

RESEARCH

How well are nurse practitioners prepared for practice: Results of a 2004 questionnaire study

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Abstract

Purpose: The purpose of this study was to evaluate the perceived preparedness of nurse practitioners (NPs) for practice after completing their basic NP educational programs and to evaluate NPs' perceived preparedness in and their perceived importance of select clinical content areas basic to NP education.

Data sources: This cross-sectional descriptive study used a written questionnaire consisting of 32 items, two of which contained 25 subitems. Subjects were asked to rate their overall level of preparedness when they completed their NP program and both their level of preparation in and the importance of 25 clinical content areas. The questionnaires were administered to attendees at two large national NP conferences in 2004; a total of 562 questionnaires were completed and used in the analysis.

Conclusions: Ten percent of the sample perceived that they were very well prepared for practice as an NP after completing their basic NP education. Fifty-one percent perceived that they were only somewhat or minimally prepared. Current age, years since graduation from an NP program, and age when attending the NP program did not differ significantly for those who felt prepared versus those who did not. For a number of content areas, subjects did not perceive that they were well prepared in the same areas that they perceived were very important.

Implications for practice: Our results indicate that formal NP education is not preparing new NPs to feel ready for practice and suggests several areas where NP educational programs need to be strengthened. Practicing NPs are the basis of the NP profession, and their views need to be sought, listened to, and reflected upon as we advance toward expanded preparation at the doctoral level.

Background

Since its inception in 1965, the nurse practitioner (NP) movement has developed into a highly respected and visible form of advanced practice nursing. NPs are now considered mainstream primary and specialty-area health-care providers and have achieved professional recognition that has resulted in prescriptive authority and independent practice, as well as reimbursement from Medicaid, Medicare, and third-party insurance providers (Towers, 2005). As well, NPs provide high-quality health care that has been demonstrated in a number of well-designed outcome studies (Brown & Grimes, 1995; Horrocks,

Anderson, & Salisbury, 2002; Mundinger et al., 2000). Additionally, individuals who are cared for by NPs report being very satisfied with their care (Benkert et al., 2002; Caine et al., 2002; Edwards, Oppewal, & Logan, 2003; Horrocks et al., 2002).

In October 2004, the membership of the American Association of Colleges of Nursing (AACN) endorsed the doctorate of nursing practice (DNP) as the entry-level degree into advanced practice nursing and based their recommendation on "extensive study, review, and consultation with multiple stakeholders and is based upon multiple concerns" (AACN, 2006, p. 1). Specifically, the

AACN listed concerns regarding increasingly complex healthcare demands, as well as overcredited master's level programs that typify much of the educational preparation for advanced practice nurses (APNs). In conjunction with the DNP recommendation, the AACN also made suggestions regarding the core competencies or "essentials" for APN education. These essentials include eight broad criteria, ranging from the scientific underpinnings of advanced nursing practice to leadership and health policy (AACN, 2006).

While there has been opposition against the AACN's decision regarding the DNP (Dracup, Cronenwett, Meleis, & Benner, 2005; Meleis & Dracup, 2005), few disagree that APN education, particularly NP education, could be substantially improved. The literature indicates that NP programs are struggling with issues such as overcredited curricula and limited clinical sites (AACN, 2004; Bellack, Graber, O'Neil, Musham, & Lancaster, 1999). In addition, while NP educational programs in the United States are guided by the competencies mandated by the National Task Force on Quality Nurse Practitioner Education (2002) and from the competencies developed by the National Organization of Nurse Practitioner Faculties (NONPF, 2002a), these competencies are generally broad and difficult to measure, and as a result, NP programs lack standardization. For example, there is great variability on the types of procedures offered by NP programs, and many programs do not teach the very skills that their program directors view as most important (Cole & Ramirez, 2003).

Review of the NP preparedness literature

While many studies have addressed issues surrounding the role, socialization, and effectiveness of NPs, there has been almost no research regarding the adequacy of NP educational preparation. A search of the PubMed and Cumulative Index to Nursing and Allied Health Literature (CINAHL) databases using the keywords "nurse practitioner," "NP," "advanced practice nurse," or "APN" along with each of the key words "preparedness," "readiness," "education," "practice," "concerns," or "recommendations" resulted in only one study directly related to NP preparedness for practice. In 1988, Brown, Tappen, and Weber surveyed 323 APNs (i.e., NPs, certified nurse-midwives [CNMs], and certified registered nurse anesthetists [CRNAs]) who had attended a school in the southeastern region of the United States. Of the 136 surveys returned, 39% had been completed by family, adult, or pediatric NPs. Results of the surveys indicated that the NPs were less satisfied with their educational experiences than CNMs and CRNAs. Specifically, NPs tended to be more dissatisfied with their education surrounding clinical pathology, differential diagnoses, laboratory diagnostics, and pharma-

cology (Brown et al.). Although these results raise questions about the adequacy of NP preparedness, they cannot necessarily be extrapolated over 18 years into a context where NPs now enjoy a higher level of support and recognition. Thus, very little is known about current perceived NP preparedness for practice.

With the high visibility and growing recognition of NPs and NP-directed care, as well as the proposed advancement of NP education to the DNP as entry level for practice, there is an urgent need to evaluate current NP education. While the AACN and NONPF are actively addressing the larger "entry into practice" issue, the specifics of future NP education, including its educational standards, outcomes, and competencies, have not been fully developed. Furthermore, there have been no recent attempts to evaluate the adequacy of NP preparation from the view of the practicing NP. According to Goolsby (2000, p. 43), "There is an urgent need to better understand the experiences and processes associated with high-quality NP education," and one of the best ways to accomplish this is to query practicing NPs about their educational experiences (Alex & MacFarlane, 1992). Thus, the purpose of this study was to evaluate the perceived preparedness of NPs for practice after completing their basic NP educational programs. Additionally, we aimed to evaluate NPs' perceived preparedness in select clinical areas and their thoughts on the importance of these areas to basic NP education.

Methods

This study involved the administration of a written questionnaire. The initial questionnaire was developed by one of the authors (AMH) and was reviewed for content validity and formatting by a panel of NP faculty at the University of Wyoming (UW), as well as two external expert APN educators/researchers. In September 2003, the questionnaire was piloted with 36 practicing NPs at a small regional NP conference in Cheyenne, Wyoming, that primarily attracts NPs from Wyoming and northern Colorado. Twenty-one NPs completed the questionnaire, and from these data, the questionnaire was revised and finalized after consulting with a survey expert from UW's Survey Research Center.

The final questionnaire was a four-page booklet that contained an explanatory cover letter and 32 numbered items, two of which contained 25 subitems. With the exception of the demographic items and two open-ended items, the questionnaire utilized a 5-point Likert scale. Specifically, the questionnaire contained items related to feelings of competency and preparation after completing NP education, as well as the need for consultation during the first year of NP practice. It also contained an item that addressed level of preparation in 25 specific clinical

areas (e.g., pathophysiology, pharmacology, and cultural theory), as well as an item that addressed the importance of each of these areas to basic NP education. In addition to standard demographic questions, there were items related to the type and general description of the participants' NP educational programs, their willingness to participate in a formal residency program, as well as items that assessed the participants' experiences as a practicing registered nurse (RN) prior to beginning their NP education. Finally, the questionnaire contained two open-ended, write-in items: "Can you suggest any changes in your NP education that would have improved your preparedness to practice as an NP?" and "Do you have any further comments?"

The questionnaires were administered to attendees at two large national NP conferences in 2004, including the 30th Annual NONPF meeting, which was held in San Diego, California, in April and the 29th Annual NP Symposium, which was held in Keystone, Colorado, in July. Official participant counts from these meetings were 432 and 900, respectively. Prior to its administration at the NONPF meeting and the NP Symposium, the questionnaire was approved by Human Subject Review Board at UW, as well as the planning boards for each of the respective conferences. One month prior to each conference, the booklets were mailed to the conference headquarters, where they were then placed in the packet of materials that each participant received during registration. AMH attended both of these conferences and set out labeled boxes in highly visible areas for participants to return their completed surveys.

Objective data from the questionnaires were double entered into a data file, checked for inconsistencies and errors, and then exported into an SPSS version 11.0. Data analysis included univariate analysis of all items and tests for associations between demographic characteristics and responses using chi-square and one-way analysis of variance as appropriate. Chi-square tests were also performed to examine associations between subjects' perceived preparedness and perceived importance of selected topic areas where there appeared to be the biggest discrepancy between these two ratings. In all cases, an alpha of .05 was used as the maximum level for a type I error.

Written results from the two open-ended items were transcribed verbatim into an electronic database and analyzed for themes using Atlas.ti version 4.2 software for qualitative data. More than half of the respondents (62%) provided comments, and a number of these were quite lengthy. Again, these items were "Can you suggest any changes in your NP education that would have improved your preparedness as an NP?" and "Do you have any further comments?" Comments provided for the two open-ended items did not differ significantly, and most respondents used the blank space under the second item to

continue their thoughts from the first one. Four major themes emerged from the analysis. In no particular order, they were (a) need for increased rigor, (b) need for more clinically relevant content and experiences, (c) need for more clinically experienced faculty, and (d) NP education has come a long way.

Results

Objective data

A total of 562 questionnaires were completed and used in the analysis. The response rates were 28% ($n = 121$) from the NONPF meeting and 49% ($n = 441$) from the NP Symposium. The sample contained 94% ($n = 527$) women with an average age of 49 years ($SD = 8$), who had practiced as APNs for an average of 11 years ($SD = 8$) since completion of their NP program. Table 1 summarizes additional demographic characteristics of the sample.

Only 10% of the sample perceived that they were very well prepared for actual practice as an NP after completing their basic NP education. Thirty-eight percent thought they were "generally well prepared;" however, a full 51% of the sample perceived that they were only somewhat or minimally prepared (see Figure 1). Current age, years since graduation from an NP program, and age when started and when finished the NP program did not differ significantly for those who felt prepared versus those who did not. Nor did those who completed a master's level NP program, compared to those who did not, differ in terms of overall perception of preparedness. However, years employed as an RN before graduating, $F(4, 509) = 3.8$, $p < .01$; type of NP program, $\chi^2(20) = 36$, $p < .05$; teaching strategies during NP program, $\chi^2(4) = 10$, $p < .05$; and time

Table 1 Demographic characteristics of sample $N = 562$

Characteristic	Value
Gender	
Male	6% ($n = 36$)
Female	94% ($n = 527$)
Age	$M = 49$, $SD = 8$
Type of NP	
FNP	61% ($n = 324$)
ANP	17% ($n = 91$)
PNP	8% ($n = 39$)
GNP	4% ($n = 18$)
ACNP	1% ($n = 5$)
Other	10% ($n = 52$)
Years of RN practice before NP program	$M = 11$, $SD = 8$
Current level of completed education of subjects	
Diploma	1% ($n = 6$)
Bachelors	4% ($n = 21$)
Masters	77% ($n = 407$)
Doctorate	18% ($n = 93$)

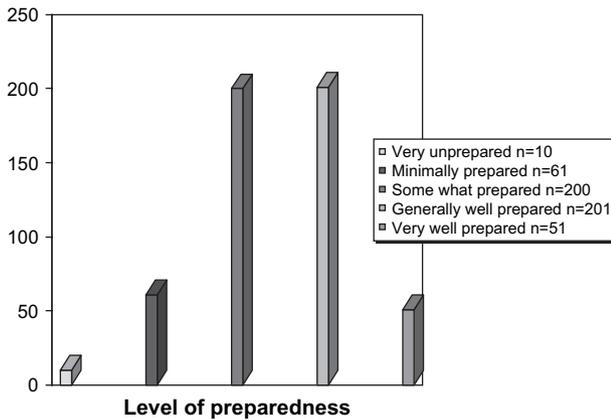


Figure 1 Number of subjects in five levels of perceived preparedness.

it took to feel competent, $\chi^2(16) = 69, p < .001$, were all associated with perception of level of total preparedness. Specifically, those who perceived they were more prepared overall had more years of practice as an RN, were in an acute care nurse practitioner (ACNP) or a pediatric nurse practitioner (PNP) program, did not receive distance courses and Internet courses, and took a shorter time to feel competent.

Subjects were asked about how prepared they thought they were in 25 different clinical areas such as pharmacology, casting, counseling, and clinical management of acute, chronic, urgent, or mental health diseases. They also were asked how important they thought it was for NP students to master these same areas. Subjects felt most prepared in the areas of health assessment, differential diagnosis, pathophysiology, pharmacology, health teaching, and clinical management of acute diseases. They felt least prepared in the areas of coding and billing, casting, complementary and alternative medicine (CAM), electrocardiogram (EKG) interpretation, microscopy, simple office procedure, splinting, suturing, X-ray interpretation, and clinical management of mental health diseases (see Table 2).

For a number of items, there were significant associations between subjects' perceptions of their preparedness in an area and the importance of that area. For the items where there was the most disparity between preparation and perceived importance, there was not a significant association. This suggests that subjects did not perceive that they were well prepared in the same areas that they perceived were important. For example, one of the strongest associations between preparedness and importance was found for the topic area of management of acute diseases ($\chi^2(16) = 230, p < .001$). In contrast, there was no statistically significant association between preparedness and importance for the area of coding and billing. Eighty-two percent of the sample indicated that they received minimal or no education about coding and bill-

ing; however, 70% perceived that the area of billing and coding was either of the utmost or substantial importance (see Table 2).

Subjects were asked about their willingness to participate in a residency program under a variety of circumstances. Eighty-seven percent of subjects indicated they would have been definitely or possibly interested in a residency program of supervised clinical training had one been available just after they completed their basic NP education. Seventy-seven percent indicated they would still have been definitely interested or possibly interested even if the residency program had paid a very low salary, and 42% would have still been interested even if they had had to relocate in order to participate in a residency program.

Subjective data

Need for increased rigor

Respondents expressed a desire for increased rigor in NP education, particularly with regard to clinical competencies. There was a general sense that NP education was rigorous in terms of theory, research, and "paper writing" but that it lacked rigor in clinical areas. Respondents expressed a desire for more testing of clinical reasoning and skills. In addition, they frequently cited how students in other health professional disciplines (e.g., medicine and pharmacy) received a more clinically rigorous educational experience than NPs. A typical response was, "Physicians receive a much more rigorous educational experience and come out ready to practice. We do not and are embarrassed by our lack of clinical preparedness."

Need for more clinically relevant content and experiences

Additionally, the written responses reflected a desire for more clinically relevant content and experiences. Specifically, respondents recommended more content on advanced clinical skills (e.g., EKG and X-ray interpretation, lesion removal, and suturing), as well as anatomy, business administration, differential diagnosis, diagnostic testing, job negotiation, mental illness management, pathophysiology, and pharmacology. With regard to anatomy, several suggested that NP students be required to complete a human cadaver lab. In addition, many respondents indicated that they had benefited from the clinical case-based assignments they had experienced in their programs and suggested that there be more of these types of exercises in NP education. Respondents also wanted to see more clinical hours associated with NP education, and many respondents specifically recommended that NP students be required to participate in a lengthy final residency or fellowship.

Table 2 Level of perceived preparation and perceived importance of 25 areas of practice

Area of practice	Extent covered*			Importance of topic*		
	Minimal or not covered	Somewhat covered	Generally or well prepared	Not needed or minimal importance	Some importance	Substantial or utmost importance
Casting	479 (85%)	51 (9%)	24 (5%)	294 (53%)	185 (33%)	71 (13%)
Management of acute disease	39 (7%)	138 (25%)	383 (68%)	4 (1%)	11 (2%)	539 (97%)
Management of chronic disease	59 (11%)	203 (37%)	292 (52%)	1 (<1%)	12 (2%)	545 (98%)
Management of urgent disease	121 (22%)	237 (43%)	196 (36%)	4 (1%)	29 (5%)	523 (94%)
Management of mental health disease	200 (36%)	228 (41%)	123 (22%)	3 (<1%)	55 (10%)	496 (90%)
Clinical pathology	119 (22%)	205 (37%)	224 (41%)	10 (2%)	80 (15%)	461 (83%)
Coding and billing	463 (82%)	78 (14%)	14 (3%)	31 (6%)	138 (24%)	387 (70%)
Collaboration and referral	110 (20%)	172 (31%)	273 (48%)	5 (1%)	82 (15%)	470 (84%)
CAM	351 (62%)	140 (25%)	62 (11%)	52 (9%)	234 (42%)	272 (49%)
Counseling	208 (37%)	195 (35%)	153 (27%)	16 (3%)	135 (24%)	407 (73%)
Cultural theory	175 (32%)	174 (31%)	206 (37%)	51 (9%)	194 (35%)	313 (55%)
Differential diagnosis	42 (7%)	173 (31%)	342 (71%)	0 (0%)	13 (2%)	542 (98%)
EKG interpretation	329 (59%)	121 (22%)	103 (18%)	60 (11%)	149 (27%)	347 (61%)
Health assessment	12 (2%)	66 (11%)	478 (81%)	0 (0%)	4 (1%)	553 (989%)
Health teaching	14 (3%)	75 (13%)	464 (84%)	0 (0%)	22 (4%)	545 (96%)
Laboratory diagnostics	110 (20%)	216 (38%)	230 (41%)	0 (0%)	24 (4%)	523 (95%)
Microscopy	239 (43%)	162 (29%)	154 (28%)	31 (6%)	143 (26%)	383 (69%)
Nutrition	115 (20%)	221 (40%)	219 (40%)	6 (1%)	108 (19%)	453 (79%)
Pathophysiology	48 (9%)	162 (29%)	347 (61%)	1 (<1%)	19 (3%)	537 (97%)
Pharmacology	43 (7%)	155 (28%)	358 (54%)	5 (1%)	0 (%)	551 (99%)
Simple office procedures	440 (77%)	86 (16%)	30 (6%)	88 (15%)	188 (34%)	289 (50%)
Splinting	427 (76%)	78 (14%)	50 (9%)	153 (27%)	184 (33%)	217 (39%)
Staying current	86 (16%)	120 (21%)	347 (62%)	6 (1%)	40 (7%)	507 (92%)
Suturing	378 (68%)	101 (18%)	75 (13%)	138 (24%)	184 (33%)	242 (43%)
X-ray interpretation	395 (70%)	115 (21%)	46 (8%)	57 (10%)	154 (28%)	344 (62%)

*Percents may not equal 100 as a result of missing values.

Need for more clinically experienced faculty

Respondents indicated that NP education should be provided by more clinically competent faculty, who were strong NP clinicians and kept their skills current while teaching. Many indicated that their own NP faculty had had little and/or outdated practice experience, which in addition to negatively affecting their credibility, hindered their ability to convey meaningful realistic concepts to students.

NP education has come a long way

Despite providing recommendations for improving NP education, respondents acknowledged that NP education had evolved and improved significantly over the past 40 years. Specifically, they commented on the increased number of required clinical hours, the variety of courses and topics now offered, and the expanded focus of NP education beyond health maintenance and disease prevention. In addition, they commented on the fact that there are now many NP-prepared faculty teaching in NP programs, unlike the early NP programs.

Discussion

Specific clinical concerns

Respondents indicated feeling most prepared in the core areas of advanced practice nursing (i.e., health assessment, differential diagnosis, health teaching, acute/chronic illness management, and staying current) and least prepared in the areas of advanced diagnostic skills (e.g., performing microscopy and interpreting EKGs and X-rays), procedures (e.g., suturing, splinting, and simple office procedures), mental illness management, coding and billing, and CAM. The fact that the respondents felt most prepared in the essentials of NP practice is reassuring and reflects that NP educators are successfully conveying the basics of advanced practice nursing. On the other hand, the areas where the NPs indicated feeling least prepared are concerning and warrant further discussion and investigation.

Most of the respondents indicated feeling inadequately prepared for advanced diagnostics (e.g., microscopy, EKG, and X-ray interpretation). When one considers that many NPs use advanced diagnostic skills on a daily basis, this

finding seems somewhat surprising. However, a closer look at the competencies for many of the main NP specialties (i.e., acute, adult, family, gerontological, pediatric, and women's health) reveals that the basic diagnostic skill competencies for new graduate NPs are quite broad (National Panel for Acute Care Nurse Practitioner Competencies [NPACNPC], 2004; NONPF, 2002b). For example, the diagnostic-related competency for the family NP simply states that the NP "Orders, performs, and interprets age-, gender-, and condition-specific diagnostic tests and screening procedures" (NONPF, 2002b, p. 22).

In contrast to diagnostic skills, the procedural competencies for the main NP specialties are more specific, making the lack of content in these areas a bit more perplexing. For example, the procedural-related competency for the FNP is "Performs primary care procedures, including, but not limited to, suturing, minor lesion removal, splinting, microscopy, and pap tests" (NONPF, 2002b, p. 22). Similarly, the competencies for the main NP specialty areas clearly specify that the NP graduate be able to assess for and manage mental illness (NPACNPC, 2004; NONPF, 2002b), a need that cannot be overstressed given that neuropsychiatric diseases are the leading cause of disability in the world (World Health Organization, 2003) and are frequently encountered in primary care (Burman, McCabe, & Pepper, 2005).

Coding and billing and CAM were additional areas where perceived NP preparation did not seem to meet the minimal competencies. In terms of coding and billing, the core NP competencies (NONPF, 2002a) state that the graduate NP possess "competence in the domain of managing and negotiating health care delivery systems" (p. 8). Furthermore the competencies specify that the NP be knowledgeable of management practices in order to maintain the long-term viability of a practice. In terms of CAM, the core NP competencies also state that the graduate NP "evaluates and counsels the patient on the use of complementary/alternative therapies for safety and potential interactions" (NONPF, 2002a, p. 4). Clearly, these are two areas where NPs need to be knowledgeable, if not savvy, in order to compete in today's healthcare market and provide safe and effective care.

Overall preparation

Over one half of the participants reported feeling somewhat prepared, minimally prepared, or very unprepared for practice following completion of their formal NP education. Not surprisingly, those who had more RN practice experience prior to completing their NP education felt more prepared than those who had little RN practice experience. While this finding is intuitively logical, additional research is needed to differentiate what aspects of

previous RN practice actually support a sense of preparedness. For example, past experience may have a general effect on the sense of preparedness secondary to general confidence and professional identity. It is also possible that professional experience leads to a higher level of thinking and practice skills, which are then transferred to the new arena of advanced practice. The fact that ACNPs and PNPs felt more prepared for practice than FNPs and ANPs is also not unexpected, considering the more focused scope of practice embodied by these specialties.

Despite the demand for and surge in distance and Internet educational offerings, NPs who had completed these types of programs were more likely to report feeling less prepared for practice than NPs who had been educated in a more traditional format. Again, this finding warrants additional exploration. One could speculate that nontraditional programs may not allow for the same level of student-to-student bonding that occurs in traditional programs. It is also possible that NP graduates from nontraditional programs feel less prepared, because they do not identify with or get to know NP faculty as practicing clinicians. The fact that a significant number of respondents subjectively offered concerns about the clinical competencies of NP faculty could be construed to support this notion.

The subjective comments regarding the need for "increased rigor" in NP education are especially telling in light of their overall sense of being inadequately prepared for practice. In no uncertain terms, respondents indicated that they desired and needed more out of their clinical education, in terms of content, clinical experience, and competency testing. The more recent addition of objective structured clinical exams, standardized patients, and clinical competency evaluations into many NP programs undoubtedly will result in improved evaluation of NP student performance; yet it is unknown whether these clinical evaluations result in NP students feeling more competent or prepared. Regardless, the concern regarding rigor points to the need for a more critical examination of clinical content and performance evaluations in NP education.

Residency

Most (87%) of the respondents in this study indicated that they would have been interested in a clinical residency program had one been available when they graduated from their NP programs. The desire for a formal residency period is consistent with the aforementioned concerns regarding overall and specific areas of NP preparation and may represent the heart of the preparation issue. Several studies have documented the challenges experienced by newly graduated NPs during the first 1–2 years of practice (Brown & Olshansky, 1998; Heitz,

Steiner, & Burman, 2004; Kelly & Matthews, 2001), which often include feelings of fear, insecurity, uncertainty, turbulence, and isolation. Thus, perhaps another way to view NPs' general feelings of being unprepared for practice following their formal education is to see it as a lack of formal support during a very difficult transition period that is often associated with a steep learning curve.

Conclusions

Our survey results indicate that in many ways, formal NP education is not producing NPs who feel adequately prepared for practice and suggests several areas where NP educational programs need to be strengthened. In addition, the results suggest that NPs desire a more rigorous clinical education provided by competent experienced NPs, who are actively involved in clinical practice. Furthermore, it appears that some aspect of having more years of experience as an RN makes an important contribution to feelings of preparedness following APN education.

Comparing NP education to basic RN education, one could argue that the goal of NP education is not to produce confident, highly skilled practitioners but rather to prepare APNs for high-level critical thinking and decision making. Considering the overwhelming success of NPs, it seems that NP education is meeting this goal. However, the transition from new graduate to competent NP is often difficult, and many NPs do not feel adequately supported during this process. The difficult transition from new graduate to competent NP could very well explain why many of the surveyed NPs felt so poorly prepared for practice and needs to be explored further.

The survey results add new knowledge to and support the existing literature regarding NP preparation. This is the first known study to assess perceived preparation for individual NP practice areas since Brown et al.'s study in 1988 and the only known study to assess for overall perceived preparedness. In addition, this is the only known study of NP preparedness that included an open-ended segment where NPs could truly "speak out" about any and all aspects of their educational preparation. Furthermore, it is the only known study on NP preparedness that included participants from around the nation. Limitations of our study include that we used a convenience sampling of NPs from two conferences and had a predominance of FNPs. Another obvious limitation is that we were essentially asking NPs to "reflect back" on their educational experiences and feelings of preparedness from an average of 11 years ago and for some participants this time gap represented as many as 42 years. Thus, our results might not truly reflect exactly how well prepared the NPs felt for practice upon actually completing their formal education.

Current dialogue about and planning for the DNP has been extremely limited in that these activities have primarily occurred among APN educators, exclusive of full-time practicing NPs and other APNs. Practicing NPs are the basis of the NP profession and have strong opinions about NP preparation. Their views on NP education and preparation need to be sought, listened to, and reflected upon as we advance toward the DNP.

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