2023 Report on Nurse Practitioner Education and the Need for Change

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Introduction

One must recognize nurse practitioner (NP) education's current state to understand the profession's trajectory and the recent national push for NP independent practice or full practice authority. To that end, one must know the evolving trends in NP education. Moreover, one must not only understand why NP education has changed over the last decade and its future direction but also be critical of the current trends and standards to evaluate NP education properly.

In 2010, the Institute of Medicine released a report focusing on NPs that included the following recommendations:

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners with physicians and other health care professionals in redesigning health care in the United States.
- Effective workforce planning and policymaking require better data collection and information infrastructure (1).

However, since 2010, nursing and NP leadership have provided no direction regarding the profession's future. The Institute of Medicine report encouraged NP programs' substantial growth since 2010. The annual number of NPs in practice has increased from 91,000 in 2010 to over 270,000 in 2019 (3). This uncontrolled expansion was caused by an increase in the number of NP schools to over 470 (2), with a growth from 10,500 NPs graduating per year in 2010 (6) to over 36,000 in 2020 (5). Furthermore, this unprecedented expansion in health care has provided the profession with NPs who care for patients nationwide.

The downside to this expansion is the reduction in admission standards and the push from all sides of academia to increase the number of NPs in the country at all costs, which is concerning from multiple angles; nevertheless, the lack of standardization in clinical education is even more concerning (7). In addition, the medical training establishment had a problem with the lack of standardization of medical training, which was not standardized until after the *Flexner Report* (44). This landmark report eliminated proprietary schools and created a gold standard for medical education. The current NP training has no academic control over clinical education, and a group of NPs challenged this standard in a grassroots effort that caused a change in the Commission on Collegiate Nursing Education accreditation standards for NP education. This update in 2018, which went into effect on January 1, 2019, had a key change in standards for NP education. Standard II-B states that "the program is responsible for ensuring adequate physical resources and clinical sites. Clinical sites are sufficient, appropriate, and available to achieve the program's mission, goals, and expected outcomes" (4). This change has since required NP

programs to ensure that NP students have clinical sites available for graduation. However, universities are not following the accreditation standards or ensuring that they are met. NP students must still find and place themselves at their clinical training sites, which provides them with a wide range of clinical training that cannot be standardized. The failure to follow the credentialing standards is a continuing disservice to the students. Universities are not maintaining academic control of clinical education and this forces students to place themselves at clinical training sites, many are unable to find training sites, and are therefore falling behind and having to retake coursework.

Moreover, mounting evidence confirms that NPs do not match up well with their physician counterparts in regards to patient outcomes. Indeed, experienced NPs and their MD/DO counterparts have observed a mismatch between NPs' current education and their expectations upon graduation and entry into practice. Recent studies reveal that physicians outperform NPs in patient satisfaction, utilization of emergency departments, and quality measures (8). This finding contradicts prior research which indicated that NPs had lower hospital admission, readmission, inappropriate emergency department utilization, and low-value imaging rates than their MD counterparts (9). Nonetheless, the differences between these studies' results are problematic when NPs are attempting to prove that their practice is equal to MDs' and pushing for independent practice or full practice authority.

From a clinical activity perspective, the current NP educational requirements necessitate 500 clinical hours minimum, which is just over three months of full-time training, to qualify for national certification (10). This lack of hours was initially considered sufficient based on nursing experience. However, a change in this pattern has occurred, as direct entry programs have now emerged and do not require students to have prior nursing experience (11). This has caused a change in messaging from academia. The thought is now that because NP education is so specialized, NPs do not need more hours of clinical training. The lack of clinical training leads to problems with NP scope of practice.

The NP scope of practice relies on three factors: population focus (age ranges, i.e., adult and pediatric and gender-specific women's health), education, and training (12). Setting is not a deciding factor in the NP scope of practice (13) and is often a misunderstood portion of the NP scope of practice. Misunderstanding of scope of practice can confuse credentialing bodies and insurance boards. For instance, family-trained NPs can work in various settings and specialties with the appropriate training. Training in scope of practice for NPs is not defined as formal or academic training but can be and often is comprised of on-the-job training. The various settings and specialties for family trained NPs include emergency medicine, orthopedics, pediatrics, women's health, cardiology, surgery, and gastroenterology. Though, this is not an all-inclusive list, it does illustrate the chaos surrounding interpreting NPs' scope of practice.

Currently, NP education is in an interesting position with no adequate review of training methods. NP training should be reviewed and revised at least every 5–10 years, which would allow appropriate changes to be made to keep the profession as strong as possible and ensure that patients have the best trained NPs to care for them. An extensive literature review reveals no

evaluation of the current NP education. A critical review of NP education is required to evaluate training levels and ensure that NPs are trained at the highest level. For this issue to be properly addressed, the current problems in education must be reviewed.

The Problems

The problems with NP education in its current state are linked to new graduate NPs' performance. First, the lack of clinical hours is insufficient for training students to be independent upon graduation. Indeed, one recent paper confirms a significant gap between physicians' and NPs' outcomes; however, the negative outcome gap closed when NPs gained more experience (43). Second, misunderstanding the NP scope of practice prevents insurance panels from accepting and credentialing NPs. Confusion over the listed credentials of certified nurse practitioner (CNP), registered nurse practitioner (RNP), and advanced practice registered nurse (APRN)—a few of the titles that NPs hold in various states—also causes this problem. Multiple credentialing bodies that compete against each other to obtain market share cause part of the problem with the numerous credentials. Third, too many NPs are graduating at the current rate, which is oversaturating the markets (15), and this phenomenon has led to significant criticism of the much-relied-upon volunteer preceptor system (48). This antiquated system has little to no academic oversight of appropriate clinical experiences and education. Finally, the number of clinical hours is insufficient to ensure independent practice or specialization. The doctor of nursing practice (DNP) degree is a poor attempt to solve some of these issues.

In addition, a recent report on malpractice claims indicates an increase in claims against NPs that coincides with the changes in education. No NP should have independent practice upon graduation with the current failures in the education system. New graduates feel unprepared and overwhelmed due to the current lack of appropriate preparation. "Emma Moore felt cornered. At a community health clinic in Portland, Ore., the 29-year-old nurse practitioner said she felt overwhelmed and undertrained" (14). These are common occurrences among new graduate NPs that are often attributed to imposter syndrome (16, 17). Instead of researching why new graduates are unprepared and reviewing the education process, health care educators have blamed NPs' lack of preparedness on imposter syndrome. Could the current NP education not properly prepare NPs for independent clinical practice?

The NP scope of practice has problems, which is not news to anyone who follows the NP profession. Misinterpreting, not understanding, and including setting in scope of practice decisions are plaguing this profession. Again, three factors determine the scope of practice: population focus, education, and training. Using this scope of practice method, one can ascertain whether an NP has the scope of practice to cover their assignment. For instance, in 2020, a study of NPs who perform colonoscopies in academic settings demonstrated that "NPs present a viable option for delivering high-quality screening colonoscopy" (20). The patients must be within the NP's population focus to prove that this procedure is within the NP's scope of practice. The study involved female and male adults, which would remove pediatric NPs, women's health NPs, and neonatal NPs based on the population, leaving family and adult NPs. They would need training to perform the required procedure. The study described the NPs' additional training as a

12-month residency with 140 completed procedures. The NPs thus obtained the additional training to perform said procedures, and the hospital credentialed them, which is how the NP scope of practice should be interpreted. Nevertheless, one cannot assume that all NPs have the same training, as the education is not standardized (7).

The APRN consensus model was an attempt to curb the confusion over the NP scope of practice and help with standardize it (18). It was designed to help interpret the scope of practice and be model legislation for NPs nationwide. However, it has failed. No evidence from the review of the consensus model that model legislation was emulated to ensure ease of interpretation, no evidence of input from clinicians, and no evidence of the review of current practices emerged when it was implemented. As of 2022, fewer than half of the states had implemented some form of the consensus model (19). From an NP perspective, it has failed in its mission as model legislation and even the basic scope of practice interpretation and title recommendations are failures.

The APRN consensus model necessitates using alphabet soup, which adds unnecessary post-nominal credentials to identification, ensuring the public's confusion. NPs are nurse practitioners, and that should be the only post-name credential listed on badges and identifications, as that is the role that NPs assume in the clinical setting. Outside the clinical setting, alphabet soup is reasonable. Whenever life can be made simpler for the public regarding understanding the NP's role in the clinical setting, it should be prioritized. Using "Joan Smith, NP" on a badge or identifier on scrubs or a lab coat would make understanding what the person's title represents easier; instead, health care professionals receive badges and identifiers that list various credentials (e.g., "Joan Smith, DNP, APRN, FNP-C, AGACNP-BC, ENP-C, CEN, CCRN, CDCES, and WCN-C"). While all these credentials are impressive, listing them on badges and identifications confuses patients and staff.

Part of the different credentials (e.g., BC and C) comes from the NP profession having several certifying bodies, which provides another potential for failure in the education system. Multiple certifying and credentialing bodies offering the same credentials leads to competition between the bodies, which results in needing more bodies with that credential, thus animating that certification. The problem lies with the competition, as the bodies do not want to make their tests "too difficult," have their credentialing processes be considered more extensive, or have lower pass rates on their exams, which might alienate a portion of the NP profession/academia, as it might reduce the number of people willing to receive certification or credentialing from their organizations. This problem is another barrier to reforming the education process since organizations are unwilling to enforce their credentialing standards for fear of losing schools to another credentialing organization. For instance, the Commission on Collegiate Nursing Education updated its standards in 2018 to be effective in 2019, changing the standards in Section II-B to ensure that academic programs place students at clinical sites. Universities' are not following this new credentialing standard. Due to this, multiple preceptor for hire companies have started to solve the problem of a lack of preceptors for NP students (21, 22, 23). Based on the considerable wage increase for preceptor programs, this is an example of a failed enforcement of credentialing standards (21, 22, 23, and 24).

The significant overproduction of NPs has led to a preceptor shortage (15, 25), which is not unexpected based on the 23,000 student increase since 2010 (5, 6). Nonetheless, this problem has illuminated the preceptor system's failure and demonstrated that the antiquated master-apprentice model must be replaced. The current organization of clinical training, with numerous students competing for clinicians to volunteer to precept them for clinical work, cannot hope to properly train students to care for patients. No volunteer system can ever succeed. The preceptors must be paid, as they are in medical education. When paid for this work, clinicians are accountable for the quality of the experiences they provide. Schools will resist this strongly; however, nursing educators must now choose between providing excellent training for capable graduates and producing many poorly trained NPs. The outdated volunteer preceptor system must be abandoned. The current method has no academic oversight of clinical education, as a preceptor provides the entire clinical education with no academic oversight. Moreover, no quality control mechanism exists since the academic instructors do not have or have limited relationships with the clinical educators and have no means to control or even affect instruction at the clinical site. The academic instructors have never even visited many of these clinical locations to ascertain their appropriateness. The lack of oversight of the master-apprentice preceptor method has led to problems with appropriate clinical education.

With a lack of oversight, the base number of hours NPs require is insufficient to properly train new NPs in clinical settings. The NPs themselves saying they are not prepared for clinical practice (45) and the exponential growth of NP residency or fellowship programs confirm as much; since they began in 2007, over 250 programs have appeared nationwide (27). The NPs who completed the residency programs have higher job satisfaction rates and greater confidence (26), which only makes sense as they had a dedicated training program, increased clinical hours, and academic oversight of clinical training. Nevertheless, major professional organizations, such as the American Association of Nurse Practitioners, argue that NP training is competency based and not "time based" and that a given amount of time performing a task or learning something does not equate to knowledge or competency (28). While this opinion might have some truth to it, the new NPs who constantly pursue more clinical training via fellowships or residencies and those who report not being prepared to practice upon graduation evidence that the current model is insufficient. The requirement for clinical education for NPs is 500 supervised contact hours in patient care (29). During discussions with NP educators behind closed doors, the educators realized that the 500 minimum contact hours were insufficient clinical time. However, preceptor shortages prevented an appropriate increase, and in 2022, a concession was made: the educators agreed to increase the minimum training hours to 750 minimum contact hours (30) in the 2022 National Task Force standards. Their FAQ states that "the expanding number of postgraduate NP residencies and fellowships underscore the need for additional clinical experiences before graduation from an NP program" (30), which confirms that NP academia is aware of the problem and realizes that the number of hours is insufficient. Nonetheless, this might represent expedience or universities' desire to graduate a large number of NPs for financial gain rather than what should be the gold standard: students' capability to competently care for patients.

The DNP degree was initially designed as a clinical doctorate endpoint for NPs to help solve the problems with NP education and increase the number of doctoral-prepared nurses in the US, as

the number of PhD-prepared nurses was decreasing. Since its inception in 2006, the number of DNP schools had risen to 357 programs in 2022 (31). The DNP degree has been inconsistent in its educational process, and these programs are not standardized. Furthermore, no discerning factors distinguish a DNP in leadership or informatics from any other DNP, which has led to an "ongoing dialogue about the benefit of the DNP model and tremendous variation in DNP program structure, curricula, and outcomes" (32). In a 2004 position statement, the American Association of Colleges of Nursing recommended that NP programs shift toward a doctoral entry level for NP programs, and the DNP was the recommended pathway (39). Beforehand, multiple doctorates in nursing, including the "doctor of nursing science (DNS, DNSc), doctor of science in nursing (DSN), and the nursing doctorate (ND)," were offered (32). The idea was to place nursing on a similar path to other professions and have an entry-level practice doctorate. This doctorate was meant to prepare the NP for clinical practice and clinical competency. However, the DNP in current production is an interpretive research doctorate, not a clinical doctorate. The clinical doctorate should be an "entry-level degree that prepares students with the competencies required to enter clinical practice and become eligible for licensure" (33). Even the American Association of Colleges of Nursing states not to utilize the term "clinical doctorate" when addressing the DNP in its summary of recommendations: "1: The term *practice doctorate* be used instead of *clinical doctorate*" (39). Nevertheless, the National Organization of Nurse Practitioner Faculties has pushed for the DNP as an entry to practice, with no evidence that the DNP is beneficial to NP practice (38). An extensive literature review reveals no evidence that the DNP benefits an NP's education or clinical performance. Indeed, the DNP has failed in its attempt to be the endpoint for clinical training in advanced nursing. As the DNP is not a clinical doctorate, the title of "doctor" should not be utilized in a clinical setting because it is misleading at best and unethical in the worst-case scenario. Some NPs with a DNP utilize the title "doctor" in the clinical setting and have even been fined for this behavior (42).

The recent report on NP professional liability exposure reveals an increase in NP malpractice damages and offers some insight into the problems associated with NP education. Since 2012, NPs have had a 9% increase in malpractice settlements greater than $500,000 (47). The most common complaints from these cases were diagnosis, treatment and care management, medication prescribing, assessment, and abuse/patient rights/professional conduct (47). The report indicates that "diagnosis-related allegations represented the most frequent allegation with failure to refer a patient to a higher level of care or to a specialist having the highest severity" (47), and the most common diagnosis-related injuries were cancer, infection, cardiac/vascular, and neurological. In addition, the average total professional liability claims have increased by 16% since 2012 (47). The cost to defend NPs against state board of nursing action has also increased by 61.1% since 2012 (46). Professional misconduct, medication prescribing, and scope of practice allegations were the leading causes of reports to state boards of nursing, and 43% of these reports resulted in some form of action against an NP's license (47). The claims that involved student NPs were most often due to inadequate supervision of high-acuity patients (47), which coincides with a lack of academic oversight of clinical training. These increases in malpractice claims are distributed along the same timeline as the changes in NP education and

the increase in the utilization of nontraditional education methods, including the shift to all or mostly online training for NPs.

With all the current problems in NP education—the lack of clinical hours, the DNP failing to solve the problems, and the increase in malpractice claims—no NP should have independent practice upon graduation. NP organizations have pushed for independent practice or full practice authority, which has been authorized in some form in 24 states (34). Some of these states have restricted this practice based on the NP having practiced under supervision for some time prior to having independent practice. This method is a safer option; as described above, the current NP education has too many problems.

The Theory

As with any change in nursing, a nursing theory must support the proposed initiative. Since no nursing theory fits the NP role, one is introduced here: the three pillars of practice. This theory's basis constitutes three factors that relate to all of advanced nursing and should be the basis of any NP practice, which would allow NPs to consider each pillar with every medical, educational, and clinical decision. The three pillars are summarized below.

The first pillar of practice is the pillar of science, which is crucial for any NP, as the basis of practice is evidence based. Scientific evidence is necessary to understand the "whys" and "hows" of practice. Overlooking this pillar leads to poor patient outcomes and can lead to malpractice suits (35). A strong base education in science and increased clinical practice training hours support this pillar's strength.

The second pillar of practice is the art of practice. While difficult to define, this pillar involves understanding the patient's perspective in care and advocating for the patient, which can be accomplished from a basic understanding of the lack of knowledge of the health care system and is confirmed to be strong in nursing, as the nurse holds the most trusted profession (36). However, as surveys such as Press Ganey demonstrate, some do not understand the art of practice.

The third pillar of practice is the business of practice. This pillar is often the most overlooked by NPs because they consistently bill lower than their provider colleagues and are reimbursed at lower rates than their colleagues (37). Nonetheless, this portion of the three pillars cannot be ignored, and NPs must ensure that they maximize their revenue generation by documenting and billing appropriately. This process is often misunderstood, but if the work is completed, it should be billed for so that the practice can succeed. It is no different from a shop performing a tire change on a car and billing the customer for two tires when it changed four, which would cause the shop to close due to mismanagement. The correlation here relates to missing appropriate billing and can cost the practice money, which can cause the practice not to capture enough revenue to keep the doors open. The practice's closure would reduce health care professionals' ability to care for patients in that region.

Following these three pillars of practice enhances the NP's practice and ensures their success. Each pillar is strong, but they resemble legs to a stool, with the successful practice on top: If one

leg breaks or is too small, the stool will fall, and the practice will be unsuccessful. Focusing too much on one leg will weaken the others, and the stool will fall. The basis of decision-making during practice should include all three pillars.

The Solution

To address the problems in NP education, health care professionals must devise a solution that addresses all the issues to ensure that we provide NPs with the best possible training, ensuring that evidence-based practice and standards of care are met with each patient encounter. The process will require standardizing NP education. The first step in this process is standardizing admission requirements for NP programs. The proposed improved admission requirement for NP programs are as follows:

- Two years minimum RN experience (e.g., acute/coronary/med-surg/OB)
    - This requirement will help keep nurses at the bedside to ensure that they want to proceed to the NP level.
    - It will also enable new graduates to understand the RN scope of practice, which is essential, as the APRN scope of practice is an expansion of the RN scope of practice.
    - Prior experience will allow RNs to expand their experience in various specialties and find their areas of interest, which will allow the RN to better understand their field before entering advanced practice in that role.
    - Finally, this requirement will inherently reduce the number of applicants and increase applicant excellence.
- A Bachelor of Science in Nursing (BSN) degree with an upper division grade point average of 3.2 or higher prior to application
- Faculty interviews to ensure candidate excellence

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Improving admission standards and ensuring that all NP programs follow the basic standards should increase applicants' excellence and remove some applicants from the pool, reducing the number of NPs being produced and facilitating adequate research to ensure that these entrance standards are appropriate and allow students to matriculate at a rate to use their training after graduation, which will be impossible if the current graduation rate is sustained, as the markets are being oversaturated (41).

In addition to improving applicants' and students' excellence, ensuring greater rigor and standardization of NP education is necessary. Base NP training should move to a generalist model, and specialization training should move to the doctoral level. Moreover, the training must move away from nursing theory, which students find unhelpful in preparing them to care for patients, and toward more scientific and clinical topics, such as microbiology, pharmacology, and radiology. Increasing the rigor also means increasing the amount of clinically useful material students learn. Most current NP students indicate that they hold full-time jobs, which does not happen in other comparable areas; their full-time job is learning to practice. Fifteen years ago, most NP schools were set up so that students could not work full time and matriculate, which may need to be the standard in NP education to produce excellent NPs. Obtaining an NP degree should be a full-time occupation.

The second step in standardizing training for NPs is moving the base NP training to a generalist model and the specialization training to the doctoral level. This step will allow NPs to know what kind of training all other NPs have at each education level. The master's level still being available as generalist education and the specialization being moved to the doctoral level will still facilitate entry-level doctoral education and specialization and enable the master's-level generalist to "test the waters" and potentially move to a different specialization before doctoral work. The generalist NP should have 2,000 hours of clinical education that is academically supervised. Furthermore, the academic institution should be responsible for training, which is the current requirement for accreditation (4). This requirement would place the academic institution in charge of clinical placement, require clinical sites to be established prior to students' enrollment, and allow the instructors to control clinical education. The clinical requirements would be as follows:

- Required hours: 2,000
    - Internal medicine: 400 hours (includes inpatient work)
    - Psychiatry: 160 hours
    - Pediatrics: 320 hours (includes inpatient work)
    - Family practice: 400 hours
    - Women's health/OB: 160 hours
    - Surgery: 160 hours
    - Emergency medicine: 160 hours
    - Cardiology: 80 hours
    - Radiology: 80 hours
    - Orthopedics: 80 hours
    - Elective rotations: 480 hours (including but not limited to cardiovascular surgery, plastics, neonatology, infectious disease, dermatology, hematology/oncology, gastrointestinal, neurosurgery, and neurology)

The generalist NP's flexibility allows the NP student and their academic instructor to focus clinical training in areas that may be a weakness for the student, which leads to job placement or specialization prior to clinical doctorate work. As the current NP clinical time requirement is as low as 500 hours (changing to 750 hours soon), the elective hour allotments enable the student to focus on areas of need. These additional requirements will also encourage academic institutions to utilize doctoral-prepared NPs in these areas of expertise for full-time academic roles because an increased academic staff will be required to cover these added areas of expertise.

The third step in the process is standardizing a clinical doctoral endpoint for NP education. The current DNP model does not meet this standard since no evidence for a move to this role exists, as it is an interpretive research doctorate. A clinical doctorate or nurse practitioner doctorate (NPD) that is less than 30% focused on research allows the doctoral-prepared nurse to teach and apply evidence-based practice principles, apply and understand how to interpret research, and gain clinical expertise and is related to licensure to practice at the doctoral level in a specialty of

advance practice. The clinical hour requirement should be increased to 4,000 hours of training in an academically supervised situation, which may be called a residency, fellowship, or internship, but the trend of NPs seeking such training and the explosion in the number of residency/fellowship programs evidence that they are a necessary addition to NP education (27). Despite the American Association of Nurse Practitioners' position that they should not be utilized (40), the literature is showing an increase in the NPs success in role transition from RN to the NP role with fellowship training (26). Moving to this model should involve a retraining method should the NP change fields of medicine since no academic controlled method for training NPs in a new field exists. This method will also allow NPDs to fellowship train for 2,000 hours in a new role. Table 1 illustrates the differences between current NP educational requirements, the current proposed changes by NP educators, and the projected changes suggested in this paper. These model changes should provide the profession with clinical experts at the doctoral level to train the next generation of NPs, nurses, and care for patients appropriately. The principles of such a doctorate are as follows:

- Focus of clinical doctorate in a subspecialty area of advanced practice
- Advanced pathophysiology related to a subspecialty area of advanced practice
- Principles of evidence-based practice, applying evidence-based practice, and teaching the principles of practice
- Interpreting research at the doctoral level
- Clinical hours in a specialty area of advanced practice: 4,000
- Advanced pharmacology related to a subspecialty area of advanced practice
- Advanced anatomy related to a subspecialty area of advanced practice
- Diagnostics related to a subspecialty area of advanced practice
- Coding, billing, and administration related to a subspecialty area of advanced practice

NPs advancing and advocating for a true clinical doctorate in nursing should provide doctoral-prepared advanced practice nurses who will be experts in their field, which will facilitate an increase in the number of doctoral-prepared educators and increase the number of advanced practice nurses who would be more willing to obtain their doctorates. The specialization in training will not need to be forced on NPs but will be sought after and eventually become required in the employment setting. Following this format will standardize credentials: the generalist will be an NP, and the doctoral-prepared nurse practitioner will become an NPD, with their specialty listed below their name on their displayed credentials. With this process, insurance panels, hospital credentialing committees, and patients will be able to easily understand that particular NP's scope of practice and reduce malpractice claims associated with scope of practice issues. Moving to such a doctorate will also ensure academic control of clinical education because the clinical sites will be established by the academic institution, be controlled by the academic supervisors, and require a larger pool of academics, as each specialty that is appropriate for every field of training will be needed. This will enable the academic leaders to ensure that the students obtain the appropriate clinical education commensurate with a clinical doctorate in their subspecialties. In addition, this will increase the clinical training hours,

which will assist with an appropriate push for full practice authority and help prove the NPs' dedication to excellent patient outcomes and education.

Table 1

Proposed Solutions to the Problems with Current NP Training

	Current Academic Standards for NP Training	Nursing Proposed Standard Changes	Base Generalist NP	Nurse Practitioner Doctorate (Clinical-Based Doctorate)
Clinical Training Hours	500	750	2,000	4,000
Academic Control of Clinical Education	None	None	100%	100%
Academic Retraining for New Specialty	None	None	None	One-year 2,000-hour fellowship (if the academic institution approves)
Minimum RN Experience Before Enrollment	None	None	2Two years	2Two years
Prior Degree Requirement	None	None	BSN	BSN
Faculty Interviews	None	None	Required	Required
GPA	None	None	3.2 minimum	3.2 minimum

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