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An Ambivalent Recognition: The Academisation of Nursing in Switzerland

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Abstract

Despite the academisation process the profession goes through in many Western countries for decades, the level of autonomy of the nursing profession is still relatively low; nurses remain broadly under the domination of doctors and health care institutions. The opening in 2009 at the University of Lausanne of a master's degree marked a new stage in the history of the profession in Switzerland. With new resources, the emergence of this nurses' profile disrupting professional relationships, both with respect to doctors as well as within the profession. After having presented the stakes of going through an academic training based on scientific knowledge, the article shows the attempt of redefinition of the practical and symbolic roles to which it gives rise as well as some of the effects of this diploma and its resources are having on the professional relationships.

Keywords

Nursing profession, academisation, power relations, Switzerland

Introduction

The nursing profession has historically been thought of as one which is subordinate in most working relationships[1]. Hughes (2008) noted that at the end of World War Two their role consisted of "of all the things which have to be done in the hospital and which are not done by other kinds of people" (p. 312). Looking at the hierarchical component of this division of labour, Freidson (1970) showed that the medical profession held a legal and symbolic monopoly on the assessment of patients' ailments; nurses had neither power nor autonomy over any decisions concerning patient care. Although these views may seem somewhat dated, later works came to similar conclusions. In the 1990s, Feroni and Kober (1995) showed that because doctors had a monopoly on diagnosis, prescription, and making incisions into human bodies, nursing remained a "profession of limited autonomy" (p. 37). More recent research came to the same overall outcomes showing that social relations between doctors and nurses remain marked by different kinds of domination—notably legal, symbolic, and gender domination (Picot, 2005; Longchamp, Toffel, Bühlmann, & Tawfik, 2020).

This picture cannot, however, conceal the long process of emancipation that the profession has undergone since its emergence. On the educational side, schools of nursing managed to largely free themselves from the tutelage of doctors during the second half of the 20th century. On the practical side, as of the 1950s, a distinct hierarchy began to appear (Feroni & Kober-Smith, 2005), with a distinctive "role of their own" (*role propre*) developing in the 1970s (Lert, 1996), partly freeing nurses from doctors. The emergence of distinct nursing knowledges (nursing sciences) further contributed to the nursing profession's potential for emancipation from the medical profession. The combination of these aspects provided nurses with a certain level of professional autonomy. Some authors were then tempted to label the relations between nurses and doctors as a "negotiated order" (Strauss, Schatzman, Ehrlich, Bucher, & Sabshin, 1963), at least in some sectors (Liberati, 2017). Others went so far as to consider the two professions as partners (Svensson, 1996).

That said, these two notable stages—the establishment of specific nursing education and the development of their "own knowledge"—were not enough to emancipate the profession. It has been observed that despite the ongoing academisation process taking place in many countries in continental Europe (Laiho, 2010; Lahtinen, Leino-Kilpi, & Salminen, 2014), the level of autonomy of the profession is still relatively low: nurses remaining broadly under the domination of doctors. This ascertainment has been shown as well in recently academised countries, such as Italy (Sena, 2017), as where academisation started way earlier, like in the USA (Judd, 2010). Tied to its past, the nursing profession seems incapable of throwing off its symbolic designation as "paramedical," which trap it in

[1] A longer version of this paper has been published in French in the *Swiss Journal of Sociology* (Toffel, 2020).

the status of a "would-be profession" largely subordinate to doctors and hospitals (Freidson, 1970).

The vertical and horizontal differentiation, which accelerated in recent years within the profession, begs questions about the definition of areas of knowledge and the care practices. Whereas the vertical differentiation (multiplication of training and career paths) to which more academic education contributes can generate tensions between different nursing profiles (Chaves, 2005; Ayala, Gerard, Vanderstraeten, & Bracke, 2014), horizontal differentiation (multiplication of institutions employing nurses due to the raise of ambulatory care) produces different conceptions of the profession, such as the varied means used in the struggle for its autonomy (Longchamp et al., 2020). These transformations are occurring within a context where professional borders are being redrawn under the influence of factors like increasing numbers of women doctors (Picot, 2005), shorter average lengths of hospital stay (Acker, 2005), and impregnated by neo-liberal reforms of the healthcare sector in OECD countries (Pierru, 2008).

Western Switzerland[2] presents an interesting case to apprehend some of these changes and their effects on the nursing profession. The master's and doctoral degree programs in nursing sciences available at the University of Lausanne's (UNIL) Institute of Higher Education and Research in Healthcare (IUFRS) since 2009 were the first academic programs at this level in this part of the country[3]. This is a new stage in the profession's history and is contributing to the general movement towards a more academic style of teaching nursing occurring across continental Europe. Nurses began to acquire new knowledge backed up by recognition of a new type: scientific. Making areas of professional knowledge more science-based is a crucial step towards giving those professions greater autonomy (Elzinga, 1990).

To grasp what is at stake in making the profession more academically based, this article focuses on nurses who have gained a master's degree in nursing sciences from the IUFRS while keeping in mind that these nurses are only a sub-fraction of the profession. This calls for a structural approach capable of embracing the profession as a differentiated social space like Bourdieu's field concept invites (Bourdieu, 1996). Some attempts to use Bourdieu's theoretical framework on the healthcare universe have been made—notably to overcome a sociology inherited by Parsons (Collyer, 2018). Unlike many loose uses of this framework pinpointed by Collyer, the in-depth employ of Bourdieu's toolbox allows to grasps the different agents (for instance individual and institutional, professionals and patients) at stake within a complex relational field of struggles (national but also trans-national) as highlighted by Hindhede & Larsen (2018). Following the work by Pinell (2005, 2011) on the medical field, the use of Bourdieu's research program permits to show what

[2] I.e., the French-speaking part of Switzerland.

[3] A comparable program has been available at the University of Basel (German-speaking Switzerland) since 2000.

ties the nursing profession but also what divides it. Considering the nursing profession as a social space firmly inserted within the medical field allows us to distinguish fractions holding specific representations and practices about nursing. These fractions are struggling around the possession of two main types of capital (nursing and medical) at stake within a "nursing space" that may be analyzing as a sub-space of the medical field (Longchamp, Toffel, Bühlmann, & Tawfik, 2018).

Following on from this, this paper focuses on the nurses whom I have termed the "scientific elites" because of where they are practicing—usually as clinical nurse specialists in university hospitals or as teachers in universities of applied sciences (UAS)—and the symbolic prestige (Bourdieu, 1984) associated with their new academic resources[4]. These nurses are called upon to play key roles in the transfer and monitoring of the use of clinical practices. Whether that occurs while they are leading care teams on wards or teaching, their ambition is to participate actively in a redefinition of the profession.

The purpose of this article is to contribute to a sociological analysis of the evolution of the nursing profession in Switzerland, and wider, to a reflection on the effects of its academisation. What are these nurses' perceptions of how the medical profession considers them? How do these nurses perceive the profession and their colleagues, particularly bedside nurses and nurse managers? And finally, to what extent does the new diploma and the new role of these nurses contribute to the autonomy process of the nursing profession? After setting out the stakes surrounding making nursing knowledge more science-based, I will present some of the effects that this academic degree has generated; particularly on a potential redefinition of the practical and symbolic roles that it has engendered, vis-à-vis doctors as well as within the profession itself.

Method and analysis strategy

This research has been carried out in Western Switzerland from 2012 to 2017. Following the theoretical framework elaborated by Bourdieu (1984, 1996), especially the field concept, the main goal of this research project was to understand the relationship between the position occupied in the profession (vertical—according to the careers and institutional positions—and horizontal—between the different wards and institutions) and the nurses' attitude toward the core of the profession and the relationship with surrounding professions. The first phase involved 21 semi-structured interviews carried out in 2012 with nurses of very varied profiles in terms of sex, age, job description, and workplace. The

[4] The "elite" can designate "social groups which, because of their position or resources, can influence a society's evolution by participating in its most important decisions" (Hartmann, 2007, p. 17, my translation). Applying this definition to the nursing profession, I harnessed the notion of a "scientific elite" to characterize the specific resources which can help nurses to reach positions of power. Even though a master's degree may not seem a high-level diploma compared to the average level in the academic field, it thus means a lot within a profession where less than 2% of the nurses in Western Switzerland have it (Longchamp et al., 2020).

second phase consisted of a survey of nurses' practices and representations (N=2923), carried out in 2014. These two phases showed what has been named a "nursing space" in which each fraction, based on volume and structure of a combination of capitals, is characterized by a specific image and set of practices, whether in relation to nursing practice, knowledge production, or the relationship between nursing and the medical profession (Longchamp et al., 2018, 2020). To investigate a sub-fraction of the profession, a third phase took place in 2017, consisting of ten semi-structured interviews of nurses holding master's degrees awarded by the IUFRS. These nurses interviewed formed a convenience sample selected according to their different institutional employers, professional positions, job description, and sex. All of them have been (or are still) working at the bedside. They were asked to speak about their academic training and about the caring side of the job. Five are working in University hospitals, three in UAS, two in retirement homes. Among other topics (for instance career path, typical working day), these interviews examined nurses' motivations for studying a master's degree, how they conceived of the profession, what they did as part of their daily work routine, and how they saw the profession's future. I conducted the interviews which lasted approximately one hour and a half each. All were recorded and transcribed. They went through a thematic and categorical analysis that highlighted their perceptions of working relations with doctors and their nurses' colleagues as well as their feeling about the nursing profession's role within healthcare. Although based on the results of the overall research, the present article relies mainly on the interviews from phase three.

Towards an academically-based profession

Nursing only became professional rather late on in its history, particularly in Switzerland (Droux, 2000). Although it evolved constantly throughout the 20th century, nursing education saw its most rapid changes in the last few decades. Until 1992, nurses in Western Switzerland could follow one of three basic career paths (general care, maternal hygiene and paediatrics, or psychiatry), but this was then substituted for more general nursing education. In their turn, as of 2002, these diplomas made way for tertiary level education in the form of a bachelor's degree at the UAS and then the introduction of master's and doctoral programs at UNIL in 2009.

Although nursing education had *de facto* become academically-based with the introduction of bachelor's degrees in nursing care at UAS, the launch of the IUFRS' new programs added a further significant stage to that education. Nursing professionals can now obtain the highest degrees given by the higher education system. And the type of knowledge produced and taught at this institute is probably even more significant because it is nurses who are doing the teaching and, above all, producing scientific knowledge—in other words: garnering scientific capital (Bourdieu, 1976). Abbott (1988) showed that the creation and maintenance of frontiers between professional groups are anchored in their "turf battles"

for the construction and conservation of expert knowledge in order to build up their own jurisdictions.

The combination of these two theoretical frameworks may seem unusual. If Bourdieu didn't investigate the health universe *per se*, he also criticized the closing effect of the "occupational taxonomies" (Bourdieu & Wacquant, 1992). But far from being incompatible with an analysis of professions, it has been shown that his theoretical framework helps to highlight the symbolic struggles at stake within professions (Schinkel & Noordegraaf, 2011). Moreover, an in-depth use of this framework, along with Abbott's theory of professions, tends to be fecund as Morel showed (2016). Instead of opposing two sociological heritage—yet based on a wide range of differences—I will show the interest in combining the two perspectives.

Making nursing education both more academic and more science-based, constitutes a major shift. Even though the skills and knowledge developed during professional training are recognized and have a certain legitimacy, with a hierarchy of academic titles and the resources provided by the cultural capital which those titles confer (Bourdieu, 1984), one can consider the move from vocational education to an academic education as being the final stage in a profession's scientific and symbolic evolution. It is well known that conquering new areas of professional knowledge requires the capacity to enlist abstract knowledge. As Elzinga (1990) highlighted, "professional groups look to academic research for the theoretical core needed to validate their knowledge, and *obtain recognition* through the institution of degree programmes" (p. 151, my emphasis). This will, too, make nursing education more academically-based is associated with a desire for legitimacy, which, according to both Elzinga and Abbott, can be backed up using two types of strategies. The first is cognitive and consists in demonstrating the components of the new type of knowledge; the second is social and rests mainly on the capacity to argue the (new) discipline's added value and utility. However, these two strategies must be thought of in combination. Although using science—in other words, the resources of a scientific capital (Bourdieu, 1976)—to lever professional autonomy is not the *raison d'être* for expanding educational opportunities in nursing sciences, it does make up a substantial part of the argument according to which nurses have great social utility. Understanding the means that these nurses use in their quest for recognition requires a grasp of the social relations that the nursing profession has with related professions, most notably the one which has dominated it since its beginnings: the medical profession.

On a level playing field with doctors?

According to the nurses interviewed, their access to a master's degree in nursing sciences is accompanied by a re-evaluation of the profession; notably, they perceive greater

recognition from doctors. As Mr. Sari mentions,[5] "with the doctors […] things went very well straight away because they immediately saw the added value that we [holders of master's degrees] can bring." Ms. Genoud even speaks about stronger professional relations:

> – It very favorably reinforces the relationships we have with doctors.
> – Isn't it a source of friction?
> – Not at all. With that professional group, it's even been a facilitating factor […]. So, there is something a little privileged being played out in day-to-day interactions.

Beyond the perception that working relations with doctors have become closer, there is also a sense that these academically trained nurses now feel empowered by that relationship. From the point of view of recognition, university graduate degrees represent a turning point for these nurses; now armed with legitimate resources of professional knowledge they feel capable of rising to the position of a doctor's alter ego. There are two closely linked aspects to this enhanced positioning: a way of expressing things and a way of doing things. These aptitudes seem to enable nurses to "be on a level playing field," as Ms. Nicole states.

Legitimate ways of expressing things

> I have the feeling that my professional language has changed (Ms. Genoud)

One of the resources acquired by the scientific elites rests on the purely symbolic effects of earning a nursing sciences diploma that is recognized as legitimate because it is from a university. These nurses seem to have gained confidence through the increase in their cultural capital associated with the award of a socially recognized degree (Bourdieu, 1984). And it is thus easier to understand nurses' feelings of being able to evolve in parallel with doctors and of "no longer being undervalued" (Ms. Demaya)—sentiments that were repeated frequently during the interviews. Contrasting before and after the award of her master's degree by the IUFRS, Ms. Nicole mentions that independently of the value of the knowledge acquired in their initial bachelor's training and the clinical acts they carried out, nurses had remained dominated in their relations with the medical profession:

> – We could be good at what we did, but we were somehow always at a slightly inferior level… or there was always a form of—How should I put it?—either humility or… I can't find the word, but a sort of complex…
> – Of inferiority?
> – Yeah, exactly. And I've got the impression that it's not like that anymore; that we can participate at the same level. So, there you go. That's what these master's degrees bring us, somehow. It's real recognition at the academic level.

[5] Names have been changed to ensure anonymity.

Ms. Nicole is reporting an essentially psychological dimension—whether it was humility or an inferiority complex. That "complex" is a mark of the symbolic violence resulting from the misunderstanding it creates (Bourdieu, 2000). That psychological dimension unconsciously determines the behavior which nurses should adopt in relation to the (especially class and gender) dominated position they occupy. In addition to the institutionalized capital recognized in the form of a diploma, there is also cultural capital (Bourdieu, 1979) in the form of a way of expressing things that gives one the tools with which to fight the effects of domination. As Ms. Nicole states, "recognition at an academic level" is undeniably effective in our "ability to align ourselves, to be able to use language where we are not just taken for silly women."

The sentiment of being able to speak to doctors from a position as professionals of equal value, thanks to different knowledge, is the result of a new language made up of two types of resources. Being newly able to express themselves using "legitimate language" (Bourdieu, 1991) becomes a cultural skill, distinguishing its "speakers" and supported by the recognition perceived by the scientific elites:

> I think that [the master's] provides a kind of credibility. Because we know how… the language to adopt to play in the big league, is what I want to say. We're not the little nurse who can't express her thoughts properly anymore, you know?… It's that we quickly get into situations where "I don't have the right vocabulary; I don't really understand what the other person's saying," it's at another level. And then [the master's] gives us, in presentation skills for starters, in being able to do literature searches, etc., with references and stuff; we have a solid background. (Ms. Nicole)

Although knowing to "express [their] thoughts properly" may bring recognition, it would not be enough to create feelings of legitimacy if it were not for a "solid background" of skills. This is the second but principal resource of these academically educated nurses seeking that all-important *recognition* (Abbott, 1988; Elzinga, 1990) from their doctor colleagues: the tools of scientific research.

A scientific way of doing things

It is because they have the skills to use a specific language—the language of science—that the scientific elites' knowledge of what to say is determinant in their perception that their relations with doctors have been transformed. As Ms. Gomes states: "at the university, at the IUFRS, the approach often advocated is basing care on scientific evidence," and the other nurses interviewed repeatedly mention the acquisition of scientific knowledge—*id est* of a scientific capital (Bourdieu, 1976). Whereas Ms. Gomes mentions that what "interested me the most were the contributions from research […], everything about learning how to

critique a scientific article", Mr. Décosterd insists on "the importance of research in the domain of nursing sciences, the *power of research* [he emphasizes]".

Ms. Nicole reveals that the principal benefit of her academic education is its approach to research, which is safeguarded by "methodology," the use of "tools," and the "scientific literature". Mr. Sari also mentions these aspects and, like his colleagues, relates them directly to nursing practice and the development of "guidelines" in order to be able to implement a clinical project. Interviewees repeated mention theoretical frameworks and, above all, learning about research methodology, and knowledge about these conferred nurses with "more standing, depending on the interlocutors":

> – Now, when I write a protocol, I don't do it like that anymore. I go and look for what's been written about it, what's being done.
> – A research approach.
> – It gets printed out, and I find that it gives me a stronger footing with the stakeholders who I've got in front of me. (Ms. Bourg)

This is the distinction between *before* and *after* higher academic nursing education, one that recurred in interviewees' answers and which was relevant vis-à-vis doctors and bedside nurses. The feelings of having evolved and of being better armed to practice their profession is also what nurses with master's degrees identify, advocate, and wish for their profession's future as Ms. Pralong states:

> I think that with the Master we are more… we are more open to some confrontations. We are not afraid to say what we think because here what the Master also teaches us: to be more leaders.

Being able to use scientific arguments is a central issue in the position which nurses adopt when faced with doctors, as it enables them to be taken more seriously and even to "convince." As Ms. Bourg states, she "really regrets no longer having any access to PubMed"[6]:

> That's how I managed to convince doctors. Typically, you shouldn't delude yourself, in the end, they are scientists really, so when you turn up with arguments, saying, "Well, here you go, three meta-analyses say this, three things say that, randomised studies…". Well, they listen to you differently.

The scientific elites acquired many resources during their academic education—resources that turned out to be very effective, both socially and professionally. In that sense, their strategy of recognition fully illustrates the strategies identified by both Abbott (1988) and

[6] A bibliographic research engine for studies in biomedicine.

Elzinga (1990). Of course, if these nurses became closer to doctors, they can also be perceived as competitors. The use of a scientific language sets up these nurses as privileged interlocutors, but this foray into their territory can also generate tensions between the two professions, as Mr. Décosterd argues:

> There are two types of doctors. There are those who are convinced that they are responsible for the world, for care. And there are those who understood that it is important to work in interdisciplinarity. So, with those who are convinced that the hospital is run by doctors and bosses, of course things go wrong.

That said, the nurses interviewed unanimously feel that they now hold the means to reach their ends; the scientific elites incarnating the heroic figures of a profession lacking in recognition and autonomy since its very beginnings. Yet it is worth asking the question of whether today's nurses are experiencing a transformation in social relations with the medical profession or whether they are idealizing the extent of those changes. Because of the dominant position of knowledge from the medical field, knowledge that nurses are using widely, perhaps we are witnessing "a conversion to the biomedical paradigm" (Holmes & Perron, 2008, p. 407, my translation) rather than the development and promotion of nurses' own knowledge anchored in the theories of nursing sciences[7]. It is not sure that the scientific capital acquired and seen as resources in the academic training is directly convertible to a clinical nursing space of practice still dominated by medical capital (Longchamp et al., 2018). Furthermore, case studies on increasingly academically-based nursing education tended to have demonstrated that relations between nurses and doctors are continuing to be characterised by dominations despite the new resources acquired by nurses. Thus, from both the cognitive and social points of view, the quest for legitimacy is continuing, and the quest for autonomy has yet to be satisfied.

In-between bedside nurses and nurse managers

The scientific elites seem quite satisfied with their working relationships with doctors—that of respected colleagues who are nevertheless kept at arm's length. They seem less satisfied with their working relationships with their fellow nurses. Whereas bedside nurses are sometimes described as being "back to the stone age," as Ms. Bourg states, nursing managers, often presented as trapped by organizational constraints, are discredited because of their great distance from the patient. When the scientific elites make the most of their university education and their scientific capital, their professional relations move in two directions: their more academically-based education brings them closer to their doctor colleagues, but it also distances them symbolically from their nurse colleagues.

[7] Knowledge which is both discussed from an epistemological point of view (Longchamp, 2005) and yet little-used within the nursing profession, whether in research (Dallaire, 2015) or in healthcare (Lechasseur, 2009).

Because they have been trained to "optimise the quality of care and patient safety" and to "collaborate in organisational changes and necessary developments to the health system,"[8] the role of the scientific elites is mainly a matter of team management. The tools which they have learnt to use in their academic education become central to the implementation and monitoring of "best practices." Mr. Décosterd is convinced of his mentor's role:

> You have to go out on the ward, show how, train, supervise constantly: you have to mentor. […] During my training, I think that I realized that maybe I had become too distanced from bedsides and that when I brought [new knowledge] to people, I have to do more than just convince them its good.

As they are implementing strategies to "convince" their colleagues of the merits of their new input, the nurses interviewed feel that they are on a mission to introduce reforms to professional practices. But the task is not easy: on one side, they come up against bedside nurses who don't always see the added value in "theoretical" input, and on the other side they come up against nurse managers who consider them to be competitors who want to exercise the managers' powers.

Bedside nurses with their "noses to the grindstone"

The scientific elites perceive the nursing profession from the commanding position they believe that they have attained. Thus, Ms. Demaya's master's degree enables her to go beyond her previous tasks centred on technical aspects of nursing practices and to think about things in a more "meta way":

> So as not to be just a nurse giving technical care like [bedside nurses], but also to think in a little bit more of a meta way about "What can we put forward?", "How can we push our profession forward?" By demonstrating the added value, in the end, of how we accompanying [patients].

Fortified by a feeling of superiority instilled by their academically-based education and their task of implementing best care practices, the scientific elites consider bedside nurses a little condescendingly. Indeed, the interviewees frequently bring up bedside nurses' lack of "responsiveness" or "critical appraisal" as Ms. Seppi states, finding them restricted to carrying out "tasks." The contrast is underlined by a classic division of labor between manual and intellectual tasks. The scientific elites distinguish themselves from the bedside nurses with their "noses to the grindstone," incapable of grasping the "true professional challenges" because of a "lack of vision"; they perceive themselves, however, as being able to take a step back, reflect and establish strategies for change "for everybody's good":

[8] Website of the University of Applied Sciences and Arts Western Switzerland (HES-SO).

> I find that nurses really get into something, with their noses to the grindstone, so they have some trouble taking a step back and saying, "We have to change this. Then let's do it, let's change it." For everybody's good. (Ms. Demaya)

However, this pursuit of the common good is manifestly not obvious to everyone. Bedside nurses do not see the added value in the new nursing knowledge brought to wards by the scientific elites; showing the struggles taking place between the different fractions in the "nursing space" (Longchamp et al., 2018). Faces with this lack of enthusiasm about their desire to use the tools learned during their Master's—and their wish to instill a new professional culture—some of the scientific elites display a hint of bitterness:

> I've got a colleague who's a nurse who once said to me, "Why are you doing a Master's? If you're going to do that, why not study medicine." I thought that it was completely off the mark for a nurse to say that. (Ms. Demaya)

Fear of being judged by bedside nurses critical of their academic training or their new roles is common. The words of Ms. Genoud's head nurse reminds her of how prudent she had to be, despite her eagerness to disseminate the knowledge acquired in her master's program:

> [She said to me] "You know, Sandy, don't forget that when you come from the nursing pool[9], people know that you are a specialist nurse clinician in my unit and they're watching what you're doing with a magnifying glass" […] Depending on existing habits and routines, arriving and, let's say, wanting to disseminate new knowledge can unsettle people a bit unless you are careful.

Yet interviewees are minimizing the potential for conflict as if time would naturally guide the whole nursing profession towards a consensus agreement on the benefits of the master's degree program and the new resources it brought to patient care. This teleology, promoted by the scientific elites, is closely linked to the perception they have of themselves—a perception in which they are the only ones empowered to lead the entire nursing profession towards a desirable or preferred future.

Thus, the scientific elites' project works on two levels. Firstly, they aspire to the development of a "meta viewpoint," which would improve the professional position of nurses in the health space vis-à-vis other professions. Secondly, they aim to develop a true professional culture based on new skills and scientific knowledge that is exclusive to their profession, which would encourage professional autonomy and improve patient care management.

[9] The "pool" is a replacement ward.

Nursing managers weighed down by daily administrative tasks

Nurse managers have often been perceived as "administrative auxiliaries," or even "collaborators," as overly controlling on theoretical aspects while not being experts in practice (Dubet, 2002, my translation): veritable "countermodels of the female caregiver" (Véga, 1997, p. 112, my translation). They find themselves frequently discredited by nurses due to their distance from the patient's bedside and the managerial approaches they embody (Resenterra, Siggen, & Giauque, 2013).

This perception is shared by the scientific elites who constantly mention these two aspects, but for two different reasons: to deplore it and to distinguish themselves. Increased distance from patient bedsides is a trait which the scientific elites particularly deplore. Mr. Sari argues that whereas the scientific elites remained caregivers, becoming a manager "removes [nurses] from practice" and thus from the profession's core mission:

> – Up until ten years back, let's say, if you trained as a nurse, it's true that after a while, career-wise, there weren't necessarily many big opportunities unless you became head nurse, and thus a manager. But if you do that, you distance yourself from practice.
> – From the bedside.
> – From the bedside. So you're, I wouldn't say, it's a bit much, but you're not necessarily still a nurse if you… […] I'm exaggerating, but the epistemological question is: "Are you still a nurse if you don't see any patients?" I don't know.

Although Mr. Sari qualifies his exaggeration, the concept of proximity to patients is central to the nursing profession. The scientific elites definitely do not want to be distanced from patients. Indeed, they want to square the circle by remaining close to them (contrary to nurse managers whose greater distance is to the detriment of their professional legitimacy) and by introducing the clinical best practices that their "meta-perspective" enables. This apparently ideal position fails to hide a paradox that Ms. Ferreira's words illustrate. Although she pleads for nurses providing "person-centred care," that care would not be given by the scientific elites but by bedside nurses who are already fully invested "in direct care." The scientific elites would be responsible for "managing care projects," and as such, would somewhat distance themselves from patients, like nurse managers, but without having the hierarchical function. Because they aspire to monitor best practices, few of the scientific elites are managers, at least not in the formal sense. Four of the ten nurses interviewed did have management functions, however. Ms. Bourg, formerly a nursing home manager, maintained very close relations with the management of the care institution where she is working. Although they are working as clinical nurse specialists, Ms. Genoud and Ms. Nicole are part of their respective departments' management teams. As for Ms. Seppi, who is heavily involved in rewriting the training curricula in her UAS.

Although they reject the symbolic managerial positions which bedside nurses might associate them with, unofficially, the scientific elites often have close relationships with their management. This can cause tensions, which are the result of poorly defined roles. Whereas role differentiation seems clear to the scientific elites vis-à-vis bedside nurses, they feel a level of competition with nurse managers who "feel threatened" (Ms. Genoud). Tensions seem to be anchored around questions of management because managers do "not always have a clear, defined vision of who does what" (Ms. Pralong). Managing working time, which is one of the nursing manager's roles, seems to have become an issue struggled over with the scientific elites as soon as the latter group got involved in patient care management. These relational difficulties are driven by both a lack of institutional recognition and strains on the hierarchy because different groups' roles remain unclear: nursing managers are in charge of care resources, but clinical nursing specialists are supposedly responsible for the introduction of best practices:

> So, it's true that I also positioned myself by saying that if I was going to have a role to play at the same level as the head nurses[10]—that means some power to orient clinical care—then I'd have to be a little bit above them, at least when it came to representing the unit. (Ms. Nicole)

On his side, Mr. Décosterd deplores the lack of support that clinical nursing specialists are receiving from his institution and how the scientific elites are subordinate—"subservient"—to nursing managers:

> Clinical nursing specialists are directly subservient to departmental head nurses, which is an aberration, in my opinion […] Clinical nursing specialists and head nurses should have a shared decision-making interface for organizing care. Those responsible for care, for clinical care, should be clinicians. And those responsible for resources and other management should be managers.

Hierarchy issues seem to be central to the power relations opposing the scientific elites and nursing managers. However, recognition of their status is not merely a challenge associated with finding a position within that hierarchy; it is also a challenge with regards to the struggle for a legitimate new definition of the nursing profession rooted in the academic-based knowledge as underlined by Elzinga (1990). The scientific elites' reformist project is only a part of that struggle, and it is a project for which they are clearly having trouble getting backing, especially from their nursing colleagues.

[10] Head nurse on a ward.

The redefinition of the role of nursing

A central element in the scientific elites' discourse concerns their grand plan to reform their own nursing role. The scientific elites intend to represent the renewal of the nursing profession through the conceptual shift from nursing practice being seen as task-based to it developing around therapeutic projects in which the profession will establish its core role. Typical of the "new entrants" in a field (Bourdieu, 1996), this redefinition will require defending a model of the profession on a scientific-based knowledge that will necessarily challenge the established order. But, if it is a necessary condition to obtain *recognition* in both Abbott (1988) and Elzinga (1990) sense, it may not be a sufficient one. Sainsaulieu (2012) recalled that "the historic socialization of nurses does not predispose them to political protest" (p. 330). Although this observation may reveal the traditional stance held by nurses, anchored in a professional history marked by dominations (notably class and gender), we have to qualify its contemporary validity when we are trying to grasp the scientific elites' new discourse. This is because these new standard-bearers for nursing have an element of militancy about them, even if that militancy bears no resemblance to classic revindications about working conditions. Asked about their motivations for taking a master's degree at the IUFRS, interviewees insist on the "added value" it brought to boost the profession's standing, as illustrated by Ms. Demaya's words:

> Throughout their history, nurses have often been under-valued. […] So, I think that, yes, when my colleague said to me, "Well, [the master's] is an opportunity to promote and develop our profession, and to put it forward. And to show that, in the end, we can also be experts in the situations we encounter." I think that motivated me too, […] I think that it's true; nurses have often been undervalued, and we've had enough now because they've also contributed so much.

The feeling that the profession is at a turning point, the affirmation that they were "experts in the situations we encounter" and the belief that they have the ability to bring "change" through the use of their "tools" in order to overcome the difficulties faced by bedside nurses is omnipresent elements in the scientific elites' discourse. One might subscribe to Dubet's remark that "nurses have the feeling that they are continually running between several definitions of their job, none of which they are completely happy with" (Dubet, 2002, p. 195, my translation) when they are talking about bedside nurses. Still, it seems that the scientific elites have now stopped "running" after definitions and now propose just one for the entire profession, that of scientific healthcare expert. However, it is by no means certain that all nurses will adhere to this.

Conclusion

The purpose of this article is to contribute to a sociological analysis of the evolution of the nursing profession in Switzerland and to understand the struggles within and out the profession that are linked to the academisation process. Obtaining a master's degree in the

nursing sciences from a university in Western Switzerland is something very new for the profession. Because of the symbolic value of this qualification, as well as the type of resources which it embodies, the scientific elites glimpse a clear future for their profession. Equipped with the latest scientific assets, they want to actively participate in the redefinition of their profession by helping to change nursing roles and practices, giving new legitimacy throughout this scientific capital (Bourdieu, 1976) to a profession that has been undervalued throughout its history. This process is consistent with the means for recognition of a profession shown by both Abbott's (1988) and Elzinga's (1990) works. However, both the reformist project and nurses' institutional positions remain fragile. So far, even though their perception of the relations with the doctors improved, the attempt to redefine nursing roles seems to have a limited effect on social relations with them. Moreover, this attempt has, above all, been a vector of tensions within the nursing profession. The scientific elites' reformist project is still a long way from being able to overturn the medical profession's dominance over nurses, and they are having trouble finding their place in a highly differentiated nursing space: somewhere between bedside nurses who are slow to adhere to their project and nursing managers who see them as a threat to the management order. Even if one can qualify these nurses as "elite" with regard to their academic degrees and the types of knowledge resources at their disposal, it has to be acknowledged that the inter- and intra-professional relations in which they currently find themselves mean that this sub-fraction of the profession is still in search of its power rather than being able to exercise it.

Based on a case study, this paper is a call for a more general process of reflection on the uncertainties of making nursing education more academic. Although it may pave the way to a reconfiguration of social relations, the process can guarantee neither recognition nor the attainment of a more legitimate place for nurses in their interprofessional relations. Enlarging the picture of the stakes that the academisation process of the nursing profession in Western countries implies with a cross-national comparison could reveal some key features that are structured by a medical field that may be considered beyond national boarder (Hindhede & Larsen, 2018). Finally, the adoption of a structural approach based on Bourdieu's field concept makes it possible to understand the varied forms and unexpected effects in which a more academically-based style of nursing education might have on relations between members of that profession as well as with the medical one.

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