Contempt Prior to Examination: Reflections of a Doctor of Nursing Practice Graduate

IN MY OPINION
Vashti Jude Forbes-De La Cruz, DNP, FNP-BC,
Vicki Bingham, PhD, MSN,
Shelby Polk, PhD, MSN, and
Addie Herrod, DNP, FNP-BC

I remember a series of discussions held nearly 15 years ago with my cohorts in our family nurse practitioner program and yet again a few years later while working on an adjunctive nurse practitioner certification in family psychiatric and mental health nursing. My cohorts and I acknowledged the intrinsic and extrinsic value of the advanced practice role, but we literally scoffed at the push for clinically prepared advanced practice nurses to pursue a doctorate in nursing practice (DNP).

I groused that the DNP appeared to be just another layer of the never-ending confusing alphabet soup of nursing certifications and degrees. I distinctly recall shaking my head and asking of no one in particular whether it was possible for our discipline to go 5 years without changing what it meant to be a credentialed clinical nurse. It was obvious that my age was showing. Curiously, I lacked no hesitancy in espousing the absolute importance of the PhD-, DNS-, DSN-, DNSc-, or the EdD-prepared nurses. As academicians, they defined, explored, and advanced the role of nursing through their theoretical research, identification of processes, educating of students, and publishing of guidelines. Yet, I was inexplicably defiant in my resistance to accepting the value of the clinical nursing doctorate. Not only was I uncertain of its need, I was also unconvinced of its description as a terminal degree.

My career as a nurse has spanned the time from when the bachelor's degree with specialty certifications to when the master's degree plus another set of certifications equated to a terminal degree for nurse clinicians. I truly believed that nursing suffered from an inability to sit still, a variant of akathisia that other disciplines seem spared. In addition to these opinions, I deemed myself both "too old" and "embarrassingly overly degreed," because, in addition to possessing dual nurse practitioner certifications, I also held a master's degree in nursing systems.

Fast forward to one night in 2012 as I lay in bed catching up on my professional journals, when I came across yet another article touting the DNP. Not only was it so nondescript that I would be unable to find it now, I also doubt whether there was anything significantly different from previous readings I had encountered; nonetheless, for some reason, it served as the catalyst to where I am today. I remember having a sudden sense of awakening, literally staying up the entire night contemplating obtaining my DNP.

I began reviewing postgraduate curriculums, searching for one that was accredited and rigorous, yet doable and affordable. I also wanted a program that "made sense." I cannot tell you what "making sense" meant, but I knew I would recognize it when I found it. I

reviewed degree plans, course descriptions, time frames, price points, locations, and online availability. Eventually, I found one that met my needs. While awaiting a response, I ran into a few of my former cohorts, who along with me had once decried the need for a DNP. Well, a third of our group of professionals now held a DNP, were in a DNP program, or were in the process of applying to one.

Looking back, I am baffled by that period of abject complacency and cynicism. It is antithetical to my view of nursing, particularly as I entered the field during the advancements put forth by nursing theorists such as Nola Pender, Sister Calista Roy, Betty Neuman, Madeleine Leininger, Patricia Benner, and Rosemarie Parse. The 1980s were perhaps the last decade of any semblance of the trope of the nurse as being simply a handmaiden. Dynamic nurse leaders, insightful nurse philosophers, innovative nurse educators, savvy nurse entrepreneurs, and indomitable nurse feminists shattered that typecast, leaving nothing but shreds of that notion. I am further perplexed, because, not unlike countless other nursing students, I studied Barbara Carper's seminal concept article, "Fundamental Patterns of Knowing," which are empirical, aesthetic, ethical, and personal or self-knowledge.[1] When challenged to consider the clinical DNP as a complement to the research-, theory-, or education-focused PhD, my cohorts, unequivocally, lacked what Carper described as personal knowledge or self-understanding.[1] Our lack of personal knowledge concerning the value of the DNP contributed greatly to our being victims of "contempt prior to examination."[2]

The phrase "contempt prior to examination" or "investigation" is often misquoted and has been misattributed to both 19th century social theorist Herbert Spencer and also to English philosopher Rev. William Poole. The true author is the 18th century British theologian William Paley, who offered the following for consideration, "…a principle which, in my judgment, will account for the inefficacy of any argument, or any evidence whatever, viz. (is) contempt prior to examination."[2(pX)] Years later, Rev. Poole paraphrased Paley in his foreword to *The British Nation, The Lost Tribes of Israel*, and stated, "There is a principle…which cannot fail to keep a man in everlasting ignorance. This principle is, contempt prior to investigation.[3]

In my role as a nurse practitioner, I have encountered many DNPs; consequently, I was able to examine the DNP in vivo. My repeated encounters with DNPs revealed subtle, but clear nuances in how the master- and doctorate-prepared nurse clinicians differed in areas such as conceptualization, analysis, implementation, and leadership. A specific example involved the identification of a workplace error by a master of science in nursing (MSN) nurse and a DNP-prepared nurse. The MSN immediately drafted a policy and procedure, then designed and disseminated a corrective action. A few months later, the corrective action had bogged and the problem remained. The 2 nurses regrouped. The DNP reviewed the original corrective action and found it satisfactory. The DNP performed a drill-down for problem identification, then sought vertical and horizontal employee participation, which revealed hindrances to the original proposal. With this information, the DNP compiled evidence to support the potential gravity of the problem if unresolved and included metrics such as predicted employee time burden and cost savings with implementation of the action plan. The DNP, MSN, and the ad-hoc team opted for a staggered rather than mass deployment, thereby allowing opportunities to make modifications. Same problem. Same solution. Different outcome. Why? The DNP employed analysis, research, organizational input, collaboration, and marketing. As the aforementioned MSN in this scenario, my plan was apropos—my strategy, not so.

Another example of my "personal knowledge development" was the growing awareness that DNPs in the workplace seemed universally regarded as both colleagues and peers when interacting with senior leadership and