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## Doctor-Nurse Cooperation Through ASALEE (Team Health Project in Private Practice): A Space Where Primary Care Practices are Being Transformed

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The experimental project named "Team Health Project in Private Practice" (Action de Santé Libérale En Équipe, ASALEE) was created in 2004 in order to improve primary care for patients with chronic diseases, through a better coordination between general practitioners (GPs) and nurses. Under this experiment, nurses are legally enabled to perform specific procedures or tasks, including the screening and care of chronic diseases, which are delegated to them by the GPs.

As part of the Doctor and Advanced Public Health Experiment Evaluation (DAPHNEE) Assessment programme, a sociological research based on a qualitative approach was carried out between 2015 and 2017. It explored, on the one hand, the implementation and organisation of the ASALEE project and it analysed, on the other hand, the practices and interactions between patients and health professionals.

Other aspects of this assessment program will be published by the Institute for Research and Information in Health Economics (Institut de Recherche et Documentation en Économie de la Santé, IRDES): a typology of the cooperation between doctors and nurses; the effects of the ASALEE project on doctors' activity and on patients' monitoring and care pathways.

The ASALEE (Action de Santé Libérale en Équipe) project, run by an association of GPs, was set up in 2004. Its initial aim was to improve primary care for patients with chronic diseases by better coordinating care provided by GPs and nurses (see Inset p. 2). The nurses, trained in patient education, work with one or several GPs, who refer outpatients to them in order to co-monitor patients within the framework of four procedures: screening and care of patients with diabetes or cardiovascular problems, screening for chronic obstructive bronchopneumopathy or cognitive disorders.

The development of the ASALEE project, on the initiative of primary care providers and with the support of the health authorities, is part of a more general primary care transformation process. The structuring of primary care has been recently improved in France, in particular via inter-professional teamwork practices associated with a specific funding scheme (Fournier et al., 2014). The key elements of the process are the reconfigurations of healthcare provision and healthcare task sharing, and of the role given to patients. The process is driven by various sanitary, democratic, professional, technological, political, and economic issues. By offering each patient individual care provided by a nurse trained in patient

education, in doctors' offices, the ASALEE project provides an alternative primary care offering to collective patient education programmes authorised by the Regional Health Agencies (Agences Régionales de Santé, ARS), that are set up for example in health networks and Multidisciplinary Group Practices (Maisons de Santé Pluriprofessionnelles, MSP)<sup>1</sup>. This project is also a laboratory in which new ways of

<sup>1</sup> Primary care teams in France can be split into two main categories: 1) "multidisciplinary group practices" where health professionals are self-employed (Maison de santé pluriprofessionnelle, MSP in French), which correspond to patient-centered medical homes in the US; 2) "health care centres" where health professionals are salaried (Centre de santé, CDS in French), equivalent of "community health centers" in the US.

working with patients and between doctors and nurses are invented. Hence, two interconnected forms of organisational innovation are emerging: first, doctor-nurse-patient cooperative practices, and second, their support by an intermediary organisation that plays the role of a third party between funders and health professionals, and between nurses and doctors.

This research follows previous qualitative studies carried out in different places with a practising ASALEE nurse. They revealed the emergence of "an original interplay between the world of treatment (cure) and the world of care" (Daniellou and Petit, 2007), which matched the expectations of the nurses and doctors involved (Mino and Ghadi, 2005). These initial analyses also showed the emergence of a new "pub-

lic health nurse" figure, whose activity involved both the provision of personal care and a population-based approach to care (Simondon, 2014). The project has developed significantly since 2012, so we used a comprehensive approach to study its transformations (see Inset "Method"). The comprehensive study focused on the practices and the organisation of the ASALEE project, and on the experiences of the actors concerned and their view of the project.

After presenting the motivations, recruitment methods, and practice configurations of the healthcare professionals involved in the ASALEE project, we describe the practices implemented, the dynamics that accompanied their development, and the actors' experiences.

### Health professionals with contrasting motivations and diversity in recruitment methods and practice configurations

When they join the project, nurses and doctors find themselves in very different situations with regard to their approach to the collaborative work they will have to build. This depends on their trajectories and expectations, the recruitment methods, and their working conditions.

The nurses have high expectations and relatively homogeneous motivations, the main one being the development of a relational work with patients, which some nurses naturally associate with an educational approach: "I really wanted to get involved in Patient Education" (N<sup>2</sup>). All of them expect greater autonomy in their work, and often to develop team work with the doctors: "I thought it was excellent for doctors and nurses to be able to create something together, so that's what motivated me" (N). Some of them see it as an opportunity to transform the nurse's profession, by experimenting with advanced nursing practices<sup>3</sup>. Hence, they are well motivated when they join the project. Most often, new participants are selected locally from many candidates, following a recruitment procedure developed and managed by a group of referring nurses. They ascertain whether the candidates have the right skills, such as the ability to work autonomously, take decisions on their own, adopt an open and non-prescriptive educational approach with patients, and also negotiate a way of collaborating with the doctors in order to facilitate doctors' contribution to the project.

The expectations expressed by the doctors generally concern a better quality of care for their patients and a greater comfort at work, but not saving time due to the fact

#### The origin and implementation of the ASALEE project

The ASALEE project was established on 6 February 2004, on the initiative of a general practitioner (GP) and an engineer with experience in medical information systems, with the support of public health doctors. The two founders evoked an idea suggested by their previous work: the idea that a trained and competent nurse, designed to be an 'informateur' (Eng M), working directly in a GP's office, may help to improve the quality of the patients' care. This had to be done while giving to the patients the time to express their needs and be supported in achieving greater autonomy in their lives while coping with a health risk or an illness. It was also intended to respond to the declining working conditions of doctors facing increasingly complex patient situations, at a time when the medical demography was decreasing.

There were two distinct phases in the development of this cooperative doctor-nurse project. During the first phase (2004–2008), thanks to institutional backing and funding from the Poitou-Charentes Regional Union of Liberal Doctors (Union Régionale des Médecins Libéraux, URML) for more than a year, 3 nurses worked with 12 GPs in 3 doctors' practices in the Deux-Sèvres region. The project was consolidated in 2005 with the establishment of the non-profit ASALEE organisation, which took over the project, with a funding from the Quality of Primary Care Fund (Fonds d'Aide à la Qualité des Soins de Ville, FAQSV). The project was piloted by a board comprising 6 GPs and a permanent guest engineer. Between 2004 and 2008, the project was only implemented in its original Deux-Sèvres region, involving a growing but limited number of doctors' practices. Hired by the association, the ASALEE "public health nurses" gradually structured their activity, which focused on preventive treatment, screening, and the care of patients suffering from chronic diseases or those with risk factors. Qualitative research demonstrated the importance of the educational work carried out by the nurses and their collective dynamics. They also highlighted, despite the doctors' limited commitment, the significant

potential of the project for transforming both medical practices and carer-patient relationships (Daniellou and Petit, 2007).

As of 2008, and above all in 2012, the project underwent a second phase of development, via a wider regional extension, followed by a nationwide extension, which was increasingly supported by the French state. The gradual institutionalisation of the project stabilised funding, but also added a number of constraints. The initial extension concerned four regions and was labelled as "task delegation" in primary care, under the condition of agreements validated by the National Health Authority (Haute Autorité de Santé, HAS), in accordance with the provisions outlined in Article 51 of the Hospital, Patients, Health, and Territories law (Hôpital, Patients, Santé et Territoires, HPST). The public authorities negotiated a new economic model with the management of the ASALEE association, based on the hypothesis that the nurse's contribution and the delegation of technical acts would help the doctor save time. In this model, a full-time nurse works on average with five doctors, who are remunerated for the time they spend in consultation with her. As of 2012, the project was extended on a national level, via its integration into the Experimentation with New Modes of Remuneration (Expérimentation de Nouveaux Modes de Rémunération, ENMR)<sup>1</sup> as a module of "task delegation". The ASALEE project then developed largely in the Multidisciplinary Group Practices (MSPs) benefiting from the ENMR. As of 2015 and for a three-year period, this funding has been continued by the Collège des Financeurs (the health ministry and main state insurers). The levels of nursing personnel were maintained at the equivalent of 167 full-time posts, 50 additional posts were added in 2016, and 50 in 2017. As of 31 December 2017, the ASALEE project involved 533 nurses, representing 267 full-time posts, working in 753 practices with 1,959 doctors.

<sup>1</sup> See note 4.

<sup>2</sup> The cited extracts from interviews are accompanied by their source, symbolised by an initial: N (nurse), D (doctor), P (patient), Eng (engineer). It is complemented, where appropriate, by their membership of M (management: the association's board or board of directors). E represents the person carrying out the survey.

<sup>3</sup> Advanced nursing practice did not exist in France when the survey was performed.

that some of their work would be carried out by nurses. Other more heterogeneous expectations were expressed, in particular due to the development of doctors' recruitment method since the project was launched. While, during the first years, the project was extended via activist doctors who were part of the medical unions network, these days doctors are not hired individually (as nurses are), but rather as members of a medical group practice that is applying to be part of the project. The doctors supporting the project in their offices express high expectations from the ASALEE project: they are attracted to multidisciplinary work and are interested in the concept of patient education. As for other doctors, some agree to take part in the project in order to test out a cooperative work that they see as interesting, while others are more reticent, and even quite sceptical. This heterogeneity tended to increase during the rapid extension of the project to the whole of France. The selection process, which was less regulated by the association, led to the recruitment of doctors who were involved in MSPs (a priori better prepared to work in conjunction with a nurse) and doctors who had no real understanding of the project.

The nurses' practice configurations are highly varied. They can work in the ASALEE association full or part time, as an employee or freelance, exclusively or complemented by one or more other jobs.

They intervene in various places and work with a variable number of doctors (see Inset "Method"). In addition, they can contribute in diverse ways to the functioning of the ASALEE association.

The doctors' practice configurations are also highly varied (individual practice, medical group practice, multidisciplinary group practices (MSP), or health care centers (CDS)), as is their working time and their contribution to other projects besides the ASALEE project. They generally work with one ASALEE nurse.

### The operating principles displayed by the ASALEE organisation

The organisation has been able to interact pragmatically with its political, professional, union-based, and institutional environment. On the one hand, it has adapted to institutional incentives by adopting a "task delegation" process, and subsequently by adhering to the Experimentation of New Modes of Remuneration programme (Expérimentations de nouveaux modes de remunération, ENMR)<sup>4</sup>. On the other hand, it has adopted certain concepts and emerging practices, while adapting them to its scope of application. This included patient education (defined in a public health law in 2009), and subsequently advanced nursing practices (defined in the

2016 health law) [see Inset]. Likewise, the hostility of the nurses' unions to a salaried status for nurses led the organisation to also offer the possibility of remuneration in the form of fees. This explains the paradox of a "masked" development of the project—in order to overcome these problems—during the first years (absence of a website and limited communication), in contrast with the important collective nurse dynamics. These dynamics, supported from the beginning by "nurses sectoral meetings", became visible at a national level as of 2015, when the association ASALEE set up every year a general assembly that brought together doctors and nurses.

Internally, the organisation structured itself on certain principles: encouraging "the autonomy of individuals" (Eng M) (patients, nurses, and doctors), with the idea that "the patient is the boss" (Eng M). The aim was also to "regulate emerging local organ-

<sup>4</sup> This experiment and its effects are described in: Fournier C, Frattini MO, Naiditch M. Experiencing the Impact of a Specific Funding Scheme for Primary Care Teams on Professional Dynamics and Inter-Professional Teamwork in France: A Qualitative Assessment (<http://www.irdes.fr/english/issues-in-health-economics/200-experiencing-the-impact-of-a-specific-funding-scheme-for-primary-care-teams-on-professional-dynamics-in-france.pdf>); and in: Afrite A., Mousquès J. Forms of primary care teams. A typology of multidisciplinary group practices, health care networks and health care centers participating in the Experiments of New Mechanisms of Remuneration (ENMR) [<http://www.irdes.fr/english/issues-in-health-economics/201-forms-of-primary-care-teams.pdf>].

## METHOD

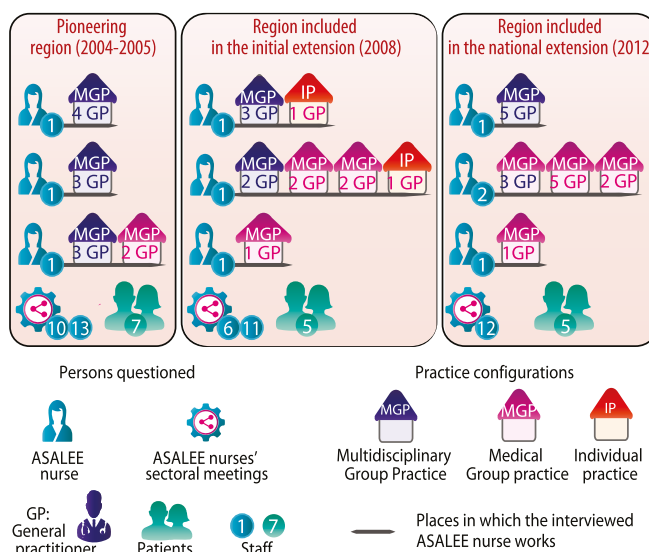
### A comprehensive qualitative approach

The regional scope of this research is presented opposite. The data was collected between 2015 and 2017. Interviews and observations were conducted in three regions corresponding to various periods of the diffusion of the ASALEE project in France. In each region, the survey examined several practice configurations according to the practices and the number of GPs with whom the nurse collaborated. Individual interviews were held with 10 ASALEE nurses and 26 ASALEE doctors (as part of 23 doctor-nurse duos), as well as with 17 patients. Complementary individual interviews were conducted with 13 nurses. In addition, 23 observations were conducted (17 patient-nurse consultations and 5 "sectoral meetings" between nurses), as well as 5 group interviews with 52 nurses.

On the national level, one interview was conducted with the person piloting the experiment at the Ministry of Health, 2 interviews with the National Health Insurance Fund (CNAM), and 19 interviews with health professionals carrying out transversal missions in the ASALEE project (8 doctors, 7 nurses, and 4 engineers).

The analysis of the interviews and field notes was carried out by a team of three researchers, based on interactionist sociology (Strauss, 1992; Huges, 1996). The monographs drawn up for each region gave rise to a thematic team analysis, which was both deductive and inductive, followed by a comparative analysis.

### Practice configurations analysed and actors encountered on the regional level



**Reading:** In the region included in the initial extension, the second nurse worked with 7 doctors practising on 4 locations (1 Multidisciplinary Group Practice (MSP), 2 medical group practices, and 1 individual medical practice).

isations as a matter of priority [...] and] only respect natural hierarchies" (Eng M). Hence, the project is organised in such a way as to encourage the creativity and commitment of the actors and ensure flexibility in the management. This responded to a number of issues: dealing with the diversity of practice configurations; managing the geographical and digital extension by working at local levels and the national level; safeguarding the nurses' daily work and their capacity for innovation by giving them sufficient time to prove themselves and recruit doctors. The organisation was primarily designed to respond to the heterogeneous wishes of the doctors participating in the project and their limited availability, by minimising their contribution, which effectively made the nurses the agents of change. A structured support therefore gradually developed around the nurses.

and defines the goals with the nurse. The consultations last for around three quarters of an hour, are free, and take place in the doctor's practice. The nurses use relational techniques that are part of a patient education approach, based on the patients' wishes, in order to help them develop and readjust their health project over time. Nurses sometimes carry out derogatory screening or monitoring procedures, defined in the procedures (biological tests, fundus and feet examination, electrocardiograms (ECGs), etc.). The carrying out of one-off procedures may also provide an opportunity to initiate a health education approach. For example, with certain overweight patients who have been referred to the nurse for an ECG, she can discuss their food and cardiovascular risk factors, and she may initiate an educational follow-up.

by entering an alert message on the medical record); and monitoring the health of their own patients in the medical files. The nurses also monitor their activity on the ASALEE Health Portal and, in part, in the medical records.

Through the interactions around different bundles of tasks (Hugues, 1996), patients, nurses and doctors are building a "negotiated order" (Strauss, 1992) of a collaborative work. It is a fragile social process, which is established over the long term and which is constantly reinvented around new tasks. The latter are not predetermined but are established "through doing", and through daily adjustments between the three actors. Within each doctor-nurse duo, the task sharing is negotiated, in particular with regard to delegated acts and with regard to the educational dimension of care. Indeed, certain doctors entirely delegate the educational dimension of the healthcare, while others prefer the nurse to provide a complement to what they have already implemented. A nurse explains the difficulty of gaining self-confidence in a job she is discovering and inventing, and, at the same time, gaining the doctor's trust in order to motivate him to work with her. Speaking of a doctor who had referred a patient to her, indicating the desired gly-

### Complex bundles of tasks developed through experimentation

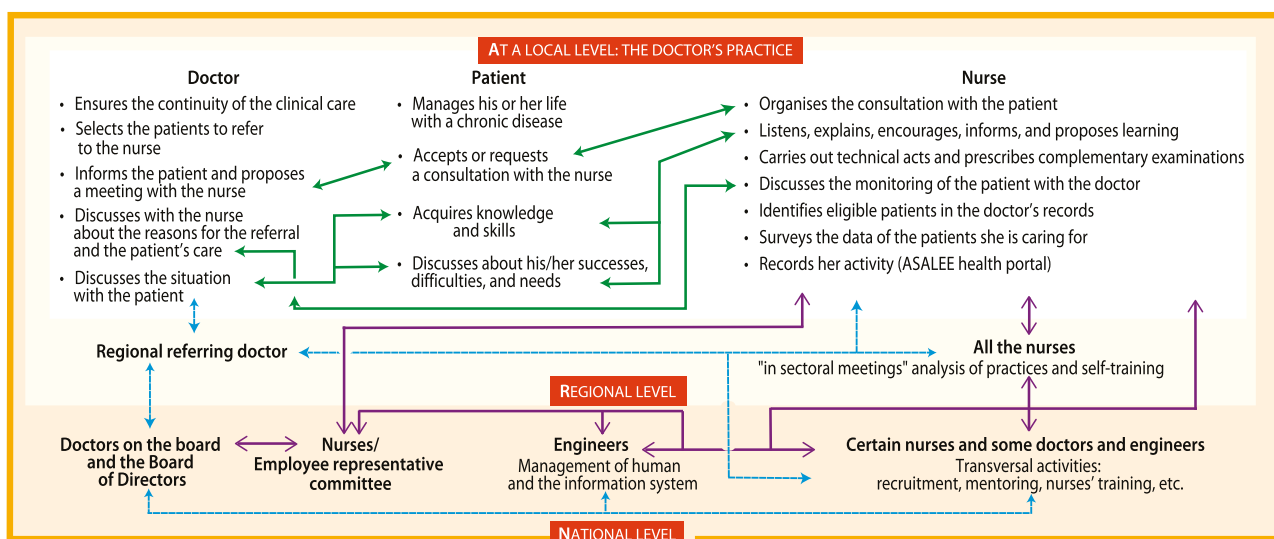
Each ASALEE nurse invents and tries out a new working method combined with that of each doctor with whom she<sup>5</sup> collaborates. The doctor initially proposes a consultation with a nurse to certain patients identified by him or by the nurse, based on certain procedures. If the patient accepts, he or she organises the next appointments

The work carried out within the nurse-doctor teams involves different tasks for the patients, the nurses, and the doctors (see Figure below). These tasks correspond with relational work between the actors, at the same time as organisational work. Some tasks are carried out individually by the patient, the nurse, and the doctor. Some of these tasks are carried out by a nurse, but without the presence of the patients (see Figure): management of the doctor's patients using computerised records (check of screenings' implementation and identification of patients' risks by the nurse who signals them to the doctor

<sup>5</sup> In this text, we use the feminine form for the nurses, as a majority of them are women, and the masculine form for the doctor.

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Principal tasks carried out by the actors involved in the ASALEE project in 2017



Note: The tasks implemented by the regional referring doctors, the board, the Board of Directors, and the nurses from the employee representative committee have not been listed.

Interactions linked to...

↔ patient follow-up and care    
 ↔ support for nurses in their activity  
↔ emerging support for multidisciplinary work

caemic target: "It means he acknowledged our effectiveness, but it wasn't like that at the outset. I could see he was far more detached and wishing to observe my work. It happened little by little, as we had successes, such as a patient who lost 10 kilos, with visible results... It needed to be proved. Even during the first year, ASALEE's effectiveness has to be demonstrated—even for me. (...) I didn't know to what extent it would work. Obviously, you're less convincing when you're not sure about something." (N).

Indeed, even if the ASALEE nurses are all trained in patient education, its implementation is new for them. This originality is due to the time that is allocated to patient in the project—"the luxury of ASALEE, which is not really a luxury, is time!" (N)—and the approach of patient education, which considers the patient to be an actor. This requires nurses to adapt their professional role: "at the beginning, it's true that it's a little disconcerting. (...) I spent six months saying to myself: what kind of work is this? I discovered an entirely different way of working that I wasn't at all familiar with, with new notions: you don't do things for the patients; it's the patients who have to manage their pathology, diabetes, or weight and do what's necessary. We're just there to guide them." (N) It also requires them to develop a new role: "The nurse plays a key role in the patient's healthcare—it's a whole new job" (N).

At the same time, a relationship needs to be established by the nurse with each doctor for the shared care of the patients. Here, the nurses are faced with the fact that what is expected of the doctors is even more disconcerting for most of them: only a few have received training in patient education (HCSP 2009 and 2015) and they claim that they rarely have the chance to develop this in practice (Fournier et al., 2018). Furthermore, some of them are not used to a multidisciplinary approach, and they often state that they forget to refer patients to the nurse. A doctor describes the solutions she found for integrating a nurse into her routine: placing a list of the criteria for participation in the ASALEE project on the corner of her desk, systematically giving patients an information booklet, preparing patients for the consultation with the nurse, and sharing the educational assessment with the nurse (Glorieux, 2016).

## The construction of a duo, or of a larger team

The collaborative work is based on the original construction of a doctor-nurse duo, in which the nurse is generally the main driving force. A doctor describes the resulting challenges: "With ASALEE, the doctor is guided to change, that is to say that from a senior point of view, he needs to shift to a collaborative mode ... from a vertical to a transversal approach. It's not simple, as we are used to being the bosses, being the best, the decision-makers, so the doctors need to be supported in the change process." (D).

It is just as difficult from the nurses' perspective:

- I1: "When we're in the medical practice, the patients look at us and don't know who we are. We don't really know how to go about it (...). How far can we go in the relationship with the doctors? (...) It's such a novel idea that even the doctors need time to get used to it."

- I2: I reckon it takes about a year.'

- I1: I agree, about a year or maybe even longer. The first stage is to demonstrate our effectiveness.

- I2: Then it establishes a relationship of trust. They have realised that we could bring them something. We can compare our opinions.

- E: What's the next stage?

- I2: Delegation, they need to be able to delegate various tasks to the ASALEE nurse."

Another doctor explains how the duo was established with the nurse: "No two ASALEE "couples" are alike. The nurse came initially, a little. She became familiar with things. I wasn't expected to give her 12 hours' work, 8 patients, or ensure she made a profit. Nothing at all. Things simply developed at our pace, at my pace. Everything was up to us, and we are establishing our ASALEE duo (...). It's really very attractive, very reassuring. So, now she comes here two days a week. I coordinate with her in the morning. The coordination lasts about half an hour to discuss about the patients she'll see, and any documents that need to be dealt with ..." (D).

The interchange in the duo ensures a better mutual acquaintance and the development of a trusting relationship, necessary conditions for the development of agreements on common organisational and collaborative principles. The interchange is based on various types of support: "alert messages" entered by the nurse on the computerised health records, shared digital documents, printed supports or post-its, SMSs, and telephone calls. But the most fundamental interaction takes place during meetings, that can be planned or unplanned, formal or informal, and at varying frequency, and which very much depend on the willingness and availability of the doctors, and the co-presence of doctors and nurses in the medical practice:

- E: "In your interaction with the nurse, you send her an SMS with a reason and she contacts your patients. She fills out the records ...

- D: She has access to the patient's records. Sometimes, we discuss the patients in a formal way, but most often it's done informally.

- E: Depending on specific criteria or does it depend on your availability?

- D: It depends on my availability. I still see her often, [the nurse's first name]. I go and see her and ask her: "Have you seen Mr X?" After, it doesn't even take long.

- E: Do you use what she notes down in the records?

- D: Of course. She makes me recommendations, which I follow. Sometimes, you have your nose to the grindstone, and you tend to forget certain things (...).

- E: Does she sometimes note down alerts?

- D: Definitely, yes! She knows she's got the right to do so and that we're not going to protest and tell her: "It's none of your business!"

This teamwork is very often limited to the doctor and nurse duo. In most cases, when a nurse works with several doctors in a medical practice, she develops a special relationship with each doctor. But the interaction sometimes goes beyond that to involve an 'extended team' that includes all the doctors. A nurse stated: "my greatest achievement is that I've been able to facilitate the collaboration between the doctors. There

## CONTEXT

The evaluation of the ASALEE project was entrusted to the Institute for Research and Information in Health Economics (Institut de Recherche et Documentation en Économie de la Santé, IRDES) by the French Directorate of Social Security (Direction de la Sécurité Sociale, DSS) at the Ministry of health, and by the National Health Insurance Fund (Caisse Nationale de l'Assurance Maladie, CNAM). It aimed to assess this experimental programme and the opportunity and conditions for sustaining it. This assessment programme of the experiment of collaboration between GPs and nurses is called DAPHNEE (Doctor and Advanced Public Health Nurse Experiment Evaluation). It resulted in the aggregation of different research works:

- A qualitative analysis of the implementation of the project and of the nurse, medical, and patient practices summarised here.
- An exploratory analysis via a declarative survey conducted with GPs and nurses, to construct a typology of the forms of collaboration.
- Evaluations of the impact of the ASALEE project on the activity of doctors and the patients' monitoring and care pathways.

was some interchange before I joined the practice, but that was primarily on a practical level. Thanks to me, they exchange about the medical practices". However, "[incorporating an ASALEE nurse into a practice] does not suffice to change the doctors' approach. (...) In my practice, one of my colleagues changed his approach, but that was because there were three other (doctors) who were very committed. (...) it didn't just change because of the nurse" (D). Yet, the doctors involved in the ASALEE project cannot or do not always want to play this role with their reticent colleagues.

In some cases, the team may incorporate other health professionals or secretaries in the medical practice, or even external health professionals. 'At the beginning of the ASALEE project, we worked more closely with the doctors than with other health professionals. Integrating ASALEE as a dimension of the Multidisciplinary Group Practice (MSP) occurred gradually' (N). In the MSPs, the ASALEE nurses do, however, hold a variety of positions, depending on the history of the establishment, the nurse's arrival in the construction of the collective health project, and prior mutual acquaintance between the health professionals. These positions vary according to a progressive scale with, on the one side, nurses working isolately to provide a

complementary service to the doctors for specific educational and monitoring activities, and at the other extreme, nurses being fully integrated to the construction of the collective health project and the everyday life of the MSP.

The nurses' work may also lead to competition, related to overlapping skills and/or funding conflicts. Competition may emerge between ASALEE nurses and certain health professionals, for example dietitians in relation to nutritional education, psychologists in terms of being receptive to patients, and patient education programmes implemented by various actors. Depending on the situation, this may cause a blockage, or on the contrary become a point of discussion that can be used to foster better coordination and collaboration between health professionals.

### Resources to support the nurse's work

The establishment and maintenance of these dynamics therefore represent a work that largely depends on the ongoing commitment of the nurse, but this construction remains fragile. Certain nurses encounter sometimes long-lasting difficulties. They highlight the fact that there is a heavy responsibility on the nurse to be of use to the patients. It is even more so because the boundaries of their job are vague and it is up to each nurse to define these boundaries. In addition to this new responsibility, the nurses are the fundamental driving force behind the development of multidisciplinary practices, even though this development does not depend solely on them. Furthermore, the nurses are the principal adjustment variable, with unforeseen events leading to call into question their work time: for example when the level of their activity is too low because the doctors refer too few patients to them, when doctors have too little time to devote to interchange, in the case of a doctor's cessation of work, or when there are not enough rooms in a practice due to the arrival of a new collaborator. The nurses indicate that the great adaptability they need to have and the effort required to encourage one or several doctors to cooperate expose them to a risk of exhaustion, above all when the doctors remain relatively uncommitted.

For this reason, resources were made available to them by the ASALEE association (see Figure on p. 4) on regional and national levels. On the one hand, this was designed to make their daily work possible: initial training, mentoring, access to health records, protocols, doctor-nurse consultation meetings, and the ASALEE health information system. On the other hand, complementary resources were deployed to underpin the nurses collective dynamics over the long term. With regard to this, the "sectoral meetings", held every six weeks, which are "entirely self-managed" (N) by the nurses, previously trained to practice analysis, are absolutely essential. The nurses describe this as a "place for interchange and training" (N) which enables them to avoid isolation, a space for self-support where they can share their concerns and resources, and an environment where they can acquire and implement knowledge and expertise. They describe the "sectoral meetings" as "an attempt to respond to our training needs that aren't catered for (...), to standardise our practices and make us feel able to train new nurses. We try to do what was missing for us" (N). The nurses can also get involved in the association's organisation: since 2012, some of them have been entrusted with remunerated responsibilities as referring nurses for transversal and structuring activities for the project, in terms of daily operations and reflection about its future: recruitment, training, the mentoring of new nurses and, more recently, reflection about research and advanced nursing practices.

**As for the doctors, some of them take informal responsibility as "regional referring doctor", a responsibility which emerged as of 2015.**

A team of engineers intervenes in the management of human resources and supplies, and to support the development and adaptation of technical tools, as well as to organise transversal missions. Adjustments were made to the organisation of these resources, with, in particular, the internalisation of patient education training in 2012, a training scheme for trainers designed to increase the association's capacity for training, and the improvement of the system

for monitoring the activity with the help of the National Health Insurance Fund (Caisse Nationale de l'Assurance Maladie, CNAM).

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### Nurse-doctor duos with heterogeneous practices and interactions

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On the whole, from the point of view of the actors themselves, the nurse-doctor duos work relatively well. In the "more successful" duos, the nurse has a defined area of responsibility and an easy access to the health records. The doctor, who is familiar with and values the nurse's contribution, refers enough patients to her. She is able to carry out her work with the patients both autonomously and in conjunction with the doctor. These doctors consider that high-quality educational input is something that enables the patient to become more involved, and "take power" (D), while being listened to and receiving personalised responses to his or her requests, in a dedicated space and time. They consider that the working conditions of the ASALEE nurses are more suited to this kind of work than their own consultations, due to the many reasons that lead the patients to consult a doctor and the often restricted time. For them, teamwork based on the sharing of activities and interaction with a nurse in the same location is a way of increasing quality of care. The ASALEE project is therefore seen as a means of commencing or perfecting this type of work. Doctors and nurses interact with one another to deal with complex situations, which enables both joint care of the patients and the gradual establishment of a specific form of doctor-nurse collaboration, which is tested out.

The establishment of collaboration depends greatly on the doctors' involvement. Indeed, not all the duos operate in this way, as several nurses reported: "With ASALEE, I worked with (...) several doctors with whom I eventually stopped because I didn't think there was enough work, and it wasn't rewarding for me, the patients, or the doctor." (N) Or: "Some doctors are ready, there are some who need to be persuaded, and some who adopt a defensive attitude" (N). In these situations, a certain number of factors that are sometimes combined

are observed: the doctor either refers no or few patients to the nurse or uses a small number of procedures; the nurse has limited material resources (no office, difficulty in accessing medical records, etc.); the interactions between nurses and doctors are rare, resulting in patient clinical care and educational care in silos; lastly, the nurse has no way of improving the situation.

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### A work and project that are generally appreciated by the various actors despite the difficulties encountered

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The patients interviewed see the nurse as a competent professional, who is available and approachable, because she works in the same location as the doctor and can be easily contacted by telephone:

- P (male): "I was talking about this to a friend of mine who's also got diabetes. I told him: "You'll see, it's nice. They'll explain everything and all it takes is a bit of your time ... just a little time, and it helps you a lot.

- E: What exactly does the nurse provide compared with the doctor?

- P: Well, it's a complement, and because she's there on the spot, it's more ... well not more clear, but you get a better idea of what's going on! She takes her time, you see, she explains things to you, because it's part of her job ! (...) Also, I can talk to her about other stuff (more personal matters)."

The nurse is seen as a close collaborator with the doctor, and as a professional who has access to the doctor's patient records and who can readily discuss matters with him or her. When the patients consult her for a screening test, for an act delegated by the doctor, or for a health exam, they highlight the practical side: simple procedures, on the same location, which helps them save time because they do not need to consult one or several specialists or paramedics in different places. Patients who consult the nurse for educational care see her not only as a source of information, but also as a provider of long-term support who can help them change some of their habits, and as a support to help them manage a chronic situation.

As for the nurses, many of them claim they are more professionally fulfilled in this new approach, which is enabling them to build up a lasting relational interaction with the patients, which is part of their core profession. They appreciate the freedom they are given to experiment relatively autonomously with new ways of working, in response to the patients' needs they identify. They also appreciate the cooperation with the committed doctors, easy access to medical data, and the doctors' recognition of their work, as well as their role as an interface with other actors who can respond to the needs (particularly educational) of the patients. Some nurses hope that the advanced practices they are testing out will receive professional recognition. All believe that the backing provided by the training and the "sectoral meetings" is essential, and could still be improved.

The doctors committed to working in close cooperation with the nurses endorse this new service offering for their patients, as the nurse's work is a complement to their individual medical practice via educational and supportive services that they had been generally unable to provide until that point. From sharing the care of patients with chronic diseases, some doctors state that they gain greater comfort in their work, quality, and security, and some even declare that it helps to protect them from the risk of burnout. The most committed doctors point out that the collaboration with the nurses has led them to modify their own clinical practices. As they were reassured by the fact that the educational dimension would be simultaneously catered for by the nurse, this made them more mentally available to manage the often multifaceted reasons for the patients' consultations and the medical objectives they establish as they monitor each patient. Hence, they mention that they are capable of optimising their interventions and more able to focus on certain activities or further develop certain treatments. A minority of doctors indicate that it gave them more time<sup>6</sup> to take on new patients, in particular in areas where the medical demography is strongly in decline. Lastly, in their opinion, the improvement in the quality of their treatment had a positive result, for certain patients, in terms of the knowledge and skills acquired in managing their illnesses, biological improvements (glycated haemoglobin), clinical improve-

ments (weight loss), and even quality of life, and in terms of a reduction in drug treatments. Some of the doctors also attest to a transformation in their relation with the patients, who having become more familiar with their illness adopt a different attitude to it: hence, they see the doctor as an ally rather than merely a prescriber.

Thanks to the collaboration as a duo, certain doctors and nurses mention the possibility of a new arrangement for their respective tasks, which would make them able to locally invent responses to some patients' needs that were hitherto not catered for, for example to support patients trying to give up smoking or begin physical exercise. This work helps to develop their local practices, while the innovations introduced are likely, in some conditions, to be extended in the ASALEE project on the national level. The doctors also underline the possible benefits of the collective collaboration in the same practice. The presence of a nurse not only facilitates the transformation of their own practices, but also leads to the gradual commitment of the more reticent doctors. Lastly, aside from the practice, the presence of the ASALEE nurse may help to develop complementarities and interactions with other health professionals and institutions (healthcare networks, MSPs, associations of health professionals or patients, etc.).

### An original construction and organisation, which facilitate adaptations to a changing context

Based on a limited number of interviews and observations relating to several practice configurations in the ASALEE project, this study does not provide an exhaustive analysis of the diversity of the practices developed, which were heterogeneous and evolving. However, it does give a good idea of the main dynamics of the construction and transformations that exist within this project. In certain cases, there is a dual displacement of patient healthcare provision: from a prescriptive offering to an educational offering proposed proactively, and which relates not only to the illness but also to health; and from a practice of

individual care towards multidisciplinary teamwork care.

This construction and these transformations, which arise from and via the interaction between nurses, doctors, and patients, are enabled by the time dedicated to the nurse consultations and the concertation with the doctor, by the nurse's own work, and via the intermediary organisation implemented. The latter plays a third-party role of trust between the doctor and the nurse and supports the structure, availability, and gradual adaptation of the resources provided to nurses.

The heterogeneity of the observed practices demonstrates the extent of the challenges encountered. Involvement in the ASALEE project is accompanied by changes in professional identity, calling into question the boundaries between the professions, and

has to be articulated with other projects or institutions. But, although the system was structured to match the heterogeneity of the practices, it did not eradicate it, in particular because it did not select the doctors who joined the project and did not specifically assist with them.

How could the support already provided to the commitment of the doctors—which is beginning to emerge in collaboration with nurses—be complemented without affecting the nursing dynamics that currently drive the project?

One issue remains unanswered: in those areas where primary care practices are being transformed, how can patients or their representatives be given a role in the construction and the management of the project so that it fully corresponds with their requirements? ◆

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<sup>6</sup> An analysis of data from a declarative survey via a questionnaire addressed at doctors confirms this result (Menini, 2016).