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Policy Analysis of the Illinois Nurse Practice Act (APRN Title Section 65/65-50)

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ABSTRACT

POLICY ANALYSIS OF THE ILLINOIS NURSE PRACTICE ACT (APRN TITLE SECTION 225 ILCS 65/65-50): USING A PATIENT SURVEY OF DNP ROLE CONFUSION AND PERCEPTION

by

Sara Kim

Chair: Jochebed Bea Ade-Oshifogun

ABSTRACT OF GRADUATE STUDENT RESEARCH

Scholarly Project

Andrews University

School of Nursing, College of Health & Human Services

Title: POLICY ANALYSIS OF THE ILLINOIS NURSE PRACTICE ACT (APRN TITLE SECTION 65/65-50): USING A PATIENT SURVEY OF DNP ROLE CONFUSION AND PERCEPTION

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Background

Physician groups claim allowing nurses to use the title “doctor” confuses patients. Nurses assert that the title is common to many disciplines, and nurses should be trusted like other professionals to identify their specialty to patients. Currently, qualified nurses in Illinois using the title “doctor” in clinical areas must introduce themselves to each patient in the following way: “Hi, I’m Dr. Smith, the nurse practitioner taking care of you today. I do not have a degree in medicine, and I am not a physician or medical doctor” (225 ILCS § 65/65-50).

Purpose

This project aimed to evaluate Illinois Nurse Practice Act APRN title section 65/65-50 (c) compared with a policy alternative requiring nurses to clarify their specialty when using the title “doctor” in clinical settings.

Method

After receiving institutional review board approval, I conducted an online survey. A descriptive, cross-sectional, nonexperimental study design was used to explore the perceptions of 476 Illinois residents who had been treated by a DNP APRN for healthcare. Survey feedback was used to evaluate the Illinois APRN title policy using the criteria of efficiency, equity, and sustainability. This project was guided by Kingdon’s Multiple System Framework and Policymaking Theory.

Results

Most respondents (66%) were able to identify the role of the nurse practitioner correctly after the introduction required by the Illinois Nurse Practice Act (“Hi, I’m Dr. Smith, the nurse practitioner taking care of you today. I do not have a degree in medicine, and I am not a physician or medical doctor.”). Most respondents (66%) were also able to identify the role of the nurse practitioner correctly after an alternative patient introduction (Hi, I'm Dr. Smith the nurse practitioner taking care of you today.) The survey results suggest the patient introduction required by the Illinois Nurse Practice Act has a more negative impact on the perception of the nurse practitioner. Most respondents (74%) preferred the alternative introduction without the language required in the Illinois Nurse Practice Act.

The project evaluation suggests that the Illinois APRN title policy may be inefficient due to the negative impact it may have on the perception of the DNP APRNs, because it may be both more burdensome than other title policies for similar providers and unsustainable due to lack of support.

Conclusion

Illinois DNP APRNs patient introductions may not have the intended impact of reducing role confusion between nurses and physicians and may negatively impact patients' perceptions of the nurse. These findings underscore the value in re-evaluating the introduction of the DNP APRN in the Nurse Practice Act.

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A Scholarly Project

Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Nurse Practice

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APPROVAL BY THE COMMITTEE:

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Member: Kelly Davis	Date approved

DEDICATION

This capstone scholarly project is dedicated to the talented nurses who have inspired me during my lifetime.

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LIST OF ABBREVIATIONS

AACN	American Association of Critical-Care Nurses
AAFP	American Academy of Family Physicians
AMA	American Medical Association
ANA	American Nurses Association
APRN	Advanced Practice Registered Nurse
CPR	Coalition of Patient's Rights
DNP	Doctor of Nursing Practice
FTC	Federal Trade Commission
ILCS	Illinois Compiled Statutes
IRB	Institutional Review Board
SPSS	Statistical Package for Social Sciences

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CHAPTER 1

OVERVIEW OF EVIDENCE-BASED PROJECT

Background

The controversy of who should be allowed to use the title "doctor" has reached the nursing profession due to the proliferation of Doctor of Nursing Practice (DNP) degrees (Chism, 2019). Physicians claim allowing nurses to use the title "doctor" may confuse patients, jeopardize their safety, and destroy trust between patients and physicians (American Medical Association [AMA], 2018). These concerns have led physician groups to promote state legislation restricting the title "doctor" by nurses with doctoral degrees (American Academy of Family Practice [AAFP], 2012; AMA, 2018). In 2017, the Illinois Nurse Practice Act was revised to prohibit a qualified nurses from using the title "doctor" in clinical areas unless they identified themselves to patients by their specialty and clearly stated their educational preparation was not in medicine and that they were not medical doctors or physicians (225 ILCS § 65-50). The Act also restricts APRNs with doctoral degrees from using the title "doctor" in advertising (225 ILCS § 65-50).

In the past, nurses have successfully blocked attempts to pass restrictive legislation by arguing that the title "doctor" is used in professions to indicate the highest academic degree in a discipline and is not the domain of any one health profession (American Association of Colleges of Nursing [AACN], 2014). The American Nurses

Association has clarified that nursing is a distinct discipline, and they do not claim to have the same education or training as physicians (American Nurses Association [ANA], 2008). Literature indicates that nurse practitioners provide safe, quality care comparable to physicians and do not threaten public safety (Kurtzman et al., 2016). Nurses also believe patients must know who is caring for them, and they support the proper display and identification of all health professionals' credentials (Nurse Practitioner Roundtable, 2008).

The concern of role confusion between nurses and physicians prompted the Illinois legislature to add a restriction to the use of the title "doctor" by qualified advanced practice registered nurses (APRNs) (225 ILCS § 65-50). This regulation is unique because it controls the wording of patient introductions if DNP APRNs choose to use the title "doctor" in the clinical setting. Nurses are responsible for exploring concerns, such as role confusion, that are used to influence nursing regulation (Chism, 2019). There is currently a void in research relating to the public's perception of APRNs with DNP degrees and role confusion between nurses and physicians. Title regulation to reduce role confusion between nurses and physicians should be effective, equitable, and sustainable.

Purpose/Problem Statement

ARPN title regulations change over time and differ across the states. Some states require qualified nurses using the title "doctor" to clarify their specialty when introducing themselves to patients (Chism, 2019). Illinois APRN title regulation stands out because it requires DNP APRNs to identify their specialty and explain that they do not have a medical degree and are not physicians to each patient (225 § ILCS 65-50).

Policy evaluation is essential in the process of developing evidence-based nursing regulations (Loversidge, 2016). The nursing profession should address concerns influencing new regulations and examine the policy to determine its effectiveness and impact on society, including any unintended consequences (Ellenbecker & Edward, 2016).

This project used a survey of Illinois patients to explore the perception of DNP APRNS and role confusion between nurses and physicians. The purpose of this project was to evaluate 225 ICLS § 65/65-50 by using a patient survey and the criteria of efficiency, equity, and sustainability. The goal was to develop an advocacy tool to inform nursing regulators, legislators, and APRN advocates.

Significance and Implications

The number of graduates from Doctor of Nursing Practice programs across the country continues to rise. There are over 357 DNP programs nationwide, with more in the planning stages (AACN, 2014). Understanding the unique issues affecting DNP APRNs, including role confusion, is critical to advancing nursing practice and developing evidence-based nursing regulations. This project impacts patients who visit nurse practitioners with DNP degrees for healthcare and DNP APRN clinicians. This project adds to the limited insight on role confusion and the perception of DNP APRNs. It evaluates the effectiveness, equity, and sustainability of APRN title policy that controls the wording of patient introductions. The results will provide evidence for nursing regulators, impact patient introductions by DNP APRNs in practice, provide guidance for educators, and advance the nursing profession.

This project will help guide nursing title regulation by providing valuable insight

into role confusion and how the wording of nursing introductions affects patient perceptions. Evaluating the efficiency, equity, and sustainability of the current Illinois APRN title regulation will benefit nursing regulators by providing evidence for future decision-making to address the public's concerns. As the healthcare environment becomes more complex, nursing regulators strive to develop effective and evidence-based policy (Loversidge, 2016).

This project will provide an advocacy tool to support evidence-based APRN title regulation. As healthcare moves towards a team approach, professional regulation must be equitable. Currently, Illinois DNP APRNs using the title "doctor" are the only members on the healthcare team required by statute to explain to each patient that they are not physicians and do not hold a degree in medicine. The effectiveness and impact of this restrictive policy should be carefully considered and evaluated. This project compares the current Illinois APRN title policy to a more equitable alternative requiring DNP APRNs to identify their specialty in patient introductions. This project provides evidence to support and advocate for equitable APRN title regulation.

This project is significant to nursing practice because it concerns patient introductions. Patient introductions are an essential communication initiating the nurse-patient relationship that relies on mutual trust and respect. Trust formed in the nurse-patient relationship is crucial to successful healthcare. This project has clinical significance because it highlights the unintended impact of 225 ICLS § 65/65-50 APRN title regulation on the nurse-patient relationship. The findings may change the way DNP APRNs introduce themselves to patients. Title regulation should facilitate transparency by encouraging DNP APRNs to share their unique DNP qualifications with patients to

foster positive therapeutic nurse-patient relationships.

The project is significant to nursing education. Educators and administrators in DNP programs should be aware of the most restrictive APRN title regulation. Educators may use this project to discuss role confusion, overcoming title issues, and the importance of patient introductions. This project identifies a need for DNP graduates to educate the public, coworkers, and patients about the qualifications of DNP APRNs. In addition, this project highlights DNP Essential V (Health Care Policy for Advocacy in Health Care) and the current necessity for DNP graduates to become involved in regulatory policy. DNP students are equipped to use their unique practice experience to evaluate, influence, and develop evidence-based regulatory policies (Zaccagnini & White, 2017).

Finally, the nursing profession's response to added restrictions on using the title "doctor" for APRNs will determine its progression across the nation. Nurses agree that patients should be aware of their healthcare providers' qualifications. APRN title regulation should address role confusion with an effective, equitable, and sustainable evidence-based policy.

Project Objectives

1. To evaluate Illinois Nurse Practice Act 225 § 65/65-50(c) with a patient survey using the criteria of efficiency, equity, and sustainability.

2. To propose an evidence-based APRN title policy based on the project findings.

3. To develop an advocacy tool to educate and influence nursing leaders and legislators to support Illinois APRN title policy change.

Concept Definitions

The following definitions are provided to promote comprehension:

Role confusion: the inability of patients to identify the correct role of their healthcare provider.

Policy efficiency: the extent to which a policy achieves its intended goal while considering any undesirable side effects or impacts that occur in the process (Bardach & Patashnik, 2020).

Policy equity: the fairness in distributing the benefits and burdens of a policy across groups of individuals in society (Bardach & Patashnik, 2020).

Policy sustainability: the ability of a policy to remain in due to the support of a variety of stakeholders over time (Bardach & Patashnik, 2020).

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL AND CONCEPTUAL FRAMEWORK

Literature Review

The purpose of the policy analysis project was to evaluate the APRN title section (c) of the Illinois Nurse Practice Act. Nursing regulation should be guided by evidence and evaluated for effectiveness. For this purpose, a literature review was conducted to gain knowledge on the background of the title "doctor" and the arguments surrounding its use by various stakeholders, including physicians, nurses, and allied health care providers. The literature review included patient perceptions of DNP APRNs and role confusion between nurses and physicians in healthcare. The purpose of the Nurse Practice Act was included in the literature review for a basic understanding of nursing policy.

This chapter will discuss the following issues: (a) history of the title "doctor"; (b) arguments from stakeholders; and (c) purpose of the Nurse Practice Act. This chapter also includes the theoretical and conceptual framework by John Kingdon, which supports this project.

A comprehensive literature search was performed to find evidence-based studies on the title "doctor"; patients' perceptions of DNP APRNs; and role confusion between nurses and physicians, role confusion in healthcare, and the nurse practice act. Search

engines utilized for this literature review were the Cumulative Index of Nursing and Allied Health (CINAHL), PubMed, Google, SAGE, and Science Direct.

Keywords used in the search included the following: *title doctor, patient perception nurse practitioner, patient perception role, role confusion, title confusion, perception of the role of the DNP, doctor nurse role confusion, nurse practitioner title doctor, confusion title doctor, advanced practice nurse title doctor, and nurse practice act*.

The review focused on informative, peer-reviewed literature beginning in 2001 when the DNP degree was first offered (Chism, 2019). Older literature beginning in the 1900s was reviewed to discover the history of the title "doctor." For purposes of this project, the search terms were limited to include literature covering concepts relevant to the APRN Title section of the Illinois Nurse Practice Act (225 ILCS § 65-50). These searches revealed the history and evolution of the title "doctor," views from various stakeholders on the use of the title, and information on the purpose of nurse practice acts.

The search included nursing dissertations, qualitative and quantitative analysis, descriptive statistics, white papers, peer reviewed journal articles, editorials, and books. There was a void in literature discussing role confusion between physicians and nurses using the title "doctor" and patients' perceptions of DNP APRNs.

The Title "Doctor"

The term "doctor" is acquired from the Latin word *docere* and means "to teach" (Skinner, 1970). In the 13th century, "doctor" took on the meaning of religious teacher, advisor, scholar, and father of the Christian church (Bailey, 2003). Original doctorates required candidates to pass tests, take oaths, and pay the required fee to the church

(Bailey, 2003). Bailey explained that original doctorates were granted by the church authorities and later by universities. Initially, doctoral degrees were only awarded in the areas of law, medicine, and divinity (Skinner, 1970). Early doctoral degrees were used as the exclusive qualification for teaching and reserved for individuals in middle age when they had proved a life dedicated to spreading knowledge in their area of expertise (Skinner, 1970). Eventually, men began earning doctorates for purposes other than teaching, and the term "doctor" came to acknowledge a doctorate conferred by a university in many professional disciplines (Marriner-Tomey, 1990).

The usage of the title "doctor" varies worldwide. For example, in the United Kingdom and Ireland, physicians who are surgeons do not use the title "doctor" but instead are distinguished from physicians by using the title "Mr." (Loudon, 2000). In the United States, it is common for clinical and professional doctorates to be referred to as doctor in social and clinical settings (Royeen & Lavin, 2007).

Arguments about who should use the title doctor still continue in the United States. Recently, the issue made news headlines across the country when the new First Lady, holding a Doctor of Education degree, insisted on using the title "doctor" in the White House (Epstein, 2020). Webster dictionary definitions of "doctor" include a learned or authoritative teacher, a person skilled or specializing in healing arts, or a person who has earned one of the highest academic degrees conferred by a university (Doctor, 2018). People holding clinical and professional doctorates have commonly been referred to as "doctors" in social and clinical settings (Royeen & Lavin, 2007).

The argument about who can use the title "doctor" in clinical settings remains an issue as many allied health professionals move toward doctoral-level education in

preparation for today's complex healthcare system. This controversy has affected various healthcare professionals, including pharmacists, audiologists, physical therapists, and nurses. Physician groups insist that the title doctor should be limited to physicians, dentists, and podiatrists (AAFP, 2012; AMA, 2018).

Arguments of Confusion

Physicians

Physicians argue that the current trend of clinical doctoral degrees among health professionals has caused patients to be confused about their caregivers' education and training (AMA, 2018). The AMA (2018) has published results from a nationwide online survey of 802 adults supporting their argument. The AMA Truth in Advertising campaign claims patients are confused about who is a physician. They aim to use their survey results to influence state legislatures in passing laws to support Health Care Professional Transparency Acts (2018). The campaign provides model legislation and claims that these laws will alleviate the confusion patients are experiencing regarding their health care providers' education and training (AMA, 2018). The AAFP (2012) argued that patients prefer to be cared for by a physician and are confused about other healthcare professionals. Physicians for Patient Protection members are concerned about the inconsistency of training among nurse practitioners and claim that the replacement of physicians with nurse practitioners has led to a dangerous health care environment for patients (Al-Agba and Bernard, 2020). The physician authors explain nurses using the title "doctor" in the clinical setting is deceptive to patients and that patients should demand physician-led care (Al-Agba and Bernard, 2020). Al-Agba and Bernard included sample directives for patients to add to their medical records, only allowing MD or DO

(Doctor of Osteopathic Medicine) providers to oversee their healthcare.

Older literature suggests that some physicians welcome additional healthcare expertise by nurse practitioners and believe it will only benefit patient care (Collier, 2016). Collier explained that nurses are trying to meet complex care demands and should be trusted like other professionals to provide their credentials to patients. Physicians and nursing professionals agree that all healthcare providers should inform patients of their credentials, and non-physician doctorates should maintain consistent and rigorous requirements (Collier, 2016).

The most recent literature suggests physician groups have become more concerned about nurses using the title "doctor" due to increased DNP graduates. Physician groups have highlighted the issue of role confusion and patient safety to advocate for laws protecting the title "doctor."

Nurses

Nursing leaders have identified a need within their profession to educate the public about the role and qualifications of APRNs with DNP degrees (Chism, 2019). O'Grady (2007) noted that nurses should not hide their DNP credentials due to oppressive policies. The public has a right to know the qualifications of their health care providers and nurses should be transparent by sharing their qualifications (O'Grady, 2007). Some nurses caution against using the title "doctor" in clinical areas because it could be misleading, as nurses do not have the same education and training as medical doctors (Buppert, 2021).

In the past, the ANA (2008) published a letter in response to the AMA representatives addressing alleged patient confusion and explained their support of efforts

to communicate with patients about who is caring for them. The ANA clarified that the title doctor is used for individuals who have earned a doctoral degree in their professional field of study. The AACN (2014) has responded to physician groups supporting title protection by clarifying that the title "doctor" can be used by nurses and is not the domain of any one health profession. The AACN noted that nurses with DNP degrees, like other providers, are responsible for displaying their credentials to ensure that patients understand their preparation as nursing providers. The AACN asserted that nursing is a distinct health discipline that prepares nurses for various roles in healthcare. In 2014, DNP talking points were created to describe the advancement of the nursing profession and explain the need for DNP education among advanced practice registered nurses. Seven of the major nurse practitioner associations published a unified statement supporting the use of the title "doctor" by nurses and recognizing that the title "doctor" for doctorate-prepared nurse practitioners facilitates parity within the health care system (Nurse Practitioner Roundtable, 2008).

Nurses do not claim to have the same training or education as physicians (Reeves, 2008). Reeves emphasized the value in educating the public about the difference between the disciplines of nursing and medicine. Nurses want the public to understand their unique role in healthcare and the added benefit of highly qualified and trained nurses (Reeves, 2008). Years ago, Waldrop (2013) warned nurse practitioners to keep watch for proposed legislation prohibiting nurses with doctoral degrees from introducing themselves to patients using the title "doctor" without immediately stating they are not a medical doctor and do not have a medical degree.

The nursing profession supports the use of the title "doctor" by qualified nurses

and explains that it provides parity within the health care system. Nurses assert that the title "doctor" is common to many disciplines and nurses should be treated like other professionals and trusted to identify their specialty.

Allied Health Professionals

Allied health professionals claim that the restriction on using the title "doctor" is not an acceptable response to apparent confusion between providers (Jennings, 2015). Jennings suggested that physician groups work with allied health professionals to develop effective solutions such as patient education to improve role identification and knowledge of providers' training and education. Solutions to limit role confusion and improve patient satisfaction include Real-Time Location Systems in hospitals that alert patients of their caregivers' identity and qualifications as they enter the room (Morgan, 2020). One suggestion to clear up potential role confusion is to be careful with word use by calling medical doctors "physicians" instead of "doctors" (Schencker, 2020).

The Coalition of Patient's Rights (CPR) and the Federal Trade Commission (FTC) have cautioned organizations representing doctors of medicine and osteopathy against advising legislators regarding the scope of practice restrictions for other licensed health professionals (CPR, 2020; FTC, 2014). The FTC released a policy perspective supporting healthcare competition and against well-intentioned laws that impose unnecessary, overbroad restrictions on competition (2014).

Allied health professionals and the public support parity among health professions and disagree with using restrictions on the title "doctor" to solve role confusion. Allied health professionals suggest patient education to raise awareness of the identity and qualifications of health care providers.

Nurse Practice Act

Laws and rules govern health care professionals to minimize the risk of harm to the public (Russell, 2012). States have the responsibility and authority by law to regulate licensed health care professionals, including advanced practice registered nurses (Guido, 2010). The nurse practice act is the law that gives authority to the board of nursing in each state to regulate and enforce nursing practice (Russell, 2012). All states and territories have boards of nursing that are governmental agencies established to develops rules and regulations and clarify the law. The state board of nursing has the responsibility of balancing nurse's rights to practice and protecting the public health, safety, and welfare of its citizens (Brous, 2012). The nursing profession is also interested in protecting, regulating, and improving nursing practice (Russell, 2012).

The APRN title regulation varies widely among the states. Most state nurse practice acts allow the use of the title "doctor" by qualified nurses, but require nurses to identify their specialty to each patient (Pearson, 2014). Under this requirement, an example of an acceptable introduction is this: "I am Dr. Smith, a nurse practitioner." Some states like Ohio prohibit the use of the title "doctor" unless a person holds a license to practice medicine (Buppert, 2021). The Illinois APRN title regulation is unique because it dictates the wording of a nurse's introduction to patients when using the title "doctor" in clinical settings (225 ILCS § 65-50). Qualified nurses using the title "doctor" in clinical areas must identify their specialty and state that their educational preparation is not in medicine and that they are not medical doctors or physicians to each patient (225 ILCS § 65-50). For example, an acceptable introduction in Illinois is this, "I am Dr.

Smith, a nurse practitioner. I do not have a degree in medicine, and I am not a medical doctor or physician."

Summary

Nurses and physicians agree that patients should know the identity and qualifications of their health care providers. Physician groups have described role confusion as a patient safety issue in efforts to advocate for laws protecting the title "doctor." Literature indicates that nurse practitioners provide adequate healthcare and do not present a safety risk to patients. Nurses and allied healthcare providers disagree with solving the problem of role confusion with stricter title regulation and assert that physicians do not own the title "doctor." Nurses and allied healthcare providers propose working together to improve patient education and awareness of health care providers' unique roles.

Besides the AMA survey, there was a gap in the literature suggesting patients are confused between nurses and physicians using the title "doctor" in clinical settings. Literature does indicate that patients and their family members may be confused between various physicians' roles during their healthcare experience, which can lead to communication barriers and disagreement about treatment (Gerwing & Gulbrandsen, 2017). More studies are warranted to understand whether role confusion exists between nurses and physicians using the title "doctor" in clinical areas when they identify their specialty.

Theoretical and Conceptual Framework

This scholarly project attempts to evaluate the Illinois APRN title policy

regulating the use of the title "doctor" by DNP APRNs in clinical settings. Policy analysis has been described as an art (Bardach & Patashnik, 2020). Evidence and criteria are used to compare alternative policies that solve a defined problem (Bardach & Patashnik, 2020). The literature search in this project suggests that the Illinois APRN title policy addresses the alleged problem of role confusion between physicians and nurses using the title "doctor" in clinical settings. This chapter will discuss the framework used as a basis for the policy analysis completed for this project.

John Kingdon's Multiple Streams Framework and policymaking theory is an effective tool for understanding the policy process and provides a guide for this project (Kingdon, 1984). The Multiple Streams Framework describes the complex nature of the policy process. It highlights the significance of exploring problems such as role confusion that may affect nursing practice and influence nursing regulation.

Kingdon (1984) described policy creation's convoluted process by using a model with three separate streams flowing towards a policy window where policymaking happens. Kingdon's theory of policymaking portrays the critical aspects of timing and flow in policy actions. The first stream in the framework is labeled the problem stream and is comprised of various public issues and concerns. An example of a public concern in the problem stream is the issue of role confusion between physicians and nurses using the title "doctor." Issues continuously float and mix in the policy stream. Issues intermittently circulate to the top as concerned stakeholders highlight data and evidence that describe the issue and define it as a problem. Actors in this stream can be described as problem brokers who frame problems and present them to policymakers using persistence, emotion, and evidence (Knaggard, 2015). The presentation of a concern in

the problem stream determines whether it rises to the level of a social issue that will gain status on the political agenda. An example of problem framing is physician stakeholders describing the problem of role confusion between physicians and nurses as a safety risk to elevate it on the political agenda. Stakeholder activity in the problem stream is critical for agenda-setting.

The second stream is labeled the policy stream. This stream is full of ideas and proposals created to address public concerns and problems. These policy proposals can continuously evolve in the stream or be left unchanged, waiting for a policy window to open. Ideas in the policy stream come from various sources such as published research from academics, presentations at hearings, lobbyists, or institutions. This project aims to act in the policy stream by proposing an alternative evidence-based APRN title policy to address the problem of role confusion. Evidence-based policies that have support from diverse stakeholders have the greatest chance of surviving in the policy stream and moving forward when a policy window opens.

The final stream described by Kingdon consists of a steady flow of politics. The flow of this stream depends on the local and national political environment and can be turbulent. Activity in this stream may not always be driven by an urgency to solve a problem but more about a political need to act or diffuse discussion of a controversial issue to appease stakeholders (Howlett, 2012). For example, an argument could be made that changes to Illinois APRN title regulations were made to appease physicians after the decision to expand nursing practice rather than to reduce role confusion. The politics stream involves considerations of political party control and campaign and election cycles. Activity in this stream revolves around balancing decision-making for groups of

citizens. The distribution of power and resources among groups of people is considered in the politics stream.

A policy window is opened when all three streams described above converge (Kingdon, 1984). The policy window can be predictable or, in some cases, unexpected. Policy windows can open when a stakeholder presents a new definition of a problem with changes of administration or when public opinion shifts on a subject. Policy windows can close with a loss of interest, lack of trust, or administration changes. At times a policy window may close because the problem appears to have been addressed or there are simply no alternatives to fix the problem. This project attempts to open a policy window by suggesting an evidence-based alternative to address the problem of role confusion. The Multiple Streams Framework illustrates the importance of activity in all three policy streams to prepare for opportunities when policy windows open.

The outcome of Kingdon's Framework (1984) is policy change. Nurses can use the Multiple Streams Framework approach to advocate for patients and the nursing profession. Greg, Miller, and Tennant (2018) described the unique role nurses can take as policy entrepreneurs within the Multiple Streams Framework to bring about change.

Application of the Theory to the Project

Figure 1 is a model of Kingdon's (1984) Multiple Streams Framework as applied to this project. It illustrates all three streams converging at the policy window. The policy window is the point where policy is created. I was able to identify the critical components of the policy development process by using the model of the Multiple Streams Framework.

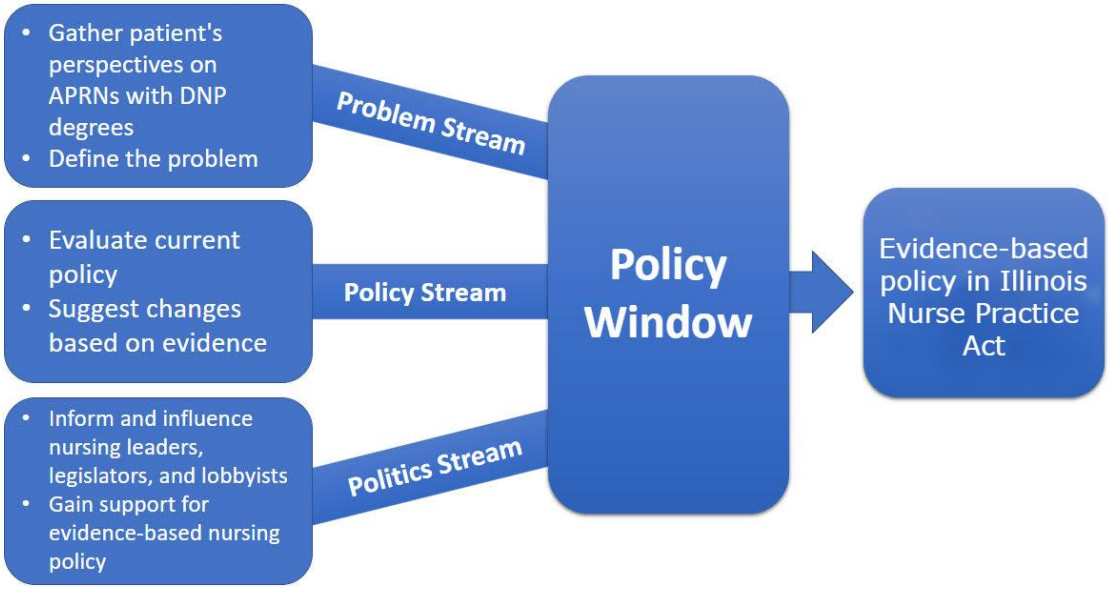


Figure 1. Multiple streams framework applied to project.

The highlighted text in Figure 1 notes how this project interacts with each stream in the Framework. First, the project acted in the problem stream to gather evidence and define the alleged problem of role confusion. The project included a survey of Illinois adults who reported that a DNP APRN had treated them for healthcare. The survey addressed the alleged problem of role confusion between physicians and nurses using the title "doctor" in clinical practice. There were several questions in the survey that gathered patients' perspectives about DNP APRNs. The results provided evidence to further define the problem of role confusion raised by physician stakeholders in the problem stream. Accurately defining the problem is critical to enable policy writers to propose evidence-based nursing policy.

Second, the project was active in the policy stream through policy analysis. The steps used to guide the policy analysis were based on Bardach and Patashnik's (2020)

recommendations for effective problem-solving in policy analysis. Commonly used evaluative criteria were selected for the evaluation including policy effectiveness, policy equity, and policy sustainability (Bardach & Patashnik, 2020). These criteria were applied to the Illinois APRN title policy to project the outcome or impact of the policy.

The project survey results were used in the evaluation to determine whether the current Illinois ARPN title policy is effective at solving the alleged problem of role confusion between nurses and physicians using the title "doctor." The survey results were also used to discuss whether the policy outcome is equitable and sustainable. A policy alternative was recommended based on the results of the analysis. Policy analysis can be impactful when proposing legislative revisions to the Nurse Practice Act.

Finally, this project participated in the politics stream by informing and influencing nursing leaders, legislators, and lobbyists to support efficient, evidence-based nursing policy. The results of this project were presented to nursing leaders and lobbyists at the Illinois Society for Advanced Practice Nurses Midwest Conference in October 2021. Recommendations for reconsideration of the Illinois APRN title policy were communicated via an advocacy tool. Dissemination of the project outcome is just the beginning of the work that needs to be accomplished in the politics stream. Policy change requires persistent efforts in all three streams of the Multiple Streams Framework to prepare for a policy window.

CHAPTER 3

METHODOLOGY

Project Design

This project used a nonexperimental, cross-sectional, and descriptive design. The project questionnaire was designed and administered using SurveyMonkey, an online platform for creating and administering custom questionnaires for business and academic purposes (SurveyMonkey, 2021). The decision to use SurveyMonkey instead of conducting a survey at a healthcare facility was to allow for a larger and more diverse sample. SurveyMonkey facilitated a targeted audience that provided feedback from a diverse group of respondents from various demographics across Illinois. The sample size and online forum were chosen to allow comparisons with the AMA's Truth and Advertising online survey.

A survey was used to gather feedback from Illinois residents 18 years and older who had received healthcare treatment from a DNP APRN. The questionnaire was administered during April 2021. The results were analyzed using a quantitative approach. The feedback was used to critique the Illinois APRN title policy compared to an alternative policy requiring DNP APRNs to identify their specialty when using the title "doctor" in clinical settings.

The steps used to guide the policy analysis were based on Bardach & Patashnik's (2020) recommendations for effective problem-solving in policy analysis. The criteria

used for the policy evaluation included policy efficiency, policy equity, and policy sustainability. The evaluative criteria were applied to both the Illinois APRN title policy and an alternative title policy to compare the benefits and burdens of the projected outcome. The project survey and literature review provided evidence for the evaluation. Ultimately, the analysis resulted in action that included a presentation to the Illinois Society for Advanced Practice APRN Midwest Conference and the development of an advocacy tool.

Population and Sample

Recruitment

Participants of the questionnaire were recruited from the Contribute Program Panelists on the SurveyMonkey platform (SurveyMonkey, 2021). Contribute Program panelists are a diverse online population nationwide who have volunteered to complete surveys on various topics. SurveyMonkey provides panelists with an incentive in the form of a 50-cent donation to the charity of their choice to complete the surveys (SurveyMonkey, 2021). SurveyMonkey uses basic demographics from their panelists to allow panel buyers the option to purchase targeted audiences.

Inclusion-Exclusion Criteria

Survey responses from panelists in Illinois were purchased using the Contribute Program targeted audience option. Email invitations were limited to survey panel members with zip codes across the state of Illinois. SurveyMonkey prevents duplicate or fraudulent respondents and regularly refreshes panelists' profiles (SurveyMonkey, 2021).

Inclusion criteria comprised participants of all genders who resided within the

state of Illinois and had seen a DNP APRN for healthcare. A pilot survey of 105 participants was conducted using the SurveyMonkey platform to estimate the qualification rate and cost of the final project survey. Fifty-two percent of respondents answered "Yes" to the question, "Have you seen a nurse practitioner with a DNP degree for healthcare?"

Participants were excluded from the project survey if they were under 18 years old or if they had not seen a nurse practitioner with a DNP degree for healthcare. Questions #1 and #2 of the survey were designed to address exclusion criteria, including age and whether the participant has visited a nurse practitioner with a DNP degree for healthcare. Participants who did not meet the inclusion criteria were immediately guided to an End of Survey page that thanked them for their time and ended the survey.

The project used convenience sampling to provide for expedited data collection of a large sample. To ensure subject variability, the target survey audience was balanced to reflect the Illinois census regarding gender and age. SurveyMonkey classified Illinois postal zip codes according to population sizes. The respondents were weighted by gender, age, race, and education within the state to match the American Community Survey Census Bureau (SurveyMonkey, 2021).

Participation

The survey participants were adult residents of Illinois who reported being treated for healthcare by a nurse practitioner with a DNP degree. The participants' responses were anonymous, and information gathered in the survey was only reported in combination with other respondents. SurveyMonkey does not provide the names, email addresses, or contact information of survey participants to Panel Buyers (SurveyMonkey,

2021). All participants responding to the questionnaire completed an informed consent question before responding to other survey questions. They were also given the option to skip questions or withdraw at any point in the survey.

Institutional Review Board

The Office of Research and Creative Scholarship at Andrews University determined that the project was exempt from Institutional Board Review due to the minimum risks associated with the questionnaire and the inability to identify the participants. A letter of approval was issued to proceed with research (Appendix A).

Sample Size

The sample size was based on the AMA's Truth and Advertising survey to allow comparisons of the results in the discussion section of the policy analysis. The AMA's survey was conducted by the Global Strategy Group and involved 850 adults nationwide (AMA, 2018). The sample for this study consisted of 476 Illinois adults who reported that a DNP nurse practitioner had treated them for healthcare. Since only proportion results are reported, the estimated minimum sample size for the project was determined by using an online sample size calculator (Epitools, n.d.) by assuming a minimum true proportion of 50%, the desired precision of 5%, and a confidence interval of 95%. Those parameters determined a minimum sample size of 400.

Tool

The self-report questionnaire used for this study was designed after reviewing the AMA "Truth in Advertising" survey questions and the APRN Title section of the Illinois Nurse Practice Act (225 ILCS § 65-50). It was partly modeled after the AMA's

published Truth in Advertising survey questions (AMA, 2018). The tool was developed to provide evidence for evaluating the APRN Title section (c) of the Illinois Nurse Practice Act (see Appendix B for the tool).

The questionnaire was designed to gather data that would be useful in the policy evaluation. The policy evaluation criteria included policy effectiveness, policy equity, and policy sustainability. The questionnaire focused on role confusion between nurses and physicians, patient perception of DNP APRNs in Illinois, and the effectiveness of Illinois APRN Title section (c) in reducing role confusion compared to an alternate introduction that included the nurse's specialty.

Questions #1-4

The first question of the survey addressed informed consent. The second question was designed to exclude participants who had not visited a nurse practitioner with a DNP degree for healthcare. The next two questions addressed demographics. Age and education are demographics that may significantly influence the perception of the DNP APRN role. These demographics will be reported, and their possible influence will be discussed in the results section.

Questions #5-7

Questions #5-7 modeled the Truth in Advertising survey questions (AMA, 2018). These questions addressed patient perception of DNP APRNs and role confusion between nurses and physicians. Question #5 asked, "Should nurse practitioners with a Doctor of Nursing Practice degree be able to use the title 'doctor' in clinical settings if they clearly identify their specialty?" This question gathered feedback from Illinois patients

regarding their support of APRN title policy initiatives. It is relevant because policy sustainability increases with the support of multiple stakeholders (Bardach & Patashnik, 2020).

Questions #6 and #7 collected data on role confusion between nurse practitioners and physicians. Question #6 asked, "Is a nurse practitioner a physician? and #7 asked, "Is a nurse practitioner with a Doctor of Nursing Practice degree a physician?" The results for these questions were compared to the national AMA survey and used to discuss the problem of role confusion between nurses and physicians.

Questions #8-11

Questions #8-11 were designed to compare the Illinois DNP APRN patient introduction with an alternate introduction including the nurse's specialty. The results were used to discuss the efficiency and equity of the APRN title policies. Questions #8-11were posed to participants following two hypothetical introductions by a nurse practitioner. The first introduction is commonly used by many nurse practitioners in other states. It includes the title "doctor" and the nurse's specialty. Question #8 read, "'Hi, I'm Dr. Smith, the nurse practitioner taking care of you today.' After reading this introduction, what role is Dr. Smith acting in?" Question #10 included the second introduction with the wording required by the current Illinois Nurse Practice Act. Question #10 read, "'Hi, I'm Dr. Smith, the nurse practitioner taking care of you today. I do not have a degree in medicine, and I am not a physician or medical doctor.' After reading this introduction, what role is Dr. Smith acting in?" The questions addressed the participants' ability to correctly identify the role of the nurse based on the wording of the introduction.

Questions # 9 and #11 were posed following the same two introductions to gain insight into how the introductions impact the patients' perception of the nurse. Question #9 and #11 asked, "How does this introduction impact your perception of this healthcare provider, "Dr. Smith"?

Question #12

The final question asked, "Which introduction from Dr. Smith do you prefer?" The results from this question provided evidence in the discussion of public support and policy sustainability (see Appendix B for the tool).

To ensure clarity and reliability, the tool was reviewed online by two advanced practice registered nurses who were asked to evaluate the relevance of the survey questions. Based on their expert feedback, no revisions were necessary. The tool was pilot-tested online by sending email invitations to a group of 20 Illinois residents. Ten respondents representing diverse age groups and a variety of educational backgrounds completed the pilot survey. The average time to complete the survey was 1 minute, 48 seconds. Following the survey, four individual respondents were contacted to gather feedback. The respondents were asked about the clarity of questions and if there were any suggestions for revisions. No problems with clarity were reported.

The first page of the survey includes the study's educational purpose and confidentiality notice. The contact information of the researchers was provided for inquiries. Respondents provided informed consent on the first page of the tool, and responses were anonymous. No direct contact between the investigator and the participants was necessary to administer the survey and receive feedback.

Statistical Analysis

The data was exported from the SurveyMonkey platform to an Excel spreadsheet. The Statistical Package for Social Science (SPSS) for Windows, version 27, analyzed the project data. The significance level was set at 0.05.

Descriptive analysis for each question in the tool was completed, including means for continuous variables and frequencies for categorical variables. Binomial proportion confidence intervals were calculated for Questions #5-7. Chi-Square goodness of fit test was conducted for questions #5-12 to determine whether there were significant differences in the answers provided by the participants. A Chi-Square test of independence, which was intended to compare the answers for introduction #1 with those for introduction #2, was not possible due to the overlapping of some answers by the participants.

CHAPTER 4

RESULTS

Overview

The project aimed to evaluate 225 ICLS § 65/65-50 using a patient survey. This chapter describes the survey results, including a discussion of the data analysis. The results of the questionnaire are presented in text, tables, and graphs. The demographics of the study sample are reported using descriptive statistics. Inferential statistics are organized by relevance to the policy evaluation criteria which include effectiveness, equity, and policy sustainability.

The study sample included 487 respondents. Participants were allowed to skip questions which caused a slight variance in the total sample size for some questions.

Demographics

The demographics of the study sample are summarized in Table 1. The gender of the respondents included 51.5% female and 48.5% male. The age range of participants spanned from 18 to 91 years of age. The mean age of participants was 45.4 years (SD = 17.66). The participants were from diverse educational backgrounds. Most participants had achieved some level of college education.

Table 1

Demographics of Study Participants

Characteristics	*n*	(%)	M(SD)
Gender			
Male	233	(48.5%)	
Female	243	(51.5%)	
Age	486		45.44 (17.66)
Education			
Less than high school	16	(3.3%)	
Completed high school	92	(19.2%)	
Some college	111	(23.1%)	
Undergraduate degree	191	(39.8%)	
Graduate degree	70	(14.6%)	

Policy Efficiency

The first criteria used in the policy evaluation is efficiency. Data from questions #8 and #10 provided insight into the effectiveness of the policy, and questions #9 and #11 explored the impact of the policy on patient perceptions of the DNP provider.

Policy Effectiveness

When provided with Introduction #1 ("Hi, I'm Dr. Smith, the nurse practitioner taking care of you today."), the respondents were able to identify the provider as a nurse practitioner correctly most of the time (χ^2 (3, 480) = 459.10, p<001). About 66% of them said that Dr. Smith was acting as a nurse practitioner (Table 2). However, when provided with the introduction in the Illinois Nurse Practice Act ("Hi, I'm Dr. Smith, the nurse practitioner taking care of you today. I do not have a degree in medicine, and I am not a

physician or medical doctor."), the respondents were also able to identify the provider as a nurse practitioner correctly most of the time, (χ^2 (3, 479) =439.99, p<001). Sixty-six percent of them said that Dr. Smith was acting as a nurse practitioner (Table 2).

After both introductions, the respondents were able to identify the provider correctly as a nurse practitioner most of the time (about 66%) (Figures 2 & 3).

Table 2

Results for Questions #8 and #10

Question	**Response**	***n***	**%**	χ^2	p value
Intro #1 "Hi, I'm Dr. Smith, the nurse practitioner taking care of you today."				459.10	<.001
After reading this introduction, what role is Dr. Smith acting in?	Physician Nurse Practitioner Physician Assistant Unclear	109 315 31 25	22.7% 65.6% 6.5% 5.2%		
Intro #2 "Hi, I'm Dr. Smith, the nurse practitioner taking care of you today. I do not have a degree in medicine, and I am not a physician or medical doctor."					
After reading this Introduction, what role is Dr. Smith acting in?	Physician Nurse Practitioner Physician Assistant Unclear	44 318 50 67	9.2% 66.4% 10.4% 14%	439.99	<.001

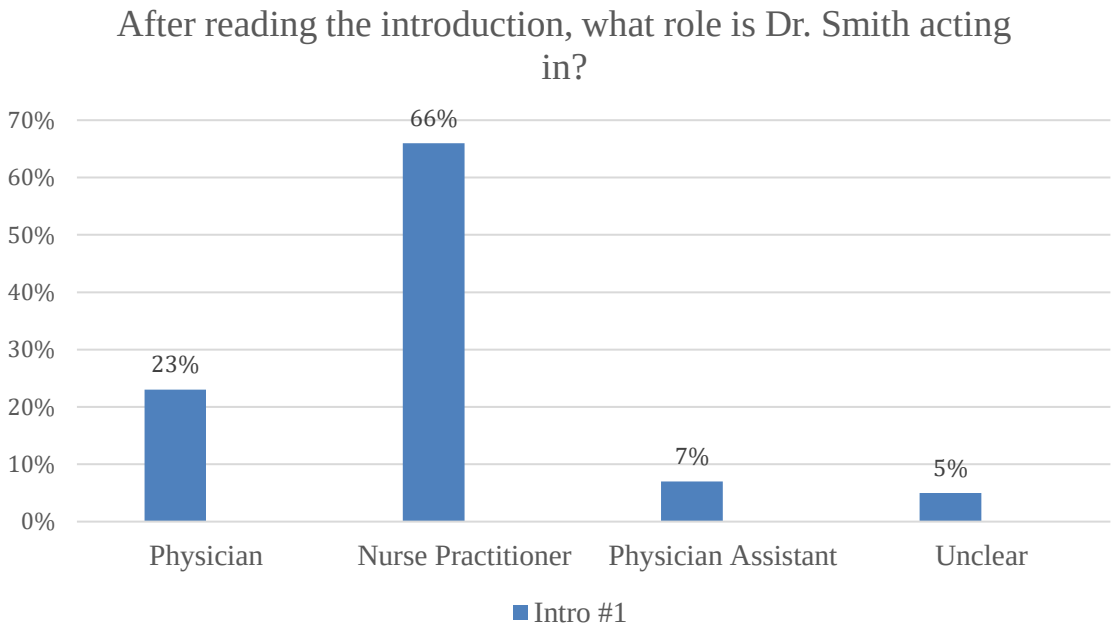


Figure 2. Policy effectiveness for introduction #1 ("Hi, I'm Dr. Smith, the nurse practitioner taking care of you today.").

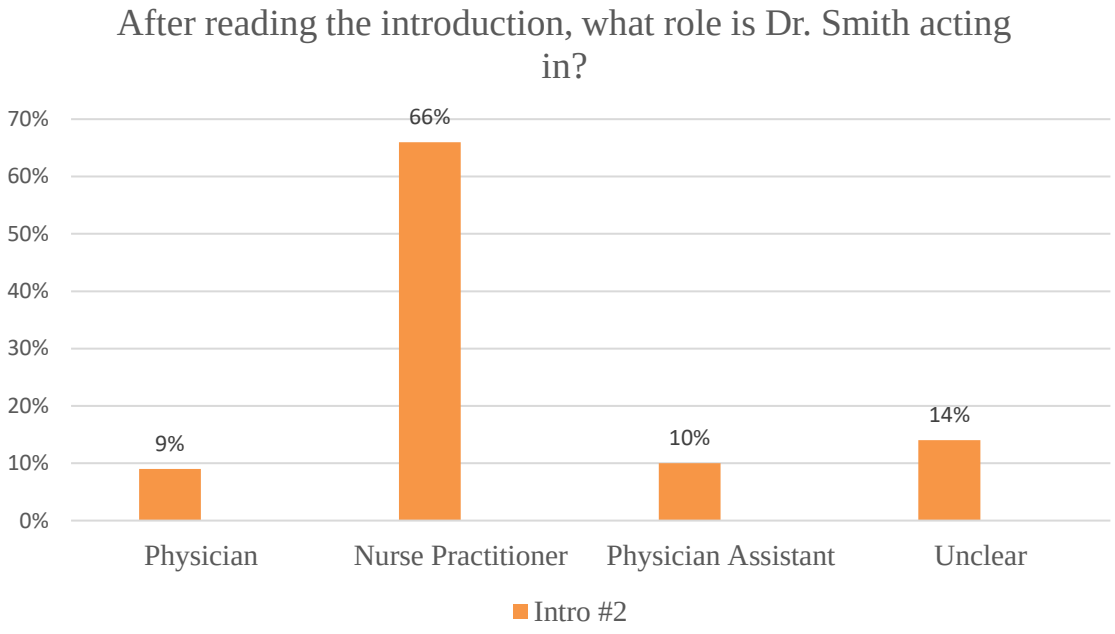


Figure 3. Policy effectiveness for introduction #2 ("Hi, I'm Dr. Smith, the nurse practitioner taking care of you today. I do not have a degree in medicine, and I am not a physician or medical doctor.").

Policy Impact on Perception

Data from questions #9 and #11 provided insight into patient perceptions of the provider after the DNP APRN introductions. The introduction in the Illinois Nurse Practice Act had a more negative impact on the perception of Illinois DNP APRNs (χ^2 (4, 476) =102.34, p<.001). About 42% of the respondents reported a negative perception of the nurse practitioner after the introduction in the Illinois Nurse Practice Act ("Hi, I'm Dr. Smith, the nurse practitioner taking care of you today. I do not have a degree in medicine, and I am not a physician or medical doctor."; Table 3). However, 25% of

Table 3

Results for Questions #9 and #11

Question	**Response**	***n***	**%**	χ^2	p value
Intro #1 "Hi, I'm Dr. Smith, the nurse practitioner taking care of you today." How does this introduction impact your perception of this healthcare provider?	Negative Neutral Positive	71 194 160	14.8% 40.4% 44.8%	229.77	<.001
Intro #2 "Hi, I'm Dr. Smith, the nurse practitioner taking care of you today. I do not have a degree in medicine, and I am not a physician or medical doctor." How does this introduction impact your perception of this healthcare provider?	Negative Neutral Positive	199 156 121	41.8% 32.8% 25.4%	102.34	<.001

respondents reported a positive perception of the nurse practitioner after the introduction in the Illinois Nurse Practice Act ("Hi, I'm Dr. Smith, the nurse practitioner taking care of you today. I do not have a degree I medicine, and I am not a physician or medical doctor."; Table 3).

The alternative introduction (Hi, I'm Dr. Smith, the nurse practitioner taking care of you today.") had a more positive impact on the perception of Illinois DNP APRNs (χ^2 (4, 480) =229.77, p<.001). Nearly 45% of respondents reported a positive perception of the nurse practitioner after the alternative introduction (Figure 4). About 15% of respondents reported a negative perception of the nurse practitioner after the alternative introduction (Hi, I'm Dr. Smith, the nurse practitioner taking care of you today."; Figure 4).

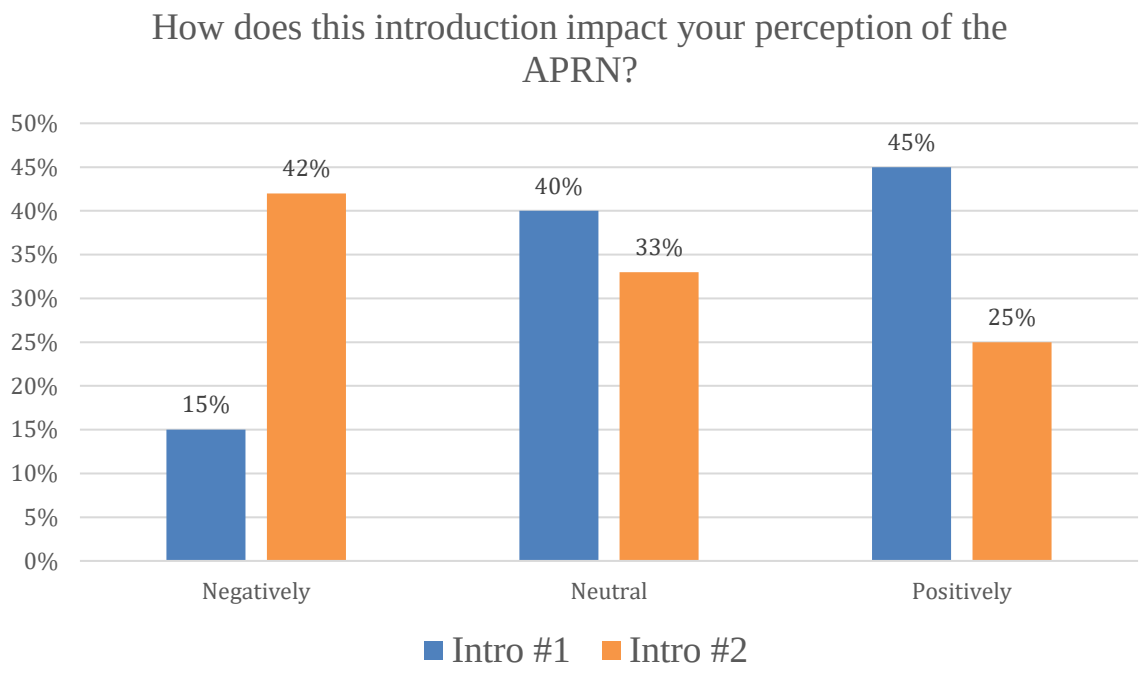


Figure 4. Introduction impact (#1: "Hi, I'm Dr. Smith, the nurse practitioner taking care of you today." #2: "Hi, I'm Dr. Smith, the nurse practitioner taking care of you today. I do not have a degree in medicine, and I am not a physician or medical doctor.").

Policy Equity

Survey questions #6 and #7 helped explore the equity of the Illinois APRN title policy (see Table 4). To the question, "Is a nurse practitioner a physician?" 30.6% of respondents answered "Yes" (χ^2 (2, 481) = 62.8, p<.001) and about 49% of respondents answered "No" (Figure 5). To the question "Is a nurse practitioner with a Doctor of Nursing Practice degree a physician?" 41.5% of respondents answered, "Yes" (χ^2 (2, 480) =33.8, p<.001), and about 38% of respondents answered, "No" (see Figure 6).

Table 4

Results for Questions #6 and #7

Is a nurse practitioner a physician?	Yes No Unsure	147 237 97	30.6% 49.3% 20.2%	62.8	<.001
Is a nurse practitioner with a DNP degree a physician?	Yes No Unsure	199 180 101	41.5% 37.5% 21%	33.8	<.001

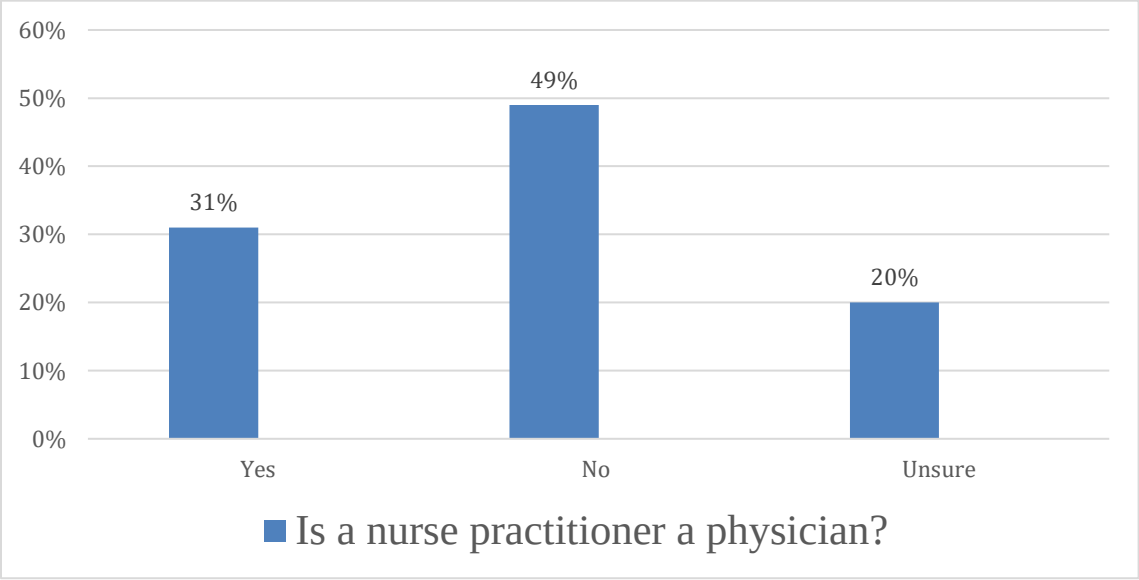


Figure 5. Nurse practitioner role confusion.

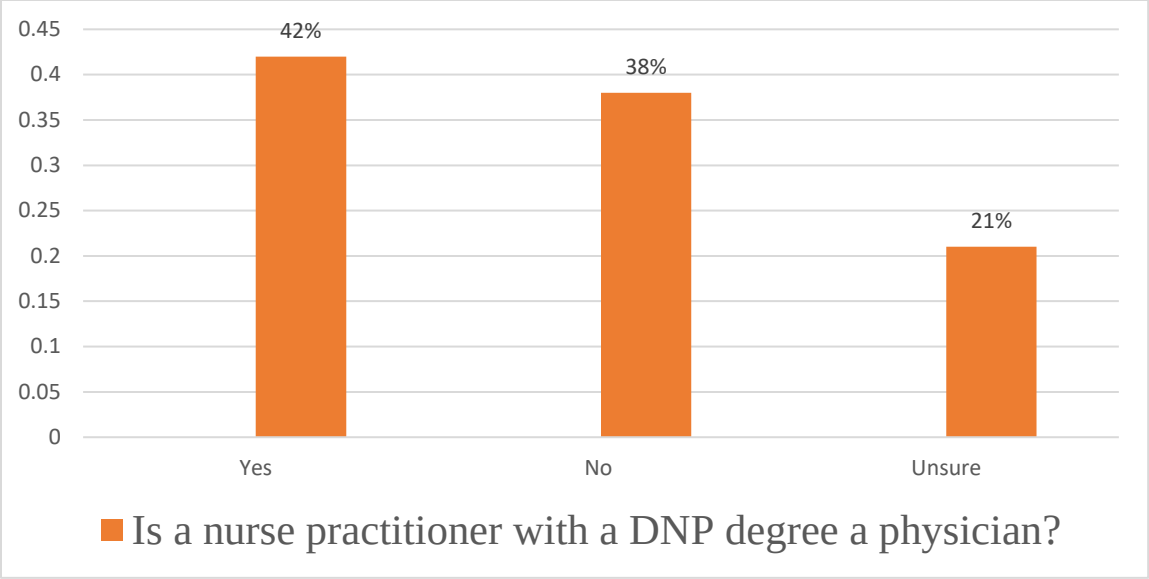


Figure 6. DNP nurse practitioner role confusion.

Policy Sustainability

Policy sustainability is the final criterion used to evaluate the Illinois APRN title policy. Data from questions #5 and #12 of the questionnaire provided evidence of public opinion and are relevant to policy sustainability (see Table 5).

Table 5

Results for Questions #5 and #12

Question	Result	*n*	%	χ^2	p value
Should DNP APRNS be able to use the title "doctor" in clinical settings if they clearly identify their specialty?	Agree Neutral Disagree	256 127 96	53.7% 26.5% 20.1%	90.2	<.001
Which introduction from Dr. Smith do you prefer?	Intro #1 Intro #2 (Illinois)	351 125	73.7% 26.3%	107.3	<.001

To the question, “Should nurse practitioner with DNP degrees be able to use the title ‘doctor’ in clinical settings if they clearly identify their specialty?” more than half of the respondents (53%) answered, “Agree” (χ^2 (2, 479) = 90.2, p<.001). About 20% of them answered, “Disagree” (see Figure 7).

To the question, “Which introduction from Dr. Smith do you prefer?” most respondents (74%) answered, Introduction #1 (“Hi, I’m Dr. Smith the nurse practitioner taking care of you today.”; χ^2 (1, 476) = 107.3, p<.001). About 26% of respondents answered, Introduction #2 (“Hi, I’m Dr. Smith the nurse practitioner taking care of you today, I do not have a degree in medicine, and I am not a medical doctor or physician.”; χ^2 (1, 476) = 107.3, p<.001; Figure 8).

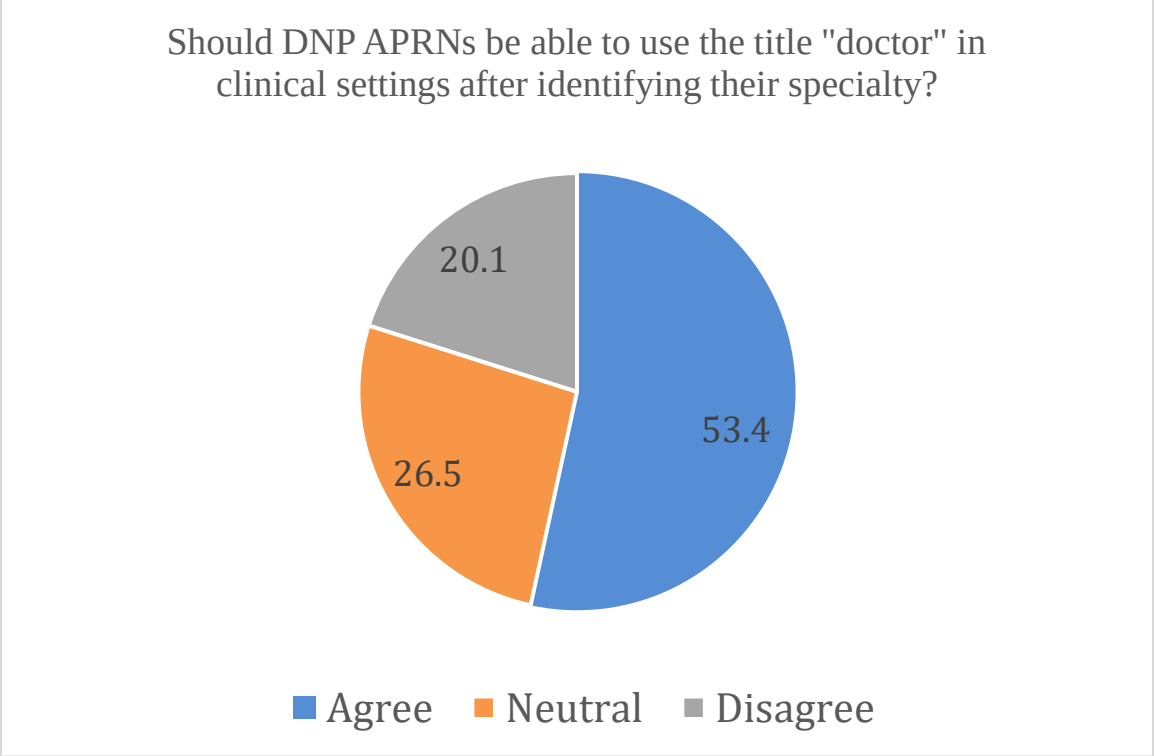


Figure 7. Public support.

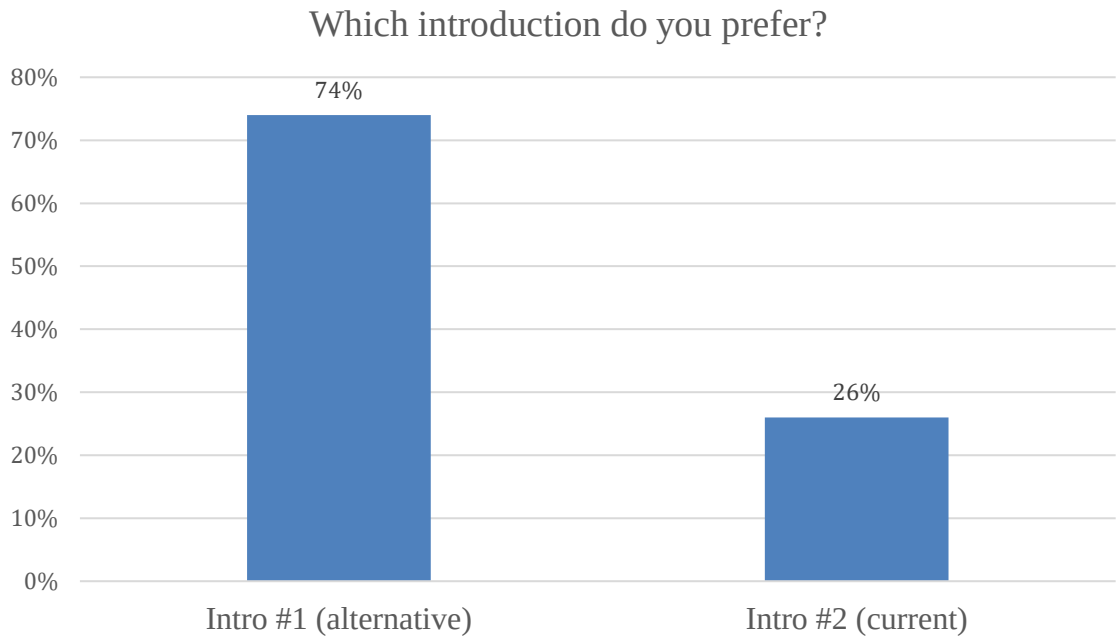


Figure 8. Introduction preference.

CHAPTER 5

DISCUSSION

Overview

The main objective of the project was to evaluate 225 ILCS APRN title § 65/65-50 (c) using a patient survey. The project findings were presented at the Illinois Society for Advanced Practice Nursing Midwest Conference and were used to develop an advocacy tool to promote evidence-based APRN title policy.

The relationship of the results to the project objectives and theoretical framework are discussed in this section. Additional discussion describes the advocacy tool, the project's limitations and strengths, and future implications for nursing research and practice. This chapter concludes with a summary of how the project relates to the Doctor of Nursing Practice (DNP) Essentials as defined by the AACN.

Relationship of Results to Project Objectives

The literature and survey results are discussed in relation to the efficiency, equity, and sustainability of the policy. Table 3 illustrates a comparative analysis of the Illinois APRN title policy versus an alternative APRN title policy. The Illinois APRN title policy requires APRNs using the title "doctor" to identify themselves verbally as APRNs, including their specialty to each patient, and clearly state that they do not have a medical degree and are not physicians (225 ILCS § 65-50). The alternative policy does not

include an extra requirement for APRNs using the title "doctor." It reads, "An advanced practice registered nurse shall verbally identify themselves as an advanced practice registered nurse, including specialty certification, to each patient."

Policy Efficiency

The efficiency criterion considers how well a policy achieves its intended goal and notes any undesirable side effects during the process (Bardach & Patashnik, 2020). The project survey results were used to discuss whether the DNP patient introduction prescribed in the Illinois APRN title policy achieves its intended goal of reducing role confusion between nurses and physicians using the title "doctor."

Effectiveness

Survey participants were asked to identify the healthcare provider's role based on the patient introduction. When provided with the introduction ("Hi, I'm Dr. Smith, the nurse practitioner taking care of you today."), the respondents were able to identify the provider as a nurse practitioner correctly most of the time (χ^2 (3, 480) = 459.10, p<001). About 66% of them said that Dr. Smith was acting as a nurse practitioner (Table 2). However, when provided with the introduction in the Illinois Nurse Practice Act ("Hi, I'm Dr. Smith, the nurse practitioner taking care of you today. I do not have a degree in medicine, and I am not a physician or medical doctor."), the respondents were also able to identify the provider as a nurse practitioner correctly most of the time (χ^2 (3, 479) =439.99, p<001). Sixty-six percent of them said that Dr. Smith was acting as a nurse practitioner (Table 2).

Both patient introductions seem to provide the same level of effectiveness. It

seems the added language in Illinois DNP patient introductions does not effectively reduce role confusion more than a simple patient introduction identifying the nurse's specialty. This finding suggests that regulating the language of patient introductions may not be the optimal solution for addressing the problem of role confusion between nurses and physicians using the title "doctor."

Other methods to reduce role confusion should be explored. One recent study found that large identification badges displaying patient care providers' roles were useful to some patients for understanding providers' role and level of training in the emergency department setting (Wray et al., 2020). Increasing public awareness of the DNP degree and providing education about the qualifications of DNP graduates may also help reduce role confusion between nurses and physicians using the title "doctor." The nursing profession widely publicizes information about the abilities of APRNs but has not focused specifically on the unique value of DNP-prepared APRNs (Wray et al., 2020). More research is warranted to discover effective methods to reduce role confusion further between healthcare providers.

Undesirable Side Effect

When evaluating the efficiency of a policy, it is critical to consider the impact, including any undesirable effects the policy may have on groups in society (Bardach & Patashnik, 2020). The population affected by the Illinois APRN title policy includes Illinois patients and APRN providers.

The project survey compared patients' perceptions of the nurse after the introduction in the Illinois Nurse Practice Act (#2) and another introduction ("Hi, I'm Dr. Smith, the nurse practitioner taking care of you today.": #1). The comparison found the

Illinois statutory introduction to have a significant negative impact on the perception of Illinois DNP APRNs (χ^2 (4, 480) =102.3, p<.001). About 42% of respondents reported a negative perception of the nurse practitioner after the introduction in the Illinois Nurse Practice Act ("Hi, I'm Dr. Smith, the nurse practitioner taking care of you today. I do not have a degree in medicine, and I am not a physician or medical doctor."; Figure 6).

The negative impact on the perception of the DNP APRN may be an unintended side effect of the Illinois APRN title policy that could have serious consequences to nursing practice. Patient introductions are a critical interaction that initiates the nurse-patient relationship (Guest, 2016). The nurse-patient relationship directly impacts the quality of nursing care and eventual health outcomes of patients (Molina-Mula & Gallo-Estrada, 2020). For example, a poor nurse-patient relationship may increase the days of a hospital stay and decrease the patient's satisfaction with care. If Illinois DNP patient introductions have a more negative impact on the perception of the APRN, it may weaken the nurse-patient relationship and ultimately diminish the patient's overall quality of care.

In contrast, about 45% of participants reported a positive nurse perception after the alternative introduction ("Hi, I'm Dr. Smith, the nurse practitioner taking care of you today.": #1). This positive perception of the DNP APRN may support a healthy nurse-patient relationship and enhance health outcomes (Molina-Mula & Gallo-Estrada, 2020).

The findings suggest both patient introductions may achieve the goal of reducing role confusion to the same extent. However, the patient introduction in the Illinois Nurse Practice Act is less efficient due to a more negative impact on the perception of the DNP APRN. The results of this project suggest that the language used in patient introductions

impacts patients' perception of the provider and has potential implications for practice. It is critical for policymakers to consider the consequences of current regulatory policies on nursing practice (Moore, Kabbe, Gibson, & Letvak, 2020).

Policy Equity

A policy equity assessment considers fairness in distributing the benefits and burdens of a policy across groups of individuals in society (Bardach & Patashnik, 2021). The groups most impacted by section (c) of the Illinois APRN title policy are patients and DNP APRN clinicians.

DNP APRNs, like physical therapists, psychologists, and pharmacists, are members of a group of Illinois healthcare providers. Role confusion is not a unique problem between DNP APRNs and physicians. Evidence indicates that role confusion is a problem between physicians and many healthcare providers. The AMA Truth in Advertising national survey results suggest that role confusion is an issue for many healthcare providers (AMA, 2018). For example, the AMA survey results found that 43% of participants identified a psychologist as a physician, and 47% identified an optometrist as a physician (2018). This project found 30.6% of respondents answered, "Yes" to the question, "Is a nurse practitioner a physician?" and about 41.5% of respondents answered, "Yes" to the question, "Is a nurse practitioner with a Doctor of Nursing Practice degree a physician?"

Title regulation across health professions should be fair and equitable. Currently, Illinois nurses are the only doctorate providers required to clearly state that they do not have a medical degree and are not medical doctors or physicians to each patient when they choose to use the title "doctor." Illinois APRN title policy is unlike other

regulations for healthcare professionals and may unfairly place the burden of role confusion on DNP APRN nurses. In the past, the FTC (2014) has warned against well-intended laws that impose unnecessary, overbroad restrictions on competition. The Illinois APRN title policy may fit the category of law that the FTC cautioned against in their policy paper.

An alternative APRN title regulation that requires patient introductions to include the nurse's specialty is closer to policy requirements for other Illinois healthcare providers. For example, Illinois optometrists can use the title "doctor" in practice, but must specify that their credentials are in optometry (225 ILCS 80/5).

The project findings suggest that the Illinois Nurse Practice Act 225 ILCS APRN title § 65/65-50 (c) is burdensome to DNP APRNs. The policy may harm the perception of DNP APRNs and is more restrictive than title policies of other health professionals despite a wide prevalence of role confusion in healthcare.

Policy Sustainability

Policy sustainability considers the ability of a policy to stick due to the support of the public and a variety of stakeholders (Bardach & Patashnik, 2020). Stakeholders involved in Illinois APRN title policy are patients, physicians, APRNs, the Illinois legislature, the Board of Nursing, and the Department of Financial and Professional Regulation.

This project's literature review provided evidence of stakeholder arguments surrounding the use of the title "doctor." Physicians were the only group opposed to nurses using the title "doctor." They claim that nurses using the title is confusing and jeopardizes patient safety (AAFP 2012; AMA, 2018; Al-Agba & Bernard, 2020).

According to the literature, physician groups support restrictive APRN title regulation.

In contrast, the literature review and survey results found diverse stakeholder support for alternative APRN title policy allowing qualified nurses to use the title "doctor" with the identification of their specialty (see Table 6). Nurses and allied healthcare providers agree that the title "doctor" does not belong to physicians (AACN, 2014; Jennings, 2015). The survey results indicate that more than half of Illinois patients (53%) agreed that DNP APRNs should be able to use the title "doctor" in clinical settings if they identify their specialty. In addition, 74% of respondents prefer the patient introduction ("Hi, I'm Dr. Smith the nurse practitioner taking care of you today.") without the additional language in the Illinois Nurse Practice ("I do not have a degree in medicine, and I am not a physician or medical doctor."). The respondents' strong preference of the patient introduction without the language in Illinois introductions is notable. Evidence of patient preference for provider introductions has been studied in the past due to its critical value in forming positive provider-patient relationships resulting in optimal compliance, outcomes, and patient satisfaction (Walley et al., 2019).

The literature and survey results seem to indicate a lack of support from Illinois patients, nurses, and allied healthcare professionals for the Illinois APRN title policy. This lack of support suggests poor sustainability of the current Illinois policy and reveals its lack of integrity and ability to sustain opposition in the future. In comparison, an alternate APRN title policy requiring DNP APRNs to identify their specialty to patients when they use the title "doctor" may be more efficient and sustainable due to support from various stakeholders including Illinois patients, nurses, and allied healthcare professionals (ANA, 2008; AACN, 2014; Jennings, 2015).

Table 6

Comparative Analysis

Title Policy	Effectiveness	Equity	Sustainability
Alternative APRN title regulation (Introduction #1)	• 66% correctly identified the nurse role • Positive impact on perception	• Like other title policies for providers	• Nurse support • Patient support • Allied healthcare provider support
Illinois APRN title regulation (Introduction #2)	• 66% correctly identified the nurse role • Negative impact on perception	• Unique requirement applied to nurses only	• Physician support

Summary and Proposed Alternative

The project evaluation suggests Illinois Nurse Practice Act 225 ILCS APRN title § 65/65-50 (c) is no more effective at reducing role confusion when compared with an alternative policy requiring DNP APRNs to identify their specialty to patients. The Illinois DNP patient introduction may be less efficient due to the negative impact it may have on the perception of DNP APRNs. The project evaluation also suggests the Illinois APRN title policy is burdensome to DNP APRNs and unsustainable due to lack of support from stakeholders outside of physician groups. These findings underscore the value of re-evaluating the APRN title policy in Illinois.

The recommendation based on the policy evaluation is to amend 225 ILCS APRN title § 65/65-50 (c). It would read, **"An advanced practice registered nurse shall**

verbally identify themselves as an advanced practice registered nurse, including specialty certification, to each patient."

The amended language omits the requirement for DNP APRNs to state clearly that their educational preparation is not in medicine and that they are not medical doctors or physicians. The recommended amendment of the Illinois APRN title may be more efficient at reducing role confusion by minimizing the possibility of a negative impact on the patient's perception of the provider. The amendment would also provide a more sustainable and equitable title regulation like rules for other Illinois healthcare providers.

Relationship of Results to Theoretical Framework

The Multiple Streams Framework approach has been an effective process used by nurses to bring about change (Gregg, Miller, & Tennant, 2018). It facilitates the understanding of the complexities involved in policymaking (Kingdon, 1984). Kingdon's Framework highlights the importance of activity in all areas of policymaking to prepare for a policy window.

The Multiple Streams Framework was employed in this project as a guide to help direct the project objectives in each policymaking stream. The project provided insight into the problem of role confusion, evaluated Illinois APRN title policy, and recommended an evidence-based alternative. Finally, the DNP student advocated for change by creating an advocacy tool and presenting the project results at the Illinois APRN Midwest Conference.

Problem Definition

The Multiple Streams Framework demonstrates that policymaking is highly

influenced by problem identification and agenda-setting (Kingdon, 1984). This project aimed to gain insight into role confusion. Physician groups have defined the problem of role confusion as a safety risk (AAFP, 2012; AMA, 2018; Al-Agba et al., 2020). This definition has influenced decision-makers to prioritize stricter title regulations in Illinois and other States. This project provides insight into role confusion between DNP APRNs and physicians in Illinois and reshapes the problem definition.

The literature review did not find evidence that role confusion between DNP APRNs and physicians creates a safety risk. The survey results and the literature review confirmed that role confusion exists between many healthcare providers and physicians. This project redefines role confusion between DNP ARPNs and physicians as a common problem among many providers on the healthcare team that does not present a safety risk to patients. The proposed solution to the problem of role confusion should be evidence-based and match its impact on society.

Policy Evaluation

The policy stream of the Multiple Streams Framework is where alternative strategies are developed and proposed to solve problems. Analyzing existing policy is essential in the policy stream. This project used a survey to evaluate the current Illinois APRN title regulation. The evaluation compared the Illinois policy to an alternate title policy using the criteria of effectiveness, equity, and sustainability. The assessment found that the Illinois APRN title policy may not be efficient, may have a negative impact on the perception of DNP APRNs, and may be unsustainable due to lack of support within the population surveyed.

The evaluation was used to recommend an amendment to the Illinois APRN Title

policy that reads, “An advanced practice registered nurse shall verbally identify self as an advanced practice registered nurse, including specialty certification, to each patient.” This alternative is evidence-based and may provide an effective solution to role confusion between DNP APRNs and physicians.

Politics

The Multiple Streams Framework illustrates the importance of activity in the politics stream. Nursing regulators struggle to make quality decisions due to the lack of available evidence (Spector, 2010). I aimed to reach leaders involved in regulatory decisions, and the project results were shared with decision-makers in Illinois through an advanced nursing conference presentation and dissemination of an advocacy one-pager to policymakers.

Kingdon (1984) described several ways that a policy window can open or close: One method of opening a policy window is to present an evidence-based alternative to address a problem. This project presents an alternative to the Illinois APRN title policy and calls for change. Support for an amendment to the Illinois APRN title policy could eventually open a policy window and remove barriers to nursing practice in Illinois.

Project Strengths

A significant strength of this project was the large sample size of the patient survey. The survey size of 476 participants exceeded the minimum sample size of 400 required for a desired precision of 5% and a confidence interval of 95%. In addition, the sample was balanced for age and gender, which matched the Illinois census to minimize sample bias.

Another strength is the online approach for gathering evidence that allowed for limited contact and maximum participation during the pandemic.

Project Limitations

A project limitation was the inability to verify whether a DNP APRN had treated survey participants for healthcare. Verification was impossible due to anonymity and the online survey platform. Based on a pilot survey of 105 participants, I estimated that 50% of the target audience would qualify as having seen a DNP APRN for healthcare. The pilot survey was sent to Illinois residents, and 52% of participants answered, "Yes" to the question, "Have you ever been treated by a nurse practitioner with a DNP degree for your healthcare needs?" The qualification rate for the project survey rate was higher than expected (72%).

The project survey was designed to gather feedback from Illinois patients. The scope of the policy analysis could have been more comprehensive if the evaluation had also included the perspectives of Illinois DNP APRNs.

Implications for Future Research

Future studies should explore the impact of APRN title regulations on nursing practice from the perspective of DNP APRN clinicians. The DNP APRN perspective will help describe the impact of restrictive title policies on the advancement of nursing. For example, an unintended consequence of burdensome title regulation could be the failure of DNP APRNs to share their credentials or training with patients. Discovering how DNP graduates use their title in practice is valuable for policy development.

More research is warranted to explore effective methods to reduce role confusion

and increase public knowledge about the qualifications and training of healthcare team members. These methods should encourage nurses and other professionals to share their unique training and qualifications with patients.

Implications for Future Practice

A patient introduction initiates the nurse-patient relationship and builds trust. Nurse-patient relationships can affect the outcome of healthcare (Ozara & Abaan, 2018). This project has shown the powerful impact the language of an introduction can have on a patient's perception of the nurse. The project findings may influence legislators to amend the Illinois APRN title policy and encourage Illinois DNP APRNs to use the title "doctor" in practice and educate the public about their unique qualifications.

This project may also influence policymakers in other states who are faced with proposals to revise their APRN title regulation. This project has the potential to advance nursing practice by promoting evidence-based nursing regulations across the nation.

Dissemination

The project results were shared through a poster presentation at the Illinois Society for Advanced Nurse Practitioners Midwest Conference. The audience included nurse lobbyists, nurse educators, nurse practitioners, and nursing leaders from across Illinois. The intervention for this project was development of an advocacy tool based on the findings of this project to influence key stakeholders and policymakers in Illinois. The advocacy tool was disseminated by email to nursing leaders and legislators in Illinois.

Intervention

A carefully prepared one-pager is a valuable tool for communicating with stakeholders and legislators (Kostas-Polston, Thanavaro, Arvidson, & Taub, 2015). The DNP student developed a one-pager to summarize the issue and raise awareness of the need to amend the Illinois APRN title regulation. I decided to create a one-pager after attending a Nurses Day at the Capitol event in Illinois. Nurse lobbyists explained the communication challenges during the pandemic. For example, virtual legislative committees have eliminated critical opportunities to meet with legislators in hallways or offices. Communication must be done through virtual platforms or by email. Lobbyists explained the need for concise communication that can be sent via email. Learning of this need led me to develop an advocacy tool to reach project stakeholders.

Purpose

A one-pager should quickly explain a policy issue and ask for the support of the recommended change (Kostas-Polston et al., 2015). One-pagers developed and disseminated by professionals with first-hand knowledge of policy impact can be more persuasive than communication from professional lobbyists. The purpose of this tool is to educate policymakers and provide evidence to make sound decisions. The one-pager also operates as a reference to share with others and to contact the author. The one-pager designed for this project included my contact information and credentials in nursing and law.

Guide

The one-pager was designed by following the steps from Kostas-Polston et al.'s

(2015) article on shaping health through policy. The essential components of the one-pager are illustrated in Figure 9. The title and subtitle state the desired change and benefit. Three main points are emphasized using evidence and are supported by sentences 9-12 words in length. The proposed solution was summarized and stressed with a call to action. The tone is positive, and the language is simple for clarity and understanding (Appendix C).

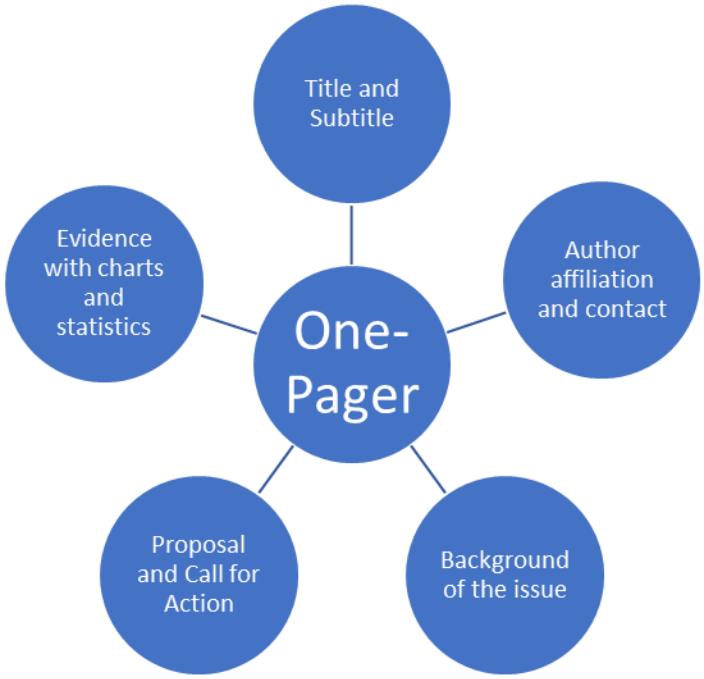


Figure 9. Essentials.

Evaluation

I sent an evaluation questionnaire to five DNP APRNs. All the DNP APRNs completed the evaluation of the one-pager for efficacy and clarity (Appendix D). The evaluators agreed that the tool was understandable, clear, and persuasive. Feedback on the strengths of the one-pager noted that the evidence was strong due to the large number

of survey participants. Evaluators also appreciated that the tool was informative and included an assessment of the policy language (see Table 7). One DNP APRN commented on its potential to make a positive impact on the nursing profession. Finally, one evaluator suggested adding additional research to the one-pager to support the argument for policy change. I sent the one-pager by email to nurse leaders and lobbyists in Illinois (Appendix C). This step is the beginning of the work required to promote an amendment to the Illinois APRN title policy.

Table 7

Evaluation of Advocacy Tool

Question	**Response**	***n***
Is the policy issue understandable?	Agree Neither agree or disagree Disagree	5 0 0
Are the survey results clear?	Agree Neither agree or disagree Disagree	5 0 0
Is the call to action persuasive	Agree Neither agree or disagree Disagree	5 0 0
What are the strengths of the advocacy tool?	• Large sample size • Informative • Assesses policy language • Positive impact on nursing profession	
What are your suggestions for improvement?	• Include more research to support policy change	

Mastery of DNP Essentials

Essential I: Scientific Underpinnings for Practice

Essential I: Scientific Underpinnings for Practice join theory and practice. Doctorate-prepared nurses are equipped to use a broad knowledge base to develop practical solutions to complex problems in the practice environment. Science-based theories help guide critical thinking and analysis to provide a foundation for clinical practice (Zaccagnini & White, 2017).

This project required that I integrate nursing science with knowledge from political science and law. Kingdon's Multiple Streams Theoretical Framework was used to design this project and understand the policymaking process. I applied analytical reasoning to develop policy recommendations. This project supports the development of evidence-based nursing regulations with scientific underpinnings.

Essential II: Organizational and Systems Leadership

Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking prepares DNP graduates to lead in developing healthcare solutions (AANC, 2006). Advanced practice leaders analyze problems within the context of systems and make decisions to maximize the results of the system. Leadership includes monitoring for unintended consequences and intervening to prevent harm.

I was able to evaluate the Illinois APRN title policy using evidence and systems thinking. The project results suggest that the language of patient introductions can negatively impact the patient's perception of the nurse. Decisions at the policy level need to consider the outcome and how regulations impact patient care at the bedside. This project uses systems thinking to recommend an evidence-based alternative to the Illinois

APRN title regulation that addresses role confusion and considers policy consequences on nursing practice.

Essential III: Clinical Scholarship and Analytical Methods

Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice improve nursing practice and outcomes of care. Evidence-based practice is based on scholarship and is used to effect a change in the healthcare system that results in better care for patients (Zaccagnini et al., 2017). Advanced nurse leaders have the skills to apply research findings and evidence to develop and influence evidence-based nursing regulations.

I combined clinical experience and knowledge of the law to evaluate the Illinois APRN title regulation and recommend an evidence-based alternative. This project resulted in a new awareness of the impact of patient introductions. I accomplished research, evidence gathering, synthesis, and analysis and I exemplified scholarship through a poster presentation at a nursing conference and the dissemination of a one-pager advocacy tool to communicate the project findings and influence policy change in Illinois.

Essential IV: Information Systems/Technology

Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care is an essential requirement to lead in healthcare environments (AANC, 2006). Doctor of Nursing Practice providers must continue to gain new competencies in computers, information systems, and technology as healthcare transforms. Effective communication necessitates the use of technology.

Technology was integrated throughout this DNP project to design and administer a survey, analyze the results, and create a poster and one-pager to communicate the results to stakeholders. I utilized information systems to facilitate a review of the literature and legislative history search. SurveyMonkey was a powerful technology tool used to design and launch the online project survey to Illinois patients.

Essential V: Healthcare Policy for Advocacy in Health Care

Essential V: Healthcare Policy for advocacy in healthcare is provided to prepare advanced nurses to influence policy on the local, state, and national levels. Engagement in the policy process is essential for nurses to improve healthcare. Doctor of Nursing Practice students are prepared to evaluate current policy and participate in designing evidence-based policies that affect many areas of healthcare, including practice regulation (AACN, 2006). Doctor of Nursing Practice graduates are powerful advocates for the nursing profession. Critical analysis of policy from the nursing perspective is one method of influencing health policy. Nurses must advocate for patients and the nursing profession by supporting evidence-based nursing regulations.

The purpose of this DNP project was to influence evidence-based nursing regulation in Illinois. Advanced Practice Registered Nurses continue to be challenged with burdensome restrictions and struggle for parity within the healthcare environment. I used knowledge in policy analysis to evaluate the Illinois APRN title regulation using a survey. This evaluation resulted in a recommendation to amend the current title regulation due to its negative impact on patients' perceptions of the DNP APRN, inequity, and lack of sustainability. This DNP project was designed to support fair evidence-based nursing regulation at the state level. I practiced advocacy by

disseminating the project findings to educate leaders and policy stakeholders.

Essential VI: Interprofessional Collaboration

Essential VI: I met the essentials for Interprofessional Collaboration for Improving Patient and Population Health Outcomes through collaboration with my team and experts from other disciplines. Doctor of Nursing Practice graduates are prepared to form interprofessional groups to produce successful work collaborations that improve health outcomes.

I collaborated with APRN clinicians during the evaluation of the project survey tool and to gather feedback on the current Illinois title regulation. I spent time with DNP clinicians observing patient introductions. Various experts were consulted throughout the project, including a statistician, librarian, and editor. I attended the Illinois Nurses Day at the Capitol event to learn about current issues on the policy agenda and identify methods to influence policy during the pandemic. Ideas from nurse lobbyists and policymakers were used to develop a one-pager summarizing the project findings.

Essential VII: Advanced Nursing Practice

Essential VII: Advanced Nursing Practice describes the DNP role in each distinct area of specialty. The increased complexity of healthcare has influenced the development of specialization in nursing (AACN, 2006). All DNP graduates are expected to obtain essential core competencies and they are skilled in advanced patient assessment, evidence-based nursing practice, policy evaluation, and education delivery in various patient care settings.

I have chosen a specialty in family practice nursing and was able to apply the essentials of advanced nursing practice in this DNP project. The essential was met by evaluating nursing policy at the state level to understand how title regulations link to nurses' daily practice. I communicated the project findings to stakeholders in order to educate them on the patient care consequences of regulatory decisions.

APPENDIX A

UNIVERSITY IRB LETTER OF APPROVAL

Andrews University
Office of Research & Creative Scholarship

April 27, 2021

Sara Kim
Tel. 630-802-4308
Email: sara@sarakimjd.com

RE: APPLICATION FOR APPROVAL OF RESEARCH INVOLVING HUMAN SUBJECTS
IRB Protocol #:21-061 **Application Type:** Original **Dept.:** Nursing (DNP) **Review Category:** Exempt **Action Taken**: Approved **Advisor:** Jochebed Ade-Oshifogun **Title:** Policy analysis of the Illinois Nurse Practice Act (APRN Title Section 65/65-50): Using a patient survey of DNP role confusion.

Your IRB application for approval of research involving human subjects entitled: "*Policy analysis of the Illinois Nurse Practice Act (APRN Title Section 65/65-50): Using a patient survey of DNP role confusion"* IRB protocol # 21-061 has been evaluated and determined Exempt from IRB review under regulation CFR 46.104 (2)(i): Research that includes survey procedures in which information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subject. You may now proceed with your research.

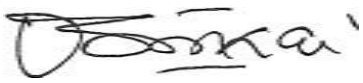
Please note that any future changes made to the study design and/or informed consent form require prior approval from the IRB before such changes can be implemented. Incase you need to make changes please use the attached report form.

While there appears to be no more than minimum risks with your study, should an incidence occur that results in a research-related adverse reaction and/or physical injury, this must be reported immediately in writing to the IRB. Any research-related physical injury must also be reported immediately to the University Physician, Dr. Katherine, by calling (269) 473-2222.

We ask that you reference the protocol number in any future correspondence regarding this study for easy retrieval of information.

Best wishes in your

research. Sincerely,



Mordekai Ongo, PhD.
Research Integrity and Compliance Officer

Institutional Review Board – 8488 E Campus Circle Dr Room 234 - Berrien Springs, MI 49104-0355 Tel: (269) 471-6361 E-mail: irb@andrews.edu

APPENDIX B

SURVEY TOOL

Welcome to My Survey

Thank you for participating in this survey. Your feedback is important.

Purpose: This survey is part of a student research project entitled "A Survey of Patient's Perceptions of Advanced Practice Registered Nurses (APRNs) with a Doctor of Nursing Practice (DNP) Degree and an Evaluation of Relevant Sections of the Illinois Nurse Practice Act".
Researchers: This survey is being conducted by Sara Kim, JD, BSN, and Jochebed Bea Ade-Oshifogun, PhD, RN-BC, CNE.
Procedure: If you chose to participate in this survey, you will be asked to complete an anonymous survey that includes questions about yourself and perceptions about health care providers.
Participation: Participation in this survey is voluntary. Once you begin the survey, you may choose to discontinue it at any time.
Confidentiality: The responses to this survey are anonymous. The information gathered in this survey will remain confidential and will only be reported in combination with other respondents.
Contact Information: If you have any questions regarding this survey, your participation, or your rights as a participant, you may contact Sara Kim (630-802-4308) or the Andrews University Institutional Review Board (269-471-6361).

* 1. I agree to voluntarily participate in this study. I understand the responses to this survey are anonymous and no references will be made in written or oral materials that could link me personally to this study.

- ○ Yes
- ○ No

* 2. Have you ever been treated by a nurse practitioner with a Doctor of Nursing Practice degree for your healthcare needs?

- ○ Yes
- ○ No

3. What is your age?

4. What is the highest level of school you have completed or the highest degree you have received?

- Less than high school degree
- High school degree or equivalent (e.g., GED)
- Some college but no degree
- Associate degree
- Bachelor’s degree
- Graduate degree

5. Should nurse practitioners with a Doctor of Nursing Practice degree be able to use the title "doctor" in clinical settings if they clearly identify their specialty?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

6. Is a nurse practitioner a physician?

- Yes
- No
- Not Sure

7. Is a nurse practitioner with a Doctor of Nursing Practice degree a physician?

- Yes
- No
- Not Sure

Please read the introductions by Dr. Smith, a nurse practitioner with a Doctor of Nursing Practice degree and answer the following questions.

8. Introduction #1: "Hi, I'm Dr. Smith, the nurse practitioner taking care of you today." After reading this introduction, what role is Dr. Smith acting in?

- ○ physician
- ○ nurse practitioner
- ○ physician assistant
- ○ unclear

9. How does this introduction impact your perception of this health care provider, “Dr. Smith”?

- ○ very negatively
- ○ negatively
- ○ neutral
- ○ positively
- ○ very positively

10. Introduction #2: "Hi, I'm Dr. Smith, the nurse practitioner taking care of you today. I do not have a degree in medicine and I am not a physician or medical doctor."
After reading this introduction, what role is Dr. Smith acting in?

- ○ physician
- ○ nurse practitioner
- ○ physician assistant
- ○ unclear

11. How does this introduction impact your perception of this health care provider, “Dr Smith”?

- very negatively
- negatively
- neutral
- positively
- very positively

12. Which introduction from Dr. Smith do you prefer?

- Introduction #1: "Hi, I'm Dr. Smith the nurse practitioner taking care of you today."
- Introduction #2: “Hi, I'm Dr. Smith the nurse practitioner taking care of you today. I do not have a degree in medicine and I am not a physician or medical doctor.”

APPENDIX C

ONE-PAGER

Illinois Advance Practice Registered Nurse (APRN)

TITLE REGULATION

May Negatively Impact the Nurse-Patient Relationship

Background

Physicians and Nurses disagree

- Physicians claim nurses using the title “doctor” is confusing and unsafe
- Nurses assert the title “doctor is common to many disciplines,
- Literature provides evidence that nurses deliver safe healthcare
- Qualified nurses using the title “doctor” are the only Illinois health professionals required by statute to state to each patient that “they do not have a medical degree and they are not a physician or medical doctor.”

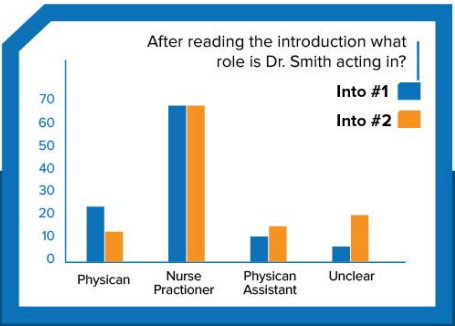
Evidence

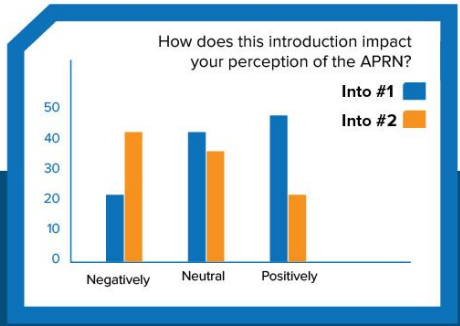
Survey of 476 Illinois patients

- Survey results from 476 Illinois patients seen by nurses with DNP degrees suggest the statutory patient introduction:
- Does not achieve its intended purpose of reducing role confusion between nurses and physicians
- Negatively impacts the perception of the nurse
  74% of patients preferred the introduction without the statutory language

Intro #1 “Hi, I’m Dr. Smith the nurse practitioner taking care of you today.”

Intro # 2 (Illinois) “ Hi, I’m Dr. Smith the nurse practitioner taking care of you today, I do not have a degree in medicine, and I am not a physician or medical doctor.”





Action

Support policy change

- A patient introduction sets the tone for the nurse-patient relationship. These findings highlight the need for evidence-based regulation that is effective, equitable, and sustainable.
- Suggested Action: Amend Illinois APRN title regulation by eliminating the requirement for qualified nurses using the title "doctor" to clearly state to each patient that his or her educational preparation is not in medicine and that he or she is not a medical doctor or physician. (Nurse Practice Act 225 ILCS § 65/65-50).
- This amendment removes the negative impact on nursing practice and supports effective patient introductions identifying the nurse's role and specialty. All APRNs shall “verbally identify themselves as an advanced practice registered nurse, including specialty certification, to each patient” (Nurse Practice Act 225 ILCS § 65/65-50).

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College of Health & Human Services

APPENDIX D

EVALUATION SURVEY

Illinois APRN Title Regulation May Negatively Impact the Nurse-Patient Relationship

1. Is the policy issue understandable?

Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree

2. Are the survey results clear?

Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree

3. Is the call to action persuasive?

Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree

4. What are the strengths of the advocacy tool?

5. What are your suggestions for improvement?

REFERENCE LIST

REFERENCE LIST

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