assistants, and certified nurse midwives share similar, but varied support in state governance across the United States when utilizing scope-of-practice skills (HRSA). Yet, a growing concern for generalist physicians is the salary equalization trend occurring between the physician generalist, and the fields of nurse practitioners, physician assistants, and certified nurse midwives (HRSA). Apparently, salaries for these three midlevel fields are rising to the level of the generalist physician, and, according to HRSA, this salary trend is likely to eliminate the demand for these four separate fields. HRSA makes no prediction as to which field might prevail, but salary is frequently an influence for student career choice as it is for many field members choosing to stay or leave a profession.

The real benefit and level of authority that clinical doctorates may provide for nursing has yet to be determined since the change in entry level degree for advanced nurse practitioners (ANP) is ongoing, and practice at the doctoral level is not well established. The transition from a master's degree for advanced nurse practitioners to the doctorate nurse practitioner (DNP) is the subject of this research. Since the purpose of this study is to clarify the institutional process involved in altering advanced practice nursing's degree, research concerned with the effect the clinical doctorate has upon nursing authority falls outside the scope of this project, and will be left for future researchers.

The Role of the Institution

When accreditation recommendations such as those made by the American Association of Colleges of Nursing (2004) alter required program curriculum and degrees awarded, the institutional leadership, defined as graduate school deans, assistant deans, university provosts, vice presidents, directors, and program directors, and graduate nursing school faculty, must

respond to the changes made by the discipline-specific association. That response can take many forms and is driven by a number of factors, both internal and external to the institution. Internal factors can include institutional strategic plans, missions, goals, resource management, faculty governance, and program requirements (Colenso, 2000; Gruba et al., 2004; Shaw, 2005). External factors can include regional as well as discipline-specific accreditation, influences from the professions, health service delivery systems, and public policy as it affects scope of practice and credentialing practices (Burke, 2002; Colenso; Gruba et al.; K.O. Skaff, personal communication, October 2, 2008). To what degree each of these factors affects institutional decisions when adding nursing professional degrees is not known; however, these factors are generally understood as guiding institutional decisions including decisions ultimately leading to curricular and program changes.

For a number of reasons, pressures imposed on schools of nursing (SON) to create DNP programs are likely to be greater than the pressures felt by university leadership outside of the nursing graduate school. In an article discussing the University of Washington's experience of developing a practice nurse doctorate, Brown et al. (2006) briefly describe the organizational approach used by the University of Washington in their decision, the formation of "a practice doctorate task force (PDTF)" (p. 131). The PDTF membership consisted of nursing leaders from the University of Washington; there is no mention of university leadership beyond those members selected from the school of nursing (Brown, et al.). This narrow perspective suggests that oversight at the University of Washington played little to no role in advancing master's level nurses to the practice doctorate. While the PDTF reports curricular alignment with their School of Nursing mission, as well as DNP program goals, and student learning objectives, nothing is mentioned about university mission and goals, let alone a discussion with the regional

accrediting body for the institution. While it is likely that UW leadership outside of the SON participated in the decision, that perspective is not discussed. Omitting institutional influences leads to questions concerning motivation, and the continuing quality and excellence of graduate schools, a concern expressed by the Council of Graduate Schools (CGS) (2007).

Professional doctoral education has evolved in recent years as a response to social and cultural forces, as well as policy changes (CGS, 2007). Professional degrees serve a number of functions in education and the professions: they promote innovation and become a focus for institutional pride, but they can also craft degree-inflated programs and advance professions for purposes of increased earnings and prestige acquisition (CGS). These extended benefits and detractors stimulate well-founded concern deserving of both reflection and research. Yet, despite the nagging doubt surrounding professional doctorate proliferation in the United States, our healthcare system still requires highly skilled professionals to meet the challenges for the nation's health in the twenty-first century (CGS; IOM, 2003). Health professions education is responding to the Institute of Medicine (2003) policy, and many fields see the professional doctorate as a means for elevating the quality of our nations' healthcare system.

As healthcare moves from the managed care system to the interdisciplinary model proposed by the IOM (2001), it will be increasingly important for all healthcare fields to have a more detailed understanding of the education and roles of their peers. Clarifying within field differences as well as understanding the nature of moving a healthcare field from one degree to the next is as important as defining general healthcare terminology, a step deemed essential to IOM's (2003) pursuit of quality healthcare for America. Clarifying the process of field advancement will serve to enhance the evolution of interdisciplinary practice, assist institutions of higher education as they implement new curriculum and degrees, and within the larger

healthcare system, hopefully, improve healthcare quality.

Problem Statement

Health professions are advancing their fields by changing the career entry degree awarded. A number of fields, like physical therapists and pharmacists, stair-stepped from the baccalaureate degree to the masters as career entry, and are now climbing to the clinical or practice doctorate. Advanced nurse practitioners have joined this trend, and are currently moving their entry-level degree from the masters to the doctorate nurse practitioner (DNP). As of 2008, there were 78 schools of nursing that have made this change (AACN, 2008b).

The institutional process altering an entry-level degree from a master to a clinical or practice doctorate, however, has not been studied. Understanding this process from the broad perspective of the institution rather than from the narrow perspective of each profession proved helpful in uncovering the basis for altering degrees for health professions by academic institutions. While the healthcare system shift to interdisciplinary care is driving healthcare education change, there is no indication that a clinical doctorate for all professions is required to make that happen.

Statement of Purpose

This research sought to examine the response of *institutional leadership* (graduate school deans, assistant deans, university provosts, vice presidents, directors, and program directors; and nursing graduate school faculty including all levels of professors) to professional nursing's accreditation recommendation. Furthermore, this investigation sought to uncover leadership's early reaction and the factors driving change within the institution and at the nursing graduate school from the point of accreditation change through program development for a doctorate in nursing practice at a private health care university. The purpose of this qualitative investigation

was to consider the process involved in creating a DNP program for advanced nurse practitioners. The specific intent was to determine why university leadership chose to add a practice doctorate (DNP) to the nursing graduate school and uncover the internal and external factors contributing to this change at this particular institution. Then, considering the goals of leadership, determine how those goals were achieved at this institution through the production of a web-based curriculum. Finally, an effort was made to determine whether the institution's mission, goals, and vision were upheld or altered in the process as supported by institutional systems, policies and practices, structure, processes, infrastructure, governance and culture. These institutional factors are interrelated and recognized as important for influencing change in higher education, as well as effecting long-term change (Colenso, 2000; Gruba et al., 2004; Shaw, 2005).

Research Questions

In order to uncover the process involved in creating a doctorate nurse practitioner program at this health care center, the following questions provided the frame and focus for the study.

1. What external and internal factors were involved in the institutional decision calculus underlying the decision to add a web-based DNP program?
2. To what extent were responses to questions about the stated institutional mission, vision and goals consistent among the university leadership (including the university provost, vice presidents, other graduate school deans, assistant deans, directors, and program directors) and the Graduate School of Nursing (GSN) (the dean, program directors, and the nursing graduate school faculty including all levels of professors)?

CHAPTER TWO

Review of the Literature

Health professions are advancing their education level in response to workforce shortages as well as through Institute of Medicine goals to improve the quality of healthcare (AACN, 2004; IOM, 2003). Faculty shortages among the health professions are related to workforce problems, because colleges and universities turn away applicants without sufficient numbers of qualified faculty available to teach (Moskowitz, 2007; ACCN, 2008a). This domino relationship produces fewer graduates at a time when demand for healthcare services is at an all time high and exacerbates shortages for practitioners and faculty alike (AAHC, AACN 2008a). As accreditation for health professions education in general, and nursing specifically, change career entry degrees the institutions serving these professions vary in their response. At the heart of these shifting policies and workforce shortages sits an ineffectual and broken healthcare system, sustaining the status quo while healthcare reform turns to education.

As health professions seek elevation of their career entry degrees to the clinical or practice doctorate, advancing scope of practice, increasing prestige, and economic reward seem all the more likely. Medicine does not seek to mend the old system, but instead intends to create a new interdisciplinary healthcare system, requiring more education for all concerned. While motivations of healthcare professions may be stimulated by looming problems of a failed system, motivations of higher education leaders for changing entry-level degrees are less clear. This review will consider the current status of the healthcare system, doctoral education in nursing, its origins as well as its current status, and institutional mission as a frame for research sequentially in this chapter.

The Current Status of the Healthcare System

As of 2006, the U.S. Bureau of Labor Statistics reported, “healthcare is situated as the largest

U.S. industry providing 14 million jobs—13.6 million jobs for wage and salary workers and about 438,000 jobs for the self-employed” (Bureau of Labor Statistics (BLS), 2008-09a, ¶ 1). Among healthcare workers, “registered nurses constitute the largest health care occupation with 2.5 million jobs” (BLS, 2008-09b, ¶ 1). Nurses represent a noteworthy segment of the American work force as healthcare extenders; although insufficient numbers are available to meet the nations’ healthcare needs (AACN, 2008a). The CDC National Center for Health Statistics reports more than “40 million people or nearly one in five U.S. adults” does not have access to necessary health services (U.S. Department of Health and Human Services, 2007, ¶ 1). Shortages in nurses contribute to problems for patient access, while shortages among nurse faculty expand the problem of nurse supply (AACN, 2008a).

Factors contributing to shortages among nurse faculty include: aging and retiring nurse faculty, the need to expand SON faculty, lack of qualified applicants for position vacancies, and fiscal restrictions resulting from reduced federal and state funding (AACN, 2008a). University access for nursing students is effectively reduced when academic institutions are unable to offer curriculum due to insufficient faculty numbers (AACN, 2008a). “U.S. nursing schools turned away 40,285 qualified applicants from baccalaureate and graduate nursing programs in 2007 due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints” (AACN, 2008a, ¶ 3). As concern for the consequences of nurse shortages mount, challenges to the healthcare system add another dimension to nursing’s quandary, although one that may actually help rather than hinder. The rise of clinical or practice doctorates has developed in large part out of the crisis in our healthcare system in terms of both serving the public and meeting nursing’s education need for qualified faculty at the baccalaureate and graduate levels.

Prevailing problems with dispensing poor quality healthcare and the need for an interdisciplinary healthcare system are forces serving to reform healthcare education. These same forces also assist the advancement of healthcare fields to the clinical doctorate (AACN, 2004; American Physical Therapy Association, 2007, IOM, 2003). Clinical doctorates are more practice oriented and de-emphasize the research requirement -- a prerequisite to the Ph.D. -- a requirement often viewed as a barrier to degree completion (CGS, 2007; Downs, 1989). Professional nursing hopes to increase the pursuit of doctoral study within the field (AACN, 2008a, 2008b). Advancing nurse practitioner degrees in this manner could potentially increase the numbers of doctoral-prepared graduates and, hopefully, from the nursing perspective, create a corresponding rise in professionals interested in becoming nurse faculty (AACN, 2008b). By increasing qualified faculty at schools of nursing, the possibility for expansion of student enrollments may also develop, and may result in alleviating nursing shortages.

Over time, the problems of our nation's healthcare system have greatly overwhelmed both professionals and the public. In response to frustrations on every level, the Institute of Medicine (2003) developed a three-prong approach for improving healthcare in America. The first phase of the IOM's effort set out to define the problems found in the system through a literature analysis. This review evaluated quality of care concerns, assessing errors with regard to death rates and iatrogenic services, leading to a report entitled, *To Err Is Human* (IOM, 1999, 2003). That report characterized the broken nature of the U.S. medical system, highlighting the human destruction and harm imposed by healthcare providers who desire only to provide quality care, but are attempting to do so in an environment lacking sound infrastructure, training, and support. The IOM's second phase involved developing a plan for reinventing the health care system, metaphorically referred to as building a bridge to cross the chasm back to quality, "the

Quality Chasm report”, *A New Health System for the 21st Century* (IOM, 2001; IOM, 2003, p. 3).

This report sets a broad based comprehensive agenda redesigning the healthcare system based upon “six national quality aims: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity” (IOM, 2003, p. 3). Furthermore, this same report emphasizes “10 major recommendations for reforming health professions education to enhance quality and meet the evolving needs of patients” by focusing on “ways of integrating a core set of competencies into health professions education” (IOM, 2003, p. 13). Ultimately, the IOM plan will require many layers of change through out healthcare, and more than a decade to complete.

The third phase of the IOM plan required consensus from the professions, as well as forward momentum. A health professions education summit assembled more than 150 interdisciplinary experts for an exchange of ideas on education reform (IOM, 2003). *Health Professions Education: A Bridge to Quality*, the resulting summit report, launched the IOM plan for healthcare education reform and the aforementioned recommendations or required competencies (IOM, 2003). Among the tenets of the plan is a notable statement driving change for nursing education, “All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics” (IOM, 2003, p. 3). The argument made by nursing’s professional accreditation body justifying the practice doctorate stems from this Institute of Medicine (2003) tenet (AACN, 2004). Furthermore, a timeline for plan integration includes altering competencies and requirements through bodies of accreditation, certification, and licensure (IOM, 2003). The Institute projects the plan will require more than a decade to complete (IOM, 2003).

The American Association of Colleges of Nursing (2004) along with other professional

groups and healthcare organizations is responding to the IOM reform recommendation. In 2004, the AACN recommended a career entry degree change for advanced nurse practitioners (ANP), a doctorate of nursing practice -- the DNP, justified by these reports circulated from the Institute of Medicine (2003) to reform the healthcare system through healthcare education. One year later, the Commission on Collegiate Nursing Education (CCNE), the autonomous accrediting body of the AACN “decided that only practice doctoral degrees with the Doctor of Nursing Practice (DNP) title will be eligible for CCNE accreditation” (AACN, 2004, ¶ 1). As interdisciplinary care resurfaces from the Institute of Medicine reform movement, nursing strives to clarify nurse education by defining its highest degrees. The response to nursing’s effort by the universities where their programs are embedded is of considerable interest to the field in general, and to higher education overall. The opportunity to study this phenomenon is timely as this process is currently unfolding at many other institutions.

Doctorate Education in Nursing

Origins

In the United States, early doctoral education grew out of the European model. The Ph.D. found its way from Germany to the U.S. in 1861 when Yale awarded its first doctoral degree (Andrist et al., 2006; Downs, 1989). The Yale professoriate had received their Ph.D.s in Germany, and in turn, brought the degree to Yale, the largest college in the nation (Andrist et al.; Thelin, 2004). Prior to that time, baccalaureate education was all that was available in the U.S.; graduate education was not offered; master’s degrees were nonexistent (Andrist et al.).

Parallel growth of Ph.D. education and professional organizations occurred in the late 1800s, coinciding with the opening of the first nursing programs in 1873 (Andrist et al., 2006; Downs, 1989; Thelin, 2004). Along with the growth of professional organizations came the rise

of university education, although even in 1890 the reality of university education was limited (Thelin). Despite the general curriculum inconsistencies of the era, John Hopkins University set the benchmark for medical school education by requiring baccalaureate degrees prior to entry and developed “a sequential curriculum, a hierarchy of instruction and certification whose capstone was the Ph.D.” (Thelin, p. 129).

The rise of the research universities in the early 1900s led to expansion of doctoral education and the addition of master’s level education (Thelin, 2004). The popularity of colleges as a social construct of the newly rich in this era as well as the increased access of post secondary education from land grant university expansion during the mid-1800s created applicant pools for graduate education (Thelin). The Ph.D. required doctoral candidates create, conduct, and defend independent research while assisting national as well as institutional interests through scientific advancement (Thelin).

Early Ph.D. curricula lacked consistent standards, were primarily available in the sciences, and generally required prerequisites outside the scope offered to nurses of this era, and, more specifically, to women (Andrist et al., 2006). Initially, nursing programs were founded in hospitals, but later, during the 1940s and 1950s; RN programs began developing in colleges and universities (Andrist et al.). As four-year programs became more commonplace in nursing, concern for the hierarchical traditions of higher education came into question (Andrist et al.). The appropriateness of the doctoral degree as prerequisite to the university professoriate was frequently addressed (Andrist et al.).

Doctoral education for nursing was established as a Doctorate of Education (Ed.D.) in 1924 at Columbia University Teachers’ College (Yam, 2005). Initially, nurse doctoral degrees grew out of schools of education as a logical solution to the need for nurse educators, although

equally important was the receptivity of these schools to nurses as students (Edwardson, 2004). Andrist et al. (2006) describes four eras of nurse doctoral education evolution: 1900-1940, 1940-1960, 1960-1970, and 1970 to present (Table 1. Phase Development of Doctoral Education, Appendix A). Despite nurses acquiring doctoral degrees during the first three eras, doctoral education for nursing was not specific to the field until the 1970s (Andrist et al.). Once the Doctor of Nurse Science (DNSc or DNS) and the Ph.D. with a nurse minor became available, programs rapidly proliferated across nurse education (Andrist et al.). Limitedly developed were nurse doctorate (ND) programs. These programs were designed to educate clinical nurse leaders, but developed only four programs nationwide, the first of which opened in 1979 (Andrist et al.; Downs 1989). As this review considers the definitional confusion between doctorates for nursing, the role the ND plays in the advancement of the doctorate nursing practice (DNP) will be discussed further.

Doctoral definitions

Poorly described definitions between the academic/research doctorate and professional doctorate fuel controversy in nursing specifically, but generally across all fields of study and particularly in those fields awarding professional degrees (Andrist et al., 2006; Downs, 1989). Professional doctorates were not viewed as equally prestigious when compared to the academic/research doctorate (Andrist et al.; Thelin, 2004). For nursing, the DNS was presumed by many in education to be a clinical or practice doctorate, but upon closer scrutiny of curriculum as well as exit mastery for the degree, requirements were noted as mirroring that of the Ph.D. (Andrist et al.; Downs). This lack of definition combined with professional education's entrance onto the university stage has tended to exacerbate the argument over what Downs noted as a "never-resolved debate about the basic purpose of the Ph.D." (p. 261). Lack

of an adequate definition with a clear statement indicating, “what constitutes the difference between theoretical and applied nursing research” contributes to consensus failure (Downs, p. 263).

Downs’ (1989) definition of the Ph.D. is based upon the Council of Graduate Schools in the United States (1977). The CGS purpose of doctoral program design is “to prepare a student for a lifetime of intellectual inquiry that manifests itself in creative scholarship and research often leading to careers in social, government, business, and industrial organizations as well as the more traditional careers in graduate study ...” (p. 261). If instead, we reference Downs’ words, “lifetime intellectual inquiry” includes “research and scholarship”; along with “government, business, and industry careers”; and ultimately results in broadly constructed knowledge; the definition seems more succinct (p. 262). Yet, in reality both definitions add to the dilemma of poorly designed doctoral education definition since this definition has sometimes been interpreted as meaning “career preparation” for both the Ph.D. and the professional degree (Downs, p. 262). While debate over the purpose of the Ph.D. continues to rage; nursing education struggles with the same concern in defining the purpose of the clinical doctorate.

Recent efforts by the Council of Graduate Schools (2007) have focused on bringing greater clarity to the definition of the practice doctorate and the Ph.D. Prior to those efforts, the AACN (2001) developed a position statement on Indicators of Quality in Research-Focused Doctoral Programs in Nursing. In this statement, the AACN delineates the differences between the two doctorates in detail, but in the Position Statement on the Practice Doctorate, they simplify. Ph.D. nursing programs (DNS or DNSc) are designated as research-focused doctoral programs for “prepare[ing] students to pursue intellectual inquiry and prepare independent research for the purpose of extending knowledge”(AACN, 2001, ¶ 3). DNP programs are a

second category or practice-focused programs with “emphasis on research application” (AACN, 2001, ¶ 4). DNP programs are then compared to programs in medicine and dentistry, programs where no research requirement exists (AACN, 2001). Then follows a discussion of the third doctoral degree, the nursing doctorate (ND), defined as preparation of students for practice, and are not research-focused (AACN, 2001, ¶ 5). The interesting connection between ND and DNP programs is all ND programs are now converting to DNP programs. Ultimately, the difference between the *research-focused* and the *professional* doctorate is the lack of research requirement for the professional doctorate; the focus is on expertise in the clinical discipline.

Returning to the researched-focused doctorate momentarily, the AACN (2008c) endorses a “preferred vision” of the “nursing professoriate” and includes these two key statements: “Doctoral graduates who will be involved in an academic role will have preparation in educational methods and pedagogies” (¶ 3); and “courses in the nursing program will be taught by faculty with graduate-level academic preparation and advanced expertise in the areas of content they teach” (¶ 7). Through these two statements the AACN upholds traditional university standards for the university professoriate degree hierarchy.

Current status

The accreditation recommendation as stated by the American Association of Colleges of Nursing (2004) requires that the entry-level degree for advanced practice nurses become the Doctorate Nurse Practitioner by 2015. Since the career entry degree for advanced nurse practitioners is currently situated at the masters level and has been for more than a decade, potentially, there will be significant demand for programs addressing the needs of an established nurse population. Furthermore, for students newly entering the field, education will most likely experiment initially, and then standardize to some degree, although still produce alternative

curriculums.

The degree for Doctorate of Nursing Practice is a recent innovation in accreditation and curriculum change for advanced nurse practitioners (AACN, 2008b). Acting as a leader among innovative nursing programs nationwide, the Bolton School of Nursing at Case Western Reserve University (CWRU) (2008) developed the first doctor of nursing (ND) program in 1979. According to the American Association of Colleges of Nursing (2001), “the Nursing Doctorate (ND) degree prepares individuals for practice and is not a research focused degree” (§ 5).

The value of the Ph.D. in nursing versus the practice doctorate remains controversial across the field (Chase & Pruitt, 2006; Dracup & Bryan-Brown, et al., 2005; Ellis, 2007; Gerrish, McManus, Ashworth, 2003). Despite this controversy, in 2005, CWRU revamped their ND program to become a Doctorate of Nursing Practice (DNP) program (CWRU, 2008). Three other colleges of nursing like CWRU previously established ND programs, but also changed their ND degree to the DNP. These colleges include Rush University (RU, 2008), University of Colorado (UC, 2008), and University of South Carolina (U of SC, 2008) (D. Dowling, personal communication, September 15, 2008). Prior to the recent nursing movement toward DNP education, there were only four practice doctorates in the United States. Currently, all former ND programs have converted their awarded degree to the DNP.

In 2005, the University of Kentucky developed the first DNP program in the nation (Dracup & Bryan-Brown, 2005; University of Kentucky, 2008). As a result of efforts initiated as early as 2004, there are now more than 62 DNP programs in the United States, with more than 60 additional programs being developed nationwide (AACN, 2008b). This is an incredible gain in program numbers. Rapid growth in the number of programs, aided by support from the Institute of Medicine and nursing’s accrediting body, assures the success of the DNP within the field and

across healthcare (IOM, 2003; AACN, 2008b). Program success depends upon a ready pool of applicants, as well as available jobs for graduates. By requiring the nurse practitioner field as a whole to shift the career entry degree from the masters to the practice doctorate, a significant pool of graduates spanning more than two decades will require additional education. As the healthcare system reforms to the interdisciplinary model described by the Institute of Medicine (2003), the nursing workforce will be ready.

Institutional Mission, A Frame for Research

As the rate of change in our higher education institutions becomes increasingly more rapid, quite often what is lost is the understanding of how and why such change comes about. Most of the literature on organizational change focuses on effecting change in organizations rather than analyzing how changes in organizations are produced. Literature specifically analyzing *curriculum change*, defined as additions or deletions of courses or programs, is extremely limited (Gruba et al., 2004). In an effort to align this study with curriculum and change, it seems prudent to consider organizational change more generally and higher educational change specifically. The purpose of this next section is to consider the analysis of the how and why, also known as the process of change (Burke, 2002).

Some textbooks on change define basic organization characteristics similar to those found in Colenso (2000) including “strategy”, representing the core or center of the organization, with “processes”, “people”, “structure”, and “hierarchy” as being the defining organization characteristics, and from Colenso’s perspective, located at the four corners of his model (p. 14). Burke (2002), on the other hand, discusses organizations in terms of open system models where every institution has “inputs and outputs” with the “throughput” operating at the discretion of the organization (p. 176). The throughput consists of whatever is embraced and applied by the

organization characteristics, but also aligns with the institution strategy (Burke, Colenso).

Burke (2002) very clearly distinguishes between the “content”, “process”, and “implementation” of an organization during change (p. 14). Content involves institutional mission, vision, values, and goals – those aspects of an institution that define its very nature (Burke). Process considers the plan for change, its initiation and integration into the institution, and its perpetuation (Burke). Process is inclusive of ideas, meetings, conversations, and the actions required to bring about the change, in essence, leadership for change (Burke). This leadership process and its relationship to the institution it serves is the essential focus for this study.

Institutions do not operate in isolation. External and internal forces act upon organizations creating pressures affecting the decisions and actions of people both intrinsic and extrinsic to the institutions. Burke’s (2002) likening the institution to an organism is most apt if that perspective is considered at its most cellular level impacted by a range of temperatures. As change occurs in the external environment, the temperature of the organism adapts producing some level of change. Without imposing some controls the organism might very well shrivel or explode from too much exposure in either direction. Institutions impose their own controls by creating missions, values, and goals and, in fact, the creation of these mission statements are requirements stipulated by accreditation organizations (Burg, 2003; Morphew and Harley, 2006). “To be a vital response to real conditions, the mission has to be aligned with the needs of a constituency of external stakeholders, and these needs change” (Berg, p. 45). Guidance by mission statements provides clear direction for people inside the organization for determining their response to pressures both within and external to the institution.

Bowers (2008) reviewed institutional mission statement language from the perspective of

select researchers in an effort to address university mission influences on capital campaign strategy. Bower's review uncovered four key points concerning mission statement development and use, including: utilization, application, success/failure, and intended use. From Bower's analysis, Morphew and Harley (2006) provided the most comprehensive analysis of mission statements involving a sample of 299 documents. The intent of the study was to evaluate mission statement content differences, and relate those differences to institution type.

From Morphew and Harley's perspective, three discrepant viewpoints are prevalent in the literature about mission statements: 1) mission statements "provide focus and direction to institutions", 2) mission statements "are just formless generalities", and 3) "mission statements are ... normative documents, designed to provide internal and external audiences with evidence of legitimacy" (p. 466). While the results of Morphew and Harley's research demonstrate clear trends between public institutions to align mission statement wording as compared to private institution wording, Morphew and Harley conclude, "institutions include in their mission what their benefactors value" (p. 467). Therefore, as supported by Morphew and Harley's research, mission statements are a reflection of the environment in which the institution is embedded rather than a force driving change. Mission statements do, in fact, provide focus and direction to the institution, as these statements represent the collective interests and values of the stakeholders both internal and external to the institution.

Berg (2003) supports Morphew and Harley's view through his analysis of three institutional external forces that confront higher education institutions including: the domain and field of higher education, external stakeholders, and society at large. Within the field and domain of higher education such constructs as traditional models, curricula, knowledge base, and gatekeepers, which include accrediting agencies are found (Berg). External stakeholders are

comprised of communities, parents, and donors, while social and cultural forces include the economy, politics, and the world-view (Berg). “Alignment exists when the institution provides what external stakeholders expect, need, and value” (Berg, p. 43). Of course, institutions do not always manage to meet the expectations and needs of all stakeholders. Yet, as Berg points out, “stakeholders will be more likely to moderate their special interests if the common goal is meaningful to them” (p. 43). What is sought in creating mission statements is a balanced perspective permitting the institution, comprised of people, its stakeholders, also made up of people, and the pressures acting upon the institution, the needs and expectations of all of the people, to provide a product in the form of graduates, research, and other such academic rewards that can be meaningful to all concerned (Berg). This is no small task for a mission statement in an environment full of diverging interests.

In Berg’s (2003) model of organization, “The Dynamics of Good Work in Higher Education”, the *Institutions of Higher Education*, including trustees, faculty, administration, and students, represent the fourth factor at the core of the model with *external stakeholders*, *social/cultural forces*, and *domain and field of higher education* representing the other three (p. 43). While basically Berg’s model expands upon Colenso’s (2000) model with a general organization structure of “processes”, “people”, “structure”, and “hierarchy” (p. 14), Berg adds specific internal pressures acting upon all four factors including: “expectations, resources, legitimacy, values, rules, models, and content” (p. 43). These pressures influence trustees, faculty, administration, and students as well as exerting influence on the factors external to the institution (Berg). Berg sees institutional mission emanating from the group he labels, “Institutions of Higher Education”, (p. 43). From these institutions, the mission is either aligned with the institution producing good work or misaligned producing compromised work.

Meanwhile, it is important to realize none of these factors and conditions influence separately; instead, the interrelatedness of individual factors and conditions is a circumstance affecting the entire model (Berg; Burke, 2002; Lane, 1996).

Interrelatedness is basic to systemic change (Trinkaus and Booke, 1980). Introducing a doctorate nurse practitioner program to a school of nursing at a health science center university affects not only the school of nursing, but also impacts the hospital, patients, as well as other healthcare professionals and students working along side these DNP students. Programs set within a healthcare environment require a sense of their own mission in order to remain connected to the fundamental purpose and essential elements of the services they provide (Dunn, 2008). Without clearly defined program missions and goals, the pressures imposed on students through the expectations of the surrounding hospital professionals and staff can be overwhelming and confusing (Dunn). However, mission statements for programs must also be congruent with university and hospital mission statements in order for the program and the institution to harmoniously co-exist. On one hand, the university and hospital environment in which this new program is embedded is likely to be program supportive, and undoubtedly aligned with the Institute of Medicine's (2003) education reform movement. On the other hand, a program designed to address future needs of a restructured healthcare system, one that does not currently exist, will initially navigate a course through the confines of an unchanged system. Resistance to change is likely to be greatest at this point of program inception. The future will remain uncertain for some time. Yet, if the program fulfills the needs required by the healthcare system and patient population, then the program will likely become an asset to the institution rather than a risky liability.

From this analysis of institutional mission statements, the importance of the institutions'

stated mission, goals, and values as they influence the organization's interrelated parts should be evident. Using mission statements that first align goals and values of all organization stakeholders and then assess organization congruence with the change process occurring inside one segment of the institution can be a very useful research tool. Aligning the process creating and implementing a doctorate nurse practitioner program in response to nursing's accreditation recommendation with institutional mission may demonstrate community support both internal and external to the institution. However, if the change process fails to align with the institutional mission, or aligns only in part, then altering the nurse practitioner entry-level degree from masters to practice doctorate may not necessarily be serving the good of the institution nor the community it serves.

CHAPTER THREE

Research Design and Methodology

As described in the introductory chapter, the purpose of this research was to investigate the decision process underlying one health science center's support for nursing advancement through the addition of a web-based DNP program, and how this curriculum satisfied institutional mission and goals. The methodology employed was a combination of qualitative and document analysis culminating in the production of a decision and process narrative followed by an analysis of influencing factors.

While the research design compared two informant groups, the actual research site constituted a single case study. This next section begins by describing the institution selected for this project, followed by a discussion of data collection activities, data analysis, specific delimiters along with study limitations, and concludes with the significance this study expected to provide for higher education, nursing, and the health care system.

Site Selection

Health Sciences University (HSU) College of Graduate Nursing was chosen as the site for this single case study, because a doctorate of nursing practice program was recently added at the college. HSU's recent experience with planning, designing, and subsequent opening of their program makes their nursing graduate school an ideal site for such a study. The Graduate College of Nursing (GCN), often referred to in many studies as School of Nursing (SON), represented the primary site, although the leadership involved in this decision was drawn both from the GCN, as well as from the entire university. As such, the site selection was actually two-fold, 1) the graduate school of nursing at HSU, primarily involving faculty of all ranks, as well as the GSN dean, assistant dean and program directors, and 2) the larger institutional leadership at HSU, involving graduate school deans, assistant deans, university provosts, vice presidents,

directors, and program directors. Two distinct informant groups were identified and will be referred to as *HSU administrators* and *GCN faculty*.

Choosing the specific site for this study was not without challenge. The institutional decision process imposed pressures and concerns for university leaders of a sensitive nature. Sharing this course of action while transitioning through the challenges was difficult for institutional leaders (like graduate school deans, assistant deans, university provost, vice presidents, directors, and program directors; as well as the nursing graduate school faculty including all levels of professors) due to the responsibility imposed by weighty institutional and quality control concerns. Not all new programs have sufficiently transitioned through the decision and implementation phase; resistance to program research during this phase relates to the sensitive nature of those concerns.

My search for an appropriate institution entailed contacting two programs. Each program fit the criteria of having recently developed a new and innovative DNP program, but the most important caveat was they must also be open to the discussions required for my understanding their decision process. Only three DNP programs existed in the state. Also, from among these three programs, only one institution, the health science center, was specifically situated within the broader context of the healthcare system. Alternative states were considered, but the research design along with increased distance would add access difficulty and expense to the study; therefore, every effort was made to select a site close in proximity to me as sole researcher. Two of the three programs were contacted, and HSU confirmed their willingness to participate in the study.

The HSU nursing graduate school not only distinguished itself by developing the first Doctorate Nurse Practitioner program in California, but also added technological innovation by

developing the first program of its kind in the nation -- a web-based DNP program (HSU, 2008). The convenience of web-based education addressed issues of limited access across social and economic barriers as well as those barriers resulting from time and location (Online Nursing Programs (ONP), 2008). The challenge in changing the career entry degree for an established profession suggested current masters graduates required additional education for the practice doctorate. At least for the current enrollment population, this DNP program will most likely pursue students from an established nursing community.

Data Collection

Single case study reliability is best achieved when multiple sources are used in data collection. Sources included interviews from multiple selected groups within the case and combined with document analysis and observation in order to triangulate data (Glesne, 1998). Both approaches served to effectively improve research reliability, but in this instance, observation occurred during interviews primarily, since the decision process under investigation already occurred. Institutional documents identifying university mission, goals, and values served to define institutional purpose and then permitted comparison against interview data. Cross checking purpose among HSU leaders and GCN leaders against the institutional purpose assisted in determining whether informant purposes aligned with the institution or were motivated by personal reasons, professional advocacy, or other special interests.

As research began and progressed, the data collection for this project primarily involved interviews from two informant groups consisting of individuals occupying leadership roles normally involved in institutional curriculum change: HSU leaders, including graduate school deans, assistant deans, university provosts, vice presidents, directors, and program directors, and GCN leaders, involving faculty of all ranks, as well as the GCN dean, GCN assistant dean and

GCN program directors. Five informants in the HSU administrator group, seven informants in the CGN faculty group, and one external informant was also interviewed, and resulted in thirteen informants altogether. Questioning two distinct groups, university leaders and GCN leaders, in one sense creates two cases and enables data comparison between groups. The comparison of the collected data from each group against the institutional purpose triangulated the data and assisted research validity.

The initial informant list was constructed from HSU's administrative leadership hierarchy, and the graduate school of nursing leadership and faculty found on the university website. At the outset of the investigation, subjects were initially sought from the graduate college of nursing faculty, followed by interviews with university administrators. Informants were also acquired through chain or snowball sampling where each interviewed informant was asked to recommend individual(s) known to them who might provide useful data for the study (Patton, 2002). The question prompting the names of additional informants was included as part of the interview guide. This question sought to assure conversations were held with all involved members of the university leadership and GSN communities, and insured complete analysis of the decision process and the DNP program design. As interviewing progressed, additional informants were added to the study until suggestions to the list of unidentified informants ceased to uncover new informants. The number of research participants was expected to be approximately 10 in each group for a total of 20 participants, but the actual total was thirteen. Informants were identified throughout the data collection process.

A preliminary analysis of each subject's actual involvement in the decision process and program design was necessary. Interviews included informants who either participated in the decision to add the DNP program to the Graduate School or who were involved with its

development, or both. The underlying assumption suggested not all informants participated in both parts of the process, or perhaps even at all. Certainly some participants were involved in both aspects while others were situated at either end of the process. These differences were accounted for and coded appropriately for subsequent data analysis.

Initial contact with subjects began after formal approval was received from the university's institutional research board. Email correspondence was sent to each subject and an initial telephone conversation requested (Initial Email Contact to Informants, Appendix B). Telephone interviews were conducted as quickly as possible in order to determine the subject's willingness to participate in the research (Telephone Interview Protocol, Appendix C). I created handwritten summary notes of each conversation to assist the telephone interviews and aided early data analysis. Upon concluding conversations, I sent follow-up emails confirming participant agreements as well as scheduling in-person interview appointments with each informant (Follow-up Email Contact to Informants, Appendix D). Individual in-person on-site interviews at times and locations convenient to subjects was the next step. A preliminary schedule of interviews was created prior to traveling to the institution; schedule flexibility was factored in for unanticipated changes.

All study informants were questioned using an interview guide to maintain the continuity and integrity of the interviews (Interview Guide for In-Person Interviews, Appendix E). I spent approximately sixty minutes with each informant, digitally recording the conversation for later transcription, as well as making notes emphasizing relevant points as interviews proceeded. Informed consent was obtained immediately prior to the interview (Research Participant Consent Form, Appendix F). A digital recorder, as well as a pen, and sufficient supply of legal note pads were used during interviews. Field notes describing observable body language and behavior as

they related to important informational points were handwritten during each interview. Memos were handwritten and recorded as the need arose throughout the site visit. An independent transcriber transcribed all recordings at a later time. As data was collected from each informant, field notes were reviewed and a formal summary document created. Field notes and memos assisted early analysis during the data collection phase (Miles & Huberman, 1994; Patton, 2002; Yin 2003). Such analysis was helpful in identifying early patterns and expedited data analysis later in the process. Informants were re-contacted following data transcription and analysis to confirm that the data reflected their intended meaning. This step insured consistency between data collection and analysis, and also promoted research validity.

In addition to the interviews, institutional documents reporting the university mission, values, and goals were sought and analyzed as a means for establishing the overarching purpose of the healthcare university. Key documents included institutional reports, publications, and web site data inclusive of program curriculum. Other records associated with the institution and accreditation body discussion and the subsequent program development were unavailable.

Data Analysis

A number of potential methods for analyzing qualitative data were considered, including meaning condensation, meaning categorization, narrative analysis, hermeneutic meaning interpretation, and ad hoc methods (Lee, 1999). From among these methods, researchers suggest the use of overlapping methodology as best practices for triangulating data (Lee). Narrative analysis along with meaning condensation was primarily employed for informant data analysis in this study. Document analysis constituted the third analytic dimension for the project, assisting overall analysis and triangulation of the data for purposes of validity.

Narrative analysis

From the recorded data, an independent transcriber produced a verbatim word-processed transcription record. I read each record from beginning to end approaching each record separately. I then re-read the same record searching for a logical order for causal events, social proportions, and any underlying plot thread (Lee, 1999). Then, through the use of word-processing, I arranged previously recorded dialogue in a more logical sequence to produce a narrative dialogue reflecting the linear occurrence of events in closer accord to chronologic sequencing. Each record was analyzed separately to produce individual narratives, the goal being to produce the most compelling, complete, and detailed narrative from among the sample. Two narratives from the data in each of the two groups, university administrators and the graduate school of nursing faculty, emerged as useful for reporting results.

Meaning condensation

From the recorded data previously transcribed by the independent transcriber, I read each record from the beginning to the end, reading through all records completely to gain a sense of what constitutes consistencies across all records within the data set. I returned to each record individually, and reread each singular record completely, and then separated succinct phrases or what Lee (1999) refers to as “units” that fit an identifiable category or theme (p. 90). Essentially, the dialogue from each record broke into themes emerging from the data. As interviews were analyzed, the dialogue was condensed eliminating “superfluous material” and refocused upon “essential” rather than “non-essential” information (Kvale, 1996, p. 192). Categories and themes emerged; pattern matching from among these themes aided the development of an explanatory theory. The relevance of the category or theme related specifically to my research questions identifying the influencing factors, both internal and external to the decision process, as well as

the influence of the institutional mission, goals, and values. The analysis tied these themes to the resulting theory or outcome. Specific research categories were drawn from known factors influencing institutional change (Research Categories, Appendix G). In order to insure the accuracy of the data, attention was paid to the use of the informants' intended meaning. Follow-up conversations with informants was employed when printed data presented as murky or unclear in its meaning, but was limitedly available.

Once data analysis was complete, the results were written to produce a comparison of each participant group against institution mission and goals, *HSU administrators* representing one group, and *GCN faculty* representing the other. Then, a comparison was made to uncover similarities and differences between groups with an assessment as to how well each group individually and then collectively aligned with the institution's mission and goals. Representative stories emerged from the narrative analysis, and highlighted examples for emphasis and validity.

Delimitations and Limitations

Choosing the single case for research design was, of course, a limiting factor for generalization. In other words, the research findings were restricted by the bounded nature of a single case; they were specific to the location being studied. The design of this study restricted the results to DNP programs embedded in a graduate college of nursing at a healthcare university center and then further restricted results to a Doctor of Nursing Practice (DNP) program using web-based curriculum. Furthermore, the specific nature of the curricular design further limited the lessons learned to programs intending to develop web-based curriculum or to ones currently designed as web-based. Single case studies, however, can also be used as exemplary when developing a model rather than intending to contrast findings (Yin, 2003), although developing a

model was not an explicit goal of this research.

Personal bias is always a concern in qualitative research. My perspective as an oral health educator and clinician with a widely varied experience in health care settings and practice shaped and influenced my researcher role as did my age -- middle age, gender -- female, ethnicity -- white, socio-economic status -- middle class. Traditional systems of health care and nursing practice have been ingrained in my thinking for more than half a century. Healthcare terminology was familiar to me, as was the interdisciplinary nature of healthcare practiced in the hospital setting. Familiarity posed a certain risk for me and resulted in some assumptions and at times caused me to overlook important details. Self-awareness was key and critical to producing unbiased research results. I remained attentive to the environment as well as the details of terminology and practices, and as on-site interviews and tours took place, I made notes concerning my own reaction to my observations and experiences.

On the other hand, my age, gender, ethnicity, and SES fit the demographics of the majority of nurse leaders and promoted a tendency among informants to treat me as one of them; still, I was an outsider to the field being studied. The outsider role was an advantage; nursing practice is not my field, and therefore, being less familiar, I was less inclined to make assumptions about nursing practice and the design of its curriculum. The tension between the outsider role, and possessing similar demographics to DNP field members, as well as my healthcare background proved useful for gaining access to sensitive information. This tension was also helpful in maintaining sufficient distance for objectivity. As a researcher, I remained self aware as I engaged in the research process, while creating a safe and receptive environment for informants.

Significance

This case study served to highlight the goals and expectations of higher education leadership at HSU while a new DNP program was developed. The degree to which institutional leadership was in alignment with the institution's mission and goals became evident. Such information may prove instructive for future institutional planning in health professions education. Additionally, this project may assist future leadership decision-making with regard to program implementation in the health sciences.

While most institutions incorporating a DNP program would consider the practice doctorate degree innovation enough; HSU's development of the first web-based DNP program in the nation produced specific insights for curriculum development and may prove useful to other institutions who have yet to add a DNP program to their nursing school. In that the graduate college of nursing was also embedded within a university healthcare center, an institutional circumstance not common to all nursing graduate schools, healthcare centers may benefit from my research findings. Importantly, DNP programs are in their infancy, and few programs have been studied (Brown et al., 2006), this study contributed to an undeveloped area for research, and assists in pointing the way for future research.

CHAPTER FOUR

Findings

Introduction

This study uses both document and narrative analysis along with meaning condensation to examine the decision adding a Doctor of Nursing Practice (DNP) program to an institution of higher education following related although undisclosed mandates by the regional accreditation body. Undisclosed mandates slowed the accreditation process for the DNP program and delayed program opening. The intent of this investigation is to identify both external and internal factors leading the institution to add their web-based DNP program, and then to examine the extent to which the responses of administrators and faculty members were consistent with the institution's mission, vision, and goals. What follows in the next five sections of chapter four are a review of the data collection, analysis, and a discussion of participant demographics. This chapter goes on to address institutional context and research findings from both faculty and administrator case groups. Findings will be positioned within the context of the two research questions originally discussed in chapter two; they will be addressed individually.

Data Collection

Data collection for this study began in March 2009. Contact emails were sent out the first week of March. Responses were requested from interested faculty within the College of Nursing as well as from college and university administrators. Email addresses were obtained through the university web site. At first, the College of Nursing participants were cautious; responses were slow. Discussions initiated by nursing faculty

with the institutional contact person improved participant response rates. Many nurse participants questioned the institutional contact person about participating in my research. They later shared their concern with me as being cautious and wanting to insure my research had received all of the appropriate levels of approval. Those who expressed concern received assurances that participation was acceptable and in-line with institutional requirements. Telephone interviews began in late March, and concluded in early April 2009. Telephone interviews were not recorded. Notes were handwritten and later typed. During the post-interview typing the disadvantages of handwritten notes over recorded data became evident -- a novice researcher error.

Some College of Nursing participants failed to respond to my emails requesting the scheduling of a telephone interview, although previously had indicated interest in participating in the study. Institutional accreditation was ongoing; administrators at all levels were burdened with added layers of work; and were the stated reasons for the non-response. The institutional contact person communicated these impediments to me through email. In the interest of expediting my research, I embarked upon a scouting expedition and traveled to the university in mid-April. My intent was to develop some contact with the administrators and/or faculty associated with the college, be available and ready to interview people should they offer. I made no formal request for interviews. At the same time I speculated that visiting the campus might assist me in developing a feel for the institution, the buildings, the general campus layout, the library, finding the college, as well as providing an opportunity to evaluate university research facilities. I was not disappointed. My scouting expedition was successful and resulted in my first administrator interview.

While initial email contact delayed the start of my in-person interviews, my scouting mission resolved the delay. I had only just arrived, parked, and obtained a parking permit. I was about to take a foot-tour of campus when my institutional contact person drove into the parking lot. While I recognized the contact person from an institutional web site photo, I was surprised this person approached me and introduced herself. Upon disclosing my identity, this contact person became very excited, left me abruptly requesting I wait for her, and returning moments later, she indicated one of the administrators would like to give me an interview since I was on campus and it was a good time for her. People were generally warm, friendly, helpful, and interested. Even campus security made an effort to insure my visit was positive and without incident assisting me with information concerning parking rules and regulations. People went out of their way to make me feel welcome, and assisted me as much as possible. I was further rewarded by one participant's willingness to be interviewed that day.

My in-person interviews began in mid-April 2009. For this first interview, I combined the telephone interview protocol with the in-person interview protocol in an effort to be thorough and address all research questions. My research protocol specified preliminary contact would involve telephone interviews with early participants. The research protocol also accounted for interview variation; not all interviews would include a telephone interview. Upon reviewing the transcription from this first interview, I realized covering data from both interview protocols was repetitive and unnecessary. All other in-person interviews were conducted using only the in-person protocol. As interviews progressed, I was encouraged to interview two participants emerging from popcorn sampling and identified as having no real knowledge of college curriculum and

education practices. For that reason, questions pertaining to program and curriculum design were skimmed over and in some instances completely eliminated for those two participants. This modification was made in response to requests on their behalf by faculty and administrator participants in an effort to expedite these interviews and focus on the specifics of their knowledge. No other modifications were made to the protocol.

On-campus face-to-face in-person interviews concluded in mid-July 2009. The process of interviewing faculty and administrators spanned four months and included twelve interviews. A final interview was obtained in the first week of November 2009 from an external perspective. This participant surfaced from popcorn sampling. Popcorn sampling produced interviews with five of the 13 participants. Additional recommendations for study participants were suggested, but resulted in non-responses.

All participants were contacted initially through email. Email contact initiated the scheduling of telephone and some in-person interviews (Table 2. Participant summary by type and interview, Appendix H). Only one administrator participated in a telephone interview. All participants engaged in the in-person interviews and the number of those interviews equaled the size of my sample. Telephone interviews were developed for initial contact, demographic data, uncovering interest in study participation, brief assessment of decision and process knowledge, and then scheduling of in-person interviews. Informed consents were emailed to participants before engaging in telephone interviewing. Participants agreed both verbally and in writing prior to all interviews. Signed consent forms were mailed from participants to my home in advance of the interviews. As interviews began, the consent form was read to the participant prior to the

interview during both the telephone and in-person sessions. All participants agreed to participate in the research.

After the completion of my data collection, and once recordings were transcribed all participants were sent copies of their transcribed data through email. Transcription review was requested from all participants for their comment or clarification based upon previous participant agreement. As of this writing, seven participants acknowledged receipt of the data; six participants did not respond. Only one participant provided additional information.

Data Analysis

Transcriptions were read in accordance with the order in which the data was collected. Gaining a broad overview of the data was the primary goal. No notes were taken during this initial reading. I combined audio listening along with transcription analysis. The audio component assisted data comprehension overall.

Data coding was included as a component of the second reading. A category-coding sheet (Research Categories, Appendix G) distinguishing nine specific color-coded categories for purposes of data break out was reference accessible throughout the coding process. Again audio recordings were utilized in combination with the reading of each transcript as data was reviewed. Transcripts were read according to the original order in an effort to maintain continuity. This arbitrary order of analysis mixed the participant perspectives among case groups. Participants were divided into two case groups: The College of Nursing faculty and the university administration. During any one reading, the investigator might have been reviewing both perspectives. This approach prevented early and possibly premature conclusions.

Transcripts were coded using the color-coding system from the category-coding sheet and line numbering was applied to the document (Research Categories, Appendix G). The data was then organized into category documents and divided by case groups as well as by primary and secondary participants. Primary participants were defined as the most knowledgeable participants corresponding with their greater role and involvement in the process. Keeping like data with like data aided the next step, data synthesis. Category folders were created for each case group and were divided into primary and secondary participants. Four folders resulted; each folder contains nine category documents. Each document maintained participant identity within the document through the use of line numbering and labeling.

After completely coding all interview data for all participants, analysis was narrowed to the most informed of the participants from each group in an effort to garner the story lines from each case. Primary participants for each case group defined the story lines. Data summaries were created for each category. Summaries were organized according to case group and participant identity was maintained throughout. This analytic approach aided retention of the contextual pieces of the data and made synthesizing the data easier while a broad outline guided the synthesis. Once the story line for each case was established, the data from other case participants was added. Overall, this system facilitated the process of filling the gaps between participants and made it possible to highlight areas of agreement and difference.

Pseudonyms used as citation references were established during analysis, and developed as an acronym coding system rather than producing fictitious Christian names like Susan for example. Acronyms served to protect the anonymity of the participants

while assisting researcher analysis reference. Acronyms created a reliable system for identification of the reference data and its source.

Demographics

The overall sample for this study is comprised of 13 participants and, as previously mentioned, is broken into two case groups, faculty and administration. Seven participants are faculty, five are administrators, and one participant represents an outside perspective from the regional accreditation agency. The demographics of faculty members will be examined initially, followed by administrator demographics, and ending with the external perspective. Participant education level will also be noted.

All college faculty participants fall into demographic categories of white, female, and middle age. This sample represents a classic demographic pattern found broadly across nursing education. In addition, degrees held by faculty participants include: the Doctor of Philosophy (Ph.D.) degree in nursing, Education Doctorate (Ed.D.) degree, Juris Doctor degree, and Master of Science degree in Family Nurse Practice. DNP student perspective is also included.

Constituent roles vary within the faculty group. All members of the group represent teaching faculty; some faculty carry various college administrative responsibilities. Faculty work status varies among participants and includes part-time or adjunct, and full-time status; the details of those assignments were not specified. Varying levels and degrees of teaching administration responsibility was shared by part-time faculty. Overall, the faculty sample represents nurse practitioner perspective over other master's level programs at the College of Nursing, and is inclusive of DNP student

perspective, a decided sample weakness. Nursing entry level is not represented in this sample.

Within the administrative sample, group demographics demonstrate that all candidates fit the category of middle age and white. Gender varies more in this group with three participants being male, and two female. Upon examining administrator education background, it was noted that all participants possess advanced degrees; two administrators hold Doctor of Philosophy (Ph.D.) degrees. One administrator participant holds a master's degree in family nurse practice and was actively engaged in earning an Education Doctorate. Degrees held by administrators include a Master's in Business Administration (MBA) and accounting.

Demographic homogeneity surfaced again for the external perspective. White, middle age, and female are consistent categories within the demographics for the faculty case and also representative of 2/5th of the administrative case participants. Furthermore this participant possesses advanced degrees in nursing, holds a Doctor of Philosophy (Ph.D.), and has extensive background in higher education administration. These education credentials broadly align with demographics from both faculty and administrators. This participant also has knowledge and background in regional accreditation.

Setting

Health Sciences University (HSU) is located in the southwest region of the United States and embodies the essence of a small sleepy western community. The town is mostly filled with small shops and restaurants; many streets are blocked to through traffic affording a slower pace for residents as well as university students. The university

buildings are clustered in a line of three city blocks located along one street on the northeast end of town. Buildings face one another with park-like walkways in between. While each block of the university has some traffic at either end of the block, the main university thoroughfare is closed to all but foot traffic with parking located in areas behind the buildings or on local streets.

For the most part, buildings are architecturally homogenous and modern in design. Student and administrative buildings are central to the campus, while individual colleges are positioned on either end, except for the College of Nursing. The College of Nursing, like the university library, is located a few blocks south of the main campus and at the most western end. Although the library emulates the same architectural influences of other university buildings, the college is housed in a two-story brick building formerly owned by a local bank. The architectural differences between the college and the rest of the university are striking. This architectural inconsistency visually suggests some lack of continuity for the College of Nursing with the rest of the university. While this architectural point was only discussed with one faculty participant, the inconsistency was duly noted as a function of differences among student enrollment numbers and resource inequity.

Findings

In the section that follows, an overview of the decision to add the Doctor of Nursing Practice (DNP) program will be revealed as it surfaced from the interview data and will be embedded in the context of the institution. A discussion of the ensuing process moving the institution from the decision forward to program approval will follow along with a brief clarification of the significance and realities of the DNP degree. My

research questions will then guide the discussion of factors both supporting and inhibiting the decision as well as the process adding this DNP program to the College of Nursing at HSU. Pertinent documents will be discussed during the section focusing on the research questions.

The Story

Health Sciences University (HSU) aspires to be one of the leading health science institutions in the country, and to that end, has acquired most of the recognized health science doctoral-level education programs available. The private university follows a humanistic tradition educating healthcare professionals to become caring and compassionate practitioners. Dedicated to creating change in the medical sciences, the university graduates highly competent health professionals that give value back to the community. All colleges from among the HSU collection of colleges graduate students at the professional doctoral level.

From among the five Health Sciences University (HSU) colleges, the College of Graduate Nursing (CGN) is a model for nursing excellence, and is in touch globally and nationally through their professional organization, the American Association of Colleges of Nursing (AACN). The college is considered an innovator among nursing colleges achieving broad recognition for their master's nurse entry (MSNE) and Doctor of Nursing Practice (DNP) programs. The university administration believes the program not only fits the university mission, but also enhances it. Motivation to create the DNP program arose from the College of Nursing perspective; being student centered is part of the college mission.

The founding program for the College of Graduate Nursing is the Master's in Nursing Family Nurse Practitioner (MSN/FNP) program, which is also a web-based program. Reportedly, the strength of the nurse practitioner program increased the likelihood of developing a strong Doctor of Nursing Practice (DNP) program, and overall, influenced curriculum design. The College of Nursing is known for strength in leadership and strives for quality. Guided by the DNP essentials, adult learning theory, as well as experiential, collaborative, and student-centered learning, the MSN/FNP program acted as a motivating force for degree change.

Across nursing, many master's prepared nurses expressed interest in alternatives to Doctor of Philosophy (Ph.D.) education. Changing degrees and advancing education standards across health science education was becoming a growing trend and professional accreditation agencies seem to be driving it. Although, as one participant noted "... it really wasn't just the American Association of Colleges of Nursing (AACN). It really was the professional need that wasn't being met by the Ph.D." (F2AD, personal communication, May 19, 2009). From the nursing faculty perspective, nurses interested in obtaining doctoral level education wanted a clinical degree not a research degree.

Health Sciences University (HSU) is primarily a teaching institution. When the university acquired a new Provost, that purpose was modified somewhat. The charge of the new Provost was to elevate health sciences research, and add vulnerable populations to the mission statement. Both goals are addressed through the university mission and strategic plan. The university focus on vulnerable populations includes educating people with disabilities, not just treating them. For example, a short time ago, the university graduated a blind medical student. The medical student developed blindness while

attending HSU. Another student enrolled in the HSU Physical Therapy program and was already blind. These two student examples illustrate educational needs and desires on the part of people with disabilities. Such students also require some level of ongoing health care. Blindness like other disabilities does not easily mesh with education models currently in use. Institutions of higher education frequently do not address the needs of such students well, if at all. The inclusion of vulnerable populations is an excellent match to the long-established humanistic tradition of the institution.

Nursing as a profession works closely with underserved populations. In this capacity, nurses look at government policies that impose barriers to getting appropriate care. Frequently, nurses provide an effective and powerful source for patient advocacy; and over time, nursing has assisted managed care organizations in modifying healthcare directives to accommodate people with disabilities. Overall, the Health Sciences University (HSU) mission fits with the College of Graduate Nursing (CGN) mission of serving vulnerable populations.

At the national level, professional nursing faces pressure to advance the nurse practitioner degree. The American Association of Colleges of Nursing (AACN) developed the Doctor of Nursing Practice (DNP) curriculum model and then proposed the degree change for nurse practitioners, a change anticipated to also address the nursing shortage. In the healthcare reform arena, healthcare education broadly influences reform, and nursing plays a significant role. In creating a DNP program for master's educated nurses, the college serves their mission of innovation and cutting edge education. By serving the College of Graduate Nursing (CGN) mission, the college also serves the

broader institutional mission for providing doctoral education across the disciplines while effecting change upon the external healthcare system.

Institutional Origins

At Health Sciences University (HSU), the university's founding President first ordered a single college in 1977, the College of Osteopathic Medicine (COM). Classes began in the fall of 1978 and graduated the charter class as a fully accredited college in 1982. Sometime after, this same President ordered the college to become a Health Sciences University. University strategic planning established the institution as a graduate university. Thorough planning in every HSU development phase is a guiding principal of the institution's leadership, and factored into the evolution of the College of Nursing broadly.

Reflecting upon the organizational structure of Health Sciences University (HSU) is helpful when considering the College of Graduate Nursing as one college from among five graduate colleges that are broadly guided by the university. Cohort colleges currently function independently and with autonomy. Each college has its own culture, functions independently from the other colleges, and acts separately as a silo of health professions education.

The university is only now moving toward faculty governance, most likely because of university age and appropriate stage of institutional growth. A favorite expression of one administrator is his reference to the Health Sciences University (HSU) collection of colleges as "five going on nine colleges in search of a university" (A2P, personal communication, May 19, 2009). While the colleges need the university, they are generally more aligned with their individual disciplines rather than with their

professorial appointments. As a result of the dominant medical college origin, the university has not been successful in organizing and implementing faculty governance broadly across the university. Long-tenured osteopathic medicine faculty members perpetuate old paradigms. The original college seeded other colleges. Resources were diverted from the Doctor of Osteopathic Medicine (DO) College to begin the College of Pharmacy, as example. Resentment over diverted resources was likely as osteopaths make up the greater percentage of faculty and have struggled to find their voice in the midst of fairly rapid growth.

Prior to establishing the first nursing program, demographic and needs assessment data identified the target population as busy professionals wishing to advance their skills. The originating master's nurse practitioner program was designed for working nurses using web-based curriculum and created by a distance education field expert in nursing. Through university strategic planning, online learning was identified as a niche for the nursing program, and then later for the college. All nursing programs became distance learning through web-based technology, except for the master's nurse entry, a program requiring pre-license skills and hands on instruction.

In the 1990s, the primary care shortage was big news coinciding with the Clinton White House and the era of Hillary Clinton healthcare reform. At that time, Health Sciences University (HSU) was evaluating how to organize healthcare services focusing on individual patient encounters, and how these encounters were occurring within organizational structures. Future planning for physician assistants was ongoing during this same period.

From this perspective, Health Sciences University (HSU) developed a satellite campus in a rural area in the state. The Master's in Nursing Family Nurse Practitioner (MSN/FNP) program was diverted to this location and was working well, but there was not a lot of local interest. At about this same time, an effort was made to implement a physician assistant program on the same campus. The branch campus was to be a model of broad clinical education for midlevel health professions. Unfortunately, physician assistant (PA) education did not work in this area.

Furthermore, and arising from program data, the master's nurse practitioner program was pulling the majority of its graduates from outside the state. From a purely logistics perspective, it was a hassle to fly students into the rural community for weekend courses, a requirement of the distance learning program. The proximity of local airports to the main institution made student travel far easier to that location. Ultimately, the rural campus was discontinued and the focus returned to main campus. This refocusing on the part of the institution may have influenced the decision to develop a college of nursing at the main campus, although no specific data arose supporting this inference.

Beginning as a program in the Allied Health College, nursing became its own college in 1999 guided by the current Dean. While the Nurse Practitioner program became very popular, it also served a very small niche, a niche unable to sustain a whole college. To become a graduate college nursing needed to elevate the college's overall level of education to fit the larger mission and plan of the institution. Prior to developing the Doctor of Nursing Practice (DNP) program, all Health Sciences University (HSU) colleges except the College of Graduate Nursing (CGN) graduated students with a clinical doctorate, a degree considered by the university as the terminal degree for

practice entry in each discipline. While, CGN developed the DNP program in response to a specific need in nursing, the broader mission of the university suggested CGN needed to align education standards with other colleges by offering doctoral level education in nursing. The other colleges were awarding clinical doctorates, not doctor of philosophy (Ph.D.) degrees.

With a change in administrative leadership in 2001, resources were made available for nursing to move to its own building. Then in 2004, nursing education standards “left the barn” with the American Association of Colleges of Nursing (AACN) directive for change (A1D, personal communication, April 20, 2009). From there, the AACN Doctor of Nursing Practice (DNP) essentials were published in 2006. These new education standards would not only establish clinical doctoral education for nursing, but also launched the first accredited doctoral degree. The College of Nursing viewed this new degree as consistent with the overall mission of the institution supporting graduate education and at the clinical doctoral level.

The Decision

A number of factors supported the process that brought a Doctor of Nursing Practice (DNP) program to Health Sciences University College of Graduate Nursing (HSU CGN), but first and foremost among them was institutional leadership. HSU is a private entrepreneurial school with a visionary President. In following this President’s standards of seeking help from field experts, institutional planning incorporated expert help throughout every level of the university. Informed guidance and planning facilitates progress for all programs, not just the DNP. Acquiring bright, hard working educators while permitting autonomy not only allows people to do the work; it generally promotes

satisfaction among the faculty and administration. The President's passion for the university mission to grow the institution broadly, his accessibility, and approachability, and his hands-off management style created a highly effective autonomous work environment and produced rapid growth. Developing a plan to promote growth was important to the overall mission set forth by the founding President.

The main mission of the university is to promote the strategic plan. The broad vision of the institution is to become a comprehensive health sciences university. In pursuing the plan for broad expansion, Health Sciences University (HSU) built three new colleges and began enrolling their first classes of optometrists, dentists, and podiatrists in August 2009. Although HSU is not the size of other medical health science centers in other states, it will grow through program enhancement. Programs cost money, but they are an investment in the future. The university is not necessarily seeking to maximum revenues, but instead seeks balance by defining itself; college and program offerings define how it is growing. Balance is key.

Strategic planning is an ongoing process at Health Sciences University (HSU). At the institutional level, organized retreats broadly engage participation from the Board of Trustees, then down through the ranks of deans, directors, and key administrators. According to one participant, February 2009 was the last university-wide retreat. Retreat activities usually include discussion of the annual report as well as pertinent information from college deans about their specific college and discipline. Sessions are usually informative and involve brainstorming for future directions.

Like the university, the College of Nursing also holds an annual planning retreat. The main point of this meeting is to get everyone on the same page by bringing university

committee reports to the session. The annual report from the university research committee is a good example of information useful to the college across programs. Program directors give reports of evaluative data for particular roles or areas of interest as well as national conference summaries. These sessions are useful for future college planning and touch on key areas where overlap occurs.

The College of Graduate Nursing (CGN) 10-year strategic plan was written in early 2000. At that time, the Doctor of Nursing Practice (DNP) was still developing conceptually within professional nursing. The CGN plan included doctoral level education, but was vague about which kind. Aligning with other Health Sciences University (HSU) colleges at the doctoral level was a factor underlying CGN interest in developing the degree. Overall, the DNP made the CGN doctoral education plan easier.

Informal and internal discussions for developing a Doctor of Nursing Practice (DNP) program began within the College of Nursing between spring and summer 2005. Specific questions were posed about the DNP:

Discussions about what is this thing, what should we do with it, should we do it, is it good for nursing, is it something that will just kind of come and go -- a flash in the pan? And when it became clear that this was going to be a requirement, especially for advanced practice nurses, the discussion became more formalized.

Early conversations were held not only within the College of Graduate Nursing, but also at the institutional level. One participant related from her perspective "...I think they had a lot of private conversations with the President and Vice-President first. So I think they kind of gained them as champions and then went both ways and went to the board" (F5T, personal communication, May 31, 2009).

Planning in the early stages for adding this program generally involved informal discussions at both the college and administrative level as a means for considering the

advantages and disadvantages; then, ultimately as a means for seeking support in moving forward. The university specifically provides graduate healthcare education and the Doctor of Nursing Practice (DNP) program seemed like a good fit with the institutional mission. Still, the lack of overall understanding by institutional leadership of what the DNP is and what the degree means also played a role in moving it forward. Once the DNP essentials were published in October 2006, the College of Graduate Nursing (CGN) elected to move the program forward. One faculty participant discusses the administration response in this way:

The decision was made internally, within the College of Graduate Nursing, by faculty and by our Dean. And the university readily accepted the decision because the other five colleges -- five colleges, four colleges -- the other colleges all grant practice doctorates. So really, it was elevating the status of the College of Graduate Nursing to a practice-doctoral-granting college, to keep in line with the other colleges.

As a result of adding the DNP as the nursing profession's entry degree for practice, the college not only aligned more fully with the cohort colleges, but also with the strategic plan for the institution.

A number of factors inherent in the College of Graduate Nursing (CGN) and promoted by the profession assisted the college decision in moving forward with the proposed Doctor of Nursing Practice (DNP) program. The Master's in Nursing Family Nurse Practitioner (MSN/FNP) program, one of the advanced nursing practice roles or specialties, is the founding program for the CGN. Professional nursing's accreditation institution, American Association of Colleges of Nursing (AACN), will require a DNP for all FNP graduates by 2015. An FNP at the master's level will no longer be sufficient education to meet accreditation standards for the college or its graduates. Based upon these preexisting factors, a broad program plan was developed and the CGN moved to

establish a Master's in Nursing (MSN) to DNP completion program as a starting point. As the CGN plan proceeded, and once the DNP program was in place, the overall plan for the college was to link the MSN/FNP program to the DNP. Importantly, the college decision to add this particular DNP program was not made as a response to the accreditation requirement for nurse practitioners. Instead, the program was designed as doctoral education for all masters' level nurses, a move that may eventually facilitate the elimination of master's education for nursing. The future of master's education in nursing is as yet uncertain.

What is the DNP?

Understanding the guiding principles for the degree known as the Doctor of Nursing Practice (DNP) is helpful for an overall understanding of its application in program models and education curriculum design. What is known about the DNP is that the degree will be required by 2015 for specific nursing groups, including Family Nurse Practitioners (FNP), Clinical Nurse Specialists (CNS), Certified Registered Nurse Anesthetists (CRNA), and Certified Nurse Midwives (CNM) (AACN, 2006). Even though the stated position of the American Association of Colleges of Nursing (AACN) requires these practitioners to graduate with a DNP by 2015, that position is still considered a matter of conjecture. The future is not certain according to some participants.

All masters' level nurses are educated with a basic core curriculum. Once students complete the core master's education, they choose a program direction from among administrator, educator, or clinical specialist. Clinical specialists vary in their training according to the patient population they treat and must be licensed, but all

clinical specialists are nursing roles. A nurse administrator and nurse educator are simply two more roles, but do not require licensing. All master's educated nurses are educated in a nursing role; and those roles vary. The 2015 education curriculum change was specifically stipulated for clinical nurse specialists, not all masters nurses.

The Doctor of Nursing Practice (DNP) is a professional recommendation since state and federal laws do not require a DNP degree for practice. The DNP is a professional degree, not an academic degree, although it is like academic degrees in that it is not regulated. In other words, state and national policies currently have no influence on the DNP. The Family Nurse Practitioner (FNP), Clinical Nurse Specialist (CNS), Certified Registered Nurse Anesthetist (CRNA), and Certified Nurse Midwife (CNM) are clinical specialties at the master's level and are nursing roles subject to licensing. Currently, Certified Nurse Anesthetists (CNA) is still educated at the master's level. No doctoral level education is yet required for this clinical nursing role, however, discussions by their professional organizations for an entry for practice degree change is in progress. One participant reports that the DNP was originally designed for nurse practitioners, but has been opened to other master's educated nurses beyond the clinical specialists.

The Process

Support across the institution by the administration and other disciplines outside of nursing were cited as a factor supporting the Doctor of Nursing Practice (DNP) program. All deans have autonomy over their respective colleges, have specified budgets, and according to one administrator participant, they do not compete for resources. Collegiality and respect is a common thread within the administration and faculty relationships. Institutional oversight for colleges is simple and direct. Decisions

are made at the college level among college deans and their program directors and then approved by the appropriate administrative people including the President, provosts, and institutional financial officers, and for the most part are accepted. Without the encumbrances of faculty governance, the decision process is simplified and facilitates forward momentum. Historically across institutions of higher education, faculty traditionally value voice in governance, although one administrator for the institution reports difficulty in motivating interests for that purpose across the Health Sciences University (HSU) colleges.

Autonomy for individual colleges is a factor sustaining forward momentum for the Doctor of Nursing Practice (DNP) program decision. The university administration does not want to impose central interference; no mandate exists for proscribed health profession education. Overall, the administration permits colleges to determine the best way to educate the next generation of providers. At the present time and across the university, decision responsibility for new programs and degrees involves individual colleges making their own decisions; however, colleges are required to defend decisions to the central administration. The Dean and faculty identify the needs of the college, then develop and write the curriculum based upon institutional domains. At the earliest stage of decision-making, the Dean meets with the Program Directors' committee. The committee consists of directors from all programs from within the college. Discussions occur over time and are intended to illuminate the variety of scholarly perspectives, and evaluate positive and negative elements. Ultimately the Dean makes the decision to move forward. Once decided, the Dean brings the program to the Provost's attention, and from that point, the process goes forward.

Resource planning also begins at the college level for new programs. Within the College of Graduate Nursing (CGN) there is a general curriculum committee; subcommittees serve the various programs. Program committees make recommendations to the general curriculum committee and then a feasibility study is developed. The CGN Dean developed the study for the Doctor of Nursing Practice (DNP) program. The study looked at five specific forces including financial stability, leadership, patient satisfaction, nurse satisfaction, and safety. A needs assessment investigated the desire and interest for the degree within the profession, employer interest, as well as determining necessary numbers of faculty and the appropriate class size. At this point, additional resources are usually petitioned. For all programs, the Dean is responsible for fighting for and obtaining necessary resources. If the Dean is able to demonstrate future growth within the college then a budgetary increase can be justified.

The College of Graduate Nursing (CGN) at Health Sciences University is one of the smallest among the five colleges. The resulting effect is that the college very likely brings in the least revenue for the university. University resource allocation, as might be expected, prioritizes larger colleges like the Medical School and the Physician Assistant program. Traditionally, the CGN has had to fight for resources. While the university gave the college permission to proceed with the Doctor of Nursing Practice (DNP), they were specifically instructed not to ask for additional resources. Resources are key and critical needs must be defensible. Not only does the institution require a critical needs justification, but both professional and regional accrediting bodies require it as well.

At the administrative level, the Dean of the college submits the feasibility study to the Provost. The Provost reviews the study, and then meets with the Chief Financial

Officer to review the information provided. A feasibility and viability review meeting between the Provost, Dean, Chief Financial Officer (CFO), and Assistant Provost follows. Generally, this meeting is for refining purposes, and typically occurs one year prior to program enrollment.

Meanwhile, obtaining institution approval for developing a Doctor of Nursing Practice (DNP) program involved a lengthy approval process and slowed forward momentum in the early stages. Since the state had no DNP programs, educating university administrators, committee members, and board of trustees was essential. Market research along with needs assessments, and other evaluative tools were important to these discussions. The process took time, and because the degree was new to nursing and generally not known, within post secondary institutions, the College of Nursing was required to explain why nursing needed to have a practice doctorate. The Health Sciences University (HSU) Board of Trustees, in particular, required discussion and convincing by CGN program developers. The chair of the Board of Trustees is a 90 year-old gentleman with generational perspective. This individual was against nurses becoming doctors, based upon traditional views about physicians and nurses. Within such a traditional view the nurse is seen as handmaiden to the physician.

Generally speaking, board of trustee approval for new programs requires formal consideration of resource allocation and distribution. The Doctor of Nursing Practice (DNP) program is small compared to other college programs on campus; other programs are much larger. Approval for the program was given on an interim basis, and did not require formal board approval. Without a significant drain on resources, the DNP program fit into the university contingency fund. Contingency funding is designed to

allow revisions or changes within the annual budget. The DNP program core amount did not have significant impact and did not require dispersing large amounts of university funds.

Meanwhile, the Board of Trustees (BOT) through the Business and Finance committee is highly involved in resource planning. Generally, program costs are folded into the annual budget. When the annual budget is recommended for approval, the financial impact of various programs is discussed. If the program is controversial, it can put the university at risk necessitating it become a discussion line item with a full BOT. The Doctor of Nursing Practice (DNP) program was not controversial; in fact, the “board widely and noticeably approved it” (A4FO, personal communication, July 13, 2009). Once the College of Nursing received final institutional approval, moving onto regional accreditation became possible.

The college’s plan for developing a Doctor of Nursing Practice (DNP) program was guided by the American Association of Colleges of Nursing (AACN) education standards. The college hired course-specific experts to be a part of the curriculum team. The program developers laid out the course sequencing and objectives placement. A series of curriculum development retreats fleshed out the course content approximately six to eight months in advance of implementation. The results of these well organized planning efforts, is a hybrid DNP program offered to master’s level graduates, a program not specifically targeting nurse practitioners. The fact that the program did not address the specific professional accreditation agency recommendation for nurse practitioners more than likely caused a regional accreditation approval delay, a point that will be addressed in the next few paragraphs.

Health Sciences University (HSU) does not have a general doctoral degree-granting authority from the regional accreditation agency. New doctoral programs require substantive change committee review from the regional agency, and must submit a detailed proposal. Once permission to pursue the degree is obtained from the university by the college, and the plan approved, accreditation review is the next step and is required by the regional and then by the professional agency.

The regional agency proposal committee met with the Health Sciences University (HSU) administrators and College of Graduate Nursing (CGN) program developers on two occasions. The proposal was submitted at the first meeting and then resubmitted three months later upon request of the regional accreditation agency. Regional accreditation approval was delayed pending further research, a circumstance reported by both case groups. At the point of initial proposal review, the accreditation committee held a conference call with program developers, and institutional administrators. The committee read the proposal, made comments based upon the reading rubric, scored the coverage of required areas, and then reported back. This discussion is a normal and usually final step in regional accreditation prior to program opening.

The resulting action by the accreditation committee postponed approval and additional information was requested. The program was originally time lined to open in the fall of 2007 (Figure 1. The university and college Doctor of Nursing Practice (DNP) decision timeline, Appendix I). The delay involved three additional months of investigative work for the college, and resulted in numerous disputes and mounting tension between the Health Sciences University (HSU) administrators and program developers. This delay postponed the program opening to January 2008.

Initially, regional accreditation was difficult to convince and became the formal obstacle. Health Sciences University (HSU) College of Graduate Nursing (CGN) was the first nursing program in the state to submit a Doctor of Nursing Practice (DNP) proposal and, according to faculty participants; the committee was unfamiliar with the DNP. Furthermore, another university School of Nursing (SON) submitted a substantive change document for their DNP program at the same time; however, the School of Nursing model was different than the HSU College of Graduate Nursing model. The SON discontinued their Master's in Nursing Family Nurse Practitioner program (MSN/FNP) and instead created a Baccalaureate in Nursing (BSN) to DNP program, a program specific response to the American Association of Colleges of Nursing (AACN) and their recommendation for nurse practitioner change. The SON program broadened doctoral education specifically for nurse practitioners beyond the master's, while the CGN model kept the MSN/FNP program and put a DNP track on top of it. The critical difference between the two models is the CGN model is a practice doctorate completion program and permits graduates from all master's level curriculum to pursue the practice doctorate, not just nurse practitioners. A large part of agency resistance resulted from two different institutions creating similar curriculum using different models while being reviewed by the same accreditation committee. The SON model met the requirement set by professional nursing's position statement to change the degree for nurse practitioners; the CGN model did not. While controversy persists over the future requirement, and despite the addition of a DNP program to HSU, the College of Nursing must still revisit substantive change to meet the same standard before 2015.

In crafting a response to proposal questions raised by the accreditation committee, discussions between the developers and administrators went back and forth. The greater challenge for administrators stemmed from the position and role of defender for the Doctor of Nursing Practice (DNP) program on behalf of Health Sciences University (HSU). The new program requires justification to the accreditation committee. In order to position the DNP program for a successful agency review, administrators needed to see a well-constructed defense at the organizational level. Administrators insisted program developers must define how DNP outcomes are different than those at the master's level. To one institutional administrator, the DNP program was a duplicate of another College of Graduate Nursing (CGN) master's program, but now labeled a doctorate. The college was firmly set on the DNP program as it had been originally presented. Argument from the college seemed little more than an expression of wants, and from a purely nursing perspective. Accordingly, the nursing argument stated the DNP essentials were written by nursing and the Commission on Collegiate Nursing Education says the degree is good. While, indeed, the nursing profession and regulating boards are very scripted, their biggest concern is patient safety and nurse competency. Those perspectives are important, but do not necessarily insure appropriate rigor for different education levels.

The regional accreditation committee did not view the Doctor of Nursing Practice (DNP) model as traditional. Departing from tradition requires a good argument. The administrators perceived the College of Graduate Nursing (CGN) view as the college wanting the program, but failing to develop a clear rationale as to why the program should be added. That rationale, it seemed, needed to include a higher education perspective, and not just the recommendations of the professional accreditation agency.

From the administrator perspective, without a clear rationale, the DNP program was not defensible.

Program developers credited the college administration and Board of Trustees as supportive to the Doctor of Nursing Practice (DNP) program. However, the Board of Trustees (BOT) was not wholly supportive; they were conceptually supportive. The college had been given the nod to proceed, but as the old saying goes, the devil really is in the details. From the College of Graduate Nursing (CGN) perspective, administrators presented a major stumbling block. Great differences existed between administrator and CGN viewpoints, and a dispute broke out over unit requirements. A typical Doctor of Philosophy (Ph.D.) degree requires 60 units. Research uncovered the same 60-unit requirement for a DNP program at a northern state university. Apparently in this state, the charter requires 60 units for all doctoral programs. Resolving the conflict entailed several months of dialogue and included multiple rounds of external program review for comparison.

Beyond the unit dispute, conceptual conflicts persisted over the rationale for the new degree. For example, the College of Graduate Nursing (CGN) model is not specifically advancing the degree for nurse practitioners as a way of enhancing NP skills in broader areas of healthcare. Furthermore, some specific design concerns were problematic to the institution. If, in the future, CGN discontinues master's level education for the Family Nurse Practitioner (FNP) program, and converts to a Baccalaureate in Nursing (BSN) to DNP model, then the college must revisit the substantive change protocol creating more work. As it turns out, the college is considering just such a plan.

Terminology use produced consistent confusion and contradiction for the administrators. The College of Nursing referred to the Doctor of Nursing Practice (DNP) as a practice degree, but then did not address enhanced clinical preparation for the degree. The curriculum is primarily focused on leadership development and achieved through distance learning education facilitated by web-based technology; student work is done on a computer. No clinical experience was evident in the designed curriculum. A clinical degree without a clinical requirement did not make sense to institutional administrators; but, eventually, the clinical hours issue was resolved by binding clinical projects at the systems level. DNP capstone projects involve program evaluation and development on vulnerable populations; projects are designed to alter care within the healthcare system where students are employed. Meanwhile, this same clinical hours problem re-surfaced during participant discussions about DNP program development at other institutions currently undergoing professional accreditation review. The American Association of Colleges of Nursing (AACN) response was to request that those programs address the clinical hours concern.

Another point of confusion from the administrator perspective arose when the college described the Doctor of Nursing Practice (DNP) as a clinical nursing degree and then stated the degree is not designed for nurse educators. Yet, when defining the DNP roles, the college stated DNP graduates could become future faculty. Clinical programs are typically better served by faculty with some working knowledge of practice, in this case, DNP practice. So while the degree is not intended to produce educators, undoubtedly some DNP graduates will teach. These contradictions no doubt added to the overall conflict, but the greatest challenge was very likely the DNP program model itself.

The program was not designed to enhance clinical skills of existing family nurse practitioners for furthering individual patient care. The Health Sciences University (HSU) DNP model addresses organization-level nursing or systems-level nursing, not education enhancement for nurse providers imparting individual patient care episodes.

Meanwhile, the regional accreditation committee harbored some concern over the intentions of the College of Nursing in accordance with the profession wanting to elevate the degree for self-serving purposes. The external participant shared this perspective:

And there is a mandate within nursing -- with nurse anesthesia in particular and the specialty organization for that group, and also among the FNP's -- that they need to have doctoral degrees. I think there's a year even established. And I can't remember if it's 2015, or -- it's upcoming, anyhow. So there's going to be a ratcheting up of the expectation for educational credentials for both FNP's and nurse anesthetists. And I think ... [the university] ... felt since they already had feeder students from their own program, as well as the fact that they could serve graduates from, in particular, the whole southern ... basin, and using the online really could attract students nationwide, I think they felt this program was a good fit for them.

Some pre-existing tension was also felt by the regional accreditation agency and can be attributed to another national accreditation body grappling with these same concerns across institutions. Aware of the efforts from this other accreditation agency, the regional agency for HSU was making an effort to study doctoral-level education and wrestle with differences. Despite ongoing efforts, clear distinction between doctoral degrees has not been made. Medicine and nursing are good examples of fields facing problems with poor distinctions among doctoral level health professions education. For physicians, the clinical doctorate is an entry-level and pre service degree; students graduate without clinical experience. Whereas the practice doctorate for nursing is an entry for practice degree for advanced practice, created for experienced nurses. These two clinical

doctorates are very different degrees based upon the student population the degree is serving.

In an effort to address some of the confusion over doctoral degrees, the regional accreditation agency cleaned up the substantive change application form and made a separate set of standards for doctoral programs. Despite these efforts, the regional agency still categorized Doctor of Philosophy (Ph.D.) and professional doctoral education within the same set of doctoral standards. This blending presented certain challenges for health science education. While medical education is more widely understood, the variability in nursing education is problematic, because it is not well understood by the general lay public let alone by other health professions. Some nurse master's curricula have less than or equal to 30 units of course work, while other Master's in Nursing (MSN) degrees are almost 60 units. A traditional Ph.D. education requires three solid years of course work before advancement to candidacy. Although the course work is ended, that only begins the process of dissertation, a period of sustained study, writing, and varying effort and length. For agencies and administrators managing a wide range of doctoral degrees, seeing equivalency is difficult when clear distinctions do not exist between types. In the case of the Doctor of Nursing Practice (DNP), it is unclear how the institution can ensure student success when wide variation in pre-requisite course work is the standard for program entry. The College of Nursing position insisted the DNP model would work despite entry differences. On these points, the conflict and discussion flared.

Internal scheduling challenges involving submission of a high volume of substantive change proposals for the regional agency also contributed to slowing forward progress for the College of Graduate Nursing (CGN). At the time of proposal submission

the standing regional accreditation committee for doctoral programs was formalizing their review process for state university joint doc programs. Recently, this university received authority to offer doctoral degree education in special fields; they had not previously awarded the Education Doctorate (Ed.D.). Health Sciences University (HSU) College of Nursing planned to open the Doctor of Nursing Practice (DNP) program in August 2007; however, the regional agency was backlogged resulting from the glut of state university applications. The regional agency calendar was packed and scheduling was offered on a first-come, first-served basis. Many institutions were ahead of the HSU College. The Doctor of Nursing Practice (DNP) proposal was bumped from whatever date was originally scheduled; the target start date was missed. This backlog of doctoral substantive change proposals and review along with the regional accreditation committee insistence for additional information further delayed the overall start for the HSU DNP program. Yet, despite these delays, regional approval was granted upon resubmission of the HSU College of Nursing substantive change proposal.

This next section will address my research questions. The order of my first and second questions has been reversed from the order listed in chapter one, because the institutional mission, goals, and strategic plan are the main frames used in this study. Mission is addressed throughout the study, and will be considered within the findings as they are derived from participants' responses to the stated institutional missions. The second research question requires a discussion of factors identified as either supporting or inhibiting the decision to add a Doctor of Nursing Practice (DNP) program at Health Sciences University College of Graduate Nursing (HSU CGN) and the process in moving the program toward inception. These factors arise from both faculty and administrative

perspectives and include areas both internal and external to the institution. Differences or conflict between case groups will be highlighted. My research questions will then be restated and addressed individually.

Research Questions One

To what extent are responses to questions about the stated institutional mission, vision, and goals of Health Sciences University (HSU) consistent among academic leadership (graduate school deans, assistant deans, university provost, vice presidents, directors, and program directors) as well as the nursing graduate school faculty (including all levels of professors)?

Institutional mission and goals are prominent themes in this study. Interview questions were designed to uncover participant knowledge of mission, goals, and strategic plan generally. These themes guided my data collection and analysis. To what extent participants acted in accordance with these institutional constructs is best reflected by the consistency of their responses. The story of the Health Sciences University (HSU) decision and process as it unfolded earlier in this chapter illustrated strong alignment among faculty and administrator participants with both college and university mission, vision, goals, and strategic plan. Only one or two adjunct faculty seemed less informed about the mission and strategic plan, but overall reflected attitudes supporting the university and college. Less knowledge by adjunct faculty more likely reflects the nature of their part-time association with the institution.

The college mission and plan was written to fit the broader mission and strategic plans of the university. Program alignment with the institutional mission is required by both American Association of Colleges of Nursing (AACN, 2004, 2006) documents as

well as by regional accreditation. This regional agency requirement is stated in the substantive change proposal guidelines for developing a program model and its curriculum. How well institutions meet this requirement varies widely. Because Health Sciences University is made up of multiple graduate colleges the university broadly developed a mission statement, each college then devised its own mission with an eye to compatibility with that of the larger institution. Achieving mission compatibility among the colleges and across the institution requires that the Health Sciences University (HSU) mission be written simply, but with an eye to embracing broad concepts for purposes of inclusiveness. To that end, the Health Sciences University mission statement reads as follows: “To produce, in a humanistic tradition, health care professionals and biomedical knowledge that will enhance and extend the quality of life in our communities” (HSU, 2010).

Meanwhile, the mission statement of the College of Graduate Nursing must reflect the general theme of the institution; yet, it should also support the mission of the discipline. The Health Sciences University College of Graduate Nursing (HSU CGN) mission statement encompasses four main points:

In accordance with the mission of ... [Health Sciences University], the faculty endeavor to

1. Promote the health and healing of diverse communities through high quality graduate nursing education.
2. In a learner-centered model, create an environment that enhances each individual's intellectual and professional capacity via mentoring, inter-professional collaboration, technology (simulation) and clinical experiences guided by objectives.
3. Value clinical relevance by engaging in faculty practice, research, and other scholarly activities.

4. Fosters excellence, creativity, innovation, self-reflection, leadership, personal and professional accountability, collaboration, cultural sensitivity, and passion for lifelong scholarship (HSU, 2010).

Findings from both the administrator and faculty cases demonstrate strong alignment among participants with institutional mission in developing the Doctor of Nursing Practice (DNP) program at Health Sciences University (HSU). Reporting consistency emerged between the faculty and administrative case groups as participants frequently echoed their colleagues in their choice of words when discussing these topics. The following excerpts from interviews with administrator participants illustrate college and university alignment with their institutional missions:

Our vision as a college is to be the innovator and to be the model of nursing excellence for innovation and quality. And so we pride ourselves on keeping up-to-date on what is going on nationally and globally. One of the -- the sort of key values at our institution is growth and innovation. We are a private institution, we know we have a niche in the market because everybody needs healthcare professionals, and there have been a lot of changes based on healthcare, etc. And so really, the President in particular, prides himself on being the first. He likes to have the first DNP. He likes to have the first master's entry. So it is valued here. And so that's where it comes into growth and resource.

... It says something like we want to educate healthcare professionals to be caring and compassionate, to make a change in medical sciences, or something like that. But the mission has always been to develop highly competent health professionals that will give value to the community. That's kind of it in a nutshell. Since we're all health professions, we're all there to assure that we have a quality product. And so that really is our mission. It has been a primary teaching institution, for just that reason, based on that mission. But there has been some change to elevate research in the institution, which came with [the new Provost].

This administrator perspective supported the consistency of wording with this next comment on institutional mission:

Administrator participant: Mission and goals and strategic plan tend to be a real focus for this project. ... Our goal still is our strategic plan -- was to be a comprehensive health sciences university. And you can tell that is -- next August I'm enrolling the first class of optometrists, dentists and podiatrists at the institution. All doctoral level ... and building facilities to house them ... That is still the mission it's been over twenty years, of a broad strategic outcome of the

vision for the university to be a comprehensive health sciences university. And we're ... almost all the major areas of doctoral-level education in the health sciences.

Interviewer: And in an environment of humanism ... isn't that --?

Administrator participant: Within a humanistic tradition.... And then our other aspect of the mission was that we were producing healthcare providers for underserved areas in the western United States. So the mission, when they added the vulnerable populations, came in there.

These two excerpts are fairly representative of the word choices and framing of the mission and institutional strategic plan consistently found among participants. The College of Nursing began with a family nurse practitioner program, and sought expansion for the college by building upon the founding program. The college added a nurse entry program at the master's level, then a clinical nurse leader program, and now the Doctor of Nursing Practice program.

By remaining cognizant of developing programs around the country and the problems encountered by those programs, the faculty was able to successfully facilitate Doctor of Nursing Practice (DNP) program development at Health Sciences University (HSU). Student enrollment reductions among established family nurse practitioner programs where scholars eliminated the Master's in Nursing (MSN) component caused a shift in thinking for HSU DNP program developers. Ultimately, the HSU college curriculum was not designed to alter the degree for nurse practitioners; instead, the HSU program provides doctoral education for all master's level nurses. This curriculum design is student centered and supports the goals of constituents and the profession.

Continuing faculty awareness of and attention to varying student interests and their needs in the midst of recommended degree change by American Association of Colleges of Nursing (AACN) demonstrate interest on the part of faculty for building

strong programs. The nursing faculty fulfills their college mission by remaining student-centered despite accreditation pressures. As program curriculum is designed, mission and goals are intended to guide the content. All Doctor of Nursing Practice (DNP) students are required to produce a final research project; projects are referred to as dissertations. DNP dissertations are clinical research projects at the systems level and are designed to create change within healthcare institutions. These projects specifically target vulnerable populations. This curricular design broadly supports the institutional mission. The focus of DNP dissertation projects on vulnerable populations fits well with the Health Sciences University (HSU) tradition of humanistic education. Furthermore, nursing research at the practice level supports the building of a research institute, the next phase of HSU expansion. With the 2009 graduation of the DNP charter class, and as DNP projects publish and begin to alter the image of the College of Graduate Nursing across the institution, future projects will be facilitated by support from the research institute.

Innovation is explicitly stated as a purpose for the college and is supported by both university and college mission statements. Distance learning education facilitated by web-based technology was developed for the founding nurse practitioner program at the bequest of university leadership. The distance program was designed for the college by distance-learning field experts, a standard required by the university President for every level of college within the Health Sciences University (HSU) cohort of colleges. Distance learning web-based education is a standing point for innovation at the college and serves the specific needs of college applicant populations. The very nature of web-based education technology serves to enhance student intellectual capacity while

broadening their world perspective. Distance education connects students across the country increasing professional collaboration and expanding systems knowledge across institutions while further enhancing their knowledge of technology. Creating a practice doctorate for nurses through distance learning positions the College of Nursing at the forefront of nursing education and addresses seven points of the college mission including innovation; student centered; graduate education at the doctoral level; cutting edge; serves vulnerable populations in the humanistic tradition; and meets the needs of the discipline.

With the university and college missions in alignment, strategic planning serves as the scaffolding that promotes the institutional mission and charts the journey for Health Sciences University (HSU), as it becomes one of the major health science universities in the country. Annual planning occurs at both the college and university levels, promotes university and college expansion, builds upon existing graduate education programs, and is ongoing.

At the moment, the college plan is to continue with the Doctor of Nursing Practice (DNP) program as currently designed with master's level for entry. Discussion is underway for developing another DNP program - one that directly addresses the American Association of Colleges of Nursing (AACN) position statement for nurse practitioners. The projected deadline for nurse practitioner programs to advance their degree is 2015, which gives the college time to reflect upon questions still plaguing this requirement. The College of Graduate Nursing CGN DNP program just graduated their charter class. The CGN plans to wait another year before taking the current program before AACN accreditation. AACN accreditation outcomes for the first seven programs

from across the country are currently pending. The CGN faculty and Dean wish to benefit from the lessons learned by those early programs before moving forward with another curriculum model.

Following the Health Sciences University College of Graduate Nursing (HSU CGN) regional accreditation substantive change review, the college received special accreditation commendation for Doctor of Nursing Practice (DNP) program rigor and quality. Such commendation thrusts the college as well as the university into the spotlight. The accolades position the CGN DNP model high among DNP programs further elevating both the university and the college as being a lofty example of excellence for developing future programs. In this way, the resulting program and plan directly benefited from the accreditation process further facilitating the next step, which was to open the program.

Research Questions Two.

What external and internal factors were involved in the institutional decision calculus underlying the decision to add a web-based Doctor of Nursing Practice (DNP) program? Factors specific to the institution and supporting the decision and process will be addressed first, followed by the external factors of support. The inhibiting factors will then be addressed secondarily in this same order with institutional inhibitors described first, followed by external inhibitors.

Institutional proponents. Many interrelated factors specific to the institution broadly influenced not only the decision to add this Doctorate of Nursing Practice (DNP) degree to Health Sciences University (HSU), but facilitated its forward progress to fruition and aided the overall curriculum design. Among the influences are the strengths

of the institution and the influences of cohort colleges and programs. Other institutional influences included the broad strategic plan of university expansion; the structure, hierarchy, and relationships within the institution; the type of university in which the College of Graduate Nursing (CGN) is embedded; and the college's web-based curriculum. These factors are all considered internal for the purposes of the study.

Institutional type refers to private versus public universities in this study. Health Sciences University (HSU) is a private university. Early in the interviewing process, two faculty participants shared their experience of working in public universities and reported that change for nursing is navigated more readily at private institutions over public. From the nursing faculty perspective, private universities and colleges experience far less bureaucracy than that found in public institutions. At one state higher education institution as reported by faculty participants, the faculty senate blocked the development of a nursing college and related programs for up to thirty years.

As a separate college within the Health Sciences University (HSU) collection of colleges, the College of Nursing develops its own programs. The administrative structure of HSU, the autonomy afforded the colleges, as well as the quality and longevity of association among the administration and faculty promotes a high level of trust according to faculty participants. This apparent trust extends from the President's office down through the Provost and Dean, ultimately reaching the faculty. The key word used most frequently by faculty who were given freedom to develop the Doctor of Nursing Practice (DNP) program was *trust*. According to one nurse participant, *trust* permits more rapid progress, and a more efficient result.

When asked about the influence of the university academic senate, two nurse faculty participants jointly report that the senate generally fails to understand nursing. This was the reason given by these participants for their preference for working in private institutions, and the reason they attributed change at public institutions as being so difficult. From this perspective, faculty participants report that many academics have absolutely no idea what nursing is.

I don't think they had any idea what we wanted to do. Or what the DNP was. I don't think they had any idea whatever. But it seemed – doctorate degree in nursing? Oh, that sounds like it would be good. And we grant all these other doctorates. Why not? I don't think they had any idea what we were doing. And I don't think anyone really expended the effort to read the DNP essentials, or look at national policy, or look at white papers, except us in the college.

Apparently, within Health Sciences University, the College of Graduate Nursing (HSU CGN) has earned institutional admiration and respect, which seemed to afford broad acceptance of college ideas for curriculum change.

Across study participants, the faculty reports the university administration broadly supported the college and facilitated Board of Trustee acceptance of the Doctor of Nursing Practice (DNP) program. Faculty case participants further suggested that the Board of Trustees was equally supportive, although they also allude to some challenge being present at that level. The Board of Trustees is comprised of individuals roughly defined by one nurse participant as “... about, I'd say, a third to two-thirds older guys and young people” (F2AD, personal communication, May 19, 2009). As might be expected and according to study participants, the youth serving on the Board of Trustees represent the highest level of support. Generally speaking from the faculty perspective, the university administration as well as the Board of Trustees did not fully understand

what the College of Graduate Nursing (CGN) was trying to do. This participant goes onto explain the Board of Trustee perspective further.

They supported it and embraced it, but because administration made the recommendation to support it -- and they do take their judgment into consideration. So they don't -- they're not obstructionist. Their main functions are to ... fiduciary responsibility -- responsible -- and oversee any kind of budget visioning changes. And since this was budget-neutral, it didn't really impact the board's decision.

Once again, faculty participants mention the word *trust* as being a key factor for facilitating consent to move forward from both the administration and Board of Trustees.

Narrowing, for the moment, to the College of Graduate Nursing perspective, faculty participants report that the college Dean as well as other nursing faculty broadly supported the Doctor of Nursing Practice (DNP) program. For the most part, nursing faculty members are nursing professionals and were highly aware of the professional recommendation for nurse practitioner change as discussions began at the college. Additionally, all faculty members were fully aware that the Master's in Nursing Family Nurse Practitioner (MSN/FNP) program would become obsolete by 2015 unless the degree level was added and then required. General college awareness of the forces and circumstances surrounding the degree change no doubt assisted forward progress as the developers moved first to the research phase and then onto accreditation. Across the college a widely held view of doctoral practice as being good for the discipline reinforced and supported forward momentum.

Beyond support and trust from administration, foundational curriculum proved to be another proponent moving the degree forward with the presence of a well-established distance education program. College of Graduate Nursing (CGN) distance learning web-based education originated through a university decision prior to the hiring of the current

college Dean. The HSU administration hired a well-known distance-education nursing consultant for curriculum planning; and created a flexible web-based distance-learning program. The distance-learning program designed as web-based curriculum was in place with a proven track record prior to Doctor of Nursing Practice (DNP) program development, and subsequently provided both the flexibility and accessibility necessary for reaching students in established work communities.

While the future degree for this program still requires change, certain curriculum inadequacies evident in the master's level program sparked interest for change among faculty. Faculty participants teaching in the Family Nurse Practitioner (FNP) program assessed the level of knowledge developed at the MSN level and determined it as insufficient education for graduates. The current demands of the healthcare system require practitioners with advanced skills in leadership. The primary problem, according to one faculty participant, is insufficient curriculum time for creating nurse leaders and the time allowed is adequate for educating students when programs are offered at the master's level. The participant explains in this way: "Not enough time and not a high enough level of knowledge. The master's advanced practice programs are really limited. Two years is not enough time to train the type of clinician that the healthcare system needs" (F1PD, personal communication, July 12, 2009). Master's-level education prepares nurse practitioners for their clinical role, but is insufficient education for creating change agents for the discipline.

Doctor of Nursing Practice (DNP) essentials were formulated in the 2006 American Association of Colleges of Nursing (AACN) publication and established outcomes assessment criteria for curriculum change in family nurse practitioner

programs. Those essentials are tied to curriculum competencies as evidence for successful program outcomes. Nurses educated at the doctoral level recognize the importance of achievement at a higher level of understanding, a doctoral level of understanding. One Doctor of Philosophy (Ph.D.) and faculty participant expresses doctoral level perspective in this way:

The students are engaging continuously in dialogue about their practice, on the web. And they're learning how to access resources about where the best evidence is, where the answers are that they need to be using in practice. They're doing it because it's a web-based program.

And then later this same faculty participant goes onto say:

And we're requiring that they do that. That's a scholarly practice, of posting their answers, so when we have criteria that says -- substantive answer says that you will share what you know and your observations. But then you will support that with what the evidence shows.

Nurses with doctoral degrees see that value is found through knowing and using research to support evidence-based practice; a doctorate assists practitioners in doing that.

Furthermore, a definitive change in the level of respect across disciplines also seems to occur.

I think about what -- how it changed for me. ... The physicians I worked with -- who I'd been working with for several years -- when they found out I was getting my Ph.D. -- now, I had expected that they would put it down or see it as competitive or something -- they were so proud. It was just like "Dr. [Roller]," you know, and they talked to me different. It just -- without -- it's just that. It's that respect and that collegial-ship.

Bringing a doctoral degree to the table in a world full of doctoral degrees seems to matter. The expectation by nursing faculty for DNP graduates is the acquisition of a practice doctoral degree will equalize their standing among other doctoral level fields.

Some participants report that the administration respects the College of Nursing Dean as well as the reputation of the college. One nurse faculty participant expresses the level of support from the university in this way:

I think that people were supportive – the university was supportive, the Board of Trustees was supportive -- because they trusted us. And had they not trusted our Dean and me and the faculty, we perhaps wouldn't have gotten as much support.

Furthermore, the college employs movers and shakers in the discipline, and the faculty is good at what they do. According to an administrator perspective support for nursing has been earned.

... They're very excited about nursing. We have been the first for so many things on the campus that we're really looked at as the movers and shakers. And so we've gotten a lot of respect for that. It's been hard work getting simulation, for example, and integrating that in the curriculum. So we're good at what we do, and we've gotten accolades from it.

HSU administration was well aware that the college was being guided by accreditation standards. Adhering to the planning vision of institutional leadership, a faculty member field expert developed the Doctor of Nursing Practice (DNP) program. Furthermore, the education advancement trend initiated by other healthcare fields supports nursing as the discipline advances their entry to practice degree. From this vantage developing a Doctor of Nursing Practice degree by College of Nursing leadership and faculty seemed credible to the administration.

Institutional proponents include university strengths and relate to Health Sciences University (HSU) being a private institution governed broadly by a strong President and administration. The academic senate has a limited role in governance thereby eliminating many traditional restrictive mechanisms of public universities. With rapid institutional expansion as a goal, a limited role by the academic senate actually supports that mission.

Meanwhile, HSU cohort colleges are all health professions and support similar trends for degree change in their respective fields. Broadly across the administration and faculty, relationships were built upon the selection of field experts for institutional guidance; while an atmosphere of autonomy and trust provided the working framework. Autonomy among the colleges created silos of health professions education a factor that likely inhibits a thorough understanding of discipline differences across professions. As a result, other health professions not understanding nursing education across the university was not surprising. A poor understanding about nursing education no doubt limited correlation between nurse licensing practices and education decision-making, and afforded the College of Nursing latitude in curriculum planning. Meanwhile, the college distance learning and web-based curriculum, through its design to reach the well-established nurse community for course distribution, supported the broad purpose of the Doctor of Nursing Practice (DNP) and the student population it would serve.

Moving beyond institutional proponents, external proponents will now be addressed. Healthcare reform involving the professional accreditation agency, indeterminate influences including other institutions, as well as program variations across institutions, poor understanding about nursing, credentialing, and accreditation from regional and professional agencies, accompanied by overarching interests of nurses across the discipline constitute a wide array of external influences. These factors contributed to forward momentum for the decision and process at Health Sciences University (HSU) and will be discussed in the next section.

External proponents. In this next section, a variety of external factors will be described through the use of participant interviews and will focus on the manner in which

these concerns acted upon the decision-making process. These proponents include a significant level of nurse interest in a practice degree. Meanwhile, variations among regional accreditation agency requirements and American Association of Colleges of Nursing (AACN) Doctor of Nursing Practice (DNP) program models produced conflicting messages about the purpose of the DNP. Not surprisingly, a lack of nursing consensus persists across the discipline over the DNP and is reminiscent of historic failings to produce discipline consensus over degree stipulations for the field. Still DNP program numbers appear to be on the rise and create conflicting notions about nursing and advancing education standards. Misconceptions, confusion, poorly understood concepts, the rising preference for practice doctorate education over the Doctor of Philosophy (Ph.D.), and the broad goal of professional nursing to advance the discipline toward the DNP contribute to pressures driving the decision for the degree and its process forward. These multilevel issues among external stakeholders will be discussed in this next section.

Despite nursing's failure to gain consensus for requiring specific degrees, professional nursing recognized the need for their discipline to be strong and unify their voice. To succeed in becoming a strong player in the healthcare team and around the world, the discipline needed to display greater levels of assertion and leadership in shaping healthcare reform. To that end, all study participants credited professional nursing's national organization, the American Association of Colleges of Nursing (AACN) as the force driving the decision adding a Doctor of Nursing Practice (DNP) degree to the college. Creation of the DNP program responds to the desire of many master's prepared nurses for doctoral level education other than the Doctor of Philosophy

(Ph.D.), and aids in breaking down education access barriers for nurses with interest. Doctorates are not required for employment in community colleges, as example, but do facilitate career advancement as many nurses recognize.

Accreditation varies among health professions and higher education institutions according to their structure and evaluative agency. Regional accreditation addresses institution-wide evaluation for schools and colleges and agencies are specific to various states and regions of the country. Again, standards vary among these agencies. In general, study participants report observing differences in rigor between Doctors of Nursing Practice (DNP) programs. Programs elsewhere appear less rigorous, and seemingly add on just one extra year. DNP programs originated in the east before the DNP essentials were written. Programs are only now developing in the west. The question of rigor arising from program comparisons played a role in DNP program and curriculum development at Health Sciences University (HSU) and pushed DNP standards to higher levels of excellence.

As Doctor of Nursing Practice (DNP) programs and related curriculum evolved, some colleges and schools of nursing applied the degree in a very specific sense to the nursing role while others like the College of Graduate Nursing (CGN) developed DNP programs available to all master's level nurses. For the Health Sciences University (HSU) college the nursing role is not exclusively tied to the professional degree, although the DNP program is open to nurse practitioner enrollment. The DNP program is offered broadly to Master's in Nursing (MSN) graduates across the spectrum of graduate education in nursing. Despite this variation, the HSU program is appropriately aligned

with the American Association of Colleges of Nursing (AACN) position statement and DNP essentials.

The American Association of Colleges of Nursing (AACN) task force on education and regulation for professional nursing practice originally developed five Doctor of Nursing Practice (DNP) program models (AACN, 1/28/10). AACN offered different versions, and afforded some variation to institutions in shaping DNP curriculum. Offering the DNP degree more broadly widens the applicant pool for the college, while from a college planning perspective seeks to support a current nurse practitioner student view that the DNP may fail to be ultimately required. Opinion varies across the field; some nursing scholars believe the degree will be required, while others do not. Another faculty participant had this to say about opinion variation over the future requirement for the DNP:

There's a lot of discussion that 2015 is going to roll around and there won't be a change. Nothing's going to happen, 'cause that's a professional recommendation. That is not in the law. There's no regulations, state-by-state or federal, that says you can't be an NP without a DNP. That's just a professional recommendation.

This next excerpt from a faculty interview focuses on much of the controversy among doctoral-levels within the discipline:

Interviewer: So what I understand, that the accreditation institution is the one that set this as the requirement. ... Based on what knowledge I have of accreditation, that once they make a decision like that it's more or less -- not so much a recommendation but a mandate.

Faculty Participant: Yeah. Yeah. But what's going to happen to people who don't get the degree is not clear.

Interviewer: ... they haven't stipulated that as yet?

Faculty Participant: Not that I know of.

Interviewer: So the discussion is a controversy of sorts. Is that true?

Faculty Participant: There's a huge controversy around the DNP. Huge. A few years ago it was unheard of. There were various doctoral programs in nursing. The Ph.D. is, as you understand, a research degree. There was a Doctor of Nursing Science, and that was supposed to be a clinical degree. There were institutions that offered both. [University Name] started out as a Doctor of Nursing Science, but midstream changed to a Ph.D. because it actually -- now, I know more about [university] 'cause that's where I went -- started out as a DNP -- I mean a Doctor of Nursing Science (DNS), because they couldn't get approval from the graduate school to award the Ph.D. And then, as the program developed and it was clearly a research degree, there was another petition and they decided that the school could grant a Ph.D. Since it took me a full ten years to get the degree, I was in process when they made the switch, and I elected -- we could elect to receive a DNS or a Ph.D., and I elected to receive the Ph.D., as it was consistent with the work I'd done. But there are those who believe that the Doctor of Nursing Practice is not a real doctorate. And that it does not qualify someone for a faculty position. And that it is not a worthwhile degree. So there's a lot of controversy around it. Not so much -- as the years go by, it's recognized more and more as an appropriate degree, but there's a lot of tension between the Ph.D. And DNP.

Another faculty participant provided this insight addressing accreditation and credentialing:

With regard to accreditation, again I will go back and say that there is yet to be a consensus ... from the credentialing bodies, as to whether or not they will be able to implement by 2015 the DNP as the terminal degree [for practice entry]. And there's still a tremendous amount of work being done to figure out, indeed, what changes need to be made in the credentialing process.

So despite the professional accreditation body driving the degree change, credentialing is a concern, although primarily involving nurse practitioners. Another faculty member in touch with the nurse practitioner community had this to say:

It affects -- it has a potential that most likely will affect reimbursement. Part of what I learned I actually learned from the advanced practice nurses at the VA, where I work, who would come and talk to me about DNP programs. Because they were realizing that, as they put it, the handwriting was on the wall. That even though the ones that were advanced practice nurses now will most likely be grandfathered in, but probably in a few years, to get Medicare reimbursement, they probably are going to have to have a DNP ... That the grandfathering may not be enough. This is all conjecture. But there has been a lot of -- there is a lot of concern from the current advanced practice nurses because they don't want to find themselves, in a few years -- 2015, 16 and beyond -- then out of a

reimbursement loop, because they may not be recognized by insurers, whether it's government or private, as advanced practice nurses and, therefore, not to be reimbursed.

Meanwhile, another faculty participant suggests the requirement for the DNP will be enforced from the capitalistic traditions of our nation and offers this opinion:

It's my opinion that's how it will be enforced, since it's not, like, regulation or law, ... how many other things are enforced in this country, ... capitalism will enforce it. The insurers will say we won't pay for that visit that the nurse practitioner did -- Blue Cross, Blue Shield, Medicare, whatever, Medi-Cal -- if they don't have a DNP.

Historically, Medicare caused a credentialing change for nurse practitioners by requiring a master's level education for certification and reimbursement. Insurers may eventually elect to take some action, but third party interests are not represented in this study, and that information is not known. Since nurse practitioners are currently certified, requiring them to change their degree to a DNP will effectively produce the same outcome as if insurers required a degree change for certification.

This next faculty participant reports a different perspective, one that is inspired by what she views as positive change for nursing.

As DNP programs increased and we looked at the product -- what comes out, what happens in this level of education -- it works. It's necessary. And I think as we graduate more DNP [students], it's really recognized as being necessary. So I think there was some -- there was controversy about the name, 'cause the DNP, you see the NP ... nurse practitioner. Or that it's for all advanced practice nurses and that's all. But no, it's for all nurses. I think there was some controversy. I think the controversy has largely gone away.

The current rapid rate of DNP program development instills a sense across the discipline that the degree will likely be required by 2015. From observations made at the January 2009 national American Association of Colleges of Nursing (AACN) meeting, one faculty participant provides this insight:

Four years ago or five years ago I started attending the AACN-sponsored doctoral nursing education conference. And they're held once a year, usually at some super-fancy resort that's really expensive. So I started going to these, and the first year that I went ...the focus was on Ph.D.s. And the DNP was a stepchild. All the issues were focused on the Ph.D. And now this last year -- so in the course of maybe four or five years -- the last conference, the national AACN doctoral education conference -- it was held in San Diego -- it was all DNP. The Ph.D.s were the stepchildren. There were a few sessions for Ph.D.s. The attendance at the conference has skyrocketed; it was, like, triple what it was even a few years ago.

As DNP programs developed, and cohorts graduated, the tide of the practice doctorate appeared to be largely overtaking nursing doctoral level education as participants report. Furthermore, as noted in periodic updates from the AACN website where program numbers are tallied, DNP programs are continuously being added to an ever growing list (AACN, April, 2010). Yet, despite, rising program numbers, the controversy over the future requirement of the practice doctorate and what the degree means for nursing across the discipline still remains.

While the Doctor of Nursing Practice (DNP) degree is serving to grow doctoral education for nursing, other health professions like Pharmacy and Physical Therapy paved the way in earlier years by advancing their degrees to clinical doctorates. The influence of other disciplines within health professional education acted as another force driving the College of Nursing decision. Pharmacy set the standard for midlevel clinical doctoral education. In the 1970s, Pharmacy was a 5-year baccalaureate degree. One year of undergraduate education was prerequisite for entry into the four-year Baccalaureate in Pharmacy program. Later, Pharmacy baccalaureate-level education was abolished and another year of general education was added to the prerequisites. Entry-level pharmacy curriculum remained as it was previously. Now, instead of five education years for a pharmacy degree, six-years of education are required while the degree morphed into a

clinical doctorate, a Pharm. D. What appears to be one extra year of undergraduate education suddenly turned baccalaureate education into a clinical doctorate. One administrator offered this perspective:

They abolished bachelor's-level pharmacy education and said what the entry-level degree for Pharmacy will be. Since we've, quote, already taken five years and a lot of courses, we just will say that it's the same curriculum, still four years of pharmacy school. Give the students two more years to get the undergraduate general Ed done, and then in six years awards a Pharm. D. degree. But there was really no change, so it was viewed from the -- outside the profession, in the content of the pharmacy curriculum it was still baccalaureate education.

Exactly who and which groups constituted perspective outside the Pharmacy profession were not disclosed; however, administrator higher education perspective represents one external viewpoint. Observing no real change in pharmacy education requirements, and according to this view, Pharmacy did not develop education outcomes specifying the skills necessary for the degree. Meanwhile, this administrator also offered practice concerns from the Pharmacist perspective indicating that decision-making had become much more complex; pharmacists frequently acted as sole source advisors for physicians and hospitals. The vast array of pharmaceutical products and changing expectations within the system demanded different skill sets than those of dispensing pharmacists in the retail world.

Other midlevel health professions observed the education and degree shift for Pharmacy and desired similar movement from within their fields. Historically, almost all physical therapy programs were established at the baccalaureate level. The Physical Therapy profession abolished all baccalaureate level education and developed a new entry-level Master of Physical Therapy. That degree was no sooner in place than the PT

profession moved the degree to the clinical doctorate. Now, the Doctor of Physical Therapy (DPT) will be standard as of 2020.

Professional nursing was influenced by these other healthcare disciplines. The American Association of Colleges of Nursing (AACN) wants nursing education to become a Baccalaureate in Nursing (BSN) to Doctor of Nursing Practice (DNP) model without requiring a master's degree. The professional nursing perspective is similar to how the Physician Assistant discipline resisted the requirement of a baccalaureate degree in transitioning PA education to the master's. Completing scholarship for nursing is the overall plan for the DNP degree. This move by professional nursing comes at the right time. Nursing work is more complex, and acute care advanced educated nurses are required to work out system complexities in order to improve patient outcomes and data collection. Current nursing research and hospital accountability standards support the move. Nursing needs leaders.

While indeed, professional nursing is responding to greatly needed change in a broken healthcare system, some aspects of this degree shift for nursing provoke some question. By American Association of Colleges of Nursing (AACN) tying the Doctor of Nursing Practice (DNP) to advanced practice in the early stages of degree development, the professional accrediting body essentially creates a misconception that licensing is tied to an academic-like degree, a misconception that will likely persist. Such degree and license association creates momentum for degree advancement; momentum is obviously a big advantage. Tying the degree initially to licensing broadly creates education demand for master's level practitioners. Yet, the influences driving this trend originate with professional accreditation, not from credentialing and licensing boards.

To the question of self-serving purpose, study participants report evidence of master's educated nurse interest in obtaining education mastery at the practice level. The Doctor of Philosophy (Ph.D.) was not meeting the needs of all of nursing. Fewer nurses desire research as a career end point compared to nurses seeking practice mastery. In addition to practice mastery, graduate-level nurses have repeatedly expressed a desire for parity across academic degrees. The notion of equivalent units for equivalent degrees has been an ongoing discussion across the discipline, as well as a desire among nurses generally to increase respect for the profession. Nursing scholars are finding the Doctor of Nursing Practice (DNP) appeals to a broad segment of a well-established nursing community, not just nurse practitioners.

Confusion persists over the purpose of the Doctor of Nursing Practice (DNP) degree and stems, in part, from state licensing requirements for nurse practitioners. Required certification along with nurse practitioner scope of practice varies across the United States. A DNP is not required by state agencies. Terminological similarities between the degree title, Doctor of Nursing Practice, and the role title, nurse practitioners, also contributes to confusion about the degree overall and its relationship to certification. This similarity in terminology coupled with the American Association of Colleges of Nursing (AACN) recommendation ties the professional degree, the DNP, to the nursing role, nurse practitioner, but not to the licensing requirement of advanced practice nurses. Nurse practitioners do not require a DNP to become certified; they require a master's degree.

Certifying boards for nurse practitioners across the country are moving toward required certification among all nurse practitioners; currently certification is not required

in all states. Reimbursement for services rendered is tied to certification. Requiring nurse practitioners to graduate at the practice doctoral level means eventually all nurse practitioners will require a Doctor of Nursing Practice (DNP) degree for licensing purposes. Licensing change will occur by professional mandate, and indirectly, rather than directly, through economic sanctions imposed by certification. Overall, economic sanctions are a more traditional force for change, but are not the forces acting upon nurse practitioner degree change here. These definitional fine points between DNP certification and required education are clear to nursing scholars and professionals, but remain vague to the public and other members of the stakeholder population.

Poorly understood concepts about the Doctor of Nursing Practice (DNP) degree, and nurse practitioners in general, supported forward momentum for degree change across all institutions. In an early interview, one faculty participant gave this perspective on administration confusion and concern over the DNP:

Administration wasn't really sure why nurses needed doctoral degrees, but once it was made clear that we would be obsolete if we didn't -- by 2015, for sure -- if we didn't go down this path, that was embraced by administration. But, you know, maybe take it slower. We wanted to fast track it a little more, and they wanted to slow us down a little, which I already talked to you about -- some of the administrators.

Wide variation in nursing education and confusion over licensing and academic degrees surfaced in this exchange:

Faculty Participant: Mine is short. Mine says [Emily Talon], Ed.D. RN-BC. I'm board certified as a nurse informatics -- in nursing informatics. Yeah. But some of them have about twenty initials out there. But that's where you delineate the difference. Right. You have to be licensed as a nurse practitioner. And you have that FNP or ANP. I think there's a GNP, for a geriatric nurse practitioner. So the first letter is the clinical specialty as a nurse practitioner. But it is confusing to some because the primary purpose of the DNP was for nurse practitioners. But now it's been kind of opened up and spread out to others.

Interviewer: So this, ... deviation from the specific purpose of it, again, is ... adding to the confusion.

Faculty Participant: Yes. Right. Right. Like with an MSN, a Master's of Science in Nursing. Everybody has -- not everybody who has an MSN is MSN. But there aren't initials after that like there are with the nurse practitioners. But there are many different foci. When I got mine, my major was in nursing education and my minor was in maternal/child clinical specialties. So it was just like a bachelor's, where you have a major and a minor. So there's a different focus on the MSN. There are the core essentials, and then you can go off as an educator, you can go off as an administrator, you can go off in a clinical specialty. But they all had the core of the MSN. We're just very different in nursing. What can I say? I don't know if it's because ... generally always been developed by women, or what it is. I don't know. I really don't. I know we are very confusing sometimes, ... no wonder the public doesn't understand us.

Then this faculty participant added further clarification:

Now, you know, the profession decides what each professional role needs as their academic preparation. So the DNP has now been determined to be the NPs' terminal degree [for practice entry]. But there's no difference between a clinical nurse leader -- I mean, there's -- excuse me. There is no comparison between a clinical nurse leader and a DNP. One is an academic degree and one is a role that you play as a nurse. One is a professional function. So clinical nurse leader and leadership and management is where most of our students get confused. So if you get your master's -- they can come into this program, this college -- College of Nursing -- and get a Master's in Clinical Nurse Leader, Leadership and Management, Ambulatory Care, or FNP -- Family Nurse Practitioner. Clinical nurse leader and leadership/management both have the word "leader" in them. And that's where most of the students are confused, and many of the -- sometimes faculty. But leadership and management is -- if you get your master's - - you're an RN and you get your degree -- master's degree -- MSN, with leadership and management, you are really an administrator. You are going to be working with personnel, on budgets, and managing a unit, and looking at issues that are really more administrative roles. You're a leader of people and the system.

The confusion over differences between the Clinical Nurse Leader (CNL) program and the Doctor of Nursing Practice (DNP) program along with another master's program in nurse management is precisely where the administrators struggled. In another administrator interview confusion about nursing was problematic.

Administrator participant: But nursing is so -- is different than any other -- look at health professions. I don't know hardly of any of the profession as these different pathways. So that's more foreign to me than -- I could more easily talk about dental education or optometric education or almost any of the other ones. But nursing has so many different degrees that have -- allow you to enter into that profession that it's -- I'm less familiar with it. So that's why I don't want to speak to it, other than I have to almost -- no, really. They have to educate me about what the field is and what the needs are, and why, the politics of it. And then we just have to justify the -- that it makes sense for the institution, that it's a viable program and there's a need for it. There's a market for it.

Interviewer: I'm empathetic with the need to be educated about nursing because as I began my research, I was very confused, and found that it was -- I had to ask many, many questions to even get a handle on the number of -- what it --

Administrator participant: Pathways. The possible pathways are multiple. I mean, you can be --

Interviewer: An RN is not an RN is not an RN.

Administrator participant: No, you can have -- you have -- they have associates. You know, trained ...

Unfortunately, this interview was interrupted at this particular point and the data did not reconnect to this discussion. However, my observation of this participant suggested she was experiencing extreme discomfort over being asked to provide information about a university program in a discipline she felt inadequate to discuss. Confusion as shown by this example can cause administrators to defer to the nursing experts who better understand the differences within the field, or slow change for nursing by producing resistance as it did with Health Sciences University's administrators. On the other hand, confusion can also be useful for achieving change for nursing across the discipline. One faculty participant had this to say:

So a lot of nurse practitioners are out there saying oh, they'll just grandfather me in. Nobody grandfathers you a degree. Sorry. Oh, well, I'll get grandfathered in. Okay. So if they actuate this by saying you have to be certified, and if the certifying body says okay, those of you who already have your certification, good

for you; anybody who's sitting for the certification exam after 2015 has to have the DNP, and then we'll all look certified and no one will know, that would work. But we don't know that's how it's going to work. We might have Medicare saying no. We want them to have the DNP. And if they do, you know, that's it. So we'll see.

Confusion and uncertainty will inspire some nurse practitioners to pursue the degree before the 2015 deadline, while others will wait to see how events unfold. As the faculty participate indicated from DNP program student reporting, many nurses have been awaiting the practice doctorate as an alternative to the doctor of philosophy (Ph.D.).

Faculty Participant: Two-thirds of the class wanted their doctorate, didn't want to go for a research degree, which is a Ph.D. -- research doctorate, which is a Ph.D. They wanted a practice doctorate. Something that showed that they'd have a higher understanding, that they've mastered a higher degree of content -- but in practice, not research. ... And so, as I said, educators and hospital leaders ... And so it really wasn't just the AACN. It really was the professional need that wasn't being met by the Ph.D.

Interviewer: For practitioners at all levels.

Faculty Participant: Even other than nurse practitioners, for nurses at all levels.

Many nursing scholars believe that inspiring nurses to pursue a more applicable entry to practice degree for nursing practice over the Doctor of Philosophy (Ph.D.) will likely serve to advance the field.

This ends the discussion of proponents signaling a transition to those forces acting against the decision and process. The following discussion includes inhibitors again broken into two sections of institutional and external. Up to this point, data reporting between case groups has been relatively homogenous; overall the data has been fairly consistent for both case groups. Individual participants in both groups fill information gaps while generally expanding the level of clarity between concepts. While this data trend continues for the most part, divergent views surfaced in the area of substantive

change approval and justification of the proposal to the regional accreditation agency committee. Conflicting perspectives within the institution as well as from the accreditation committee delayed forward momentum for DNP regional accreditation approval. The conflict arose out of unclear doctoral education parameters and was furthered by a poor understanding about nursing. Confusing terminology used by the discipline served to add to the conflict. The institutional inhibitors section will begin with a discussion of this internal resistance.

Institutional inhibitors. In reviewing the factors slowing the program process at Health Sciences University (HSU), internal resistance to the design of Doctor of Nursing Practice (DNP) curriculum surfaced as the leading candidate from among the six institutional factors and added three months of discussion to regional accreditation. In addition, the poor relationship between program developers and administrators reflected little cooperation from developers, and alignment with the regional accreditation agency perspective by administrators, all of which added to the conflict. Poor understanding of preexisting College of Nursing curriculum and programs by administrators prolonged the discussion and fueled adversity. Problems with nursing image and public relations across the institution may also have slowed the process, but more than likely fueled Medicine's resistance through the Osteopathic community at HSU. Overriding support from the administration for the College of Nursing likely kept resistance by other HSU colleges in check.

During the three-month delay imposed by regional review, significant internal resistance developed between HSU administrators and the Doctor of Nursing Practice (DNP) team of developers. Since program developers were responsible for constructing

the self-study, personal investment in the writing of the document likely played a role in the conflict, because changes were required. In any case, faculty participants reported being sent on many wild goose chases by the Health Sciences University (HSU) administrators. Resistance ensued along with noncompliance to administrator requests. One faculty participant shared a narrative describing the conflict; she refers to it as “the sixty units story” (F1PD, personal communication, July 12, 2009).

According to this faculty participant, the administrators expected the new doctoral program should contain a specified number of course units, although the participant could not recall the exact number. Numbers ranging from 60 to 120 were mentioned. In recounting background data on administrator perspective, the faculty participant suggested administrators possessed out-of-date standards. As the story proceeded, the faculty participant specifically highlighted the conflict:

So I wrote the self-study, I put together the substantive change document, it was reviewed internally, we ran into some internal resistance that I kind of ignored and just kept going. We got sent on a whole bunch of wild goose chases: no, you have to do this, you have to do that, do this, look at this -- which sometimes we did and sometimes we just said we did 'cause we knew it was a wild goose chase. If you know what you're doing, you know what you're doing.

What became clear through the sharing of this story was this nursing faculty participant believed assigning specified coursework units, as a defining standard for doctoral education, is an out-of-date concept. This is the point where differences between health professions education and higher education perspectives drew stark contrast. Even from the external perspective, concern about course requirements was an issue.

... There was concern about the length of the program. The team felt it was too short to warrant a doctoral degree. And it was not clear how -- the program was developed for people who were [either] FNPs or CRNAs, but it became clear that nurses with other master's degrees would be admitted.

The faculty participant further explained how the College of Graduate Nursing is aligned with national education standards set by the American Association of Colleges of Nursing (AACN) requiring competency-based rather than unit-based education. Yet, the basis for the overall conflict was not just the unit requirement of the Doctor of Nursing Practice (DNP) program itself, but also the variability in unit requirements from among the prerequisite master's program applicants. Some Master's in Nursing (MSN) programs required 75 units while others only 35. If all master's level nurses can qualify for acceptance to the DNP program, then this seemed problematic in the eyes of administrators, and also for the accreditation committee. The DNP program model requires only 30 units to complete the degree. Overall, this meant that not all DNP graduates from the Health Sciences University (HSU) program would be required to complete a specified number of units for program entry, but, ultimately, would receive the same doctoral degree.

While unit based education is a curriculum design for the Doctor of Philosophy (Ph.D.), competency-based education is the current formula for health professions education. Another contributing factor to the conflict as viewed by one faculty participant was her perception that administrators were completely unfamiliar with nursing education. This point had some merit, as it turned out, and was later confirmed by one administrator participant. The administrator viewed Doctor of Nursing Practice (DNP) students as similar to other first professional degree students. The administrator failed to realize students enrolling in this program would be a mature field expert having extensive background in the discipline, rather than enrolling as unpracticed novice clinicians as is often the case for other health professions.

Further disagreement arose over curriculum already present at College of Graduate Nursing (CGN). Administrators had a poor understanding of the differences between the Clinical Nurse Leader (CNL) program at the master's level and the Doctor of Nursing Practice (DNP) program. These two programs apparently bear strong resemblance to one another from a curriculum perspective calling into question why both programs would be necessary.

The 60 units story highlights the confusion created by the lack of clarity in nursing education and, in this case, impeded forward progress. Misconceptions between administrators and program developers generally slowed the process. Residual frustration over the internal resistance resurfaced later in this interview.

So in the proposal for the DNP -- again, consistent with other DNP programs and with national guidelines -- our program was competency-based and not unit-based. You just don't get to 120 units and oh; we stick a crown on your head and give you a doctorate. It was competency-based. The students have to meet competencies.

From administrator perspective, the underlying problem was nursing's failure to consider other perspectives. The documents and literature justifying Doctor of Nursing Practice (DNP) curriculum originated solely from nursing sources. On the other hand, faculty pointed at the proposal telephone conference as supporting their view that this problem, like so many encumbrances before it, related to viewpoints external to nursing. In the meantime and partly by design, the accreditation committee had nursing perspective, although knowledge about the DNP degree was apparently limited in the early stages. Ultimately, the necessary justification for accreditation approval of the DNP proposal came down to unit-based education, the higher education perspective.

Moving beyond design conflicts for the moment, the image of nursing across the institution presented itself as another institutional inhibitor acting as a public relations problem. Nursing has a significant image problem at Health Sciences University (HSU) according to faculty participants. Apparently, the College of Nursing has not “been in their faces with our research presentations” (F3SF, personal communication, June 5, 2009). Although prior to developing the Doctor of Nursing Practice (DNP) program, there may have been considerably fewer projects to show case. Show casing research between colleges is one way to create a higher profile within the larger institution, but without doctoral level research the College of Nursing probably had little to share. Other colleges within the HSU cohort such as physical therapy and pharmacy are of like kind to nursing, yet, their knowledge is equally lacking about what nursing is and especially about advanced practice nursing. As might be expected, administrative leadership in the College of Osteopathic Medicine does not understand the whole concept of the DNP. Yet, despite public relation failings by nursing, the university is open to nursing changing their image. The institution functions on the order of a learning campus, and from that perspective would likely encourage the sharing of ongoing research.

The Health Sciences University (HSU) osteopathic medical community as situated within the larger medical profession provided yet another public relations challenge for nursing. The College of Osteopathic Medicine is the founding college for HSU. This college established early education standards as well as formulating the humanistic tradition for the university. Osteopathic physicians are educated with some basic philosophical differences relative to whole health and prevention over the disease intervention philosophy of medical doctors. While osteopaths are socialized with an

elitist medical field perspective, they fought and subsequently won recognition battles in the medical field, not unlike ongoing trials for nursing. Still, the Doctor of Osteopathic Medicine (DO) College and community are a part of the overall medical community. The position of the medical community generally opposes a doctorate for nursing.

One faculty participant describes the medical sciences as a professional degree type, and a better fit for the institution. This medical sciences distinction seems to relate more specifically to long-standing and traditional doctoral level roles as those found among the newest Health Sciences University (HSU) colleges. The new HSU colleges include podiatry, dentistry, and optometry. These programs generally appear to be a better match for the institution based upon program type. The sheer momentum of those degrees having been around longer with well-established traditions of inter-disciplinary relationships facilitates institutional fit. The various disciplines and roles know how to interact with one another. While these newer programs align more consistently with traditional health professions models, the general result for nursing is a continued marginalization as these newer programs take hold.

Despite institutional pressures, changes and conflicts slowing forward progress, the Doctor of Nursing Practice (DNP) program ultimately received approval and moved ahead. This concludes the discussion of institutional inhibitors for the decision and process.

This next section considers inhibitors external to the College of Nursing and university - influences that generally act more broadly upon Doctor of Nursing Practice (DNP) programs and the degree. These influences include challenges from the medical community, lack of nurse consensus across the discipline, institutional type, DNP

curriculum models at other institutions, misconceptions about education parity and rigor, American Association of Colleges of Nursing (AACN) delay in publishing standards, regional accreditation inexperience with DNP evaluation, regulation and economic sanctions, along with influences from other health professions. While all of these inhibitors emerged from the findings of this study and have a general influence upon forward momentum of the degree overall, not all inhibitors had a specific influence upon the degree and program at this institution. For that reason, the discussion will focus on those inhibitors directly affecting Health Sciences University (HSU). These inhibitors include DNP curriculum models at other institutions, misconceptions about education parity and rigor, AACN delay in publishing standards, regional accreditation inexperience with DNP evaluation, regulation and economic sanctions, and influences from other health professions.

External inhibitors. Education parity among degrees based upon equivalent units for the various levels of education is an argument often used to promote the Doctor of Nursing Practice (DNP) degree. Across nursing, a number of misconceptions over what constitutes education parity persist. Some nursing scholars fail to address questions of program rigor and curriculum rationale. Faculty participants observed problems encountered by early programs over rigor, missing clinical hours, and program length as these programs engaged with the professional accreditation process. Problems arising from curriculum outcomes and review rather than research on doctoral level education influenced the College of Nursing and subsequently DNP program curriculum design. The external participant had this to say about accreditation agency concern for rigor.

I'm working with another university that's doing a DNP, and when I raised a question about the length of their units, they said well, what do you mean? I

said have you done any comparison of the number of units these students are going to end out with compared to other clinical doctoral programs? Well, no, they hadn't even thought about it. And I said you know, nursing can't -- 'course, I am a nurse -- nursing can't just say we're going to do a clinical doctorate and put a year of post-professional education out there and call it a clinical doctorate. You've got to say what is the comparability, because in order for this degree to be a credible degree, it has to be credible. It has to have enough substance to it that, in fact it's like other clinical doctoral degrees.

Well, they hadn't -- you know, it caused some real soul-searching, and this faculty had to go back and do some homework, 'cause they really hadn't thought about that. They thought that if they added a year to the FNP and CRNA that would be enough. I said you know you're missing the boat here. You don't understand that this is not just a master's degree with a year added on. One of the things that the people at [the agency] and the substantive change committee have to look at is how does a master's degree become a clinical doctoral degree. It's a master's degree.

The regional accreditation agency perspective was the basis for the conflict between the administrators and the program developers at HSU. While neither faculty nor administrator participants made the specifics of the dispute clear, one administrator was sensitive to role responsibility in aligning the university with regional accreditation.

Many nursing educators believe that adding a few more classes or even just another year of education is sufficient curriculum development for doctoral levels in clinical practice. Yet, what the HSU College of Nursing was doing in creating a program for all master's level nurses meant that considerably fewer units of education would be required for DNP students graduating from master's programs with 30 units when compared to nurse practitioners graduating with between 50 to 72 units. The degrees would not be comparable. While the college followed the AACN DNP essentials, the unit dispute at Health Sciences University (HSU) reflected some of this same problem of expected parity for curriculum already in place. Broad misconceptions continue over what constitutes sufficient doctoral level rigor, as well as what course work is essential for establishing education and degree parity.

While Doctor of Nursing Practice (DNP) program openings have been ongoing since 2004, these programs are only now surfacing in the western United States. Early programs were established in the eastern region. An apparent lack of experience with reviewing DNP programs on the part of the regional accrediting agency is credited as slowing the process for HSU College of Graduate Nursing (CGN). One administrator had this to say:

First of all, [the agency] was hard to convince. So I would consider them a bit of an obstacle in the beginning. We were the first one to submit a proposal, so, of course, they didn't know what a DNP was. And so there was some push back to have to re-do the proposal or add this or add that.

The HSU DNP program was the first program of its kind in the state, and one faculty participant understood that the regional accreditation agency committee in not knowing what a DNP program was might require clarifying information.

The very first question they asked us as we're apply- -- after we've done the self-study -- applying to do this new program, was: why do nurses need doctorates? So the Dean put her hand over my mouth, and went -- 'cause it was a telephone conference -- "Be quiet! Don't start yelling at them yet. We'll yell at them later." No, we never yelled at them. But they had questions, and they had some critique of the self-study. They asked us seven or eight additional questions, wanted additional data. This is not unusual. So I revised the application, answered their questions, gathered the additional data.

This participant felt the revisions were sufficient to meet the accreditation committee's request. While the regional agency request for clarifying information slowed the process, the real obstacle became the internal conflict with administrators. From program developers' perspective, administrators were misguided in requiring additional units over competencies as a mechanism for evaluating the program. Still another faculty participant shared this perspective on the regional agency and its impact upon the DNP program approval process:

... With regard to accreditation from [the agency], we were the first ones in [the region] to apply for accreditation for the DNP program. And they had no idea what to look for.

Meanwhile, the external participant had this to say.

So we had to look at the gestalt. Was the degree -- and since we didn't know how many permutations there would be of the students coming into the program at [HSU], what we had to do was look at what were their systems of appraisal.

The purpose of accreditation is, after all, to insure quality and appropriate rigor among programs. The delay imposed by the accreditation agency on the college as supported by administrators was an appropriate and necessary step for aligning doctoral education standards within the institution. The College of Nursing eventually satisfied the committee that “in the aggregate students would have comparable units” (WCC1, personal communication, November 6, 2009). The process was slowed, but purposefully, and insured continuing standards of education excellence for the college and the university.

Regional accreditation broadly evaluates institutions educating health professionals across the spectrum of disciplines. By virtue of that charge, regional agencies consider both similarities and differences between degrees. An interesting and not well-known point about health professions education is that medical education is defined as an undergraduate degree. In osteopathic medicine, the Doctor of Osteopathic Medicine (DO) includes three years or 90 units of total required prerequisite general education coursework. Within those 90 units, 40 units are course-specific. Internships vary as to when they begin along with the length of time required, but overall osteopathic education involves three years of course work followed by a year internship for a total of eight required semesters. The residency year is where the medicine is learned, and is

required one year prior to licensing; two additional residency years are required for a specialty certificate.

Professional degrees vary across health professions, but in the particular case of medicine and nursing, they are not equivalent. For nursing, the practice degree is an entry to practice professional degree. This administrator reports the difference in this way:

Administrator participant: Undergraduate medical education it's called, in the profession. You're just given a ticket. You really learn medicine as a resident.

Interviewer: Right.

Administrator participant: You just have the general -- general Ed background in medicine. That's all that degree goes to. You have to spend another year in a hospital, at least to be licensed, ... and two more years to -- specialty certification. So you're not an autonomous physician until you pass those things. The degree that we grant is the beginning, not at the end, whereas, in nursing it's kind of a terminal degree.

Licensing for nursing occurs at the associate or baccalaureate level and begins their practice, very often long before Registered Nurses (RN) pursue a terminal degree. The Doctor of Philosophy (Ph.D.) produces independent researchers, and once achieved, the researcher begins practice. No license is required. The Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), and podiatrists are professional doctorates. These doctorates are academic-like professional degrees awarded at the end of medical school. The degree begins the career, but not practice. A residency is required prior to licensing. Licensing occurs after the doctorate is awarded. One administrator participant clarifies how these licensing concerns influenced the internal conflict at Health Sciences University (HSU):

Administrator participant: -- not equivalent. ... The Ph.D. ... Okay ... you can be an independent researcher. That's what the Ph.D. has done. You show that you can do this. For an MD or DO, just the start of your career. For podiatrists, yeah, you had to do a residency. Other ones, like PT, it's terminal [for practice

entry]. There is no residency training for them -- component here. So that was the -- You have all that conjures of historical tradition, and now you -- ... and now you've got this accrediting body that's trying to rationalize all of this, when there really is no rationality to it.

Interviewer: There's lots of discussion ... rationality.

Administrator participant: Right. So that was what -- so that was my challenge, and, you know, ... I looked like the enemy to them. Or I was trying to do that when I says well, I'm trying to raise the issues that a regional accreditor ... so that you can build the argument.

Interviewer: You looked like the enemy to the nursing program?

Administrator participant: Yeah.

Similar unit equivalency challenges existed for the transition of the Physical Therapist (PT) master's to the Doctor of Physical Therapy (DPT) as those found for nursing with the Doctor of Nursing Practice (DNP). The PT program transitioned from the master's by adding only 19 units. A Doctor of Philosophy (Ph.D.) requires two years of education plus a dissertation beyond the master's. PT curriculum requires 144 master's units. From the PT perspective, education levels had already achieved doctoral status for units earned, and so as one administrator participant queried "why stand on that formality" (A2P, personal communication, May 19, 2009)? Meanwhile, administrators and regional accreditation wanted to know what was new. What makes this doctoral level education different than what was offered at the master's level? What compels this move? From administrator and regional accreditation perspective, nursing colleges along with other health professions need to demonstrate not just consistency across education standards for creating clinical and practice doctorates, but difference from what was offered at the master's level. Doctoral education is expected to be distinct and separate from master's education. Despite the view of many health professions that existing

degrees are already doctoral equivalent, the fact that these degrees have been offered as master's education is in itself a limitation. Expectations by the regional accrediting agency require difference.

Attending professional meetings for ongoing education and collegial discourse is fairly standard practice across the health professions, and supports the College of Nursing faculty interests in remaining at the forefront of nursing education. Professional meeting reports uncovering problems with student enrollments at other institutions influenced Doctor of Nursing Practice (DNP) curriculum design at Health Sciences University (HSU). Across institutions student enrollments were adversely affected for those programs offering the nurse practitioner DNP curriculum model. Students seeking nurse practitioner education at the master's level where the DNP is yet an unproven requirement has caused enrollment avoidance for family nurse practitioner programs already converted to the DNP level. This circumstance was an observable outcome for early DNP programs that converted nurse practitioner programs to an entry to practice degree by dropping the Master's in Nursing (MSN).

Nursing applicant pools include students who want to become nurse practitioners, but aren't necessarily interested in pursuing a doctorate. Some students are anxious to complete their master's in nursing practice, as example, before the doctorate becomes the degree for entry to practice for the nursing role. With a Master's in Nursing Family Nurse Practitioner (MSN/FNP) program already in place, along with widely varied applicant perception about the DNP, the program developers appeared to bypass the specific American Association of Colleges of Nursing (AACN) requirement for MSN/FNP programs until a time when the future of the DNP for all nurse practitioners

becomes clear. Faculty participants shared their views as to the factors influencing curriculum design for the college:

...There are a whole group of potential students who aren't necessarily interested in doing the doctorate, but really want to be nurse practitioners. And these are the people that are really anxious to do their master's FNP before the doctorate becomes the terminal degree [for practice entry]. So you're losing this whole set of potential students. And I was recently at a conference of the National Organization of Nurse Practitioner Faculty, where there have been a few universities that have taken the same move and eliminated the middle stuff. And it's quite rocky going for them right now. ... Their pool of applicants has dropped.

Another faculty participant offered perspective from that of established doctoral educated nurses:

And those who already have doctorates were very concerned because there were some schools in the other parts of the country already that were offering DNP [degrees], where the impression was that there wasn't the rigor, there wasn't the requirements. And the DNP requires less units than other doctorates, than according to the minimum requirements of the [AACN] ... But all of the people that I knew with either an Ed.D. or a Ph.D. were all saying well, now they're going to have this DNP, and they're not going to have to work near as hard as I did to get mine, but they're going to get to be called doctor, too. So it was almost like a jealousy thing, ... and a concern that it was going to devalue the others, because everybody would get to be called doctor.

Later in the same interview, the faculty participant explains difference and rigor in another way:

Faculty Participant: ... I don't see those who have the DNP, of having the same level of understanding and practice as an Ed.D. or a Ph.D. That's because the focus wasn't education. You know, they don't understand, and they didn't have to take near as much. And I didn't -- now, like, say -- they didn't come from [HSU]. And I think there will be a difference there. But I didn't see near the rigor. And I don't think they have near the understanding of statistics and research, and higher-level inquisitive thinking and things like that.

Interviewer: From other programs, you mean.

Faculty Participant: From other programs. Right.

Interviewer: You're not talking about [HSU]...

Faculty Participant: I'm not talking [HSU] at all.

In this next excerpt a faculty participant comments on the strategic plan for curriculum:

[College administrators] were very much interested in creating an advanced practice program. And they were involved with publicly funded schools in the past. ...I think what they recognized is that with the -- first of all, the nursing shortage, the shortage of enough primary healthcare providers, enough advanced practice nurses, that we were going to have to change the way we offered these programs, to get more people interested in pursuing these advanced practice degrees. I've talked to a hundred nurses who said I would love to go back and get my master's and my FNP, but I can't pack up and move to [some city]. Or I can't take two years off of my job to do this. I can't afford it -- I can't afford the time, the money and that sort of stuff.

Recognizing that our pool of applicants, the people that we were looking at, were people who were already nurses practicing, as you said, in their communities, comfortable in their communities, established, and trying to design a way of getting this education to them I think was the initial idea toward going to the online.

Some students are not interested in acquiring a doctoral degree, but still want to become nurse practitioners. Questions of rigor still pose problems across the discipline for nurses with other doctoral degrees. The mature nurse population as returning students presents another challenge for curriculum planning. While nursing as a discipline constitutes a varied collection of levels and interests, the College of Nursing as guided by expert curriculum planners attempted to fashion curriculum around those concerns.

Early Doctor of Nursing Practice (DNP) programs were just beginning to navigate the professional accreditation process while I was collecting my data at Health Sciences University (HSU). Faculty participants made observations about that process in highly disapproving tones.

Administrator Participant: And the other area is that the -- and I think this is a real shortcoming of the DNP -- is that they developed the DNP, they developed the standards, but it was two years later they developed the accreditation outcomes. So because they developed the programs, people started their programs, they didn't know how you're going to be accredited. So I think there's been some mushiness in the original curriculum to now, how you're going to be

accredited. And there are some changes that are occurring in the rollouts. So for example, [our program planner] went to a doctoral conference in January. And ... came back and ... goes "Oh, my God. There're seven schools up for accreditation, no one's been approved yet, they're obsessed with the clinical hours, and this is what they're going to look at when they come to do the accreditation visit." And so they -- in a sense, they didn't have their act together. If you're going to start a program, then you should be able to measure the outcomes. And they have that, but then how are you going to regulate the outcomes? So I think that has -- they have lost some credibility as an organization, at least from my point of view, because you can't have something out there and then change it as you're trying to evaluate it. That's -- certainly, you get input for change, but generally, you get your standards out there, you do it for a couple years and then you call for a vote on what you need to change. So --

Interviewer: You mean the AACN?

Administrator Participant: Yeah. So, I mean, you -- and so [the planner's] message, when she came back, was we're going to sit on our heels for another year before we go up for accreditation because we don't even know what's holding up those first seven, and what are the lessons learned. I don't want to jump into the firing squad if I don't have to. So we're letting the dust settle and see how those schools fare, and what is the data to support what's their new thing they're concerned about. So the one thing I think they're really concerned about is the clinical hours, and probably looking to standardize that a little bit.

A cautious administrator suggested holding a wait and see position before navigating the same process for HSU, a similar tactic used when determining the appropriate time to move forward with developing the DNP program for the college.

While the professional accreditation agency stipulated a requirement for nurse practitioner change, education standards were not published for two additional years. The time delay represents a specific inhibitor to the College of Nursing slowing the creation of the Doctor of Nursing Practice (DNP) program at Health Sciences University (HSU). The American Association of Colleges of Nursing (AACN) recommendation for curriculum change was published in October 2004, while the DNP essentials were not published until 2006. Programs opening prior to the 2006 publication experienced the consequence of unmet accreditation standards during professional accreditation review.

The unmet standards addressed clinical hours. Clinical hours were not among the requirements of the 2004 document. Early programs used the original position statement and followed evolving curriculum requirements trusting that AACN would support early efforts. These programs did not anticipate accreditation accountability to a document published after program development, a decision that later proved costly. Disapproval of AACN actions was evident even from among those nursing scholars teaching in DNP programs closely aligned with the 2006 essentials. A notable planning difference for the HSU DNP program was the specific delay for program development until final DNP standards were published in 2006.

This concludes the discussion of external inhibitors. The overall findings demonstrate five external factors contributed primarily to the slowing of the process for the Doctor of Nursing Practice (DNP) degree at Health Sciences University (HSU). The regional accreditation agency concerns for sufficient program rigor ultimately led to conflict between the administrators and the DNP program developers. Furthermore, the process of and differences among other health professions in creating their professional doctorates influenced the perspective of the regional accreditation committee and institutional administrators. Finally, the delayed publication of DNP standards by AACN slowed the process early on, but acted within the College of Nursing directly.

CHAPTER FIVE

Conclusion

This qualitative case study examined the decision and process of adding a Doctor of Nursing Practice (DNP) degree program to the College of Graduate Nursing at Health Sciences University (HSU). Nursing faculty and university administrators – two groups of participants with potentially very different perspectives -- were interviewed, responses examined, and then compared for understanding of both the decision and the process. This investigation resulted in a story of decision and process situated in the context of an expanding graduate education institution with entrepreneurial goals. Common participant experiences revealed the extent to which administrator and faculty behavioral responses were consistent with HSU mission, vision, and goals.

In this chapter, a discussion of the findings is linked with literature discussing constituent roles (the various roles held by administrators and faculty during the decision and the process), change models, and the role played by the institution. Subsets for institutional role include institutional type, mission, strategic plan, and culture. The scope of practice is also discussed, followed by recommendations for future research, and then implications for policy. The chapter concludes by reviewing study limitations and reflecting upon the investigation process through the researcher's lens.

Findings and their Relationship to the Literature

Constituent Roles

Important to this discussion is how Burke (2002) distinguishes between the content of organizational change and its process. The content of organizational change focuses on those elements providing vision and direction for change such as purpose,

mission, strategy, and values, the essence of factors defining the institution, while the process has to do with how change is planned (Burke). As such, the leadership required for developing content is different than leadership required for the process of change (Burke). Developing content requires taking a position, creating vision, and composing the essence of the story (Burke). Health Sciences University leadership with guidance from an entrepreneurial President provided that vision through institutional mission and strategic planning. Broad expansion for the institution was the result.

Burke (2006) discussed developing a process for change. The process of adding a Doctor of Nursing Practice (DNP) degree caused participants to engage in multilevel meetings and discussions, as well as engaging a task force for curriculum development. Process requires participatory leadership like that provided by nursing's field experts; such leadership promotes activities moving organizations toward the desired change, in this case the decision for adding the DNP curriculum to the College of Graduate Nursing (Burke). The leadership of the college includes experts in education and curriculum design, and field experts in policy, informatics, technology, practice, and research.

Constituent roles pointed toward institutional knowledge levels for participants as well as the extent of their involvement in the decision and its process. The criteria for inclusion as a study participant required faculty and administrators have some knowledge about the decision and its process. Sample selection imposed a natural exclusion of individuals without that knowledge, and resulted in a relatively small number of participants. This limitation is likely institution-specific and related to the nature of governance at HSU. Despite the sample limitation, faculty participants painted a broad picture of the decision and process while the details surfaced through data analysis.

Of course, qualitative research data always needs to be triangulated, because the data relies entirely upon perceived realities (Perrakis, personal communication, May 6, 2010). For the college, the leadership-driven creation of the Doctor of Nursing Practice (DNP) program involved a few people and crossed both administrator and faculty groups. While nursing faculty credited one faculty member as primarily responsible for program inception, other faculty were also involved. Meanwhile, administrators gave similar credit to one administrator, yet the process required administrative involvement on multiple levels. Early discussions between university administrators and the college required efforts from the Dean of the college and nurse practitioner experts for educating institutional stakeholders. Later, college faculty and administrators provided expert testimony supporting program curriculum design with regional accreditation. The responsibility reality for program initiation demonstrated evidence of wide variance in involvement among developers and administrators at different times and levels.

Change Models

The Nadler and Tushman (1977) congruence model is an open system for diagnosing organizational behavior (Burke, 2002). The core components of this system include the task and individual components of organizational arrangements and informal organization, and are consistent with my findings (Burke). From my research, the Health Science University (HSU) environment, resources, and history served as inputs. These inputs assisted the College of Nursing in developing a strategy for pursuing the new Doctor of Nursing Practice (DNP) curriculum, and at the same time supported the broad mission and plan of the university. Since the decision to add a DNP program to HSU originated in the college, focusing on the influence of institutional stakeholders seemed

logical. Tying the decision and process to the mission, goals, strategic plan, and resource management served the intended purpose, uncovering decision and process congruence with the broader purpose of the university. Focusing on known external stakeholders is another logical piece, but addressing external stakeholders as participants fell outside the scope of this study.

Berg (2003) used a systems model as a means for uncovering the influence of institutional choice in constructing mission statements and evaluating the ability of educators and administrators to do good work. Berg's model is dynamic, comprehensive, and includes four primary domains producing either good or compromised works. The Berg model bears some loosely constructed likeness to and may be a modification of the Nadler-Tushman congruence model (Burke, 2002). In Berg's model, the Institution of Higher Education domain has a direct relationship with institutional mission; mission alignment produces good works while misalignment produces compromised works. At the top of Berg's circle is a social/cultural forces domain involving the economy, politics, and the world-view. Extending away on either side is the external stakeholder domain and then the domain and field of higher education. Interestingly, the latter domain of higher education includes accreditation rather than categorizing in the external stakeholder domain. After contemplating the relationship of accreditation with Berg's Domain and Field of Higher Education, I decided the association was correct, but I also noted my data did not correlate perfectly with the model.

At the center of Berg's (2003) model is the Institution of Higher Education domain and includes trustees, faculty, administration, and students. The Berg model also situates mission as stemming directly from the Institution of Higher Education domain.

While the relationship between Institution of Higher Education and mission matches this relationship in my study, health professions programs also establish missions separately and need to be considered. Berg aligns mission with either good work or misaligned with compromised work. Mission alignment and misalignment in my study equates with the decision outcome, presumably producing different results when mission is not aligned. Mission alignment within the context of my study produced a decision supported by institutional stakeholders. Institutional stakeholders agreed the college should develop a program; however, college strategy likely influenced the type of program adopted by the university overall. That strategy produced conflict, but did not affect the mission of the college or university. Mission alignment may not be evident at other institutions and mission misalignment would likely produce a different decision.

Berg's (2003) model has connecting arrows demonstrating the interconnectedness of relationships between and among domains. Interrelatedness has been shown across the literature to be a hallmark of organizational change (Berg). Interrelatedness holds true for health professions, but may have some limitation between fields.

Many of the component pieces of the Berg (2003) system are consistent with my findings but require minor modification. Broadly lumping faculty and students into Institution of Higher Education domain doesn't account for differences among the health professions. Those differences matter, because each health profession may have one or even more than one professional accrediting agency. Those agencies act upon each profession differently, and specify curriculum standards in varying degrees. While regional accreditation acts upon institutions and across the professions, professional accreditation does not function in this same manner. Health professions accreditation is

specific to each discipline influencing education standards in ways that are frequently mandatory and may or may not have the broader institutional standards of excellence at the core of their purpose. Professional advisory boards act similarly, but with less authority than professional accreditation. These boards are part of the external community and can be organized into Berg's external stakeholders' domain, but, again, are field-specific.

Health professions education has discipline specific accreditation, not just institutional. Health professions accreditation bodies frequently are seen as having ulterior motives for field advancement and gain, rather than acting as oversight bodies for institutional effectiveness and excellence. In this way, professional accreditation operates as an external stakeholder acting directly upon specific health professions, and indirectly upon the larger institution. Professional accreditation should be explicitly listed within the external stakeholder domain to account for influences acting directly upon the health professions, a small modification that would more accurately represent what occurs in that environment.

The Role of the Institution

Morphew and Hartley (2006) point out that mission statements "are used to signal and symbolize", although their overall purpose may actually be far more complex (p. 469). Institutions generally use mission statements to "communicate their utility and willingness to serve in terms that are both normative and politically apt" (Morphew and Hartley, p. 469). Furthermore, these researchers suggest "mission statements may be a way of establishing institutional uniqueness and therefore are a potentially useful tool in institutional decision-making" (p. 460). This tool point speaks to the purpose of my

study, and drove the methodology toward the use of institutional mission as a methodology frame. Viewpoints are fairly divergent about mission statements, their purpose, and how they function at the institutions for which they are designed to serve. Frequently among public institutions these documents are considered normative and positioned to communicate the function of the institution to both internal and external stakeholders.

Institutional type. While the purpose of Morphey and Hartley's (2006) research was to study mission statement wording broadly and across institutions, their study is a truly comprehensive work on mission statements in that it underscores the importance of institutional type in determining the wording of, and purpose for, mission statements. One major finding suggests that "public colleges' and universities' mission statements contain[ing] elements different from those of ... private" institutions are most likely to "reflect, rather than drive, the realities of these institutions' environments" (Morphey and Hartley, p. 467). This finding suggests that the values of institutional stakeholders most likely determine the elements of mission statement.

The broad mission of Health Sciences University (HSU) is to expand and become a major graduate and doctoral level health science university; as such, expansion was ongoing and strategically planned. During data collection, the university was rapidly building colleges and programs, and also included a future plan for a research institute. This Institute would likely facilitate growth for existing programs and colleges; a point also noted by faculty participants who indicated the institute would support nursing's effort to grow Doctor of Nursing Practice (DNP) research and expand the college's

research agenda. Of course, expansion and future planning broadly serves the needs of the university as well as those of the individual colleges.

Another point made by Morphew and Hartley involves the use of like elements in mission statements across postsecondary institutions. Specifically, they argue that mission statement elements within the same institution might function in a similar fashion as like elements found in “unlike -- but similarly funded -- institutions” (Morphew and Hartley, p. 466). Similarity among elements suggests mission statements may be used as “icons to signal key external constituencies that the institution shares ... group values and goals” (Morphew and Hartley, 2003, p. 466). In addition, Morphew and Hartley report “there is a prevalence of elements related specifically to “service” either by the institution or through the inculcation of civic values in students,” (p. 462). The use of similar or like elements was noted in my findings through the adoption of specific core values across the university and College of Nursing. The adoption of humanism by the institution early in its history, followed by adopting the value of treating and educating vulnerable populations served to join mission values.

Humanism began as the core value for the founding college and developed as the institution grew. Historically, nurse practitioners evolved because there were physician shortages and vulnerable populations were not being served. Nurse practitioners caring for vulnerable populations grew out of changes in the healthcare system; in other words, using the history of the nurse practitioner field fit well with the established core value of humanism. As such, vulnerable populations linked the two values for both the university and the college; however, while, aligning these two values seemed both logical and appropriate, the actual value driving the college in developing the DNP degree was not

service to the vulnerable population community, but instead was the goal of professional nursing advancing the discipline through degree upgrading.

From Morphew and Hartley's perspective, "it is likely that the subject of college and university mission statements is more complex and that institutions are using these documents to communicate their utility and willingness to serve in terms that are both normative and politically apt (Morphew and Hartley, p. 469). In this case study, the college delayed developing a Doctor of Nursing Practice (DNP) program until standards were established and outcomes from early programs produced more information and direction for curriculum development. Based upon the college strategy of waiting and watching developments in DNP education and accreditation, normative and political positioning seemed like underlying elements in the college process.

Finally, Morphew and Hartley (2006) reference public institutions and point out their mission statements contain more blended content, parameters that are less distinct, less well-defined. Public institutional mission statements seemed to reflect the reality of their environments rather than driving a plan for institutions (Morphew and Hartley). This question of reflecting the true institutional environment surfaced when two faculty participants reported experiences with public institutions where resistance to change for nursing was problematic. No clear evidence exist supporting participant views across institutions since this faculty perspective may be anecdotal or specific to one institution. Upon reviewing my data further, I noted three out of seven faculty participants attended the same public university; no other participants identified their affiliations. While it is not possible to directly apply nurse participant observations to public postsecondary institutions, my findings suggest that evaluating decisions through the lens of mission and

goals at both public and private institutions might serve to uncover factors affecting change for nursing.

Institutional mission and strategic plan. Mission statements are an important and necessary element for strategic planning (Morphew and Hartley). A significant overall finding affecting this college decision was the realization that education at the graduate level and the awarding of clinical doctorates for entry to practice is part of the Health Science University (HSU) mission. Meanwhile strategic planning as a necessary mechanism for organizational change among post secondary institutions nationwide was liberally applied at HSU. The strategic plan is the virtual roadmap for institutions; while the role of mission points to the map and says goes here. Ongoing and constant planning by the university coupled with college-level strategic planning supported the general concept of strategic planning as an ever-developing road map for the institution. HSU mission set the institutional compass to achieve graduate level education at the clinical doctoral level for all colleges, and for nursing that meant the practice doctorate. The strategic plan of the College of Graduate Nursing designed the route taken by the college and university together; the practice doctorate would broadly address nursing education, not just nurse practitioners.

Morphew and Hartley (2006) suggest two potential benefits of mission statements in postsecondary institutions. Mission statements can be instructive and may also assist in developing a shared sense of purpose (Morphew and Hartley). Communicating to faculty and students the overall institutional purpose can align programs and curriculum around a common purpose and can also assist decisions for appropriate inclusion or exclusion of curriculum (Morphew and Hartley). For the purposes of studying a specific

institution's decision, the research frame of institutional mission grounded Health Science University (HSU) data within the context of its own mission and included the underlying elements of leadership, goals, values, strategic plan, and resource management. While mission is the first step in strategic planning, the mission directs the plan.

Generally speaking, the type of change required among various institutions involves both revolutionary and evolutionary change at different times in the life of organizations (Burke). Health Science University (HSU) had been growing over time, and during this investigation, was actively engaged in effecting significant change on a large scale by adding three new colleges. Change at that level included infrastructure building, the addition of new program curriculum, faculty and administrative hires, as well as marketing campaigns reaching out to new student populations. A future research institute was also being planned with similar requirements. HSU broad expansion imposed change at a total system level; however, Burke was not suggesting these types of change are mutually exclusive. Evolutionary change had been ongoing for HSU since the 1990s, while the most recent decade witnessed rapid revolutionary change and was likely stimulated by forces external to the institution.

From the Colenso (2000) text on successful organizational change, Colenso reports, "the climate in which modern organizations operate is turbulent, discontinuous with the past, and it is hard to predict what is likely to happen next" (p.18). Building institutional capacity is essential if post secondary institutions plan to survive an ever-changing environment (Colenso). In fact, only through capacity building will institutions be successful in producing the necessary evolutionally and revolutionary change

(Colenso). From this perspective, strategy develops not so much in terms of mapping out a defined plan as much as it involves the building of institutional capabilities for responding to necessary change (Colenso). Strategic planning at Health Sciences University allowed for unanticipated programs by establishing contingency funds for program development. The nature of web-based distance-learning education also facilitated adding new programs while requiring minimal resources. These planning strategies built institutional capacity for the university and college.

Burke (2002) argues that major change requires a shift in the external environment. Health Sciences University was founded in 1977 and remained primarily medical education through the 1980s. Momentum for institutional change grew out of healthcare provider shortages in the last decade of the 20th century as the university added a college of pharmacy and an Allied Health college inclusive of nursing, physician assistants, and physical therapy. Public outcry for healthcare reform in the 1990s grew louder into the 21st century as the Institute of Medicine identified the brokenness of the system and the need for healthcare education reform (IOM, 1999, 2001, 2003). The IOM reports alerted the U.S. Surgeon General and marked an external shift for healthcare education. According to Burke, the rate of external environmental change in the 21st century, unlike the early 20th century exceeds the rate of institutional change. The cry for national healthcare change reached a crescendo during the 2008 Presidential election, and in 2009, our nation's President responded to public outcry by mandating congress reform healthcare. Pressures in the external environment exceeded institutional capacities to effect the necessary changes for consumer economics. Krause (1996) in his discussion on professional guilds in the U.S. suggests "a loss of control by the profession over the

numbers trained, in particular—has coincided with precipitous increases in the costs to both capitalism and the state of services provided by the professions” (p. 32). The external environment had shifted over the course of more than half a century, and healthcare had become the central focus of national policy change in Washington D.C.

According to Burke, “the most critical point of all ... a fundamental ... is the consumer, the customer out there in the external environment ... determines the fate of any business” (p.6). Demand for products and services drive industries; demand for doctoral level education for health professions had begun with pharmacy, and continued growing and changing with physical therapy, and now nursing. The institutional response to consumer demand for doctoral education was ongoing at Health Sciences University. Along with programs added during the previous decade, the university developed a new library in 2001, and then added three new programs and colleges in 2009 with future plans to add a research institute.

While institutional change was ongoing for the university, the College of Nursing experienced change resulting from the external shift. The American Association of Colleges of Nursing (2004) used the Institute of Medicine position on healthcare education as support for the mandate. The decision by nursing to add a Doctor of Nursing Practice (DNP) program to the college began well before the mandate was issued as discussions had been ongoing across the profession long before. Yet, without the external shift, it is doubtful the mandate for change by AACN would have had the same affect. Professional nursing’s decision represented significant change for both the field of nursing and the college by virtue of the type of degree being offered within the discipline. While an external shift had occurred for health professions education

broadly, and public policy change in the form of healthcare reform generally, the tipping point for nursing came from their professional accreditation body. Despite ongoing controversy over the DNP degree across the discipline, professional nursing exercised their voice through accreditation change and required nurse practitioners alter their practice entry degree.

With the 2015 deadline looming for nurse practitioner degree change, curriculum planners sought to protect nurse practitioner program enrollment, but still respond to the mandate generally. Maintaining the current Master's in Nursing Family Nurse Practitioner (MSN/FNP) program kept applicant enrollment numbers stable. Meanwhile, adding an overarching Doctor of Nursing Practice (DNP) degree increased overall enrollment numbers by tapping into stakeholder interests. With five remaining years to alter the nurse practitioner degree, the college bought more time for reflection upon change for the DNP across institutions. As the college added a doctoral level completion program and made it available for all master's students, the advantages included advancing nursing interests and gaining experience in training DNP students. Since the Health Sciences University DNP program does not address the specific mandate for nurse practitioner program change, altering the current MSN/FNP program will still be necessary should the requirement become a reality. Since ongoing strategic planning is already present at the college, a plan could easily be developed, regional accreditation revisited, and the college can grow in the interim.

Burke (2002) pointed out that change takes place at various levels within the organization and occurs at the individual level, within the group or work unit, and at the total system level. The college was developing new faculty and curriculum for the

Doctor of Nursing Practice (DNP) program. Adding another new program and broadening the mix of programs at the College of Nursing affected the college as a collective group. Some faculty moved laterally within the college, others were new program-specific hires; still others were new hires and teaching across programs. The DNP faculty was recruited as field experts and from known contacts, people who had shared graduate school experiences with program developers and had achieved some level of recognition based upon those experiences. While philosophical alignment can be useful for developing curriculum, this alignment can also serve as a barrier for other faculty with alternative perspectives. A few faculty participants suggested tension was evident across the college as the DNP program developed, and seemed related to conflicts over course and program scheduling. Participants de-emphasized the importance of these conflicts, but were consistent in pointing them out as jealousies between programs.

Change at the unit level primarily affects activities such as development and training, recruitment, replacement, and displacement of unit stakeholders, while at the group level change develops through team building and self-directed groups (Burke, 2002). Team building and self-directed group meetings were reported by both faculty and administrator participants. Well-organized curriculum planning for the Doctor of Nursing Practice (DNP) program was accomplished in teams and through discussions across the program faculty, and involved extensive individual preparation in advance of the planning sessions. Colenso (2000) identifies people-related changes as producing huge productivity increases and likely to generate creative solutions. The level of enthusiasm expressed by faculty participants for DNP education, their willingness to volunteer effort, and their creative design of curriculum for the DNP program support

Colenso's perspective. People-related changes are frequently the most enduring form of change generating high levels of staff satisfaction (Colenso). High levels of job satisfaction were noted among most faculty participants.

Building upon established programs as part of the overall strategic plan of this institution made the Doctor of Nursing Practice (DNP) model a good fit. All master's level programs could potentially feed the applicant pool for the DNP program creating the end of what one faculty participant liked to refer to as a curriculum "bookend" (F1PD, personal communication, July, 22, 2009). The reality of web-based education as an already well-established curriculum element created system readiness for adding a program at this level. The ease with which it offered doctoral education for the well-established and interested nurse applicant pool minimized the need for additional resources and required only the necessary faculty time for research and development.

A notable finding arising from the data was that the Doctor of Nursing Practice (DNP) curriculum was designed for all master's level nurses rather than meeting the specific American Association of Colleges of Nursing (AACN) mandate for nurse practitioner degree change. In general, program applicants did not support changing the Family Nurse Practitioner (FNP) program from a Master's in Nursing (MSN) to a DNP degree. With applicant pools diminishing for programs adopting the recommended model, nursing colleges were struggling; following professional nursing's specific recommendation appeared risky. With alternative DNP models available, the college elected to innovate while planning for growth and expansion with the added advantage of stimulating doctoral education change for the discipline more broadly.

Institutional culture. Burke (2002) discusses the role of culture in organizational change. In order to develop change across an institution, the mission and values of the organization must shift from what was previously entrenched within the culture (Burke, 2002). Culture plays a role of either supporting or rejecting a change in institutional mission and tends to be the area of greatest resistance during the change process. The Doctor of Nursing Practice (DNP) program aligned with both institution and college mission and goals; and while internal resistance arose between program developers and administrators, it had little to do with the stated institutional mission.

“Controversies and degree differences for practice exist at the national professional level and impact higher education institutions; the institution must decide the level of education and degree” (Skaff, personal communication, April 26, 2010). Internal resistance at Health Sciences University (HSU) surfaced at the point of regional accreditation review, and related to program design as it pertained to rigor and difference. Distinguishing differences among doctoral degrees has long been problematic and well documented in the literature (Downs, 1989; Sperhac, A.M. and Clinton, P, 2004). The problem persists despite efforts on the part of many accreditation agencies to differentiate more clearly between degrees. Unfortunately, accreditation agencies do not converse with one another, and standards still vary. As a result, higher education institutions continue to struggle with variations in doctoral standards as well as the challenges posed by doctoral level inconsistencies across health professions.

Professional doctorates have evolved over several decades. While professional doctoral curricula, in general, do not require independent research like the dissertation for the doctor of philosophy (Ph.D.), culminating projects are usually required. The

terminology applied to these projects varies, but also includes the term *dissertation* as it does at Health Sciences University (HSU). This final Doctor of Nursing Practice (DNP) project is clinically based research intended to effect change at the systems level.

Discussion with faculty participants revealed a general dissatisfaction with the use of such terms as capstone or culminating projects as applied by other institutions. The use of the term *dissertation* as it is applied by the primarily Ph.D. nursing faculty at HSU is confusing. Original research is a hallmark of Ph.D. dissertations, but is not required for DNP students. However, faculty participants point out that creating original research for final projects is possible for their students; some students will do original research. The term *dissertation* signifies rigor, challenge, and prestige. Retaining the aura of rigor may be possible by applying the term *dissertation* to final DNP projects, and may serve to elevate DNP prestige and at the same time assist in redefining entry level for the discipline. Professional nursing has a protracted history that aspires to altering the entry-level degree. These efforts continued through vague innuendos built into the DNP degree and curriculum; but served to highlight rather than camouflage nursing's aspirations. Change for nursing's career entry remains the force driving the practice doctorate.

According to the *Task Force Report on the Professional Doctorate* from the Council of Graduate Schools (2007), "the Ph.D. and the professional doctorate are different, though there is less agreement on what that difference is" (p.14). Variations in doctoral standards, rigor, and difference among degree levels for creating new clinical doctorates have caused concern for institutional administrators and education stakeholders including accrediting agencies. Even as the Council of Graduate Schools

published the task force report on the professional doctorate, the report identified that the category of professional doctorates needed greater definition.

The Doctor of Nursing Practice (DNP) represents a doctoral degree subset within the category of professional doctorate. While some agreement has emerged regarding the different subsets of professional doctorates, they still require definition (CGS, 2007). As such, the Council of Graduate Schools (CGS) has called for national standards and shared oversight between accreditation agencies and institutions. The internal conflict arising from accreditation review at Health Sciences University (HSU) certainly supports the CGS recommendation for national standards. The HSU conflict forced an intensive examination of DNP curriculum and eventually satisfied regional accreditation concerns over difference and rigor. Rigorous examination of developing professional doctoral programs by accreditation agencies and postsecondary institutions will likely insure the retention of rigor and high standards among doctoral degrees, as was seen at HSU.

Scope of Practice

The American Academy of Nurse Practitioners (2007) publishes practice standards for the field and defines this nursing role as “licensed independent practitioners who provide primary and/or specialty nursing and medical care in ambulatory, acute and longer term care settings” (AANP, 2007, p. 1). Nurse practitioners are educated at the master’s ... or doctoral levels as a requirement for entry-level practice (AANP). The process of care or actual procedural responsibilities for nurse practitioners include patient assessments for health status and diagnosis, as well as treatment planning development and implementation (AANP, 2007). These primary care providers are “responsible and accountable for the continuity of health care regardless of the presence or absence of

disease” (State of California Department of Consumer Affairs (SCDCA), 1998, pp. 2).

This continuity of health care requires nurse practitioners to conduct, supervise, and interpret diagnostic tests (AANP, 2007). Furthermore, they prescribe and order pharmacologic agents and non-prescriptive therapies, provide patient education, and refer patients to other appropriate health professionals and agencies as necessary (AANP).

In contrast, discipline entry-level begins with the nursing RN. Entry-level education for the RN requires only two years of community college education; practitioners graduate with an associate of arts or sciences degree (AA/AS). Four-year baccalaureate degrees (BSN) are also available, and recently, entry-level for RN education has been made available at the master’s level. All three levels of degrees create board eligible candidates for the national RN credential, but the care provided by entry-level practitioners is different than that provided by advanced nurse practitioners. Entry-level practitioners provide “direct and indirect patient care services” not primary care services (SCDCA, pp. 1). Furthermore, physicians, dentists, podiatrists, or clinical psychologists are the responsible practitioners ordering all necessary patient medications and therapeutic agents administered by the RN (SCDCA). Physician scope of practice determines responsibility for RN practice.

Nurse practitioners acquire an RN as a first step in their education and before acquiring advanced education as a nurse practitioner. Just as the entry-level degree for the RN is now offered at the master’s level, other master’s level nursing degrees are not nurse practitioners. These other nursing roles include educators and administrators, but receive no further education for providing advanced clinical patient care. Until the recent change offering entry-level education at the master’s level, most masters educated nurses

began their education with entry-level RN education (two or four-year degrees) as a foundation. All nurses require an RN, but not all master's educated nurses become nurse practitioners. By elevating the entry-level degree to the master's level, and then offering a DNP degree to all master's educated nurses, the distinctions between degrees become blurred even further. One American Association of Colleges of Nursing (2005) model for DNP education suggests a four-year baccalaureate degree will be the prerequisite education for DNP program entry (Chism, 2010). Changing the nurse practitioner entry-level requirement to a DNP eliminates the master's level and essentially creates the BSN to DNP model. While DNP curriculum models are adjusted for variances in competency levels across program applicants, the general public will fail to understand these differences and these differences matter.

“The AACN position states the DNP is required, but acceptance within the discipline is questionable” (Skaff, personal communication, April 26, 2010).

Certification and licensure is required in many states for nurse practitioners (although not all) and scope of practice varies from state to state. At the moment, certifying boards and agencies require a master's degree for entry to practice for reimbursement, a standard imposed initially by Medicare, but then followed by all third party payers. While it is not uncommon for health professions to seek direct reimbursement through advanced degrees, there is no guarantee certifying boards and agencies will require nurse practitioners to acquire DNP degrees. By the AACN adoption of their position requiring a DNP as the entry to practice degree for nurse practitioners, the degree may eventually be required for certification as a universal standard. In this way, the DNP becomes a Trojan horse for future credentialing requirements. Whether the DNP will serve to alter

entry-level education for nurse practitioners is still the subject of much debate. In any case, opening the degree to the discipline at large may grow the degree more broadly and then possibly serve the larger purpose of the profession. Professional nursing wants to move entry-level nursing education away from two-year degrees.

Policy Implications

While much has been learned by the study of this institutional decision and its process, recommendation for policy change is limited and restricted to private health science universities, since they were the focus of this study. Keeping in mind this caveat, the following lessons may prove useful for some institutions and colleges developing missions and or programs at the professional doctoral level in nursing.

Entrepreneurial leadership with autonomous governance appears to be a factor contributing to private university and college expansion. Alignment with institutional mission along with active engagement in strategic planning can lead private institutions to clear decisions about adding curriculum and degrees. Planning for ongoing institutional expansion facilitates the addition of new programs by building necessary resources into the budget. In the current economic and healthcare climate where organizational change is essential for institutional viability, the advantages afforded by strong leadership and mission alignment involving multiple planning levels, cannot be denied. Post secondary institutions would do well to examine the real purpose of their missions and determine whether institutional strategic plans are promoting their mission or reflecting the status quo.

Differences among nursing levels remains unclear to the lay public and to other health professions. Clarifying nursing education for the public at large would likely

assist higher education stakeholders as well as nurse service users for improving nurse utility overall. Meanwhile, higher education institutions would be better served by clarifying nursing education differences across colleges and programs. Developing public relations efforts toward this end would serve to educate students, faculty, and administrators, and eventually lead to broader public awareness of nursing education.

Recommendations for Future Research

The details of the Health Science University (HSU) decision process are illustrative for faculty, and administrators interested in curriculum change in nursing. Furthermore, nurses, nursing faculty, as well as other health professions may also find this study useful for gaining insight into health professions education at the professional doctoral level. The findings from this research may prove helpful in comparing the use of Doctor of Nursing Practice (DNP) curriculum models, as well as the decisions and processes guiding their creation. Future research should include studies evaluating DNP programs at other institutions and between institutions.

Limitations

While case studies can produce useful information, they typically limit generalizations across institutions. This study is specific to one private health science university comprised of five colleges and engaged in massive expansion of curriculum and infrastructure at the time of data collection. Furthermore, this institution has unique faculty governance. The study is further limited to the Doctor of Nursing Practice (DNP) program decision and process at this particular college and is again limited to web-based programs. While many of these specifics may be found at other institutions, they will not be found in this precise context.

Comparing web-based Doctor of Nursing Practice (DNP) programs to in-person DNP programs is not a fit either, nor is a web-based master's to DNP program comparable to a DNP program that eliminates a master's level family nurse practitioner (FNP) program. The Health Science University (HSU) DNP program permits entry from any master's level nursing program. Only web-based DNP master's completion programs afford some level of comparability.

Narrative analysis developed the story line, in this case the story of Health Sciences University College of Graduate Nursing decision to add a DNP program to their curriculum. Narrative analysis is not intended to generalize, but rather reports the details of how the decision occurred and what happened in the process. The themes discussed in this study may or may not provide assistance to other private health sciences universities.

The faculty sample was self-limiting. Nursing faculty not directly involved with the DNP program did not respond to interview requests. Similar problems existed with administrators. As such, the sample for both groups was self-selected, with all the associated problems and biases.

Demographics worked both for and against my data collection. I work in oral healthcare as a practicing dental hygiene clinician in specialty practice. Furthermore, I have considerable background educating dental professionals ranging from dental hygiene to post-doctoral specialty residents. However, nursing is not foundational to my education and background. On the other hand, my demographics, white, middle age, and pursuing an advanced degree, fit well with nursing field demographics.

At first my background was unknown to interviewees, but as the interviews progressed most faculty participants had developed some idea, because they would ask.

Frequently they would forget that I was not a nurse. My demographics aligned well with the demographics of both the college and that of the university administration. Still, most of the problems I encountered with regard to my demographics resulted from nursing faculty presuming I had knowledge in nursing matters unfamiliar to me. Prompting participants for explanations in areas that were vague or lacking clarity would inevitably point out my nonalignment with nursing as a researcher. My lack of familiarity with graduate health professions education and associated influences was clearly a limitation.

Personal bias is always an area of some concern in qualitative research. At times I found myself drawn to the nurse perspective. I admired these obviously very bright and accomplished women. Their educational backgrounds and experience varied from renovating homes into elder care facilities to acquiring degrees in law, education, and nursing practice. I resisted becoming chatty and maintained reasonable researcher distance without appearing standoffish. Although, admittedly there were times I had to actively stifle engagement in open conversation.

At the same time, I found the higher education perspective fascinating, and in some ways preferable. While nursing faculty participants were chatty, interesting, and filled with layers of information, administrators were more succinct and linear in their communications. The information was no less dense, but getting to the story seemed more direct and also appeared to require fewer storytellers. Despite leanings favoring both directions, I remained vigilant against favoring one case voice over the other; both perspectives demonstrated valuable and rich data.

In creating the case groups for this study, one participant aligned with both groups. At the time of data collection, this participant was limitedly teaching. Distracted

by education pursuits this participant had stepped away from usual teaching responsibilities; and at the time of data collection the role of this participant lay primarily in administration, yet participant perspective straddled both case groups. This participant was placed in the administrator group; however, their inclusion might have skewed the administrator case toward nursing over a more neutral or differing administrator perspective, but was offset by the external perspective. Of course, dual faculty and administrator roles are not unique in health professions education. While this problem did not appear to overtly influence the results of this study, the dual role of this participant created another limitation and should be considered when applying the findings.

Curriculum design for the college also arises as a limitation for this study. Most nursing colleges are traditional and embrace the trend of adding web-based curriculum to already established programs. Traditional in-person education is still the normative situation for nursing education. Most programs at this college are web-based, originated as such, and are limited by the web-based nature of this college curriculum.

Reflections

A problem encountered in this study involved obtaining in-person interviews with participants. Faculty, like students can be located anywhere, not necessarily at institutions or even in the same city, because this Doctor of Nursing Practice (DNP) program is web-based. Web-based education creates interesting data collection problems for the researcher. I was logistically challenged and traveled the four points of the compass across the state in order to obtain interviews in a timely fashion. Interviews were held in faculty homes, as well as hotel and university conference rooms and offices.

Every effort was made to maintain a quiet highly professional environment affording both privacy and confidentiality. While I believe I was successful, managing the interview arrangements was challenging.

Observing students or program operations was a similar challenge. Students are located in cyberspace except for two weekends each semester. While, indeed, I was studying the program decision as well as the process moving the decision through regional accreditation to program inception, my early efforts in understanding curriculum design for the program was thwarted by it being virtual rather than located on-site and in a classroom. Despite these encumbrances, I developed a sense of the faculty, the curriculum, and the student body by attending portions of the weekend required course work for DNP students. The program director, faculty, and students were very welcoming. While faculty participants were well aware of my identity and why I was there, for the most part, many students thought I was just another Doctor of Nursing Practice (DNP) student. This blending in with the DNP class was a direct tribute to my demographics.

My observations of the program classroom led me to understand the degree has foundations in leadership studies. I observed three classes; Doctor of Nursing Practice (DNP) students have required coursework in policy, informatics, and research. Active and very rich discussions spanned a broad range of clinician experience, and engaged in problems of current practice. Observations of DNP course work improved my understanding of administrators' confusion over similarities between the clinical nurse leader programs at the master's level and the DNP program.

A careful review and comparison of curriculum on the university website demonstrated the two curriculums are very different, with the CNL program requiring 50 units at the master's-level and the DNP requiring 30 units. This curriculum design means that a CNL must earn 80 units beyond a baccalaureate degree to earn a DNP. While, both programs focus on leadership, this situation isn't different than master's level leadership programs compared to doctoral level leadership programs within schools of higher education. The confusion arises when leadership is coupled with a health care discipline, and the degree has a specific purpose other than advancing nursing knowledge at the patient care level. Practice and patient care are not synonymous.

Perhaps the overarching concern among administrators and regional accreditation agencies is the possibility of the eventual elimination of master's level education for nursing altogether. Pharmacy achieved this same shift to the clinical doctorate from the baccalaureate level without adding master's level education and expanded a four-year degree to a six-year. Despite this curricula shift, the Doctor of Philosophy in Pharmacology is pharmacy's terminal degree. Moving nursing to the practice doctorate as the goal for the discipline creates a baccalaureate in nursing (BSN) to Doctor of Nursing Practice (DNP) education shift, a purposeful movement on the part of professional nursing. Yet, the Ph.D. in nursing remains nursing's terminal degree. Despite unit requirement differences among master's level degrees in nursing, blurring master's level education into a practice doctorate will serve to impede understanding of nursing education further. "These differences in nursing education have resulted in different advanced degree programs, and subsequently, different credentials ... [that] ... may be misunderstood by the public" (Skaff, personal communication, 5/4/10). "As the

DNP becomes more readily accepted as the preferred (standard) degree for advanced practice in nursing, it helps to understand the curriculum and the degree approval process at various institutions” (Skaff, personal communication, 5/4/10).

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Appendix A**Table 1. Phase development of nursing doctoral education**

Table 1. Phase development of nursing doctoral education

Phase	Degrees
1900 – 1940	Doctor of Education, Ed.D.
1940 – 1960	Ph.D., Social Science
1960 – 1970	Ph.D., Social Science with Nurse minor
1970	DNSc and PhD, Nursing

Note: Andrist, L.C., Nicholas, P. K., and Wolf, K.A. (2006) *A History of Nursing Ideas*, Jones and Barlett Publishers, p. 385; and Stevenson, J.S., & Woods, N.F. (1986) Nursing science and contemporary science: Emerging paradigms in G.E. Sorensen (Ed.), *Setting the agenda for the year 2000: Knowledge development in nursing* (pp. 6-20) Kansas City, MO: American Academy of Nursing.

Appendix B
Initial Email Contact to Informants

Dear [Participant Name],

I am a doctoral student at the University of San Diego, School of Leadership and Education Sciences and am currently working on my dissertation entitled, The Role of Higher Education in Advancing Nurse Practitioners: A Look at the Institutional Decision Calculus of a Health Sciences University. I will be conducting my research at your institution during the month of _____ 2009. Preliminary telephone interviews will be held in _____.

Based upon [insert appropriate qualifier: such as information gathered at the institutions' web site or personal recommendation of], I know you were involved in the development of the Doctorate Nurse Practitioner Program for Health Sciences University College of Graduate Nursing. Your perspective has great importance for my research, and will add to the richness and quality of my study. I invite you to participate in this project through a preliminary telephone interview; the outcome of this conversation may lead to an in-person on-site interview.

Other administrative leadership decision makers as well as faculty will be invited to participate. Both telephone and on-site interviews will be conducted on days and times convenient for participants. I anticipate telephone interviews may require somewhere between 30 to 60 minutes of your time. On-site interviews will have similar time constraints, and may require some follow-up by telephone. Every effort will be made to respect your generosity in giving of your time.

Thank you for considering my request. I hope you will participate in my dissertation research as I greatly value your individual perspective on the process involved in creating a DNP Program at HSU. Please feel free to email me for confirmation of your willingness to participate in this study, or should you have questions, I am available by phone and invite you to call at your convenience. I look forward to hearing from you in the near future.

Sincerely,

Debra Jo Johnson, M.Ed.

debra@sandiego.edu

858-692-7196

Appendix C

Telephone Interview Protocol

Good (morning, afternoon, evening). Thank you for agreeing to speak with me. I appreciate your willingness to participate as a subject in my study.

This interview will last between thirty to sixty minutes. I will be making notes as we proceed to assist my retention of the most relevant points of our conversation. My primary goals for this conversation are to obtain background about your position within the institution, your role in the decision process and program development, then determine what your involvement has been in bringing the Doctorate of Nursing Practice to the College of Graduate Nursing at Health Sciences University. This information was previously communicated to you through email and an informed consent was also sent.

I have received your signed consent form, and would like to review the form with you before we begin our discussion. *Review Consent Form.*

Grand Tour Questions

1. Tell me about the process for developing new program curriculum at this institution.
 - a. PROBE: Is there a central curriculum committee or does each college have its own?
 - b. PROBE: What or who initiated the decision to develop a curriculum for a Doctorate Nurse Practitioner Program in the College of Graduate Nursing at HSU?
2. Tell me about your position at the university
 - a. PROBE: Has this position existed for a while?

b. PROBE: How does this position fit into the organizational hierarchy of Health Sciences University?

c. PROBE: How long have you been in this position?

Mini Tour Questions

3. What was your specific role in the decision and development of the DNP curriculum?

4. How were you chosen for this role?

a. PROBE: Is it related to your expertise related to academics/research/clinical methods or your institutional capacity as administrator?

Structural Questions

5. What impact (if any) has the DNP program had upon the health sciences center?

What impact has the DNP program had upon the College of Graduate Nursing?

a. PROBE: Have any advantages or disadvantages of adding this curriculum surfaced since the new program opened?

6. What factors facilitated or impeded progress in developing the DNP program?

Chain Sampling

7. Do you know of any other person who may have been involved in the decision and or development of the DNP program at Health Sciences University?

Closing Remarks

Thank you for speaking with me today. I appreciate your contribution to my research and

your kind donation of your time to this process. I will continue conducting telephone interviews, but plan to schedule an on-site visit to your campus in the next few weeks. If I require clarification or further detail regarding our conversation, may I contact you for a follow-up conversation either by telephone or in-person? Follow-up conversations usually require less than twenty to thirty minutes. Is there anything else you would like to share with me about the decision and subsequent development of the DNP curriculum at Health Sciences University? Do you have any questions of me?

Spradley, J.P. (1979) Taxonomy of Ethnographic Questions

Appendix D
Follow-up Email Contact to Informants

Dear [Participant Name],

I am a doctoral student at the University of San Diego, School of Leadership and Education Sciences and am currently working on my dissertation entitled, The Role of Higher Education in Advancing Nurse Practitioners: A Look at the Institutional Decision Calculus of a Health Sciences University. I will be conducting my research at your institution during the month of _____ 2009. Preliminary telephone interviews will be held in _____.

Based upon [insert appropriate qualifier: such as information gathered at the institutions' web site or personal recommendation of], I know you were involved in the development of the Doctorate Nurse Practitioner Program for HSU College of Graduate Nursing. Your perspective has great importance for my research, and will add to the richness and quality of my study. I invite you to participate in this project by meeting with me at an in-person on-site interview.

This on-site interview will be conducted on a day and time convenient for you. I anticipate the interview will require approximately one hour of your time and possibly some follow-up conversation by phone. All aspects of your interview and your decision about participation will remain confidential. Your participation is completely voluntary. This investigation is in no way related to your job, nor will it impact you or your current place of employment.

I hope you will participate in this study and be willing to meet with me. Your participation will greatly assist my progress with my dissertation research. I am also contacting other administrative and faculty leaders at your university, and plan to arrange interviews during the week of [dates]. Please consider within these dates a selection of possible appointment times when you are available. Once I receive confirmation and time/day preferences from all subjects, I will contact you again through email to confirm your appointment.

I greatly value your individual perspective on the process involved in creating a DNP Program at Health Sciences University. Please feel free to email me for confirmation of your willingness to participate in this study, or should you have questions, I am available by phone and invite you to call at your convenience. I look forward to hearing from you in the near future.

Sincerely,

Debra Jo Johnson, M.Ed.

debra@sandiego.edu

858-692-7196

Appendix E

Interview Guide for In-Person Interviews

Good _____ (morning, afternoon, evening). Thank you for your willingness to participate as a subject in my study, and for arranging to meet with me today. As I indicated to you previously, this interview will take approximately one hour of your time, and will be digitally recorded.

Our discussion will center on the discussions, meetings, decisions, and activities leading HSU to bring a practice doctorate in nursing to the graduate school of nursing. My goal is to gain insight into your perspective on the institutional response to the professional accreditation body's recommendation for altering the terminal degree from the Masters for Advanced Nurse Practitioners to the Practice Doctorate (DNP). The consent form stipulates the details of your participation in this study, which I request you review with me before proceeding with the interview. *Review Consent Form.*

Grand Tour Questions

1. Tell me about the organizational decision process at your institution for adding a new degree requiring new curriculum to a graduate school, specifically the nursing graduate school.
 - a. PROBE: What year did the institution begin discussions considering the DNP?
 - b. PROBE: What or who initiated the idea for developing a DNP program at the HSU's Graduate School of Nursing? Board of Trustees? President? Dean, Directors or Faculty from the Nursing Graduate School?

Mini Tour Questions

2. What role did you play in the decision process or development of the curriculum?

3. How were you chosen for this role and what responsibilities did you have?

Structural Questions

4. How did institutional factors such as mission and goals, strategic plan, resource management, faculty governance, and any other similar factors influence the decision to move from the master's level terminal degree to the DNP?

- a. PROBE: Mission and goals?
- b. PROBE: Strategic plan?
- c. PROBE: Resource management?
- d. PROBE: Faculty governance?
- e. PROBE: Other factors?

5. Is there anything in your existing program that influenced the decision to move forward with the DNP? If so, please tell me about it.

6. How did circumstances such as accreditation (both institutional and program), health service delivery systems, and state and national policies governing scope of practice and credentialing influence the decision to move from the master's terminal degree to the DNP?

7. How did the nursing profession influence the decision to move forward with the DNP program?

8. What influenced curriculum design for the DNP?

a. PROBE: How did the college of nursing choose online learning?

9. How does the DNP web-based curriculum contribute to improving the quality of care provided by the healthcare system through graduates from this program?

10. How has the decision to add the DNP to the nursing graduate school and resulting DNP program affected the rest of the university healthcare center?

Chain or Snowball Sampling

11. Is there any other person(s) you would recommend I speak with concerning the DNP program decision or curriculum design?

Closing Conversation

Thank you for so generously sharing your time with me today. Your contribution to this research is invaluable and our discussion was most helpful. My next task is to have our conversation transcribed, and begin coding the data gathered from the interview. I will draft my analysis from there. Should I have additional questions or require further details, I will to contact you for a follow-up discussion either by telephone or in-person, and will require no more than thirty minutes of your time. Do you have any final comments you would like to add to our discussion about the HSU's response to this accreditation recommendation for the DNP becoming the terminal degree for advanced nurse practitioners?

Appendix F

Research Participant Consent Form

The Role of Higher Education in Advancing Nurse Practitioners: A Look at the
Institutional Decision Calculus of a Health Sciences University

Debra Johnson is a doctoral student in Leadership Studies at the School of Leadership and Education Sciences at the University of San Diego. You are invited to participate in a research project she is conducting for the purpose of exploring the institutional response to professional nursing's accreditation recommendation to alter the entry-level degree from a masters for advanced nurse practitioners to a practice doctorate (DNP).

The project will involve a preliminary telephone and an on-site interview that asks questions about the institutional response and decision process as well as the rationale for the design of the program curriculum. The interviews will last about 60 minutes and also will include some questions about you, such as your demographics and occupational roles and responsibilities. The interviews will take place at a time and place convenient for you. Following the interviews and after the data has been transcribed, I will require some follow-up telephone discussion with you to insure the collected data accurately reflects your intended meaning. Such discussion will likely require approximately 20-30 minutes of your time. Participation is entirely voluntary and you can refuse to answer any question and/or quit at any time. Should you choose to quit, no one will be upset with you and your information will be destroyed right away. If you decide to quit, nothing will change about your current employment or reputation. All personal decisions made by you related to this research are confidential, and in no way influence your standing at this institution.

The information you give will be analyzed and studied in a manner that protects your identity. That means that a code number will be used and that your real name will not appear on any of the study materials. All information you provide will remain confidential and locked in a file cabinet in the researcher's office for a minimum of five years before being destroyed.

There is essentially no risk related to mental anguish associated with this study. Therefore, no outside counseling resources are deemed necessary. Remember, you can stop the interview and withdraw from this study at any time for any reason.

The benefit of your participation in this research will be in knowing that you assisted in developing a fuller understanding of the institutional process influencing the professional advancement of nursing. Institutional leaders such as graduate school deans, assistant deans, university provost, vice presidents, directors, and program directors; and nursing graduate school faculty including professors, and assistant, and associate professors will benefit, and the resulting data will inform future decisions for institutions of higher education.

If you have any questions about this research, please contact Debra Johnson at 858-488-8901 or by email at debra@sandiego.edu. You may also contact Dr. Athena Perrakis at the University of San Diego at 619-260-8896 or via email at athena@sandiego.edu, or Dr. Fred Galloway at (619) 260-7435 or via email at galloway@sandiego.edu.

I have read and understand this form, and consent to the research it describes to me. I have received a copy of this consent form for my records.

Signature of Participant

Date

Name of Participant (Printed)

Participant email address

Signature of Principal Investigator

DateDebra Jo Johnsondebra@sandiego.edu

Name of Principal Investigator (Printed)

Project No. 2009-03-083

Action Date: March 19, 2009

Expedited Review

Approved, Dr. Thomas R. Herrinton

Administrator, Institutional Review Board

herrinton@sandiego.edu

Appendix G

Research Categories

Research Categories

Proponents: those things supporting the addition of a professional doctoral degree for nursing at HSU.

Inhibitors: those things delaying or stigmatizing the addition of a professional doctoral degree for nursing at HSU.

Constituent Roles: various roles held by administrators and faculty during the institutional response to professional accreditation recommendation for DNP, and its program curriculum development.

Mission: the issue surrounding the addition of a professional doctoral degree for nursing at HSU either supporting or detracting from the mission of the healthcare university.

Subcategories: university mission vs. CGN mission

Resource Management: the issues surrounding the addition of a professional doctoral degree for nursing causing either a drain upon, or a contribution toward healthcare university resources.

Health Service Delivery Systems (HSDS): the issues surrounding the addition of a professional doctoral degree for nursing will either improve or hinder patient services.

Strategic Plan: factors and issues surrounding the addition of a professional doctoral degree for nursing that enhance the strategic plan of institutions.

Healthcare Reform: factors and issues surrounding the addition of a professional doctoral degree for nursing driven by healthcare reform movement.

Indeterminate influences: factors and issues that may have influenced the development of a professional doctoral degree for nursing but neither inhibit or support the degree.

Appendix H

Table 2. Participant Summary by type and interview

Table 2. Participant summary by type and interview

Participant and Interview Summary

<i>Participants</i>	<i>Type</i>	<i>Telephone Interviews</i>	<i>In-Person Interviews</i>	<i>Total Interviews</i>
1	External	0	1	1
5	Administrators	1	5	6
7	Faculty	8	7	14
13 total participants		8 total Telephone Interviews	13 total In-Person Interviews	21 total interviews

Appendix I

Figure 1. The university and college Doctor of Nursing Practice (DNP) decision timeline

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