Educators' Perceptions of the Development of Clinical Judgment of Direct-Entry Students and Experienced RNs Enrolled in NP Programs

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/Abstract/Background: Nurse practitioner (NP) education was originally reserved for experienced nurses, but it has gradually opened to nurses with little to no clinical experience at the registered nurse (RN) level as well as to non-nurses. The existence of multiple paths to NP training and practice raises questions about the role of generalist RN experience in learning clinical decision-making and other aspects of the NP role. **Purpose:** To describe educators' perceptions of the role of prior nursing experience in the development of clinical judgment during NP graduate education. **Methods:** In this qualitative descriptive study, 27 NP faculty from four universities participated in individual interviews. Transcripts were analyzed using a thematic approach. **Results:** According to participants, previous nursing experience—or any relevant experience—can either be helpful or detrimental in the development of NP students' clinical judgment. Three themes were generated: variations in students' baseline knowledge and skills, different frames of reference to grasp new content and skills, and challenges related to professional identity. In addition, participants described factors that they believe can affect the impact of different types of experience. **Conclusion:** Students with and without prior nursing experience face distinct challenges in learning NP-level clinical decision-making and judgment, but they reach similar end-of-program competence. Educators are confronted with contradictions

between generally held wisdom, their professional socialization, and first-hand observations regarding the role of experience (inside and outside nursing) in preparing students to become NPs.

/Keywords/*Keywords*: Nurse practitioners; clinical judgment; clinical decision-making; graduate nursing education; entry-to-practice; graduate-entry

/text/The nurse practitioner (NP) role emerged about 60 years ago in the United States from the idea that, after receiving specialized training in diagnosis and treatment, experienced registered nurses (RN) could assume selected duties previously reserved for physicians (Silver et al., 1968). At the outset of the movement, applicants were required to have at least some experience as RNs before beginning NP education (Crosby et al., 2003). Although a number of schools still require post-graduation nursing experience before entering an NP program, some schools accept students directly from undergraduate nursing programs (El-Banna et al., 2015). Some other schools offer accelerated programs that provide graduate education for students who hold a degree in another discipline (Rich, 2005; Pellico et al., 2012)—a path pioneered at the Yale School of Nursing in 1974 (Slavinsky & Diers, 1982). In the latter case, both pre-RN licensure credentialing and NP training are incorporated into the same program. The proliferation of pathways to NP education has been driven by workforce shortages and the desire to attract college graduates to nursing and advanced practice. There is considerable variation within and across programs in admission requirements, length and structure, and clinical hours (Mark et al., 2019; Pellico et al., 2012). In the United States, curricula are expected to include didactic (advanced pathophysiology, health assessment, and pharmacology coursework) and clinical (at least 500 supervised patient care hours) portions congruent with national standards for advanced nursing practice and the NP role

within a population-focused area (National Task Force on Quality Nurse Practitioner Education, 2016).

The very notion of access to NP education for students without RN experience poses a challenge to widely held—but by no means universal—ideas about the foundation for the development of NP competencies (Jackson & Marchi, 2020). Studies of the transition from RN to NP in acute care, primary care, and family practice report that students tend to perceive nursing experience as beneficial in adapting to the NP role (Cusson & Strange, 2008; Fleming & Carberry, 2011; Heitz et al., 2004; Kelly & Matthews, 2001; Sharu, 2012; Sullivan-Bentz et al., 2010; Steiner et al., 2008). However, research has failed to demonstrate differences between NP students with and without RN experience (Barnes, 2015; El-Banna et al., 2015; Patzer et al., 2017; Pellico et al., 2012; Richard-Eaglin, 2017). One study even found a negative correlation between pre-NP nursing experience and physician ratings of NP skills (Rich, 2005). Overall, current evidence suggests that experience as an RN before graduate education is not a prerequisite to becoming a successful NP. Yet, a debate continues as to whether it is desirable or even preferred.

One argument for requiring RN experience before NP education is the assumed connection between clinical experience and clinical judgment, whereby field experience as an RN builds clinical sophistication. However, no research has examined how prior nursing experience affects NP students' learning of decision-making and clinical judgment. Most studies of NP decision-making have been descriptive and have involved practicing NPs rather than students (Beckstead & Stamp, 2007; Burman et al., 2002; Chen et al., 2016; Kosowski & Roberts, 2003; Offredy, 2002; Offredy & Meerabeau, 2005; Ritter, 2003; Stamp, 2012; Thompson et al., 2017). A better understanding of the belief system underlying this presumed association is potentially useful for both educators and leaders interested in improving the quality of NP education and students'

experience of it. It could also be useful for the broader range of stakeholders concerned with the quality of care that NPs provide and the fit of the components of NP education relative to healthcare system needs. Therefore, the purpose of this study was to describe NP educators' perceptions of the role of prior nursing experience in the development of clinical judgment during NP graduate education. We chose to focus on NP educators because they are key actors in the development of NP students' clinical judgment and decision-making but their perspective has received little attention (Downey & Asselin, 2015).

/H1/Methods

This qualitative descriptive study explored NP educators' perceptions of the role of prior nursing experience in the development of clinical judgment during NP education. Qualitative description is rooted in naturalistic and subjective approaches and aims to describe and understand a phenomenon from the perspective of those involved (Bradshaw et al., 2017). This report follows the COnsolidated criteria for REporting Qualitative research (Tong et al., 2007).

/H2/Participants and Setting

Participants were educators involved in the delivery of "traditional" (i.e., for RNs with at least some clinical experience) and "entry-to-practice" or "direct-entry" (i.e., for students to obtain an RN license and NP credentials in the same program) NP programs in the state of Massachusetts for a minimum of 2 years. Educators whose contact information was publicly available on their school's website were invited to participate by email and asked to share information about the study with colleagues in their networks. Based on typical sample sizes in interview-based studies, we expected to recruit 20 to 30 participants (Vasileiou et al., 2018). Recruitment remained open until we deemed that sufficient data had been collected to produce a rich description that would

resonate with the experience of readers familiar with the topic (Kim et al., 2017). No incentives or payments were offered to participants.

The study was approved by the Boston College Institutional Review Board. When eligible NP educators contacted the research team, they received an electronic copy of the consent form that detailed key elements of their expected participation in the study. Individual in-person or telephone meetings were scheduled with interested parties at times and locations of their choice. During the interviews, they were reminded of the study's purpose and procedure and informed that they were free to leave the study at any time for whatever reason without penalty.

/H2/Data Collection

Participants completed a questionnaire regarding their sociodemographic characteristics, education, and professional experience. They participated in individual semi-structured interviews from 60 to 90 minutes-long between March and June 2018. The interviews were conducted in person or by telephone by the first author (P.L.) using an interview guide. Based on the research questions and the literature review presented above, we created an interview guide with questions about participants' definitions of clinical judgment, the typical progression of NP students' clinical judgment during their education, and the role of RN experience in the process (see Appendix A). At that time, the first author was a postdoctoral researcher at one of the participating institutions but was not collaborating with any of the participants. Interviews were audio-recorded and transcribed verbatim. Transcripts were imported into MAXQDA18 (VERBI Gmbh, Germany) for qualitative data analysis.

/H2/Data Analysis

Interview transcripts were analyzed using an inductive thematic approach (Braun & Clarke, 2006). Consistent with qualitative description (Vaismoradi et al., 2013), inductive thematic analysis consists of a stepwise process of coding, reducing, and organizing data to delineate and define themes that capture the responses of participants to the research questions. Codes are not defined in advance and are formulated according to participants' responses.

The researchers began the analysis by reading the transcripts to familiarize themselves with the data and verify their accuracy. Transcripts were coded with short phrases that reflected the features of the data. The list of codes after initial coding was scrutinized to sort and collate the different codes under larger categories. From this process, a map representing the relationships between codes and categories was drafted and refined in a two-step procedure. First, all data attached to a single code or category were examined to confirm if and how they fitted together. Second, mapped relationships were verified by examining the data that supported them. Through this procedure, codes, categories, and relationships were refined until they captured the essence of the data. This process allowed identifying themes, which were refined throughout the analytic process.

Various strategies were implemented to enhance the trustworthiness of the findings. Participants from multiple institutions were recruited to increase the transferability of the findings. Coding was performed by two researchers until a 90% agreement was reached. An exhaustive audit trail was constructed to establish credibility, dependability, and confirmability of the findings. The researchers discussed the process and findings with experienced researchers from their professional network at numerous points in the process. In the present report, care has

been taken to show both positive and negative cases, highlighting excerpts from the interviews that illustrate the findings. The participant number is provided after each excerpt.

/H1/Results

We contacted 111 NP educators from 10 schools and received 49 responses. Of these 49 responses, 8 educators did not meet inclusion criteria (i.e., they no longer taught in NP programs), and 14 either declined the invitation or were unavailable to be interviewed. The characteristics of the remaining 27 educators from four schools who agreed to participate are shown in Table 1. The majority (n = 24, 88.9%) had taught both traditional and direct-entry NP students. In terms of education, 20 participants (74.1%) attended traditional NP programs and seven (25.9%) attended entry-to-practice programs. They all held master's degrees, and the majority (n = 22, 81.5%) had doctorates.

Participants defined clinical judgment as the NP's ability to harness his or her knowledge, skills, and intuition together with the details of a patient situation to make an assessment and decide on a course of action in partnership with the patient. Despite a shared understanding of NP clinical judgment, they expressed strikingly different opinions about the role of RN experience in its development in NP students: 12 participants voiced opinions that experience was beneficial, one claimed that it was detrimental, and 14 participants saw both benefits and drawbacks. Opinions varied similarly between those who attended traditional and those who attended entry-to-practice programs. Most importantly, all believed that prior nursing experience only mattered during education and that it was impossible to distinguish traditional from direct-entry students by the end of their programs.

> *At the end of my semesters, I almost can't tell who is a traditional and who is a [direct-entry student]. I feel like that's my responsibility. If I've done my job right, then they should all have the same working knowledge, not one more than the other.* (NP01)

> *At the end of the day, I like to think that we are graduating NPs who are equally well prepared to be entry-level providers […], but that first year of work is the learning curve. […] They know a lot, but they gain a lot more knowledge with experience.* (NP08)

Thus, the overarching theme was "Previous nursing experience—or any relevant experience—can either be helpful or detrimental in the development of NP-level clinical judgment." The remainder of this section presents the themes regarding educators' perceptions of how previous experience affects NP students' baseline knowledge and skills, frame of reference, and identity related to clinical judgment, in addition to a discussion of factors that the participants believe moderate the impact of experience (Table 2). Of note, participants used the term "direct-entry" to refer to students beginning the NP programs with no prior nursing education, as well as those with undergraduate nursing degrees who directly entered NP education. Thus, the term "direct-entry students" refers to both trajectories in this article.

/H2/Variations in Baseline Knowledge and Skills

According to participants, traditional students begin NP education with a baseline knowledge of healthcare and foundational physical assessment and relationship-building skills. Their knowledge about clinical care—especially regarding tests, medications, and treatments—and their familiarity with the language of healthcare were deemed to put them at an advantage relative to their direct-entry counterparts. Furthermore, their predisposition toward nursing knowledge and "the essence of nursing" was often contrasted with direct-entry students' inclination toward

the medical model and struggles to "talk about patients' response to illness rather than the diagnosis of the illness" (NP24). Participants described traditional students as having a more holistic focus and a better understanding of the patient's family dynamics. These students were praised for their capacity to understand, connect, and empathize with the background, experience, and preferences of individuals, which participants termed "knowing the patient." However, these various types of knowledge merely form a base from which traditional students need to build to reach NP-level clinical judgment:

> *[Traditional students] come in and are ready to hit the ground running. They already know the language of medicine. They already understand a lot of the social norms that we have […]. There's a lot of pieces they already know, so they can really just start and learn and get the next piece of clinical knowledge. […] [Direct-entry students] know nothing, so really, they have to play a lot of catch-up.* (NP23)

> *Some of [the direct-entry students] miss the essence of nursing. […] The [direct]-entry students have an easier time looking at the medical model whereas the nurses question things because they're so into that nursing diagnosis and alteration and pain rather than […] addressing and prescribing something for the pain. [Direct-entry students] miss the caring, the personal care, the old-fashioned stuff, the bed bath, taking them to the bathroom. Sitting, talking with them in the middle of the night when they can't talk.* (NP10)

In terms of skills, participants perceived traditional students to have stronger physical assessment skills and to be better at identifying normal and abnormal findings by virtue of "doing it regularly" in their RN practice. However, traditional students would often rely on basic assessment techniques and struggle to integrate more advanced ones: "They think it's enough to just listen to the lungs. They forget that you can also percuss, check for pectoriloquy, and so forth. They've just been doing certain things for their physical exam for so long" (NP22).

Furthermore, these students often carry bad habits in the form of improper assessment techniques that they must unlearn—sometimes with difficulty—during their NP education.

Relationship-building skills were defined as the ability to focus on a patient by taking time to listen and connect—sometimes called "being present." Participants described traditional students as generally more comfortable and capable of building such connections. Because they have experience in interacting with different people in the context of healthcare, they know how to approach individuals from various backgrounds (e.g., special strategies for interacting with children and families). They are also more comfortable with intimate interactions in which patients are put in a vulnerable position (e.g., asking uncomfortable questions, touching patients, asking them to undress). This ability to connect with patients was described as a cornerstone of NP clinical judgment because it allows easier data gathering and facilitates partnering with patients in a way that feels warm, personal, and levelheaded. Conversely, participants believed that direct-entry students, who had not honed those skills, were often intimidated by their first interactions with patients, which sometimes led them to proceed mechanically:

> *[Direct-entry students] don't have the interpersonal skills of sitting and talking with the patient. It's almost [as if they] have a script [in their head]: "Good morning. My name is…. I'm a student NP. I'm working with so and so. How are you today?" If there is any deviation from that script on the part of the patient [they are lost.] And oftentimes there is. They have a lot more to say, or what they give back to you is not what you expected.* (NP08)

/H2/Different Frames of Reference to Grasp New Content and Skills

Participants generally agreed that traditional students fit the details of their NP training into a different and perhaps more fleshed-out "frame of reference"—i.e., a repertoire of previously encountered cases that they can connect with new content. Traditional students have mental images of how situations discussed in class can unfold in real life; they are familiar with various

clinical presentations of a single symptom or disease process and know that the content taught must be adapted to the situation at hand. In contrast, direct-entry students were described as more likely to take a "cookie-cutter" approach, relying on textbook descriptions, and, by extension, to struggle with the nuances of real-life presentations and the grey areas of clinical practice. Congruent with this, participants believed direct-entry students to be more comfortable applying clinical guidelines in a stepwise, methodical manner than adapting to the uniqueness of specific patient situations:

> *The RN students […] are much less likely to say, "Well, I have my computer here in front of me, and what you're saying is not what it says in the computer." An RN knows that there is no cookie-cutter approach, that what you are seeing in the computer of the patient with this disease […], that in real life, that's probably not the case. There are so many variables.* (NP09)

> *Direct-entry students […] have less to trust, they're a little bit more cookbook-oriented: "This is how you do it." […] The nurse with a lot of experience will get, "This is the way you do it, but this is different. There's something about this [case] that makes me think maybe that's not exactly the way to do it for this person." […] There are guidelines, but the more experienced person and the person who's a better provider takes that as a starting point and not an ending point.* (NP17)

Furthermore, participants explained that students who have extensive nursing experience can notice and recognize clinical patterns in a more intuitive fashion, "bypassing the analytic process of generating hypotheses and ruling things out" (NP03). Because "they've seen it a hundred times" (NP26), they can sense "when something's going bad, and that only comes with being present and being around patients" (NP02). Although some participants doubted the reliability of intuition, most agreed that learning to trust and act on it is an important milestone in the development of NP-level clinical judgment. One participant shared a telling example:

> *A person with no nursing experience who goes and meets with a patient who has congestive heart failure for the first time may not notice that the person is working hard to breathe or has really swollen ankles. [By comparison,] the nurse who has critical care experience immediately subconsciously knows all that. […] Those little, small things that we notice clinically just become part of who you are as a nurse. Certainly, RN students may have that ability versus non-RN students.* (NP27)

However, pattern recognition can also create baggage for experienced RNs: "They think of one or two things that [the diagnosis] can be, and they can be very rigid. […] They're quick on jumping to a conclusion without looking [further]" (NP08). Furthermore, participants believed that traditional students' often have developed acute care or "hospital-centric" habits, which are apparent in their tendency to rely on various sources of assistance and support:

> *[Traditional students] get reliant upon technology in the hospital. They get reliant upon the availability of stat labs and consults. […] We have to take those traditional nurses and break them of some of their old habits in order to get them to move forward into their new role. [Direct-entry students] don't have that problem.* (NP01)

> *Traditional [students] have to unlearn some of the bad behaviors that are out there. They've learned how to make quick decisions and they all want to readmit everybody. […] I think those are really hard behaviors for traditional nurses to unlearn because they've been so ingrained.* (NP19)

Relying on habits from a previous role is not exclusive to traditional students: participants described any prior healthcare experience as having the potential to shape habits. For direct-entry students, this is often related to the roles that they occupied previously and the specialties in which they worked. For example, students who have experience in a non-nursing healthcare capacity often try to apply their previous ways of doing things in the context of NP practice:

> *Paramedics know exactly what to do to save your life. But what they do on the street is completely different than what they're taught to do in nursing. […] Same with medical assistants. They start to apply the scenarios that they've seen in practice [and] they definitely struggle. Even [internationally educated] physicians, they're used to the medical model and it's very different. […] They're focused on finding a medical diagnosis, whereas, in nursing, you're looking at holistic scenarios.* (NP11)

Thus, a challenge with those students is to deconstruct their frame of reference to have them "think like nurses," which was described as a more holistic, humanistic approach to health:

> *It really is about a humanistic approach to another person. […] That meaningful interaction with another person to bring them to a place of wellness and health. Health not necessarily being no illness, but health being much bigger than that. Health being the best person you can be and striving for even more. Having the potential to know that you have more within you.* (NP19)

However, they also believed that direct-entry students who are trained and have experience in other disciplines (e.g., public health, psychology, social work, philosophy) bring different knowledge to the classroom. Their frame of reference was perceived as an under-recognized asset that enriches case discussions and brings a perspective "that others who have just had pure healthcare experience may not consider" (NP27). One participant commented:

> *Educators need to figure out a better way to […] recognize and honor what people bring because I think it's hard for them to embark on a new educational experience. […] Traditionally, nursing education has said, "I don't care what you were before, now you're going to be a nurse. You've got to be socialized to be a nurse."* (NP02)

/H2/Challenges Related to Professional Identity

Participants explained that both traditional and direct-entry students face two identity-related challenges during their NP education: (1) letting go of their prior status as competent or expert practitioners of another field and accepting that they are novices again and (2) taking on the role of care provider (i.e., diagnostician and prescriber) and the responsibility for this level of decision-making. Regarding expertise, many students either with or without prior nursing experience often begin their NP education with overconfidence in their knowledge and skills. Some students tend to believe that their mastery of the knowledge and skills required for a previous role provides a more solid foundation for NP practice than may be the case, not realizing how much they must learn before reaching NP-level decision-making. Direct-entry students were felt to be especially vulnerable to overreaching if they had experience in helping roles (e.g., lawyers, social workers) or in any healthcare capacity. Thus, both traditional and direct-entry students must not only acknowledge what they do not know, but they must also be able to position themselves as novice learners, even if they were considered experts in their prior careers or jobs. Participants described this as a vulnerable time, especially for students who have many years of experience:

> *They think that they are already mastering all the advanced practice knowledge and skills. Sometimes you just have to be a little bit more sensitive and gentler in how you tell them that it's okay to be a beginner again. […] Then it opens their eyes and most of them do great, it's just that initial component that they just need to struggle through a little bit, that they're a novice in the advanced role.* (NP18)

> *[Traditional students] don't come in with the depth of knowledge. They sometimes are not aware that they need to develop it because they are thinking that their experience has already provided that to them, but we're looking at a different level of using the information. We need to assess things that they may not have needed to assess in their RN role because they were not the ones making the decision.* (NP20).

Regarding the care provider role, traditional students tend to struggle more with such a change in identity because they must "break free of the idea that they are going to be implementing orders; instead, they are going to be making orders" (NP01). Because these students are accustomed to operating within the boundaries and scope of RN practice, they often rely on other professionals to make assessments and decide on a course of action. In contrast, direct-entry students build an image of themselves as providers from the beginning of their time in nursing and do not have to reinvent themselves:

> *You don't have the nursing baggage. When you go in, you see yourself as a primary care provider. Some of the traditional students, they still are going to defer to what the doctor wants, what the nurse practitioner wants; they haven't found their own voice. […] The [direct]-entry students, they're learning things at the advanced practice role. And so, they don't have that frame of reference. It's very clear what they're focusing on and what their role is, and they own it.* (NP03)

For direct-entry students, the struggle lies in adopting a realistic view of the NP role. Participants explained that these students often have an idealized image of the role, not grasping the nature of the work, its complexity, and the weight of responsibility that comes with it. Conversely, traditional students are often more aware of the level of responsibility and expectation of an NP and are more intentional in undertaking their education:

> *The direct-entry student doesn't fully appreciate what they've learned, or what they've been asked to learn, until they're out, until they are the one with the responsibility for making a diagnosis and prescribing treatment: "I am responsible for what happens with this patient." […] I think the [traditional] student has a much better grasp of that [responsibility]. […] Writing prescriptions, giving orders—to [direct-entry students], that's very glamorous. They don't understand the level of responsibility.* (NP09)

/H2/Factors Affecting the Benefits of Experience

Participants insisted that not all experience was created equal and described factors that could mitigate the influence of prior experience. The setting of previous experience influences the variety of patient situations that students have been exposed to, the types of care they have provided, and their expectations regarding how they need to learn and develop. As examples, participants often compared exposure to outpatient care to inpatient or specialized settings:

> *There's a limited amount of information that you can take from the hospital and apply to outpatient [care]. […] For the nurses who continue to work in their inpatient jobs, it's a good foundation, but they don't have the advantage of the nurses taking outpatient jobs, who are answering phone calls, putting patients in the rooms, seeing things over and over again. They just grow much quicker.* (NP14)

> *If you're in an urgent care facility or a teaching hospital, you're going to learn a lot more than if you're out in an operating room in a small town, taking appendices out, over and over again. […] That experience isn't going to be necessarily as helpful. It might actually hinder your creativity and your openness. […] In a teaching hospital, there's always going to be this culture of integrating new information, learning, and teaching; helping each other learn.* (NP25)

They also perceived drawbacks of lengthy prior experience in terms of frames of reference and work habits, especially if students' pre-licensure education was some time ago:

> *I think some [traditional students] have just so many entrenched years of experience at the lower skill set. There's this nice window of a couple of years, maybe somewhere between 1 and 5 years. I think you're able to develop that clinical decision-making more rapidly at the NP level better than somebody who has not worked at all as a nurse [or] somebody [who has] worked 20 years as a nurse.* (NP22)

Finally, participants explained that various personal or professional experiences can be beneficial to the development of NP students' clinical judgment. They believed that any experience involving problem-solving and analytical thinking can provide exposure to advanced decision-making. Although they recognized that students with nursing or healthcare experience have assessed patient situations and formulated plans—or witnessed others doing it—they also felt that other experiences, such as research or humanitarian work, could provide exposure to similar processes. In addition, personal caring experiences, such as parenthood, taking care of a relative, or experiencing a loss, were deemed beneficial. Participants believed that getting to know and interacting with vulnerable individuals provides students with a sense of what it means to care and helps build empathy and sensitivity to others' experiences:

> I suppose if you never were sick and never knew anyone who was sick and you never saw anyone take care of anyone, you'd be at a real deficit in trying to become a nurse of any kind. Certainly, if you have those experiences, whatever they are, a sick brother or even loss, any kind of thing that you have lived through, that you've experienced, affects who you are and how you interact with other people. (NP17)

/H1/Discussion

Overall, findings from the current study suggest that students with and without prior nursing experience face distinct challenges in learning NP-level clinical decision-making and judgment. Participants painted a nuanced picture, neither dismissing nor idealizing the importance of prior clinical experience, and identified situations where "popular wisdom" about RN experience as the basis for learning NP practice might be at odds with their observations of student progress. Although some participants had stronger opinions than others, all recognized that students in both pathways had similarities and differences in their needs and learning trajectories. They also reported that differences were more striking in the first few months of the programs, but eventually, students could not be distinguished based on their previous experience. These

findings align with prior studies that showed equivalent outcomes for NP students with and without RN experience in terms of academic success and successful entry to practice (Barnes, 2015; El-Banna et al., 2015; Patzer et al., 2017; Pellico et al., 2012; Richard-Eaglin, 2017). It is still important to note that direct-entry students have often been described as especially academically gifted by participants and in the literature (Downey & Asselin, 2015; Pellico et al., 2012). This might imply that well-honed "student skills" may offset lower levels of experience and contribute to similar outcomes between the two groups in the long run.

These findings can be interpreted through the concept of professionalization, the lifelong developmental process of envisioning, becoming, and being a professional (Bélisle et al., 2021). Professionalization, especially within the context of an educational program, entails three dimensions: the development of professional competencies, the appropriation of a professional culture, and the construction of a professional identity. This process is not unique to nursing; it has been documented in a variety of health professions as well as other fields, such as engineering (Bélisle et al., 2021). However, it takes on particular dimensions in fields such as nursing, where students may enter a field not only at different points in their life trajectories but also pursue educational pathways that prepare for accelerated entry into specialized and advanced roles, "leapfrogging" over more common experiential paths to access "higher-level" positions such as NP. This study documents what is, at times, a struggle of educators to deal not only with their values, beliefs (often a reflection of their assessments of their own professional paths), and widely held ideas in the profession in relation to the structures of the educational programs that employ them, but also the observations that at times, their values, beliefs, and ideas often do not match the "common wisdom." Furthermore, it provides insights into how experience can affect each of the specific dimensions of professionalization in NP education.

Participants believed that the benefits of prior nursing experience could be primarily linked to a head start on the first two dimensions (i.e., competencies and culture). Students with RN experience already know some of the physical assessment and relationship-building skills they need to hone to develop NP-level competencies, even though they sometimes have habits that need to be unlearned. They also have mental images of previously encountered care situations, which they can draw upon to build their knowledge and ability to recognize clinical patterns. In addition, they are familiar with the language and norms of healthcare that are critical elements of professional culture (Bélisle et al., 2021). Direct-entry students need to catch up on these fronts, but there is no indication that doing so is not possible over the course of their NP education.

The greatest struggles for NP students from both tracks appeared to be in developing a professional identity and having to depart from their competent—if not expert—status in prior roles. Those with prior nursing experience also struggled to accept the responsibilities inherent in the types of decision-making involved in the provider/advanced practice role. These struggles have been identified in multiple studies of the transition from RN to NP in the first year of practice (Barnes, 2015; Cusson & Strange, 2008; Faraz, 2016; Fleming & Carberry, 2011; Sullivan-Bentz et al., 2010). For example, Sharu (2012) described how new NPs experienced major concerns with their new accountability and responsibility, which were demonstrated in their heavy reliance on textbooks and frequent referrals to physicians and other consultants. The current study adds that identity-related struggles are not exclusive to experienced RNs or those in early NP practice; rather, these struggles seem to affect students with little to no prior nursing experience as well as those with considerable RN experience, and they appear early during NP education. Although residency programs have been created to ease the transition for novice NPs during the first year after graduation (Martsolf et al., 2017; Thompson, 2019), a number of students may benefit from additional guidance support during the formal portion of their

education. According to Bélisle et al. (2021) and literature on professional socialization (Salisu et al., 2019), frequent opportunities to experience a new role, to reflect on one's developing identity, and exchange feedback with peers, educators, and mentors appear to be effective strategies in that regard. Furthermore, examining the development of NP students' professional identity and self throughout their graduate studies, perhaps from an interactionist perspective, could strengthen the anticipatory guidance students receive about the changes they can expect in relation to their experiences prior to and during their NP education.

The results also point to a disciplinary tension experienced differently by NP students with and without prior nursing experience. According to participants, experienced RNs were more inclined toward the "essence of nursing," whereas direct-entry students preferred the medical model. Prior studies also have indicated that new NPs must learn to function at the interface of nursing and medical practice, a unique position that is neither RN nor physician (Cusson & Strange, 2008; Fleming & Carberry, 2011; Kelly & Mathews, 2001), and they are often called upon to demonstrate their specific contributions to patient care (Fleming & Carberry, 2011; Sharu, 2012). This tension reflects the hybrid nature of the NP role and preparation, which typically rests on a combination of nursing knowledge and medical content (Ljungbeck et al., 2021)—although a decreased emphasis on nursing knowledge is observed (Wood, 2020). This hybrid role may partially explain why traditional students seem to have a closer affinity with the practical and philosophical approaches of the nursing care traditions to which they were exposed more intensively during their undergraduate education and RN practice. At a time where NP education is increasingly shifting to the entry-level practice doctorate (International Council of Nurses, 2020), these findings invite reflection on the foundations of the NP role and its ties to nursing knowledge. To illustrate that point, participants reported that direct-entry students tend to perceive NP practice as wholly different from RN practice: "I've heard from several [direct-

entry] students since I've started teaching: 'I never wanted to be a nurse, I just want to be an NP.' You are a nurse if you're an NP. They don't connect that" (NP12). It is notable that the participants themselves often stated that they were nurses first and affirmed that they were strongly grounded in nursing as a broader discipline.

Additionally, participants discussed several factors influencing the variable benefits of prior nursing experience (e.g., length, variety of patients, type of care) and how experiences outside of nursing can have a positive effect on the development of NP decision-making. In their accounts, it was clear that experience was not just a matter of spending time in a particular setting and that certain features were more helpful than others. For example, they reported that education in a discipline other than nursing brings a different perspective that enriches classroom discussions. Many confided that they inquire about the characteristics of applicants' prior experience, both in and out of nursing, during admission interviews to gauge their potential as NPs. Still, the nature and duration of previous experience required of applicants differ across various health professions and even across programs within the same profession. In other fields, such as physician assistant (PA) education, most programs require hands-on patient care experience before admission. In the United States, most students start PA education with 3 years of experience in healthcare (American Academy of Physician Assistants, n.d.). There is some evidence suggesting that the length of preadmission healthcare experience influences PA student success (Honda et al., 2018; Wolf et al., 2020), whereas other evidence suggests the opposite (Brown et al., 2013; Hegmann & Iverson, 2016; Higgins et al., 2010; Lolar et al., 2020).

Perhaps it would be worthwhile to acknowledge the benefits of all forms of experience for NP student success more overtly and to study their contributions in a more formal way. However, research about this relationship has been limited, not only because of challenges in conducting

such research but also because of the strength of beliefs from different stakeholder groups and concerns about the possible policy consequences of findings that may result. Entrenched views of the matter among clinicians and educators seem tied to convictions about the preferability of their own professional paths as well as experiences with students over time. As one participant stated, "The extent to which I have a feeling about [the role of experience] is maybe based more on my prejudice. I can't say I see a difference" (NP25). Applicants and students from different experiential backgrounds are of course concerned about access to and success in programs, as well as perceived competition for career mobility within nursing and advanced practice. NP programs and the universities that house them need a critical mass of tuition-paying enrollees whose paths through programs are smooth, which requires finding preceptors who accept students for clinical placements. They also need to make a case that their students have successful career paths after graduation. Though rarely discussed, to the best of our knowledge and experience, the creation of entry-to-practice paths has often been a business decision involving profitability and institutional branding. NP employers' views on RN experience have not been systematically studied, but anecdotal evidence and the continued enrollments of students in all types of programs suggests that while some employers may prefer NPs who have prior RN experience, many more do not take a hard position on requiring RN experience.

\H2\ Strengths and Limitations

There are several strengths and limitations of this study. In terms of strengths, it addresses an acknowledged gap in documenting NP educators' perceptions on the question of routes to NP practice (Downey & Asselin, 2015). Additionally, the inclusion of participants from four different universities likely increases the transferability of the findings. Likewise, the multiple strategies implemented to optimize the rigor of the analysis enhance trustworthiness.

In terms of limitations, faculty who attended traditional NP programs were heavily represented in the sample, which may have influenced the findings. In addition, participants were recruited from a single U.S. state. Therefore, some findings might reflect local or state-level conditions, policies, or regulations. Future studies might explore the similarities and differences between what has been described here and the experiences of students and faculty in other professions with multiple routes to entry-level or advanced roles. Future research might also probe directly into the socialization, identify formation, and career trajectories of those pursuing different routes and with various types of experience. Such studies could use students themselves, their educators, or colleagues as informants.

/H1/Conclusion

This study's findings suggest that, as would be expected from research on clinical decision-making and understandings of professional socialization, prior clinical experience as an RN offers some benefits to NP students in terms of acquisition and consolidation of clinical knowledge, reasoning processes, and socialization to NP practice, at least initially. However, the advantage is far from absolute or unconditional; the length and setting of previous clinical experience, as well as the types of care one is exposed to, all seem to modulate the benefits of experience prior to NP education. In addition, more than one type of experience may be helpful (e.g., personal caregiving experiences, work experiences involving problem-solving or analytical thinking even if they have occurred outside the healthcare arena). The findings here highlight how the multiplicity of educational and career paths in a profession and its specialties may lead to sharply held opinions about the preferability of some over others that may neither be supported by evidence nor the lived experience of all stakeholders. Further research into the development of NP-level clinical judgment and decision-making that considers the role of various types of

experience could provide valuable insights for the design of curricula, assessments, and systems for recognizing and remediating difficulties encountered by NP students. A deeper understanding of the assumptions held within and across different stakeholder groups in health professions education may also prove useful as questions are posed about returns on investment in education, career mobility, and workforce adequacy as healthcare delivery and program offerings continue to evolve.

For regulators, several principles related to "right-touch" regulation (Cayton & Webb, 2014) come into play in the face of an issue like experience requirements prior to education for "higher" level roles in terms of deciding on the best distribution of responsibilities among professionals, educators, regulators, and employers, and choosing a regulatory strategy (or opting for none at all). Several points in local, state, and national guidelines are relevant here:

- Students must hold valid RN licenses before beginning any clinical experiences counted toward NP program requirements
- Faculty have a key role in setting admission requirements and selecting students (which is not to say that a single or majority opinion on a particular point always holds sway)
- NP programs and those providing precepted experiences to students make qualitative decisions about access based on the match between individuals' profiles and program/setting demands that are above and beyond minimum standards for entrance to graduate education
- Success on national certification examinations is required of all those seeking NP licensure

- Employers shoulder bear considerable responsibility for the selection, credentialing, and integration of NPs, as well as for monitoring their practice.

There is no evidence that systematic safety problems result from multiple pathways to NP practice; on the contrary, it appears that the flexibility of program entry requirements has facilitated greater diversity in the NP workforce. It also appears that employer decisions have generally reflected what the participants here articulate—by end of the programs, competency outcomes appear remarkably similar for graduates who have taken different paths.

"Right-touch" regulation seeks to balance the degree of risk to public safety with the risks and benefits of regulation as guided by an understanding of the underlying questions and the roles and responsibilities of stakeholders close to the issues (Cayton & Webb, 2014). The results of the present study, viewed alongside these principles, suggest that continuing to allow for multiple routes and allowing local variations in terms of experience requirements—and leaving those responsible for program quality as well as NP licensure to continue their current paths regarding this issue—may be the most reasonable approach, especially because questions regarding the advisability of RN experience prior to NP education are unlikely to ever be answered conclusively.

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Table 1

Sociodemographic Characteristics of Participating NP Educators (n = 27)

Characteristic	***n* (%) or *M* (*SD*)**
Age[a]	53.6 (10.9)
Gender (female)[b]	26 (96.3)
Doctoral training[b]	22 (81.5)
Specialty[b]	
Family	9 (33.3)
Adult and geriatric	7 (25.9)
Pediatric	5 (18.5)
Psychiatric and mental health	5 (18.5)
Women's health	1 (3.7)
Years of work experience[a]	
As a registered nurse	7.7 (5.8)
As an NP	18.9 (7.1)
As an educator for NP students	12.7 (6.9)

Note. NP = nurse practitioner. [a]Data presented in mean (standard deviation). [b]Data presented in numbers of participants (percent).

Table 2

NP Educators' Perceptions of How Prior RN Experience Affects the Development of NP students' Clinical Judgment

Themes	Traditional Students[a]	Direct-Entry Students[b]
Variations in baseline knowledge and skills	• Inclination toward use of a nursing perspective (e.g., response to illness, holistic, knowing the patient)	• Inclination toward the medical model (e.g., pathophysiology, diagnosis)
	• Stronger relationship-building skills (e.g., being present, connecting with patients)	• Intimidated by first interactions with patients; sometimes mechanical interpersonal style
	• Stronger foundational physical assessment skills	
	• Reliance on basic, sometimes improper assessment techniques	
	• Baseline knowledge of healthcare and language of healthcare	
Different frames of reference to grasp new content and skills	• Repertoire of real-life cases; familiarity with variations in presentation	• "Cookie-cutter" approach; reliance on textbook descriptions
	• Understand needs to adapt to the uniqueness of specific patient situations and presentations	• More comfortable with guidelines; struggle with nuances and grey areas
	• Hospital-centric habits (e.g., reliance on various sources of assistance and support)	• Habits from previous roles (e.g., paramedics, internationally educated physicians)
	• Intuitive recognition of clinical patterns	• Application of perspectives from different disciplines to discussions
	• Quick to jump to a single diagnostic hypothesis before full patient history and examination is obtained	
Challenges related to professional identity	• Letting go of prior expert status and accepting becoming novices again	
	• Accepting the level of responsibility of the care provider role	
	• Taking on the diagnostician/prescriber role, rather than implementing investigation/treatment plans	• Adopting a realistic view of the NP role

Note. NP = nurse practitioner. [a]Traditional students were students who entered the NP program after some clinical experience as a registered nurse. [b]Direct-entry students were those who begin the NP program with no prior nursing education as well as those with undergraduate nursing degrees who directly entered NP education.