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Advanced Practice Nursing (APN) in French Primary Care: the Difficult Implementation of a Fragile Profession

Louise Luan and Cécile Fournier (IRDES)
In collaboration with Anissa Afrite (IRDES)

After completing an additional two years of training, advanced practice nurses (APNs) acquire an expanded range of competencies, including clinical examination skills and prescribing additional examinations and medication. Previous research have revealed the difficulties faced in France by the first graduating APNs in developing their activity in the hospital setting as well as the private sector.

This qualitative sociological research, based on interviews, studied the practices of these primary healthcare professionals, in a context of considerable tension with regard to the redefinition of the division of care work between healthcare professionals, particularly in private practice. Despite the interest the first APNs expressed in their new role, they all spoke about major difficulties in developing their clinical activities, and had to supplement their work by implementing care coordination activities within multidisciplinary teams, or by continuing, in parallel with their APN work, to practise as general nurses. The study of the first nurses to qualify as APNs, including a few ones who succeeded in building up a substantial patient base, shed light on the components of their work, and made it possible to analyse the conditions for its development.

Apart from the role played by medical demography in France, the diversity of the situations encountered depended, in particular, on general practitioners' willingness to develop – or not to develop – interprofessional collaboration, on the social proximity between the general practitioners and nurses concerned, and on the type of autonomy sought by the nurses.

Developed abroad over several decades in some cases, advanced practice nursing was introduced in France by the Law of 26 January 2016 and the Decree of 18 July 2018 (see Inset 1). To become advanced practice nurses (APNs), State Registered Nurses (SRNs) receive an additional two years of training, at the end of which they are awarded a State Diploma (DE) in advanced practice nursing, that is equivalent to a master's degree. There are five specialisations: the field of "Stabilised chronic conditions; prevention and common multiple disorders in primary care", which is the focus of this study, and also specialisations in oncology, nephrology, psychiatry and mental health, and emergency care. At the end of their training, the French Public Health Code stipulates that APNs have an expanded range of competencies and can, in particular, carry out a clinical examination, pre-

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Advanced practice nursing: a non-consensual role

During the debates over the creation of this new professional segment, the conceptions of what the APN's role should be differed considerably according to the various stakeholders. The first representatives of the future APNs, most of whom had a preliminary master's in clinical nursing science, for which they had studied in Aix-Marseille and Paris, had different ideas about the model that should be adopted – between that of nurse practitioners, working in primary care, and that of the clinical nurse specialists, specialists in a pathology, working in secondary care. Furthermore, while most of the GPs' representatives preferred to work withing the framework of delegation under medical responsibility, representatives of multidisciplinary structures were in favour of a redefinition of the sharing of tasks and responsibility. Lastly, the public authorities saw it above all as a means to free up medical time in the face of the declining medical demography.

Some of the issues raised during the creation of the APN specialisation (Luan, 2021a) have still not been addressed, and have recently provoked a strong reaction during debates on the proposal of a new law to improve access to healthcare, put forward by the MP Stéphanie Rist and submitted in January 2023: should APNs have direct access to patients in primary care or should access be controlled by the GP? Should APNs complement or replace part of the medical activity? Should this nursing activity be based on the follow-up care of stable patients, mainly focused on the renewal of prescriptions, or, more broadly, on initial prescriptions, preventive care, and non-clinical activities such as the development of clinical and professional leadership (analysis of practices, training, development of the nursing role, development of interprofessional coordination and research, etc.)?

scribe additional examinations, make a "clinical conclusion", adapt patients' follow-up care, and renew prescriptions. Paraclinical activities have also been included, such as the assessment of professional activities and participation in research. The APNs are fully responsible for their activities and the procedures they perform, in contrast with nurses practising under cooperation protocols.

In primary care, it was not until January 2020 (amendment 7 to the Convention Nationale Infirmière) that APNs could work on a self-employed basis (see Inset 2). They can also work as employees in Healthcare centres (*Centres de santé*, or CDS) or as employees of the ASALEE (Team Health Project in Private Practice, *Action de Santé Libérale en Équipe*) association.

This new nursing role has emerged in the context of the redefinition of task sharing between the various healthcare professionals (Hassenteufel et al., 2020). On the one hand, the development of cooperation protocols has given nurses and other "medical auxiliaries" access to new competencies, in particular those practising in Multiprofessionnal Group Practices (*Maisons de santé pluriprofessionnelles*, or MSP*s*) and nurses delegated to public health (*Infirmières Déléguées à la Santé Publique*, IDSP) within the ASALEE association. On the other hand, new functions have been created, such as MSP coordinators, and, more recently, medical assistants. More broadly, primary care practice is undergoing major transformations, with the development of private group practice specialised in primary care – which can take a relatively moderate form, referred to in this study as a primary care team (*Equipe de Soins Primaires*, ESP), or a more developed form in MSPs – and the increasing attractiveness of salaried practice in Healthcare Centres (CDS); APNs cannot practice outside these types of structures. There are also new instruments for intersectoral coordination on a broader scale, such as Local Health Professionals Communities (*Communautés Professionnelles Territoriales de Santé*, or CPTS). The public authorities support these various developments, which are considered as levers to maintain access to healthcare in view of the decrease in the number of GPs in France, while, at the same time, primary healthcare needs are continuing to increase.

However, the introduction of a new nursing role in the private sector cannot be achieved without causing or reviving economic, professional, and symbolic rivalry. When it was introduced, advanced practice nursing met with considerable opposition from general practitioners' (GPs') representatives, and also from general nurses, which resulted in a practice framework under the control of GPs (the requirement for an "organisation protocol" signed by each physician and the advanced practice nurse, an absence of direct access for patients who have not been referred to APNs by a doctor, and patient referrals exclusively made by GPs) and unstable economic conditions (see Inset 2).

The qualitative sociological survey, based on interviews, which was conducted in order to study the first APNs' practice in primary care (see Method Inset), showed that most of these pioneering nurses struggled to develop their clinical activities, and that they were obliged to develop coordination activities within multiprofessionnal group practices (MSPs), or continue, in parallel with their APN work, to practise as general nurses. However, some of them succeeded in building

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An economic model that remains precarious

Innovative at the time of its conception, the remuneration of self-employed advanced practice nurses (APNs) is based, unlike that of other self-employed healthcare professionals, not on a fee-for-service payment but on a "flat rate" for monitoring a patient over a certain period. This is similar to remuneration via capitation, as the APN is allocated a set fee of €177/year/patient, paid every three months, whatever the number and duration of the consultations, on condition that they can justify a three-month contract.

This flat rate, negotiated at the end of 2019 between the National Union of Health Insurance Funds (*Union Nationale des Caisses d'Assurance Maladie*, UNCAM) and the organisations of general nurses, turned out to be ill suited to the practices of the APNs (IGAS, 2021). It was increased by 25% in November 2022 (Amendment 9 to the *Convention Nationale Infirmière*, signed on 27 July 2022). On this occasion, the aid provided to help APNs set themselves up was increased and its attribution criteria broadened.

up a substantial patient base. In a difficult professional environment, under what conditions was advanced practice nursing possible for the first APNs in primary care? What were the components of their practice and how was this built?

After describing the range and variability of the bundle of tasks carried out by the APNs, we show that creating the very conditions for their nursing practice in primary care was, for these pioneering nurses, a job in itself, which was based on negotiations with other healthcare professionals. The results of these negotiations were influenced by the social proximity between the APNs and the GPs with whom they worked, by their professional careers, and also by the degree of clinical autonomy they were seeking in advanced practice.

An advanced practice that struggled to develop and remained very different from what was anticipated

When it was created, the APN role was initially conceived by the public authorities around the idea of the regular follow-up care of patients with stabilised chronic conditions, which was complementary to and partly replaced the care provided by a GP: renewing prescriptions after assessing the stability of patients' health states, in order to enable the GPs to free up time to treat more patients. In practice, the activities of the first APNs were very different from this framework, which affected the sustainability of the APN role.

Small patient bases, largely composed of medically "complex" patients

While the APNs were expected to contribute to improving access to healthcare, the research underlined the low numbers of patients they treated, often limited to a few dozen. For example, Béatrice, who had been working for six months as an APN – employed by the ASALEE association – and worked in a MSP with 5 GPs, said that she provided follow-up care for around forty patients. Françoise, who worked 80% of full-time hours and who had also been working as an APN employed by ASALEE for ten months, only held 20 consultations per week. Aurélie, the APN who had the most favourable working conditions because she benefitted from a large number of patients referred to her by the main GP with whom she worked in a "medical desert", provided follow-up care for around 200 patients.

The second major finding was that all the APNs interviewed said that their patient bases were largely composed of patients that many of them described as "complex", because they suffered from one or several chronic conditions that were not stabilised, or whose follow-up care was considered difficult due to their social situation, poor treatment compliance, the fact that additional examinations had not been carried out, and so on.

The APNs linked these preliminary observations with GPs' reluctance to refer to them patients that only required routine consultations, due to the loss of "easy" consultations and the associated income. But APNs cannot practise outside the framework of an "organisation protocol", signed by an APN and a GP, and the patients can only consult an APN when they are referred by a GP.

> "[The APN] said that she could renew prescriptions (hesitates) for straightforward patients, and it's true that we like to keep these patients, because they're easy to deal with and that gives us a bit of a break in our busy days. Then (...), she could also deal with complex cases, and it's true that, with regards to coordinating care for complex cases, I could really see that there was a major benefit in working with an APN".
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> **Salaried GP (observation)**

In contrast, all the APNs highlighted the ease with which the GPs entrusted them with the follow-up care of "time-consuming" patients.

> "He selected a patient who was particularly difficult for him to treat (...), a patient for whom I couldn't actually provide follow-up care only four times a year! Because the patient's level of literacy was so low, or the patient had mental or psychological disabilities that were so severe that there was a NEED for a really proactive approach, with support, rewording, re-explanations... (Laughs) They were the sort of patients he entrusted me with".
>
> **Céline, working in a primary care team (ESP) with one general practitioner (GP)**

The APNs described the core of their clinical activities as being composed of long consultations that could last an hour, and even longer, due to the profiles of the patients who required many explanations, referrals, and appointments – practices that they valued. Some of the APNs also linked the length of the consultations to their lack of experience in questioning patients and performing physical examinations, which they regretted not having been able to sufficiently practise during the first placements of the State

Context

This study was conducted at the Institute for Research and Information in Health Economics (*Institut de recherche et documentation en économie de la santé*, IRDES) as part of a medical thesis, specialising in public health (Luan, 2021a). It is also based on the results of an initial research project, as part of a master's in public health law and policy (Luan, 2021b).

Method

This qualitative sociological survey was conducted between February and July 2021, based on semi-structured interviews that lasted on average 1 hour and 38 minutes.

Those interviewed comprised 9 women and 1 man[1], with a median age of 46, from the first two cohorts of nurses to qualify in advanced practice nursing (APN). They practised as self-employed professionals (n=7) or were employed in a Healthcare centre (n=1) or by the ASALEE association (*Action de Santé Libérale en Équipe*) [n=3], in 7 regions. Before becoming APNs, all of them were already working in primary care: 9 were self-employed and 2 also worked part time as employees of the ASALEE association. They had all been practising as APN for at least six months (duration of practice: between six and twenty months), and most practised exclusively as APNs (n=7). They worked alongside 1 to 7 GPs, in a total of 8 MSPs and a Healthcare centre (CDS).

The analysis was also based on observations made during two ASALEE APN meetings, and on two interviews conducted with APNs working in primary care, from a previous study (Luan 2021b).

The first names have been changed.

1 In this article, we use the feminine to reflect the vast majority of women among the IPA.

Diploma (DE) in advanced practice nursing. Others also mentioned filling out incomplete patient files. The APNs also highlighted the significant amount of time spent listening to patients, as well as systematically discussing issues relating to their living conditions and lifestyles, which contrasted with the GPs' short consultations.

Furthermore, all the self-employed APNs questioned stated that the number of patients they followed was too low to enable them to make a living as an APN. The flat-rate payments, designed for short and infrequent simple follow-up consultations, were described as insufficiently remunerative. Aurélie, who treated 200 patients, considered that her work would become economically viable if she had 500 patients. The loss of income was all the more significant for the previously self-employed nurses (Douguet and Vilbrod, 2007).

Activities that may go beyond the APNs' competency framework

According to the APNs, the GPs had a tendency to delegate tasks that they valued less or considered tedious or time-consuming – tasks that were akin to "dirty work" (Hughes 1951).

The referral of "complex" patients with chronic conditions that were not stabilised sometimes led the APNs to go beyond the framework of their competencies, which were in principle restricted to the follow-up of patients with "stabilised" chronic medical conditions. Several APNs mentioned their concerns about practising outside the applicable legal framework, or hence to do so the need to have a GP on hand, who could, if necessary, be contacted during a consultation. But, for the APNs, this more difficult follow-up care was also work that was valued and appreciated, work in which they used knowledge and competencies acquired while studying for the State Diploma (DE), and the results obtained in terms of observance of treatment and the stabilisation of medical conditions were very satisfying, as Céline explained: "*Well, I'm pleased that I was able to gain this clinical expertise, because I was able to resolve clinical situations that were sometimes in a bit of an impasse.*" Dealing with a patient complaining about memory impairment, Françoise, who was practising as both an APN and a nurse delegated to public health (IDSP) under the ASALEE scheme, expressed her satisfaction: "*He accepted the diagnosis of depression, and he began taking antidepressants fifteen days ago. I thought that was great!*"

Two APNs also said that they prescribed – working closely with a GP – acute treatments to patients presenting with decompensation:

> "When I'm treating a patient presenting with decompensation, I can prescribe antibiotics, corticosteroid therapy, aerosol or oxygen therapy – things that aren't normally within the scope of my competencies".
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> **Aurélie, working in a primary care team (ESP) with two GPs**

An extended range of clinical tasks – duties seldom performed by general practitioners (GPs)

Some of the APNs carried out an extended range of tasks, particularly in terms of secondary prevention.

> "Then, I also provide preventive care and perform screening examinations. I do a lot of ABIs [Ankle Brachial Pressure Index Tests] to screen for PAD [peripheral arterial disease]; I hold consultations dedicated to MMS (Mini-Mental Status) [sometimes] in patients' homes".
>
> **Jérémy, working in 2 primary care teams (ESP) with 5 GPs**

These APNs spontaneously performed duties that were seldom performed by GPs; they primarily performed activities that in fact complemented rather than replaced GPs' activities, thus avoiding competition with them. They extended healthcare provision, in particular preventive care. Several APNs spoke about their role in the coordination of patients' treatment programmes, by helping with the scheduling of appointments and calling hospitals to obtain information about patients' healthcare information. Several APNs also held consultations in Residential Aged Care Facilities (*Etablissements d'Hébergement pour Personnes Âgées Dépendantes*, EHPAD), which experience difficulty in mobilising GPs.

The need to add self-employed nursing or team coordination activities

Since the income of APNs who worked exclusively in advanced practice was too low, many self-employed APNs continued to practise, in parallel with their work, as general SRNs, and were not entitled to claim installation grants (this changed in 2022). As for APNs who practised exclusively in advanced practice, they frequently performed, in parallel with primary care, other self-employed or salaried activities (coordination, Covid screening tests, clinical activities in hospitals, etc.), which were an additional source of income.

Since the self-employed APNs could only practise in primary care teams or MSPs, it was their responsibility – when GPs agreed to work with them but did not practise in such organisations – to do what was sometimes considered another "dirty job", which was completing the administrative formalities required to create these structures, often on an unpaid basis. In the case of a MSP, once established, the centre's activities needed to be coordinated, which could be carried out by the APNs and was remunerated, generally on a sessional basis. While some of the nurses had already carried out this type of mission before they became APNs, several APNs said that the decision to do so was primarily motivated by the additional income. Some of them were also considering coordination on a territorial level that was broader than that of the MSP.

> "I push for more coordination activities to increase my income [in the MSP] because a lot of my working time is unpaid (...). I think I'm going to switch to a regional group of health professionals [*Communauté Professionnelle Territoriale de Santé*, CPTS], in order to actually increase the extra income I receive from the coordination of care".
>
> **Béatrice, working in 1 MSP with 5 GPs**

As mentioned below, care coordination was often required to make their work as self-employed APNs feasible, before eventually ensuring an additional income.

The impossibility of developing activities to increase the clinical autonomy of this new nursing role

Amongst the range of activities set out in the legislative texts, none of the activities that could be performed independently from GPs were developed by the APNs, apart from teaching for the State Diploma (DE) in advanced prac-

tice nursing. An analysis of practices, "clinical leadership", and research were areas that remained unexplored due to a lack of funding and methodological support, and also due to a lack of possible collaboration with other nurses or partners. With regard to research in primary care, the collaborative networks are yet to be created:

"[Research] is something that I was really interested in, and I feel really frustrated (...), it's very difficult in primary care. I am not in a MSP linked with a University (...) with respect to searching for financing and other resources. I won't have the support of a research department in a University Hospital".

Béatrice, working in 1 MSP with 5 GPs

This contributed to limiting the range of the activities performed by the first APNs, as well as their autonomy.

Creating the conditions for advanced practice nursing in primary care

Working in advanced practice roles was not straightforward; the first APNs in primary care had to create their own conditions of practice. What did this process consist of and under what conditions was advanced practice nursing possible?

Achieving recognition of the new nursing role and gaining a reputation

First and foremost, the APNs encountered administrative difficulties, which, in some cases, prevented them from receiving any pay. Being registered as an APN with the Order of Nurses (*Ordre des Infirmiers*), the ability to charge flat rates payments by the Primary Health Insurance Fund (*Caisse Primaire d'Assurance Maladie*, CPAM), and getting their prescriptions approved by pharmacies and biomedical laboratories were prerequisites.

Furthermore, due to the insufficient communication from the public authorities, the onus was on the APNs – irrespective of their working place and form of practice – to inform their interlocutors about their advanced nursing role, the competencies they had acquired, and hence the advantages – for a healthcare professional – of working with an APN. They also had to gain a reputation in the region in which they worked.

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The slow rise in the number of self-employed advanced practice nurses (APNs) in primary care

There are now more than 98,000 self-employed SRNs working in France (ameli.fr). Although the French Ministry of Health had announced a goal of 5,000 APNs by 2022, half of whom would be working in primary care, the increase has been more modest, and there is still no official information about the number of APNs who are currently working.

On the basis of flat rates billed and obser-ved in the data provided by the French National Health Insurance system (*Assurance maladie*)[a], we counted 35 self-employed APNs working in 2020, 106 in 2021, and 122 in the first six months of 2022, 79 and 43 of whom were new to the profession of APN in 2021 and in the first six months of 2022 respectively. Mainly female (75%), they are on average 44 years old. In addition to these APNs are nurses employed by the ASALEE association and 19 Healthcare centres, whose activities are not recorded in the National Health Data System (SNDS).

Certain limits relating to these initial exploratory results need to be specified: there is insufficient hindsight to be able to describe the increase in the number of practising APNs and their use of the specifically created flat-rate codes; and the initial difficulties in invoicing the flat-rate fees.

[a] Source: the National Health Data System (*Système National des Données de Santé*, SNDS); characteristics of the APNs (simplified DA_PRA_R) and healthcare consumption data (01/2020–06/2022) of their patients observed over the period 01/2020–02/2023 (inter-scheme consumption data, DCIR); exploitation of data: IRDES.

"I lost time; well, I had to create a whole network, so [during that time], you're not working (...). Right now, I'm starting to see some results, but I had to create everything, all the contacts; it easily took a year".

Jérémy, working as a self-employed nurse for nine months

Finding GPs who agree to interprofessional cooperation

While some of the APNs succeeded in continuing to work with GPs with whom they had practised as self-employed nurses before their training, most of the APNs had to approach other GPs to develop their advanced nursing practice, as the GPs they previously worked with refused to continue working with them. Several factors seemed to influence the outlook of these GPs, who did not know them. For some of the APNs, the declining medical demography in a region facilitated the development of their clinical practices, which, a fortiori, replaced those of GPs. When APNs work in areas with the least healthcare provision, with GPs who can no longer meet the healthcare needs, they are perceived as healthcare professionals who help maintain patients care. Aurélie explained why a GP referred a large number of patients to her, rapidly increasing her patient base: "*He works in a MSP in a mountainous region; three GPs suddenly left and he found himself working on his own*" (Aurélie worked in 1 primary care team (ESP) with 2 GPs).

The younger generation of GPs was not always favourable to sharing tasks with the other health professions, and many APNs highlighted, in particular, the "multidisciplinary culture" of the GPs who agreed to work with them, and spoke about the more horizontal relations between the GPs and the nurses in that case.

"I thought that it might be easier to work with newly qualified general practitioners (...). And, in fact, I realised that it wasn't necessarily related to age or generation, and that it was more closely linked with a professional culture".

Céline, working in 1 primary care team (ESP) with 1 GP

These GPs were often involved in the reform of primary care, as they played a leading role in creating and animating collaborative networks in multidisciplinary structures, such as MSPs and regional groups of health professionals (CPTS).

"This is really the beginning of the innovation, so it's the ones who are visionaries. For me, the regional group of health professionals [CPTS] was the first [in the region]! (...) The GP had a well-established multidisciplinary culture."

Isabelle, working in 1 primary care team (ESP) with 2 GPs and in a clinic

Several APNs readily described these GPs as "pioneers" or "visionaries", an

image that they also identified with. However, all the professionals in a MSP did not necessarily share this culture. An APN said that she had to stop practising as an advanced practice nurse due to the hostility of the colleagues of the GP with whom she had developed an advanced nursing practice that was nonetheless fulfilling for both of them.

Negotiating the scope of advanced nursing practice with each GP

For the APNs, it was not just a question of one or several GPs agreeing to work with them. As has been demonstrated in the ASALEE scheme (Fournier et al., 2018), the range of tasks carried out by the APNs had to be negotiated with each GP. Indeed, while the extent of the APNs' competencies was established via a decree, they also had to accept de facto to restrict themselves to what the GP – no matter how much he or she was interested in working with them–, was prepared to share. This was the condition to obtain the GP's agreement and co-sign the indispensable organisation protocol, which may have had an impact on the APN's patient base. When they worked with several GPs, the APNs generally adapted the organisation protocol, as Aurélie (working in 1 primary care team (ESP) with 2 GPs) explained: "*I presented it to the GPs and we rewrote a section with each GP*".

The initial phase of their advanced nursing practice was often marked by caution when making proposals, as the APNs preferred to refrain from using all their competencies from the outset:

> "So, we began with the patients recognised [by the French National Health Insurance system] with a chronic condition [*Affection de Longue Durée*, ALD] and, in fact, we gradually included other patients who did not have an ALD, but who had problems with high blood pressure and cholesterol."
>
> **Jérémy, working in 2 primary care teams (ESP) with 5 GPs**

The restriction in the scope of their practice was an obstacle to the development of their patient base, which therefore limited their income. Many of them introduced themselves primarily as complementing and not replacing part of the GP's activity, or offered to relieve the GP of work that he or she did not wish to do, to avoid raising concerns of competition. The APNs sometimes had to be able to deliberately set aside some of their skills:

> "In fact, when I presented him with the protocol (...), he signed it and told me: "*There you go, I have every faith in you, the only thing I ask is that I stay in control of the patient referrals*"."
>
> **Céline, working in 1 primary care team (ESP) with 1 GP**

Those who were also ASALEE nurses had an advantage over the other APNs: they had already been selected for their ability to work hand-in-hand with the GPs (Fournier et al. 2018), without hurrying them, as Françoise (an ASALEE APN and nurse delegated to public health (IDSP)) explained: "*Yesterday, I wrote a letter for the cardiologist for a patient; I did it but I asked him [the GP] to read it before signing it: "Is it ok? Is that what you wanted?" I'm very careful about such matters*".

While the very first APNs had great difficulty in obtaining a prescriber number, Françoise stated that her prescriptions were systematically validated and signed by the GP after his consultations, whereas another nurse interviewed, having had the same problem, said that the GP entrusted her with pre-signed prescriptions.

Establishing their position within primary care teams of the area and with regard to the patients

In order to negotiate their roles in primary care teams and amongst the other primary care professionals, the APNs often become involved in coordination activities, which were additional sources of income: "*I met [the self-employed state registered nurses (IDEL)] directly and said: "I want to establish a MSP with you". (…) I introduced myself from the outset as a coordinator*", explained Béatrice (who worked in 1 MSP, alongside 5 GPs). They had to reassure the nurses, particularly the self-employed ones, who were often worried about the arrival of a colleague who might see herself as the "boss" (Laetitia and Jérémy). Hence, their involvement in this coordination work was another way of highlighting their role aside from their classical nursing work and thereby showing that they were not going – as explained by Aurélie – "to step on the toes of the self-employed nurses".

This "nursing dilemma" – having to abandon nursing care to be able to advance up through the paramedical hierarchy, like the nurses who become healthcare managers – has existed for some time (Freidson, 1970). This paradox now also affects advanced practice nursing, which, for its proponents, is supposed to open up the possibility of a career in clinical practice, outside the specialisations of anaesthesia, surgery, and puericulture.

The APNs also had to confirm their new expertise, which was sometimes questioned by their nursing colleagues, as stated by Béatrice, Carole, and Sonia: "*[the self-employed nurses] think that when they change the dose of antivitamin K, they are doing the work of an APN. But it's not the case!*" (Sonia, involved in a union on a national level).

The links that were gradually created enabled the APNs to establish their role with regard to the other professionals: by organising information meetings intended for the self-employed professionals (Jérémy), by contacting them individually (Laetitia), or making themselves available to answer clinical questions or issues relating to the organisation of the MSP (Françoise, Béatrice).

> "Now, when they (the nurses) have a problem with a patient, they send me a message. I have many different interlocutors: the nurses and the physiotherapists; they've got the situation. And also the networks and the nursing auxiliary services. In fact, they know that if they go through the GP and leave a message, they won't get a response."
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> **Françoise, an ASALEE APN, working in 1 MSP, alongside 6 GPs and 7 nurses**

An APN (Laetitia, working in 2 primary care teams (ESP), alongside 6 GPs) set up a vaccination centre to deal with the Covid pandemic. She explained the advantages of this work, which involved coordination and management to become known in an area, despite the resulting extra workload, as she was also reachable on weekends and during holiday periods: "*And, above all, it's advantageous, as it means I can establish my presence in an area. Now everyone is aware that I'm an advanced practice nurse*".

The APNs also tried to give patients a broad outline of their consultation role through flyers and posters. This work

was sometimes challenged by other healthcare professionals, in particular the pharmacists when they rejected their prescriptions:

> "[The] patients (...) already find it difficult to understand an APN's role, so if you tell them that I'm not allowed to write prescriptions, which is completely untrue, then I'd have no credibility at all!"
>
> **Béatrice, working in 1 MSP with 5 GPs**

The development of a new nursing role influenced by social determinants

Several elements seemed to be decisive in the development of advanced nursing practice in primary care.

The influence of the nurses' relation with their profession

Initial training wishes expressed by the respondents influenced their nursing practice once they had become APNs. Like the self-employed nurses (Douguet and Vilbrod, 2007), the APNs interviewed often had parents who were employees or worked in intermediary professions. The desire to become a nurse was described as vocational: "*At the age of 17 I wanted to help others, so becoming a nurse was the right choice for me*" (Mélanie); or, on the contrary, as a logical choice: "*there weren't many offers with regard to secondary studies, and there was a nursing school, and as I have a knack for studying I opted for the first thing that was available*" (Béatrice). These nurses said that they had not considered studying medicine.

But, a considerable proportion of the respondents also expressed regret at being unable to continue their studies (Giraud and Moraldo, 2022). They would have liked to become physiotherapists, midwives, or GPs, but their families could not afford to pay for their studies. Yet, these are the very nurses who managed more easily to establish partnerships with GPs, and who invested most in all of the advanced nursing practice competencies, in particular the renewal of prescriptions and patient referrals without systematically consulting a GP. Some of them went beyond the decree regulating their competencies (unscheduled care, initial prescriptions, etc.) and took on more of a physician-replacement role.

The importance of social proximity with the general practitioners

The social characteristics of the APNs played an important role in being able to create a space for negotiations with GPs. Those who had the greatest social proximity with the GPs, via their network of family and friends, found it easier to sign an organisation protocol and develop their patient base. This was the case for several APNs who were the daughters or wives of medical doctors.

> "This is my private network. [GP 1], our children were at school together. [GP 2], we go kiting together."
>
> **Isabelle, whose father and husband are medical doctors, works in 1 primary care team (ESP) with 2 GPs**

When the referral from a first GP was not enough, they managed to complement their activity more easily by setting up multiple partnerships. Thanks to the fact that the GPs spoke about them with their fellow GPs, Isabelle stated: "*We've understood that the more we're referred to when we're not present, the better it is. You can't have a better recommendation than [the clinic's two specialist doctors].*"

Some of them said that they had been financially supported by their spouses – medical doctors or pharmacists –, while they continued with their studies, and during the start of their APN activity, which enabled them to look for partnerships more easily. In contrast, other APNs continued to work as self-employed nurses in order to maintain their income:

> "Ah, the nurses who work exclusively as APNs have a husband with an income... [laughs] a fairly large income, but, in any case, for someone like me who's single it's out of the question!"
>
> **Aurélie, working as an APN and a self-employed SRN (IDEL) in 1 primary care team (ESP) with 2 GPs**

The situation in which nurses worked as both APNs and self-employed SRNs (IDEL) created a vicious circle, making it more difficult for APNs – who worked less with GPs – to increase their active patient base.

Gender may also have a role to play, as demonstrated by Jérémy, the only nurse who spoke about receiving advice from the GP who had supervised his training, as the latter would have done for a young colleague.

A link between practices and the type of clinical autonomy sought by the nurses

The nurses who underwent APN training did not have the same aspirations with regard to clinical autonomy. Two ideal type models influenced the development of their nursing practice.

On the one hand, some APNs, who considered their core nursing role too restricted, wished to work in the medical field to diversify their nursing practice (Rosman, 2014). In return for their new competencies, they derived greater satisfaction from a nursing practice that remained somewhat "mandated" (absence of primary care and patient referral by the GP).

> "I felt restricted, frustrated; I felt that I needed to go further in my role (...) I was really expecting some input (...) on pharmacology, conditions ... (...) which examinations to prescribe, the type of follow-up care... which is, after all, a medical culture that we don't have as nurses – not so much."
>
> **Aurélie, working in 1 primary care team (ESP) with 2 GPs**

On the other hand, nurses engaged in advanced practice to obtain recognition of their "nursing expertise", gained from years of experience and often a preliminary master's in clinical nursing science. They also hoped that the new form of nursing practice would enable them to free themselves from GPs who, in their view, frequently failed to recognise their competencies.

> "I think I would have done anything because I just couldn't continue practising as a nurse (...) There was no longer any point in doing things mindlessly, carrying things out. (...) I'd even applied for occupational health nursing posts, where there was a bit more autonomy, because there were no GPs on site'. [And referring to the Canadian APNs]: "*They can burn a wart away, carry out a smear test, etc*"."
>
> **Cécile, working in 1 primary care team (ESP) with 1 GP**

As an example of the first ideal type, an APN expressed regret – with respect to a previous bad experience with another GP – that the APNs had to "work entirely under a GP's supervision and submit to a GP's whims". However, on several occasions, she used the term "medical delegations" to describe her new competencies, a term

that is challenged by the APN representatives. From a clinical perspective, she could use all her competencies, by monitoring (follow-up care) chronically ill patients, as well as occasionally providing care for patients with decompensation.

> "I'm extremely fortunate to work with a GP who is truly pro APN, who has told me that he doesn't know how he did it all before I was here, and who gives me plenty of autonomy – far more than the autonomy set out in the decree."
>
> **Aurélie, working in 1 primary care team (ESP) with 2 GPs**

Hence, she described a GP-APN team that was very satisfied with this way of working, in which, as has been demonstrated by the midwives and GPs, the perceived autonomy reflected the acceptance of interdependence (Schweyer, 1996). These APNs were also those who often pointed out in their statements their proximity with the GPs, acquired while studying for the State Diploma (DE) and then during their nursing practice. They valued the support they received from GPs in their clinical skills, an expectation which in return reassured the GPs about the fact that they could entrust their patients to them. Although they also argued for better valorisation of the new nursing role, these APNs were less likely to make demands for the recognition of nursing sciences. Some of the nurses wanted to change the name of their profession, removing the very term "nurse" and retaining only the notion of advanced practice, which would address the issue of better highlighting all their competencies by distinguishing themselves from core nursing practice.

Amongst these nurses who wanted greater autonomy – sometimes even independence – with regard to the medical profession, some of them had more difficulty in reaching an agreement on organisation protocols with GPs, which for them symbolised less autonomy than expected.

Hence, an APN from a less privileged social background, and who knew no medical doctor in her circle of family and friends, faced a number of difficulties: advocating a more independent approach, she found herself in a difficult financial situation as she was unable to establish enough partnerships with GPs, and said that she could no longer stand the idea of having to "sell herself": "*I've knocked on many doors; I don't have any dignity left; I've spent the last year knocking on every door*". (Cécile, who did not pass her baccalauréat exams, was working with a GP in a primary care team (ESP)). She said that when she spoke about her new nursing role she did not manage to overcome the reticence of the GPs, and she described situations in which she was reproached for taking the initiative. She explained that she had to both affirm her autonomy and the added value she represented for the GP, telling him:

"Either you work with the pharmacists who can now renew the prescriptions, but they won't ask the patient to lie down on an examination couch or look at them, and you'll have no feedback whatsoever. Or you work with an APN, and I can do an auscultation on your patient and give you feedback".

Advanced practices whose implementation provides information on the transformation of the primary care system

This study provides a detailed and unprecedented description of the activities undertaken in primary care by the first graduating APNs. In particular, it highlights the tasks they had to perform only to make possible the use of their competencies as set out in the Law, and the influence of their social characteristics and those of the GPs on the results of this work. The study contributes to documenting the poor development of their clinical activities, and the difficulties they encountered on a daily basis in developing them. Amongst the APNs we contacted, two had already had to cease practising, due to the fact that the GP had left or because they faced hostility from other practitioners. All the self-employed APNs interviewed spoke about financial difficulties, and this "financial precarity" (Bouhour, 2021) was all the harder to accept after the financial and family sacrifices involved in the resumption of studies during a career.

The experiences of the first APNs shed light, more broadly, on the ongoing changes in the organisation of primary healthcare. Firstly, some of the APNs contributed to the reorganisation of primary care, in particular via the creation of structures gathering health professionals. But they were all affected by the superimposition of many schemes – advanced practice, cooperation protocols, the ASALEE experiment, and new functions such as medical assistants and coordinators –, which have been added over the years and can compete with one another. Then, the APNs questioned the role of the GPs. In the same way that GPs argued – in relation to other medical specialties for holistic care and a pivotal role in patients' treatment programmes, the APNs also wished to perform these missions, highlighting the time they devoted to patients. In this study we show that two poles – clinical and coordination activities – emerged in the nursing practice of the APNs practising in primary care, just as, traditionally, the work of nurses who perform core nursing activities comprises technical and relational poles. The APNs competed with the GPs in these two areas, as the desire to adopt a management role in patients' treatment programmes was also one of the "key identification areas" in general nursing (Sarradon-Eck, 2010).

Lastly, the APNs contributed to transforming the nursing profession and its image amongst other healthcare professionals and patients. They benefitted from having an extended role, and from greater autonomy, and enabled a small number of nurses to pursue careers in clinical practice. However, the APNs' relation with core nursing practice was ambiguous – somewhere in tension between an extension of this practice and a desire to break away – and resulted in a lukewarm, even hostile reaction on the part of the nurses' and GPs' union representatives.

Although advanced practice nursing is continuing to grow, at a rate that is lower than expected by the public authorities, there are several outstanding questions. Will advanced practice nursing in primary care – an area of the health service in which the financial viability of primary care practices is yet to be proven, and in which the autonomy of the APNs remains limited, despite the progress made in 2021 and 2022 with the experimenta-

tion allowing direct access to patients and the ability to write out the initial prescriptions, and with regard to the amount of the flat-rate payments and aid to help AMNs set themselves up – become a more attractive option for nurses? How will the changes in the profiles of the new APN students, who are less demanding than their predecessors, affect the development of their activities once they have set themselves up? And, lastly, in the longer term, how will the increase in the numerus clausus, or quota, of GPs affect the ongoing redefinition of task sharing between healthcare professionals? ♦

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