

Becoming a Nurse

Options and Pathways for All Walks of Life

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Foreword

Whether you're in high school, or a mid-life career changer, this e-book is for you. It is the product of many hours spent researching the various pathways leading to nurse licensure, and on into the Master's-prepped specialty fields.

There is no "best" way of becoming a nurse – though there are less expensive methods of achieving your goals than others. There are dozens of possibilities leading from where you are today to where you want to be, but they tend to follow a few basic paths which I've outlined here.

This book is written conversationally, and I've done my best to avoid jargon while clearing up some of the mist that has traditionally enshrouded *how* you can become a nurse. The path ahead is not obvious, especially if you're an older student with a Bachelor's degree already or are a career changer. While this book won't make the decision itself any easier, it should save you many hours of research so you can spend your time on the hard part: deciding whether nursing school is worth it, and how to go about doing it.

I've tried to ensure that the content has its basis in fact, and I've done my best to ensure that any trend- and program-specific ambiguity is addressed up front. If you find an error, please let me know so that I can correct it for the next version.

I hope you find this book accessible, easy-to-read, and informative.

What you'll find here

- Educational pathways
- Money saving methods of accomplishing your goals
- Student scenarios
- De-mystification of jargon and acronyms

What you won't find here

- Information on nursing exams
- An overview of what being a nurse is all about
- Specialty-specific salary information other than trends

Employment trends

In recent years, the nursing field has become an increasingly attractive option for those looking for stability in the face of economic and financial uncertainty. As one of the few sectors of the economy that continues to grow, health care appeals to many people for a variety of reasons, but the big two are these:

1. The ability to make a secure middle class income while
2. Doing meaningful work that makes a difference in people's lives

There's nothing wrong with these motivations, but it pays to understand that most health care professions are harder to get into during times like this due to the nature of the health care labor market and health care itself.

How does this economy affect nursing?

Just like any other career, during times of high unemployment, it's harder to find a nursing job for a new nurse, and it's harder for a part-time nurse to get more hours than it is when things are going well, even though the health care field is still growing.

Why?

Demographics. Nursing is a pink-collar job. That means that it's historically been a women's profession, and while this is changing, the fact of the matter is that the *vast* majority of RNs are women. Over 92% of them, in fact.¹ Women are more likely than men to work part time.²

Statistically-speaking, women work fewer hours than men throughout their careers. Due to the high barriers to entry for health care professionals, it is possible for men and women to work part time and still bring home a decent salary. (Indeed, this freedom is one of the main appeals of being a nurse!) During a recession, if an individual is worried about their partner losing some or all of their income, they will usually try to increase their hours in response, especially if they're in a profession like nursing.

This works fine in principal, until large numbers of nurses start increasing their hours, or delaying their retirement plans until the recession is over. This phenomenon is not

¹ ["Quick Facts on Registered Nurses"](#) - United States Department of Labor

² ["Women at Work: A Visual Essay"](#) - US Bureau of Labor Statistics (PDF)

limited to nursing, either; the same thing happens to pharmacists, physicians, and other allied health personnel.

Nursing shortages are temporarily alleviated.

Individuals flee to security in the face of uncertainty, and nursing looks *very* secure. This means that new grads may have difficulty finding positions in the hospitals and locales that they prefer. It also means that those looking to attend nursing school may be rejected when they might otherwise have been accepted under better economic conditions. Admissions committees can afford to be very picky because the applicant pool is so large.

In short: it's harder to get into nursing school, and it's harder to find the ideal nursing job when times are tough. When the economy improves, the nursing shortage will return, and your options will open up.

Salaries

One of the appeals of being a nurse is financial independence no matter what stage of life you're at. There are a number of recurring salary questions that are asked on nursing discussion forums all the time. Probably the most popular is:

Is there a salary difference between an ASN and a BSN?

The short answer is no. But... there are a few provisos and a couple of quid pro quos that you should know about. First off, when it comes to floor nursing, there's no meaningful salary difference between an RN with an Associate's degree and an RN with a Bachelor's degree. An RN is an RN regardless of whether you have an ASN³ or BSN. In many cases, nurses with an MSN working the floor make the same as their colleagues with an ASN. That said, some institutions have a policy of paying their BSN nurses more than their ASN counterparts, but normally this differential is small: less than a dollar an hour to do the same job is quite common. This trend holds true from numerous anecdotal reports on nursing discussion boards to salary search engines which try to normalize a large quantity of salary data.⁴

That doesn't mean that it's not worthwhile to get your BSN. Having your BSN opens doors that are closed to nurses with just an ASN. This includes management, clinical research, getting your Master's later, and/or becoming a Nurse Practitioner. Does that mean you can't do research or get into management with just an ASN? No, but having a BSN does make it easier.

³ For you sticklers: I'm aware that there are two main types of Associate's degrees for nursing: Applied Science or Associate of Science in Nursing. Some individuals use "ADN" (associate's degree in nursing) to refer to all associate's in nursing degrees, but I will abbreviate it "ASN" for the sake of consistency (ASN → BSN → MSN).

⁴ [Hourly Rate Snapshot for Registered Nurse \(RN\) Jobs](#) (Payscale.com)

High School graduates

So you're done with high school, and you're considering a nursing career... congrats! As a high school graduate without any college-level coursework, you've got the most options as far as going to nursing school is concerned, and the least amount of academic baggage to hold you back.

Historically, nursing programs have been designed for students who have just graduated high school. This includes both two-year and four-year programs. To get an idea of the differences between the two programs, it's helpful to take a look at the basic program of study for each. You'll note that the only Liberal Arts requirement for an ASN degree tends to be Composition-related. (I don't consider computing, statistics, psychology, or sociology to be outside the realm of the health sciences, because basic competency in these subjects is required to be an effective health professional.)⁵

Typical ASN requirements:

- Anatomy and Physiology I + II (+ lab)
- Microbiology (+ lab)
- English Composition I + II
- Nursing I + II + III + IV
- Nursing Clinical I + II + III + IV
- Nursing Lab I + II + III + IV
- Pharmacology I
- Psychology I
- Psychology elective
- Statistics I
- Anthropology or Sociology I
- Transition into Nursing

⁵ These requirements are a composite of five different two-year nursing programs. There may be program variations in the schools near you. Examples may be the requirement of an ethics course, a second semester of pharmacology, and/or demographic-specific nursing (e.g. geriatrics or pediatrics).

Typical BSN requirements by year:⁶

Freshman year

- Anatomy and Physiology I + II (+ lab)
- English Composition I + II
- Psychology I
- Psychology elective
- Sociology or Anthropology I
- Calculus I + II

Sophomore year

- Microbiology (+ lab)
- Chemistry I (or nursing-specific chemistry)⁷
- Research Methods
- Gerontology/Geriatric nursing
- Human growth and development
- Pathophysiology
- Nursing I + II (+ lab)
- Statistics I
- Nutrition

Junior and senior years⁸

- Nursing assessments and interventions (+ lab and/or clinical)
- Pharmacology
- Adult nursing I + II (+ clinical)
- Pediatric nursing I + II (+ clinical)
- Intensive care nursing (+ clinical)
- Public health nursing (+ clinical)
- Mental health nursing (+ clinical)
- Health care leadership
- Transition into Nursing

⁶ Not including the Gen Ed requirements that all four-year bachelor's degrees require

⁷ Some schools require two semesters of chemistry, some may require more.

⁸ Course names and content vary widely from school to school, but programs cover the same body of material by the time you graduate.

Possible career paths

As a high school graduate without any college experience, your options are wide open. This may sound strange, but it's true. Nursing is a profession, which means that once you're accepted to a program, you'll make it through provided you don't do anything to get yourself kicked out.

What's that supposed to mean?

That means that if the program requires you to maintain a GPA of 2.5, you'll be a nurse provided you stay above this minimum threshold. But if you're a college student who studied something else, and either graduated or are looking to transfer into a program with a cumulative GPA of 2.5, you probably won't get accepted. You've established that you're not the best candidate for the school to take a chance on, especially if there are other, stronger applicants.

It very much pays to have a clean academic slate. Tens of thousands of people who didn't take their first run through college very seriously have discovered this the hard way. That said, a poor academic record hurts you less as time goes on. If you weren't a good student in college, but are in your forties now, your grades hurt you less than if you are in your late twenties.

Option 1: an Associate's degree

Maybe it's been assumed for most of your life that you'll attend college after high school. If so, pursuing a two-year degree may not seem compatible with these assumptions, but it might actually be the smartest thing you could do as a future nurse.

Most two-year programs are run by community colleges or trade schools. In general, it's best to investigate a community college program first, particularly if you're a strong applicant. Community colleges are generally inexpensive, and have good working relationships with the state universities in their area.

Assuming you get accepted to a community college, complete the requirements, pass the NCLEX-RN, you are qualified to practice nursing. This means you'll be making a nursing salary of between \$40,000 and \$70,000 per year, assuming you work full time. It

costs about \$6,000 to complete an Associate's degree in the US.⁹ This figure varies widely based on how much money your state spends on higher education, but in general, the cost is quite low, even in states like New Hampshire, where the average cost is over \$10,000.

All things considered, you save two years, which gives you anywhere from \$80,000 to \$140,000 in income in your pocket because you're working, and you'll save a significant chunk of change because you're not paying tuition. The average cost of a four-year, in-state Bachelor's degree is about \$55,000.¹⁰

Here's a quick cost breakdown:

Two-year ASN:	
Cost of attendance:	\$6,000
Opportunity cost	\$60,000
Total cost of attendance:	\$66,000
Four-year BSN:	
Cost of attendance:	\$55,000
Opportunity cost:	\$120,000
Total cost of attendance:	\$175,000
Side-by-side:	
Four-year program:	\$175,000
Two-year program:	\$66,000
Difference:	\$109,000

Opportunity cost is what something costs if you were doing something else. In this case, if you weren't a full-time student, you would be working. The average wage of a worker with a high-school diploma is about \$15/hour.¹¹ So in two years, you'd earn about \$60,000. So that's \$60,000 that you give up by going to college. Add that to the tuition costs, and your actual cost is \$66,000. That sounds like quite a bit, but it's not. Not when you compare it to a four-year BSN degree.

⁹ I sampled schools from NYC, Austin, Texas, central Massachusetts, and the SF Bay Area.

¹⁰ "What does a college degree cost?" Delta Cost Project white paper series. (PDF)

¹¹ "Salary Survey for High School Diploma" – Payscale.com

Assuming you get no raises – a terrible assumption, but useful nonetheless – your opportunity cost for attending college for four years is \$120,000. If you factor in potential raises, that number is higher. Couple that with the cost of an in-state college degree, and your total costs rise to \$175,000.

That's a difference of over \$100,000 within just four years.

Option 2: Going BSN from the get-go

This is the other popular, post-high school option. You graduate, go to a four-year public or private college or university, and finish four years later with your Bachelor's of Science in Nursing.

If you read Option 1 above, you might think that I'm arguing against going right from high school to a BSN program, but I'm not. I have talked about the costs associated with doing so, purely from a financial point of view. For many college students, the *college experience* – whatever that means to you – is valuable. This may be living away from home in a new place, having the freedom to take your time and pick and choose your own courses, or it might mean something else entirely.

Most Associate's degree programs are geared towards the population in the region surrounding the college. This means that students typically live at home, and commute in every day. This appeals to many students, and horrifies many others. If the idea of living at home and commuting to school holds no appeal, then maybe a BSN program where you can live on campus and have more freedom is best for you.

It's a popular notion that education is "priceless", and this is just what student loan companies would like you to believe. The reality is that education costs money, and if the value you're getting from that education is less than the money that you're paying for it, you should find another way. Just make sure that going directly into a BSN program makes sense for you; graduating with a mortgage without owning a home is no way to start a working career.

Regardless of what you do, I would encourage you to aim at a state school rather than a private school. Tuition and fees at private schools average over \$26,000 per year¹². That

¹² "2009-2010 College prices" – CollegeBoard

means you'll be spending about \$105,000 over four years, *not including residence hall fees*. \$105,000 tuition and fees + \$120,000 opportunity cost = \$225,000 total cost.

Ouch.

Option 3: Getting an ASN and then getting a BSN

This last option ends up being what many nurses with an ASN degree do. For newly-minted RNs with an ASN degree, it usually includes some work experience along the way. A typical pathway goes something like this: you attend community college, complete your degree, pass the NCLEX-RN, and start working as a nurse. Maybe you thought you'd save some money this way, or maybe you knew you were going to use it as a springboard to a BSN.

What usually happens in this case is that the organization you're working for has an education allowance as part of your compensation. This means that you can complete your BSN at little to no cost to yourself. It's true that there could be some opportunity cost, but most people give up leisure time to complete degrees rather than working fewer hours; this is especially true if your employer's contribution is predicated on your working full-time.

Most universities have good relationships with the community colleges nearby; the graduates of these programs are known quantities, so they feel comfortable accepting these RNs into their BSN completion programs. Many of these programs can be completed entirely online, and are very attractive options for RNs with families, or for those who prefer to go at their own pace.

Couple this academic freedom with not having to pay tuition, while bringing in a full-time income... well you can see why it's very appealing for many people.

Diploma RN programs

There are diploma programs which operate out of hospitals. I have looked through the course requirements for several of these programs, and they appear very similar to the ASN programs that operate out of community colleges, except that they tend to be more expensive. The upside is that if you work for that hospital for a length of time, they will usually forgive your student loans.

For people with a college degree already

Nursing is a popular career to switch to, for many of the same reasons that people choose it from the outset: financial independence, and/or because it's a "helping profession". Whatever the reason, there has been considerable demand over the last two decades for nursing programs to acknowledge and account for a person's past educational experience. Consequently, many institutions have tailored programs to suit these students' needs.

For all intents and purposes, a person with a college degree has *more* nursing options available to them than someone just out of high school. But there are some tradeoffs, too. These tradeoffs come as a result of academic baggage. Most college students weren't perfect little angels when they were in school the first time through. Many of them got bad grades in classes that they didn't like or weren't interested in. Whatever the reason, most people don't have perfect college transcripts, unless they knew from the beginning that they wanted to be a doctor, lawyer, or wanted to go to a top-tier graduate school.

At the very least, a person with a college degree has all of the same options available to them as someone just coming out of high school. They can go to a community or technical college and get their ASN, and be done with it. This may not be a very desirable path, however, as it's likely that they've done a lot of the requisite work already, particularly with respect to statistics, composition, psychology, and sociology. If they've come from a life or health science background, it's likely that they've already taken microbiology and/or A&P.

But even if you haven't, all is not lost.

Accelerated or "second degree" BSN programs

The most popular option for individuals with a Bachelor's degree in another field is the accelerated BSN program. All things considered, it's the fastest way to finish school and start being a nurse if you have a college degree already. These programs typically last anywhere from twelve to eighteen months, and are extremely intense. They cover a lot of material very quickly, and require a full-time commitment. Don't assume that you'll be able to work while going to school.

Due to the current economic climate, these second-degree programs are fiercely competitive right now.

Typical accelerated BSN pre-requisites:¹³

- Anatomy and Physiology I + II (+ labs)
- Microbiology (+ lab)
- Chemistry
- Human growth and development
- Statistics I
- Nutrition

There's not a lot of magic involved here. Find an accelerated BSN program near you, or in whatever region of the country you'd like to study in, and apply.

What if I had a low GPA?

Good question. Unlike some individuals, I don't believe that grades have any bearing on how good a professional you can be. There's a weaker correlation between grades and ability than some would care to admit. Grades tell only one side of the story: how well you took exams and wrote papers. It says nothing about family life, health (or lack thereof), financial considerations, or anything else. Unfortunately for you, the applicant, grades are an easy metric whereby an unquantifiable thing (a person) can be quantified. This makes sorting individual candidates easier, even though it misses the majority of the picture that is you.

¹³ The most common variation is dropping the Nutrition requirement and adding a second semester of chemistry.

Alas, grades are inescapable. There's no magic bullet to solve "Bad GPA Syndrome", and anyone that tells you otherwise is trying to sell you something or is pitching an unaccredited school. If you have a college degree already, and you don't have the greatest of GPAs, all is not lost. Your road will just be a little harder. The upside is that most application packages allow you to show more than how well you sit in class or in front of a keyboard. In order to be a stronger candidate, you need to do a few things:

1. Do really well on your pre-requisites. While most programs require a GPA of 3.0 (a grade of B) in these courses, you need to get A's.
2. Paint a comprehensive picture of who you are, and what you're capable of. As a candidate with a not-so-good GPA, you need show your school that not only are you a good candidate, *you need to show them via your actions that they'd be foolish not to accept you.*

Just make sure that whatever method you choose to demonstrate that you're an amazing candidate is consistent with *who you are* as a person. Do something interesting and noteworthy that dovetails with your other interests. If you enjoy writing, do some freelance health journalism. If you enjoy mathematics and/or study design, dig into a source like data.gov, and see what you can come up with. If you're interested in women's health, volunteer for a women's health organization or battered women's shelter. If you enjoy computer science, do something with health informatics like volunteer for the HL7.¹⁴ The possibilities are endless. You don't have to be limited by the normal pathways that wannabe nurses and physicians normally choose like volunteering at a hospital. (Though this isn't a bad idea.)

Whatever you choose to do, don't let it look like you did it because it was something you needed to check off a To Do list. Be consistent. Application committees can see through To Do list-type volunteering, which is why it's essential that you do something that *you* enjoy and find meaningful. Individuals with higher GPAs may be able to get away with this, but you cannot.

When crafting your nursing school application package, there is no way to skirt around your grades. You must address them. Acknowledge them; briefly explain what happened, and then move on to showing why you're awesome. Don't belabor the

¹⁴ [Health Level 7](#) is a volunteer, non-profit organization that's developing a standardized framework for the management of electronic health information.

reasons. While a story about taking care of your grandmother while she had cancer might win some sympathy points with an admissions committee, *this doesn't explain why you're not a risk*. Committees don't know if you *can* perform in a rigorous program; you're still an unknown, academically-unproven quantity. Administrators have statistics that they're shooting for, because program funding and internal and external academic clout are often tied to student body performance.

Establish a better academic track record

This is the route that many students take. In some sense, every student that didn't have the greatest GPA is doing this when they take (or re-take) their pre-requisites. Some students take this a bit further, and attempt to establish themselves academically by doing a certificate program, or getting a Master's in a related field. Common fields include:

- Clinical laboratory sciences
- Nutrition
- Health management
- Exercise physiology/Kinesiology
- Health education

Other options include Public Health-type fields like epidemiology and biostatistics; however these programs are often very competitive themselves, and may be a stretch for someone that doesn't have a strong undergraduate GPA behind them.

The other upside is that some certificate programs and Master's degrees allow you to put more letters after your name. In the health professions, it often seems as though the more letters you have after your name, the more important you are, and by extension, the more valuable you are.

By getting a Master's degree, you also demonstrate that you can handle the rigor of a Master's program. This is useful if you think you'd like to get an MBA, MPH, MSN, DNP, PhD or some other advanced degree. You're showing the admissions committee that you're a good risk; *that you can hack it*.

Unconventional financing

Some organizations offer tuition repayment or will pay for a nursing student to attend school in return for a work contract for a specified length of time. For example, at one time, students at Creighton University could have their tuition and fees covered provided they agreed to work full time for one of two hospitals for a specified length of time. Costs were 75% covered for a three-year commitment, and 100% covered for a four-year commitment.

Program information is no longer available on their website so far as I can see, so the program may not be available any longer, probably due to the oversupply of nurses in the surrounding areas. It may return when the economy picks up and the nursing shortage returns. It wouldn't hurt to investigate programs at the schools you're interested in to see whether they have anything like this.

Direct-entry MSN programs

Direct-entry MSN programs are designed for students with a bachelor's degree in another field, who would prefer to go straight for their Master's degree. The pre-requisites are essentially the same as those of the second Bachelor's degree programs. Often these MSN degrees are focused on a specific field of nursing. The most common specialties are:

- Clinical Nurse Leader (CNL)
- Nurse Educator
- Clinical Nurse Specialist (CNS)
- Women's Health
- Nursing Administrator

Clinical Nurse Leader vs Clinical Nurse Specialist¹⁵

The two most confusing specialties up there are the CNL vs the CNS. The easiest way to describe a CNS is an Advanced Practice Nurse (APN) prepared in a clinical specialty that has a Master's degree or higher, and they usually have prescriptive authority, with some limitations and/or exceptions by state.¹⁶ A CNL is prepared at the Master's level as a generalist; by definition, they don't have a specialty.

Please note:

None of these are Nurse Practitioner programs. Some direct-entry MSN programs *do* lead to being a Nurse Practitioner, and I go into detail on these programs next, as they are the most popular MSN programs for individuals who want to be nurses.

¹⁵ "[Working Statement Comparing the Clinical Nurse Leader and Clinical Nurse Specialist Roles: Similarities, Differences and Complementarities](#)" – AACN (PDF)

¹⁶ Some APNs do not have Master's degrees, because they have been grandfathered in before educational requirements changed. This grandfathering process is fairly common in the health care fields.

Direct-entry Nurse Practitioner programs

The direct-entry NP programs are the most popular programs that students like to dream about and ultimately shoot for, except for maybe CRNA programs. The appeal is easy to understand: admission to and completion of one of these programs is seen as the ticket to six figures a year and less of the "menial", bread-and-butter nursing work.

Understand something now: Nurse Practitioners are nurses. They are not physicians. In most states, they practice under a supervising physician, and have limits on their scope of practice that physicians do not. What they do is considered the practice of nursing, as opposed to practicing medicine. This distinction may not seem significant to the public – especially if an NP is seeing patients in an office, and managing drug therapy – but it *is* important. Legally, an NP is a nurse, and is practicing nursing; therefore their liability is that of a nurse, not of a physician. This means that as a Nurse Practitioner, you don't pay the same high malpractice premiums that a physician would, even if you're doing the functionally the same job.

By the same token, you might not be taken as seriously as "a real doctor" when it comes to patient interactions. If you're planning on attending nursing school, this is a scenario I hope you've already considered and come to grips with.

Primary care specialties

I'm lumping the various primary care nursing specialties together. They are, in no particular order:

- Family Nurse Practitioner (FNP)
- Adult Nurse Practitioner (ANP)
- Pediatric Nurse Practitioner (PNP)
- Geriatric Nurse Practitioner (GNP)
- Women's Health Nurse Practitioner (WHNP)¹⁷
- Psychiatric and Mental Health Nurse Practitioner (PMHNP)

How do you choose which one to specialize in? Well, only you can decide based on your likes and dislikes, but bear in mind that if you choose to be a PNP, and work with kids,

¹⁷ Unlike some, I consider women's health a primary care specialty, not because it's easy or not specialized, but because the need for it is so universal.

your scope of practice is limited to just pediatrics. *This includes that disaster-relief trip you were planning on taking as a newly-minted NP.* The same holds true of all of the other primary care NP specialties except one: Family Nurse Practitioner. Being an FNP is sort of the best of all worlds, except that you'll have to deal with children or adults while you're in training, which could be problematic if you don't like working with one of those groups of people. That said, you have quite a bit more freedom once you begin your professional career. Many FNPs work only with adults, or only with children. The point is that they have more freedom than their counterparts who chose a more specific primary care specialty. As a result, FNPs often have an easier time finding employment than one of their counterparts who chose pediatrics, for example.

If you're thinking of going FNP for the flexibility, and planning to work with the elderly, you need to make yourself an expert on both clinical and social geriatric issues, because you won't get the same educational depth as a GNP would in these areas during your training. (This goes hand-in-hand with being an excellent clinician in general, in my opinion.)

Nurse Practitioners that want to specialize in a particular area of nursing outside the acute care arena are generally graduates of one of these primary care specialties. These specialties include:

- Dermatology
- Cardiology
- Gastroenterology
- Endocrinology
- Hematology and oncology
- Many others

Psychiatric and Mental Health Nurse Practitioner programs

These programs vary as to whether they allow direct entry. For example, Columbia University School of Nursing requires one year of psych experience¹⁸ whereas the MGH Institute of Health Professions does not.¹⁹

While I have grouped the PMHNP programs together for the sake of brevity, it should be noted that many programs are specific in what kind of PMHNP you'll be on the other side. Some allow you to be a generalist – not unlike the FNP track in general nursing – some are focused solely on adults, and some focus solely on children. The trend seems to be that PMHNP programs pretty much all let you focus on adults. Fewer programs have pediatric options, but those that do allow you the option of being a family PMHNP as well, so make sure you check the program you're most interested in to make sure that you're not limiting yourself to one specific demographic by accident.

Other considerations

Quite a few direct-entry NP programs have clinical requirements that you may not be expecting. For instance, many programs may have a one- or two-year clinical work requirement. This means that after you complete your initial nursing coursework, you take the NCLEX-RN, and work as an RN in your chosen specialty before continuing on to complete the work that qualifies you as an NP. Look at the programs you're interested in carefully if this is something you'd prefer to avoid.

¹⁸ <http://sklad.cumc.columbia.edu/nursing/programs/pmhnp.php>

¹⁹ <http://www.mghihp.edu/academics/nursing/degree-options/master-of-science-direct-entry/default.aspx>

Nurse Practitioner specialties without a direct-entry option

These are programs that only accept nurses with enough prior, specialized experience to matriculate. They are the acute care specialties, and the reason they do not accept direct-entry students is that they want to be sure that you have what it takes to complete the program and be a successful clinician in your chosen specialty.

Why?

Good question. The difference is risk. These programs are structured so that you get this experience before they accept you: you need work experience before you can even apply. If these requirements were structured any other way, both you and your school would be taking a big risk. If you get accepted right out of college to a CRNA program, and discover on your first day as a SRNA²⁰ that you can't handle the stress of making life-and-death decisions with only a split-second to think, then you've lost years of your life, tens to hundreds of thousands of dollars in tuition and fees, and over a hundred thousand dollars in opportunity costs. The school has used up a slot in their competitive program for two years, and it's a black mark on their post-graduation statistics.

That's not fair, medical students don't need prior experience

The world isn't fair, but in this particular case, it serves a purpose. For medical students, the sorting process has already occurred because of the way medical school itself is structured. Medical school is four years long, and consists of two parts: two years of classroom and lab education, and two years of clinical work. The required rotations are:

- Internal medicine
- Surgery
- Pediatrics
- Family medicine
- Obstetrics/gynecology
- Neurology
- Psychiatry

²⁰ Student Registered Nurse Anesthetist: an "intern" CRNA, if you will.

Various other elective specialties are done at this time as well. Because of the lab and clinical rotational experience, medical students have already dissected cadavers; seen and participated in serious surgical procedures; and otherwise been in quite a few high-stress situations before they opt into something like anesthesia, surgery, or other, high-stakes, acute care medicine.

If a medical student is unsuited to that kind of high-stress environment, he or she won't choose it, and if they *do* try to choose it, their preceptors won't give them the required recommendations to get into these residency programs. (In theory.) At this point in their education and career, they will have options more suited to their personality type and temperament. As a direct-entry CRNA student, for example, you wouldn't, because that's not how your classroom education will have been structured. You also wouldn't have been exposed to these experiences until it was too late to change tracks. There are quite a few nurses who thought they wanted to be CRNAs until they spent some time in the ICU, and opted to choose a different Nurse Practitioner specialty instead.

There's nothing wrong with this, and acute-care nursing programs must account for this tendency rather than being stuck with a gaggle of students who can't handle the pressure. When the time comes, you'll be glad you had the ICU experience before starting a job that combines heightened responsibilities with a steep real-world learning curve.

What makes these programs different from the NP programs with a built-in clinical component?

Structuring a program with a built-in clinical component is fine; indeed CRNA programs have this built in where you spend time as an SRNA. This doesn't get rid of the problem of risk, however. If you spend a year or two in a classroom, and then discover you can't handle the stress of anesthesia, you can't exactly go be a Family Nurse Practitioner without another significant investment of time and money. You have lost, and so has the school.

Acute care specialties

All of the NP specialties that require a certain amount of experience prior to admission are related to acute care. What "acute care" means is specialty-dependent, but you can think of it as "high-risk" nursing where patients are in a severely compromised state. Some programs do accept experience in areas that are not acute care, but this puts you at a disadvantage relative to the other applicants. For those interested in being a midwife, your experience should be in labor and delivery (L&D); if you're interested in being a Neonatal Nurse Practitioner, it should be in the neonatal ICU (NICU); etc. In general, ICU experience is the most broadly practical place you can be in if you're interested in any of these specialties.

- CRNA schools require a minimum of two years in the ICU. This experience *must* be in the ICU. CCU experience isn't acceptable, neither is time spent in the med/surg or emergency departments.
- Some programs require specific specialty experience. For example, the University of Rochester School of Nursing requires a year of med/surg experience for their Acute Care NP program²¹ whereas the Frances Payne Bolton School of Nursing requires a year in the ICU.²²

If you're absolutely certain that you want to attend a specific school, make sure you look at their exact requirements. That said, I have a hard time imagining that the University of Rochester would reject an applicant to their ACNP program because their experience is in the ICU rather than med/surg; the idea being that if you can handle ICU, you can handle med/surg.

The acute care specialties:

- Acute Care Nurse Practitioner (ACNP): cross-spectrum acute nursing care
- Neonatal Nurse Practitioner (NNP)
- Certified Nurse Midwife (CNM)
- Certified Registered Nurse Anesthetist (CRNA)

²¹ <http://www.son.rochester.edu/programs/nurse-practitioner/nurse-practitioner-masters.html>

²² <http://fpb.case.edu/MSN/ACNP.shtm>

Certified Registered Nurse Anesthetist (CRNA)

Being a CRNA is the specialty that most pre-nursing students think they want to shoot for. Don't believe me? Check out the discussion boards at sites like allnurses.com, and you'll see what I mean. There is an order of magnitude more posts in the CRNA-related forums than there are in the other NP and MSN specialties.

The reasons aren't difficult to understand: money and freedom. A CRNA is the highest-paid member of the nursing profession, and arguably has the most autonomy. Many CRNAs make more money than primary care physicians, and they are seen as having more freedom than other Advanced Practice Nurses because they often practice independently. Their job is also pretty cool: they have a similar scope of practice as that of a physician anesthesiologist, so it's an attractive option for many individuals who think they might like to be anesthesiologists, but don't want to make the twelve year sacrifice to get there: four years of undergrad, four years of medical school, three years of residency, and a mountain of student debt as opposed to six to seven years of school, and a whole lot less debt.

The opportunity costs of being a CRNA certainly heavily favor it over going the more traditional physician anesthesiologist path.

Bickering between the MDs and CRNAs

There's a lot of (mostly academic) arguing between physicians and CRNAs over what a CRNA should be allowed to do, and who is "better" to have in an OR. Surveying the literature that's available, most of the anti-CRNA arguments boil down to turf protection. (And many of the anesthesiologists, gas residents and wannabes freely admit this.) The American Society of Anesthesiologists has released an official position²³ on what they think the scope of practice for a CRNA (and other Nurse Practitioners) should be. A few bullet points on their position:

- They oppose nurses being able to prescribe controlled substances
- It's more cost-effective to use an MDA²⁴ than a CRNA, because physicians can do more, and have a wider scope of practice

²³ <http://www.asahq.org/Washington/nurseanesscope.pdf>

²⁴ Rather than repeat "physician anesthesiologist", I'm going to abbreviate it MDA, which is very common.

- Procedures involving MDAs result in better outcomes than procedures which use a CRNA²⁵

Consequently, they suggest that a CRNA's scope of practice be limited to (direct quote)²⁶:

1. Provide nonmedical assessment of the patient's health status as it relates to the relative risks involved with anesthetic management of the patient during performance of the operative procedure
2. Based on the health status of the patient, determine, in consultation with the responsible physician, and administer the appropriate anesthesia plan (i.e., selection and administration of anesthetic agents, airway management, monitoring and recording of vital signs, support of life functions, use of mechanical support devices and management of fluid, electrolyte and blood component balance)
3. Recognize and, in consultation with the responsible physician, take appropriate corrective action to counteract problems that may develop during implementation of the anesthesia plan
4. Provide necessary, normal post-anesthesia nonmedical care in consultation with the responsible physician
5. Provide such other services as may be determined by the responsible physician

In their official position statement, the ASA cites a study done by Dr. Silber at the University of Pennsylvania entitled "Anesthesiologist direction and patient outcomes"²⁷ which suggests that when anesthesia is performed by a physician, patient outcomes are better. There are a few problems with this study, however:

- Approximately two-thirds of the cases which Silber et al. classified as not involving an anesthesiologist in the patient care either
 - Did have an anesthesiologist involved in some, but not all, of the patient's procedures
 - Had no bill for the anesthesia care, making it impossible to confirm whether an anesthesiologist was or was not involved

²⁵ "Anesthesiologist direction and patient outcomes" – Anesthesiology July 2000.

²⁶ "The Scope of Practice of Nurse Anesthetists"-American Society of Anesthesiologists (page 8)

²⁷ <http://www.ncbi.nlm.nih.gov/pubmed/10861159>

- Cases in which anesthesiologists worked alone were not distinguished from those in which CRNAs and anesthesiologists worked together.
- Only cases in Pennsylvania were included in the study.

In a follow-up the AANA took issue²⁸ with quite a few things, which I've quoted at length here:

- *Complication Rates.* After adjusting for case mix and severity, the study found no statistically significant difference in complication rates when nurse anesthetists were supervised by anesthesiologists or other physicians. Dr. Pine noted that poor anesthesia care is far more likely to result in significant increases in complication rates than in significant increases in death rates. Therefore, Dr. Pine concluded that *this finding strongly suggests that medical direction by anesthesiologists did not improve anesthesia outcomes.*
- *Failure to Rescue.* For the most part, failure to rescue occurs when a physician is unable to save a patient who develops non-anesthesia complications following surgery. Therefore, it is not a relevant measure of the quality of anesthesia care provided by nurse anesthetists. It is a relevant measure of postoperative physician care, however.
- *Patients Involved in More than One Procedure.* For reasons not explained in the abstract, patients involved in more than one procedure were assigned to the non-anesthesiologist physician group if for any of the procedures the nurse anesthetist was supervised by a physician other than an anesthesiologist. It is impossible to measure the impact of this decision by the researchers on the death, complication, and failure to rescue rates presented in the abstract.

To emphasize the importance of this, consider the following hypothetical scenario: A patient is admitted for hip replacement surgery. A nurse anesthetist, supervised by the surgeon, provides the anesthesia. The surgery is completed successfully. Three days later the patient suffers a heart attack while still in the hospital and is rushed into surgery. This time the nurse anesthetist is supervised by an anesthesiologist. An hour after surgery, and for reasons unrelated to the anesthesia care, the patient dies in recovery. According to the researchers, a case such as this would have been assigned to the non-anesthesiologist group!

²⁸ "[Anesthesiologist Distortions Concerning Quality of Care](#)" – AANA

- *Patients Who Were Not Billed for Anesthesia Services.* As noted in the discussion on death rates, most of the "undirected" cases had no bill for anesthesia care. The actual figure is 14,137 patients, or 61% of the 23,010 patients defined as undirected. The researchers' flimsy rationale for lumping all non-billed cases in the undirected category is as follows: "The 'no-bill' cases were defined as undirected because there was no evidence of anesthesiologist direction, despite a strong financial incentive for an anesthesiologist to bill Medicare if a billable service had been performed" (emphasis added). Of course, one might ask how many of those cases were not billed because an anesthesiologist had a bad patient outcome.
- *Referenced Studies.* The researchers claim that their research "results were consistent with other large studies of anesthesia outcomes." Interestingly, the two studies cited were by Bechtoldt²⁹ and Forrest³⁰. As indicated [...], neither of these studies agrees with the conclusions reached by Dr. Silber and his team of researchers on the Pennsylvania study.

The Centers for Medicare & Medicaid Services (CMS) agrees with the AANA's position, and is one of the reasons it does not differentiate between MDAs and CRNAs for reimbursement purposes. Many states have evaluated the evidence and come to the same conclusion as CMS and the AANA: there's no evidence to suggest that patients fare better when an anesthesiologist is involved as opposed to a nurse anesthetist.

In fact, recent research indicates that anesthesia-related patient deaths are usually the result of poor monitoring in the OR, and have nothing to do with education level.

If the argument is "mostly academic", what's the issue?

Money. Physicians are worried – and rightly so – that if a nurse is doing the same job they are, the work they do will be de-valued. If there's no difference in outcomes between the two professions, why should an MD anesthesiologist make \$350,000-500,000 a year, when a CRNA doing the same job makes \$180,000-250,000? Does the physician's longer training give him or her some advantage over the CRNA? The evidence suggests that for practical purposes (patient outcomes and satisfaction), it

²⁹ "[Committee On Anesthesia Study. Anesthetic-Related Deaths: 1969-1976.](#)" – *North Carolina Medical Journal*

³⁰ "[Outcome - The Effect of the Provider.](#)" -- *Summary of Pertinent Quality of Care Studies and Data*

does not. I don't think that we'll be seeing some kind of "final resolution" very soon. In the meantime, I suspect that many states will continue to relax the restrictions on CRNAs as they are a less expensive alternative to their physician counterparts.

Nurse Practitioner autonomy

What a Nurse Practitioner can and cannot do is limited by the state that he or she practices in. There are a few trends that you should be aware of. In general:

1. An NP that practices in a state with many underserved regions will have more autonomy and choice available to them when it comes to practicing.
2. An NP that practices in an underserved region will make more money than an NP who practices in an urban area.

This is because most individuals don't care to practice in the middle of nowhere, so the pot has to be sweetened in some way. The same holds true for physicians; because it's difficult to attract physicians to these rural locations these states must rely on midlevel providers like Nurse Practitioners to fill the gap. It's a lucky bonus for these states that greater autonomy can be a greater motivating factor than a higher salary.

Creative financing

(No, we're not talking about financial engineering here.)

Underserved regions

It's important to remember that underserved regions generally have a very low cost of living. So nurse who makes \$70,000 in Boston might make \$90-100,000 in North Dakota, but it costs five to ten times more to buy a house in Boston than Fargo, so not only are you paid more in absolute dollars, but each dollar buys a lot more than it otherwise would.

I could express this as another form of opportunity cost, but I won't torture you with that any more. Just remember that by living in a more expensive region, you're giving up more than just a portion of what you could otherwise make; you're also paying more for goods and services, too.

Loan forgiveness

One benefit of working with an underserved population is that the Health Resources and Service Administration (HRSA) Nursing Education Loan Repayment Program (NELRP) may be available to you. This program cannot be used to forgive non-nursing loans, so if you have a non-nursing degree with outstanding debt, you'll have to pay for it out of your salary. The program will forgive 60% the balance on qualifying loans, and has no bearing on the salary you negotiate with your employer.

Many states also have loan forgiveness programs, but they are usually more limited in scope. For example, Florida will forgive up to \$4,000 every year you work for a qualifying institution for up to four years, for a maximum of \$16,000. Iowa will forgive up to ~\$6700 of qualifying Stafford debt.

That said, many second Bachelor's BSN and direct-entry MSN programs cost quite a bit of money, so it's an option worth investigating, especially if you have a desire to live in a rural area and/or work with an underserved demographic.³¹

³¹ "[NELRP Eligibility Requirements, Service Sites, and Funding Preferences](#)" – HRSA

About the author

Rian is a long-time science and health writer starting as far back as high school. He has a diverse formal educational background that includes computer science, pharmacy, economics, and psychology. He is a member of the American Medical Writers Association and the American Statistical Association. He loves data and data-driven decision making. He resides in Massachusetts, and can be reached via email at rian@blottedink.net.