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Nursing boundaries and work identity construction among nurses exercising an advanced role: A qualitative study

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ABSTRACT

Research on the deployment of advanced practice nurses (APNs) in healthcare settings highlights significant challenges for APNs transitioning to a broader, less well-defined nursing role in negotiating professional boundaries and a new work identity with other health workers. However, theories of boundary-work and professional identity have been rarely applied to APNs relationships with general nurses and colleagues in lower professional position such as nursing-assistants. APNs relationships with these colleagues remain poorly understood. This article aims to contribute to addressing this gap. It is based on qualitative research on a pilot-project prefiguring the introduction of APN (pre-APN) in the French Health system entitled the Prefiguration of Clinical Nurse Specialists (PrefICS). Data were collected through field observations and interviews with pre-APNs, general nurses, nursing-assistants, doctors and nursing hierarchy, to assess the implementation of PrefICS project in four hospitals, one health centre and one cancer control centre. The analysis shows that facing the risk of their role being limited to collaborations with doctors, pre-APNs engaged in different forms of boundary-work with general nurses and nursing-assistants, to negotiate new professional relationships with these colleagues. Some pre-APNs presented themselves as resource persons and led activities aimed at developing and sharing nursing knowledges and competencies with general nurses and nursing-assistants. Other pre-APNs shaped their work identity around a reformist role in terms of both the nursing profession and work environments. Pre-APNs boundary work with general nurses and nursing-assistants produced work spaces in which pre-APNs interwove their work identity with these colleagues by negotiating new professional ties and brokering knowledges between different professional worlds. Changes in levels of pre-APN self-categorization reflected different views of the nursing and nursing-assistant professions, from which pre-APNs started building new alliances for a shared reflective work on their practice and about caring.

1. Introduction

In the last four decades health care organisations and systems across the developed and developing world have been facing challenges that have called into question their modes of functioning and demanded for a capacity for transformation [1–4]. The health situation of high-income countries has been marked by a combination of multiple changes, such as the demographic and epidemiological transitions along with the emergence or re-emergence of infectious diseases such as HIV and most recently COVID-19, as well as

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scarcity of medical resources in certain territories and increasing economic constraint [5–7]. This health situation, together with the aspiration of some health care workers, particularly nurses, to extend their fields of intervention, has led to various reforms in health professional education and policies [8,9]. Nurses, among other health care givers, have obtained the recognition of a more autonomous and prominent role.

This article deals with the development of the Advanced Practice Nurse role in the French health system.

Following the definition formulated by the International Council of Nurses [10], the Advanced Practice Nurse (APN) role is an advanced role exercised by nurses with a Master's degree who have acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice. Nurses exercising this role have greater autonomy than general care nurses, allowing them to make choices in terms of patient education, prevention, screening and therapeutic follow-up, and to carry out a more in-depth analysis of clinical situations.

The results presented in this article are drawn from qualitative research based on semi-structured interviews and field observations, conducted in six health-care institutions in the Paris area, which were involved in a pilot-project on Advanced Practice Nurses (APN), entitled the Prefiguration of Clinical Nurse Specialists (PrefICS) project. As the project and the study of its implementation were carried out before the official establishment of APNs by legal decree in France in July 2018, in this text we use the denomination pre-APN for convenience.

2. Background

The APN role was officially introduced in the United States and in Canada in the mid-1960s, and then gradually expanded all over the world, so that the phenomenon of nursing based on advanced practice roles now has a global dimension [11–13]. However, the development of the role in different countries around the world has contributed to a proliferation of titles in use as well as to variability in role characteristics [14–16]. Roles associated with advanced nursing practice have been influenced by different factors such as the health care context, socio-political imperatives, social and political movements, and professional identity and values [14,17,18].

In France, the notion of advanced practice nursing has gradually emerged in a context of global changes in the supply of care [19, 20], while being part of the national project to modernise the health system [21]. In particular, in France as in other European countries where advanced practice nursing has been introduced since the late 1980s [22,23], the main drivers for the introduction of APNs have been the shortage of medical staff, the changing demand for care linked to the increase in chronic disease, an ageing population with health problems and reduced autonomy, and the need to enhance the attractiveness of nursing.

The decrees of July 18th, 2018 [24] relating to the interventions, activities and education of advanced practice nurses have formalised their practice within a national health context marked by different extensions of the range of nurses' practice in response to unmet needs within the health-care system [25–27].

2.1. The pilot-project on pre-APN

In 2014, the Île-de-France Regional Health Agency [28–30] together with seven universities situated in the Paris area, represented by their faculties of medicine, and with volunteer teams recruited in 13 health institutions,[1] set up a pilot project on the implementation of advanced nursing roles, entitled the Prefiguration of Clinical Nurse Specialists (PrefICS).

The teams were composed of three representatives from each health institution including a doctor, a nurse and a member of the care board. The PrefICS project was based on five key APN roles proposed by the ICN [10] that fall within some of the areas of expertise described by Hamric et al. [31]: the clinical role, the advisory and consultative role, the leadership and team-building role, the teaching and training role and the research role. The implementation of this project led to the education and integration of 27 pre-APNs within these 13 institutions in four priority areas of care needs of the population: care of the elderly, mental health and psychiatry, support for the dependent sick (chronic diseases, cancer), and primary care. These pre-APNs were educated through the master's degrees available at that time, for example, the degree in "clinical nursing sciences" offered by the High School of Public Health (École des Hautes Études en Santé Publique) in partnership with the University of Marseilles.

2.2. The pilot-project implementation assessment

Qualitative research bringing together field observations and interviews was carried out between January 2017 and June 2018, in response to a call by the Île-de-France Regional Health Agency for projects to examine the implementation of the PrefICS pilot-project. The objectives of the study were to analyse pre-APN deployment processes in different healthcare settings and to identify obstacles and favourable factors for pre-APN activities in relation to their professional collaborations in health care-settings. The investigation brought to light that pre-APNs worked to shape their role in the context of multiple professional collaborations which varied according to their working environment: with doctors, generalist nurses and, in some cases with nursing assistants as well.

Results concerning the deployment of the pre-APN role in relation to collaborative practice with doctors were presented in an article entitled, "Foreshadowing the exercise of advanced nursing practice: a co-construction at work in the care setting" [27]. These results highlight the ambivalence of relationships between pre-APNs and doctors [27]. Doctors interviewed were favourable to the

[1] 8 hospitals, 1 cancer control centre, 1 healthcare institution and 3 health centres.

introduction of pre-APNs and contributed to the development of pre-APN clinical competencies and activities. But at the same time they exercised a restrictive power over the extended pre-APN role [27] to the detriment of pre-APN professional relationships with other colleagues such as general nurses and nursing assistants. Like APNs working in Canada and in the United States [18,32], some pre-APNs stressed during the interviews the risk of being assimilated within the professional group of doctors [27] as "less skilled doctors" [32].

The present article deals mainly with the data from this research that illustrate the ways in which pre-APNs engaged in various forms of "boundary-work" in collaboration with generalist nurses and nursing assistants, with the intention to structure, facilitate and reinforce their professional relationships with these colleagues and interweave their work-identity with them.

This article emphasizes in particular an alternative view of professional boundaries as sites of connection and mutual recognition between different categories of health-workers, rather than as barriers for defensive protection or sites of conflicts over professional jurisdiction. Pre-APN work-identity constructions appear as relational processes arising from the boundary-work in which pre-APNs engaged with general nurses and nursing assistants, to counteract their partial and inconsistent assimilation to the medical profession.

3. Theoretical framework

This research is informed by the stream of sociological thought that considers work identities and professional boundaries as dynamic, context dependent, and interactionally produced. It draws on theories about boundary-work and professional identity as well as on the notion of profession as a process characterized by a plurality of work identities, values and interests shared within groupings of professionals that tend to be more or less undergoing change [33].

3.1. APNs, nursing boundaries and boundary-work

Boundaries are usually understood as lines that delimit entities such as countries, jurisdictions, professions, organisations, disciplinary fields. In the sociological research about professions, Abbott defines professional boundaries in terms of "sites of difference" [34] that are created by actions to manage conflicts and hostilities between different groups of actors, and are then linked to one to another to create what is recognizable as an entity. However, like other types of boundaries, professional boundaries are not fixed and perpetually defined. They are sites of multiple actions, and they can be breached, expanded, blurred, reinforced, repaired, or remade by groups of actors situated on opposite sides of them.

Research into the nursing profession has mostly focused on the medical-nursing boundary. Issues like intra-professional differentiation or internal conflicts and alliances among nurses, and their professional relationships with other health workers occupying a lower position such as nursing assistants, have been much less studied.

Within the huge volume of literature about APNs in different countries around the world, research into APN professional relationships with generalist nurses and nursing assistants is still very limited. Some studies have focused on the "cultural barriers" to APN role that the nursing profession has developed, in terms of "cultural conservatism" [35–37] while also noting the lack of empirical attention that this phenomenon has received [35,38], as well as its categorization as "unpalatable or taboo" within nursing [36]. MacLellan, Levett-Jones, and Higgins have described different forms of resistance from generalist nurses towards newly qualified ANPs in Australia, ranging from dismissive and secretive behaviour to open hostility [39]. Piil et al. in particular stress specific forms of elitism towards generalist nurses by nurses exercising an advanced role [40]. By contrast, Trotter examines the ways in which some Nurse Practitioners (NPs) in education negotiate a new nursing identity by re-inscribing their expanded role in the "old work" of bedside nursing [32]. The author mobilizes the notion of "reparative boundary-work" to describe protective strategies utilized by "nurse-practitioners-in-training" [32] in order to repair boundaries that have breached by both outside and internal pressures due to the expansion of the NP role.

Following the theoretical perspective developed by Abbott about professional 'ecologies' and 'jurisdictions' and their interdependence [34], Trotter stresses that "boundaries legitimate identities as well as resources" [32]. They also facilitate the structuration of collaborations and working relationships [41,42], although within the work context professional boundaries are dynamic features because of the ongoing rearrangement of the division of labour. They may thus be blurred [43,44], breached and repaired [32,45,46], or reinforced and shaped as more rigid barriers [35,36]. As this article will show, they may also be enacted as sites of connections and mutual recognition between groupings of workers while preserving their professional distinctiveness. These different sorts of boundary work are constitutive of the construction processes of professional identities.

3.2. Nursing, professional identity and work identity construction

As Lewis remarks [14], professional identity has historically been defined "in terms of a self-concept or self-image based upon a set of unifying beliefs, values, and experiences". These unifying values, beliefs, and experiences are historically produced and patterned through the educational apparatus of the professional group in question, the knowledge transmitted and the qualification procedures. T[2]hey vary from country to country and throughout the history of the profession. In the case of nursing, intra-professional debates in different countries about nursing identity have arisen at the same time as changes in the educational field and the introduction of new

[2] Real first name changed.

roles [32,47,48].

However, when work identities are associated with new roles like APN emerging from more established occupational groups such as nursing, these professional identities appear as more flexible and malleable, and more dependent on work context and individual characterization [14,35]. Fairman has drawn attention to the struggle that NP pioneers in the United States undertook to present themselves as nurses wielding medical tools [47]. Trotter emphasizes the "reparative boundary-work" undertaken by NP against the risk of being considered as less skilled doctors rather than as differently skilled nurses [32].

In this article we analyse pre-APN work identity construction processes with respect to general nurses and nursing assistants through the lens of the "relational identity" [49]. As Andersen and Chen remark, "the self is relational or even entangled with significant others" [50].

This article emphasizes that the pre-APN self-concept and self-image are produced not only in relation to their professional values, beliefs and goals but are also framed by working relationships with colleagues considered by pre-APNs as "significant others", namely general nurses and nursing assistants. In particular we highlight the values and beliefs that pre-APNs mobilize to build work relationships with general nurses and nursing assistants, by explaining the reasons why these colleagues were considered as "significant others" by pre-APNs in building their new work identity.

4. Methods

The data analyzed in this paper were produced in a qualitative survey that combined field observations and semi-structured interviews.

4.1. Data collection

The survey was conducted by a PhD anthropologist, between January and April 2017, in six of the thirteen partner establishments in the PrefICS project that agreed to participate in our survey (namely 4 hospitals, 1 cancer centre, 1 health centre).

Semi-structured interview guides were drawn up for each professional category involved in the survey (Table 1). Informed oral consent was obtained after presenting to the interviewee the survey, the conditions under which the information was to be anonymously collected, and the option not to participate. Informed oral consent was also obtained from patients through the pre-APN for the observation sessions. However, the researcher did not have any direct or informal exchange with patients.

The informants perceived the interviewer as their spokesperson vis-à-vis the Regional Health Agency that initiated this pilot-project and also initiated the research. It was therefore easy for the researcher to gather the health professionals' critical views on their working environments, the status of the nursing profession in the French healthcare system and the difficulties encountered by pre-APNs in developing their role.

Specifically, the interviews aimed to ask the actors about their different understandings of advanced nursing practice, their expectations in relation to the pre-APN role, and more particularly about the local processes of its implementation.

Observations of the activities of pre-APNs were made at each site for a total of 10 observation sessions. Their duration varied depending on the nurse's observed schedule and the activities in which he or she participated. The researcher played the role of an "observer who participates" [51,52] in certain peripheral activities of the pre-APNs, such as helping them to assemble the material needed for the patient's consultation, putting it away, tidying up the consultation box.

The observations provided insight into the professional environment of pre-APNs, the conditions under which they perform their duties, and their various professional interactions. They enriched the information obtained by interview, because they enabled us to go beyond a collection of information based on formal and official speech, which may sometimes be only an idealised restitution of real practices.

4.2. Sample characteristics

The 29 participants in the semi-structured interviews were recruited from pre-APNs (10), generalist nurses (2), managers of care units (1), doctors (10), representatives of the care board and hospital management (6).[3] This is a convenience sample including the actors directly involved in the PrefICS project who volunteered to participate (Table 2). The individual face-to-face interviews, which lasted between 45 min and 2.5 h, were conducted at the interviewees' workplaces. Informal interviews took place during the observation sessions with 4 generalist nurses and 4 nursing assistants. The researcher recorded these exchanges in her field note book.

Data saturation was discussed by the researchers, and they agreed about the redundancy of the information collected after the realisation of 29 interviews and 10 observation sessions.

4.3. Data analysis

Audio-taped interviews were transcribed and anonymised. The materials collected (interviews and field notes) were organised according to professional categories. The content of each interview was broken down according to a thematic matrix. Six themes

[3] 2 Directors of Care, 1 Deputy Hospital Director, 1 Senior Nurse Specialist, 1 General Care Coordinator, 2 Senior Health Executives.

Table 1
Semi-structured Interview guides.

Informants	Main topics
Representatives of health care nursing departments and hospitals	• Definition of pre-APN role • Expectations with regard to pre-APNs/needs of health institutions • Policies to support the introduction of pre-APNs • Obstacles/Levers
Pre-APN	• Education, background and career plans • Motivations and expectations of the pre-APNs position • Obstacles/levers to Pre-APN introduction • Relationships with the nursing hierarchy/doctors/generalist nurses/nursing assistants and other colleagues • Professional collaborations
Generalist Nurses	• Explanations about pre-APN activities • Expectations with regard to pre-APNs/needs of health institutions • Definition of pre-APN role • Working conditions of pre-APNs • Relationships and collaborations with pre-APNs • Obstacles/levers to Pre-APNs introduction
Doctors	• Explanations about pre-APN activities • Expectations with regard to pre-APNs/needs of health institutions • Definition of pre-APN role • Working conditions of pre-APNs • Relationships and collaborations with pre-APNs • Obstacles/levers to pre-APN introduction

Table 2
Socio-demographic characteristics of interviewees.

Profession,	Sex	Age (years)	Health Care Institutions, practice area
Pre-APN	W	58	Hospital, Psychiatry
Pre-APN	M	42	Hospital, Psychiatry
Pre-APN	W	39	Hospital, Psychiatry
Pre-APN	W	33	Hospital, Geriatrics
Pre-APN	W	40	Hospital, Urodynamic Consultation
Pre-APN	W	53	Hospital, Diabetes
Pre-APN	W	37	Hospital, Cystic Fibrosis Resource and Competence Centre
Pre-APN	W	28	Health Centre
Pre-APN	W	41	Health Centre
Pre-APN	W	34	Cancer Centre, haematology
General Nurse	W	42	Hospital, Diabetes
General Nurse	W	37	Hospital, Cystic Fibrosis Resource and Competence Centre
Health Executive	M	60	Cancer Centre, haematology
Senior Health Executive	W	60	Cancer Centre, haematology
General Care Coordinator	W	57	Hospital
Senior Health Executive	W	57	Hospital
Assistant to the Hospital Director	M	42	Hospital
Director of Care	M	62	Hospital
Director of Care	W	61	Cancer Centre
Doctor	W	39	Hospital, Diabetes
Doctor	M	50	Hospital, Geriatrics
Doctor	M	54	Hospital, Geriatrics
Doctor	W	49	Hospital
Doctor	W	49	Hospital
Doctor	W	54	Hospital, Cystic Fibrosis Resource and Competence Centre
Doctor	W	60	Hospital, Cystic Fibrosis Resource and Competence Centre
Doctor	W	46	Hospital, Cystic Fibrosis Resource and Competence Centre
Doctor	M	40	Health Centre
Doctor	M	61	Cancer Centre

correspond to the main issues in the interview guides: theoretical definitions of the pre-APN role; expectations of the pre-APN role; motivations of pre-APNs; barriers and favourable factors for their introduction; collaboration; and professional relationships. Two other themes emerged in the course of the survey: the active role of pre-APNs in the process of implementing their role; and the construction of their work identity.

The interviews and the conditions of emergence of the discourse were linked to the notes taken during the observation sessions of the interactions in professional context.

5. Results

The description of both the boundary-work and the work identity construction in which pre-APNs engaged with general nurses and nursing-assistants highlights that professional boundaries and identities are dynamic constructs which vary with both the work context and also pre-APN visions of nursing, work relationships and working conditions.

5.1. Nursing boundary work and pre-APN identity construction, as seen through nursing segmentation processes

Interviews with 10 pre-APNs and observations of their routine clinical practice in the six selected health care institutions led us to identify the development of different kinds of relationships between pre-APNs on the one hand, and generalist nurses and nursing assistants on the other hand. These are the results of multiple processes tending to create different groupings of nurses sharing the same values, interests and objectives, and which have the potential to become patterned as "profession *segments*" [33]. These processes are particularly shaped by the engagement of pre-APNs in different initiatives aiming to give new sense and new forms to nursing work and caring. Furthermore, our survey underlined that these segmentation processes play specific roles in the construction of intra-professional and inter-professional nursing boundaries, which in geriatric hospitals are also at the interface with nursing assistants.

5.2. Crafting a pre-APN identity in the eyes of general nurses and nursing assistants: achieving transparency and building new work relationships

As the interviews with pre-APNs revealed, their role was, in various ways, misunderstood among both generalist nurses and nursing assistants. Two pre-APNs reported during the interviews that they were perceived by generalist nurses as privileged nurses working in an office closed to doctors, and thus quite distant from and invisible to other nurses.

> No, I'm not considered like a normal nurse, and since I don't work weekends, that's [laughter], I'm …, and that's it, I'm a nurse who works in an office, so no visibility of what I do …

(Pre-APN Cystic Fibrosis)

> Well, I write down everything I do (…) because other nurses and nursing assistants might actually have questions: "She is in her office, we don't see her, what does she do?" Or, "She doesn't do anything."

(pre-APN Urodynamic)

Informal exchanges with 4 generalist nurses, on the other hand, highlighted both their lack of concrete knowledge of the pre-APN role and their reluctance to envisage forms of cooperation and exchange with these expert nurses. Pre-APNs were generally perceived by generalist nurses as being much closer to doctors than to them, because of their activities and also because of the spaces they occupied.

By contrast, semi-structured interviews with two nurses who worked closely with two pre-APNs in a paediatric teaching hospital, for the management of cystic fibrosis and type 2 diabetes respectively, revealed their positive appreciation of this role and particularly of the education in advanced nursing practice:

> - I let my colleague prepare the way and I see that she always comes with new ideas, a lot of enthusiasm, and so maybe me too, I will engage in this way …

(generalist nurse in Cystic fibrosis)

> - The Masters requires a lot of investment from her (pre-APN diabetology) … I think that it opens other perspectives in the approach to the patient, and how to communicate with each other.

(generalist nurse in Diabetology)

Informal interviews with four nursing-assistants working in two geriatric wards highlighted the fact that the two pre-APNs introduced themselves to the care assistants to inform them of their availability to offer health-care staff advice and counselling.

> Actually, before Diane[4] talked to us about her work, I did not know that she was a nurse … and she really helps us in improving our care, she is always available when we ask for her.[5]

(nursing assistant in geriatrics)

In their turn, pre-APNs developed two different attitudes: an attitude of solidarity, positioning them as resource persons for generalist nurses and nursing assistants, and an attitude of reformism, reflecting both their desire to reform work environments and their criticism of the professional posture of generalist nurses.

[4] Field notebook.
[5] Field notebook.

5.3. Pre-APNs as resource workers for general nurses: creating an intra-professional boundary for brokering expert knowledge and advanced skills

Interviews with four pre-APNs showed their commitment to share resources and information about advanced nursing practice with other nurses. They also expressed their willingness to engage in various educational activities for general nurses and to disseminate the culture of evidence-based practice through, for example, the creation of workshops for collective reading of scientific articles and studies.

> I wanted to create a staff library for nurses, precisely because I find that in our professional practice we do not have enough time to read, but it is really important if we want to argue with doctors …

(pre-APN Diabetology)

> Nurses are not given enough to read … APN can accompany them and say "we have a science, we are able to do things and propose things and have a philosophy …" (…) but today we don't know how to think about our work collectively and theoretically and make proposals … Maybe … working groups related to projects on quality of care …

(pre-APN Cystic Fibrosis)

Thus, far from placing themselves in a hierarchical relationship with other generalist nurses, these two pre-APNs, as well as others among the ten interviewed, considered themselves rather as resource persons with a solidary attitude. They engaged in planning activities aiming at sensitizing to and developing nursing knowledges and competencies. Two pre-APNs working with geriatric patients stated:

> I have a lot of freedom, but acquired precisely through sharing, and especially transmission, transparency of what I do. I told nurses and nursing assistants about my role, what I can do for them. They know I am available for counselling and advising teams in the services and they call me when they need …

(pre-APN of palliative care in geriatrics)

> The nurses and care assistants, as I make references to the theory from the daily life of what they experience, it speaks to them straight away. (….) I tell them - My job is also to pass on good practices to you, to try to do things right for the patient, to improve our quality of care, to professionalize what we do.

(pre-APN urodynamics consultation in geriatrics)

In their attempt to construct a new work-identity these pre-APNs opened themselves to being identified as resource providers for their colleagues, by privileging dialogue and the dissemination of information about their role and their work's relationships.

5.4. The pre-APN as a reforming agent in nursing work: making a selective intra-professional boundary

Two pre-APNs in psychiatry expressed some criticism about the fact that the majority of general nurses are reluctant to break out of their routine work:

> We limit ourselves, and … how many times do I hear "well, for me, it is not prescribed, there are things I don't do", but … um … for example, making a home visit because you think that a person is in trouble on a particular thing … nothing prevents you from going to the doctor and saying, "Look, it's strange, this patient hasn't been seen for 15 days … We'll try to see him".

(pre-APN Psychiatry)

> As a nurse, at the grassroots, what I noticed is that there is not enough preventive health work on sexuality for psychiatric patients, but where I worked nobody was willing to undertake prevention programs … and that is part of the nurse's role.

(pre-APN Psychiatry)

In addition, these two pre-APNs highlighted the fact that the implementation of their new role was also linked to a will to reform both the work environment and the current representation of the nursing profession among nurses themselves, in order to make their practice more dynamic and autonomous.

> *The difficulty, quite often, is in our own profession. Sometimes, we can't coordinate, and we can't move forward together, but maybe as an APN I will be able to create new projects in which some nurses may be willing to be involved … Maybe create Therapeutic Patient Education sessions …*

(pre-APN Psychiatry)

> In nursing you should have the opportunity to do research, except that actually, for example here, there is no PubMed access for nurses, so we should start with that … we have to ask for that together with nurses if they are interested in it. … Do you know? I don't want to be a resource person, not for doctors and not for nurses, but instead I want resources to be available … We are making a library open to nurses right here, if they want they go there …

(pre-APN Psychiatry)

These pre-APNs expressed their criticism of nurses' working conditions and of their profession as well. They raised the possibility of

leading projects involving general nurses, or advocating with some of them for some resources like the access to a platform for biomedical literature. However, their discourses emphasize their selective attitude in favour of those nurses who may already be interested in breaking with their routine work by participating in new activities and actions.

5.5. Tracing the inter-professional boundary with nursing assistants: a space for reflective and formative work

Two pre-APNs working with geriatric patients were particularly engaged in advising and counselling nursing assistants and developing collaborative work with them. During the interviews they explained the reasons:

> I work a lot with the nursing assistants. They spend the most time with the patients, and they are always going to know them very well, it's just that they are not aware about that … I help them to become aware, they give me many important pieces of information about patients

(pre-APN of palliative care in geriatrics)

> Here nurses' assistants are at the frontline, quality of care depends on their job … I say to them: "You can call me if you need. I am Diane, not 'Madam', because we are among colleagues. Yes, I am a nurse in urodynamics consultation, but I am also called by the teams, and then I go to the services to give advice and counselling".

(pre-APN urodynamics consultation in geriatrics)

Further exchanges with pre-APNs about their collaboration with nursing assistants highlighted the fact that, in spite of their essential work with elderly patients, they lacked recognition from the health-care staff. Pre-APNs also stressed that nursing assistants were accustomed to considering their tasks as degrading, and were not aware of the complexity of their care giving, especially personal care and grooming of patients. These two pre-APNs had therefore organised training sessions about these areas of care, and were used to giving counselling specifically about them.

Informal interviews with four nursing assistants brought out their feelings of being invisible to their colleagues, and a lack of communication with other health professionals and of recognition from them.

> Here we are invisible staff in the eyes of our colleagues … only the patients, their families sometimes say thanks to us … [6]

(nursing assistant in geriatric wards)

> I used to wonder about the patients, about the care I provide, but who to talk to about it?[7]

(nursing assistants in geriatric wards)

During the observation of the activities of the pre-APN in the mobile "palliative care and pain" team, the researcher witnessed her intervention with a patient with advanced Alzheimer's disease with retraction of the lower limbs. This pre-APN intervention had been requested by a team of nursing assistants: they reported that the patient communicated by shouting, and about their difficulty in performing personal care and grooming. The pre-APN performed a complete personal care of this patient, during which the patient was able to relate to and even cooperate with the pre-APN. This intervention was a form of assistance to nursing assistants in the specific approach to take in the management of this patient, and of advice about different techniques used for the removal of dressings and oral hygiene.

During this intervention the pre-APN emphasized the relational dimension of the patient's personal care, the importance of verbalizing the actions of the nursing assistants towards him/her, and respect for him or her as an aspect of patients' rights.

This pre-APN had also been involved in the writing of several texts on this form of care, and on the complexity of touch in caregiving work. At the time of our investigation she told the researcher that she had a project to write an article on this same subject with a nursing assistant.

6. Discussion

Research on APN boundary-work and professional identity construction has highlighted the challenge that these nurses faced in redefining their scope of practice in the nursing field [18,32,47]. Trotter examines rhetorical ways in which future NPs in education build a new work-identity based on the bedside-care of nurses [32]. Chulach and Gagnon refer to a hybrid professional identity that accounts for the incorporation by NPs of their nursing framework of care into a "new professional world, a space in-between nursing and medicine" [18]. In these studies, professional boundaries are described either as porous and malleable lines of demarcation or as sites where different actions of breaching and repairing take place. Here we have particularly emphasized that professional boundaries between pre-APNs, generalist nurses and nursing assistants are on the one hand the result of the mutual recognition by pre-APNs and their colleagues of their respective working fields, and on the other hand we have shown that these boundaries represent spaces of connection and structuration of professional relationship and collaboration.

The forms of boundary work in which pre-APNs engaged with generalist nurses and nursing assistants symbolise firstly the coming

[6] Field notebook.
[7] Field notebook.

together in different structured ways of professionals who would otherwise be at risk of drifting apart, with pre-APN activities being monopolized by doctors. Secondly, these intra-professional and interprofessional borders represent spaces of alliance between different workers for a shared work of reflection on their activities and about caring. By engaging in this boundary-work pre-APNs have expressed their freedom to identify the "significant others" [50] with whom they can interweave their new working identity, while changes in levels of pre-APN self-categorization reflect differences in views of the self but also different views of the nursing and nursing-assistant professions. In the interviews, pre-APNs referred to their relationships with generalist nurses and to nursing in idealised ways. These interviews thus brought out their vision of the nursing profession and how this aligned with their commitments to make it evolve in terms of professional practice, autonomy and nursing knowledges. The analysis of work relationships between pre-APNs and nursing-assistants in particular sheds light on the ways in which the specific modes of distribution and production of knowledge, among health care professionals situated at the bottom of the health workers hierarchy, offer opportunities for them to discover other aspects of their tasks and to revalue their roles.

Evoking the observation of Delvin et al. about the professional identity of Canadian NPs [52], our research has shown how for pre-APNs, moving from the centre of the health system, occupied by doctors, to the different margins can enable them to ally with colleagues to revalue the essential characteristics of nursing with the aim of improving both working conditions and patient care.

7. Conclusion

As many researchers into APN around the world have stressed, communication, role definition and understanding of the APN role are critical and challenging processes even in those countries like Canada and the United States where APNs were officially introduced almost 60 years ago. These processes are marked by different initiatives taken by APNs to shape their role and their work-identity.

This article has illustrated some of these initiatives, which consist of pre-APN engaging in structuring working relationships with general nurses and nursing assistants. These working relationships, based upon collaborative practices of dissemination, and development of nursing knowledge and competencies, have the potential to improve the working conditions and the quality of life at work of these health professionals who, while playing an essential role in the care of patients, lack professional valorisation and recognition in their work environments.

8. Study limitations and implications for future research

This article has offered an original and detailed description of the emergence of working relationships between general nurses, nursing assistants and nurses exercising an advanced role at the moment when APN role started to be introduced in different health settings in France. We have not extended this to deal with the further developments of these relationships, and their effects on health professionals and patients have not been assessed. Future research is needed and should focus on the evolution of these relationships as well as their effects on the work environment and the quality of care.

Ethical approval

Ethical approval was obtained from the Inserm Ethics Review Committee (Comité d'évaluation éthique de l'Inserm CEEI, [n°IRB00003888]) in November 2016.

Author contribution statement

Carolina DE ROSIS: Conceived and designed the experiments; Performed the experiments; Analyzed and interpreted the data; Wrote the paper.

Maria Teixeira, Ljiljana Jovic: Conceived and designed the experiments; Analyzed and interpreted the data.

Data availability statement

The data that has been used is confidential.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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