Temporal boundary work: Critical Care Nurses' professional identity in Tasmania

Abstract

Professional identity is constructed through boundary work at the macro and micro level. However there is little attention paid to the influence of the temporal dimensions of work on boundary work in professional groups where shift work is an essential feature. This study builds on empirical and theoretical knowledge of the influence of temporal structures of shift work upon professional identity construction and its expression in nursing.

I present data from an observational study that analyses how critical care nurses construct professional identity in their work environment. Data were generated from 92 hours participant observation and semi-structured in-depth interviews of 13 critical care nurses working in a single Intensive Care Unit in Tasmania.

Professional identity is constructed through intra-professional processes of similarity and difference, specifically in terms of politics, individual personalities and collaborative practice. These occur across the boundaries of three shifts that constitute the temporal dimensions of work within the Intensive Care Unit. I conclude consideration of the influence of temporality on professional identity extends our knowledge on intra-level boundary work, specifically in professions characterised by shift work.

Keywords: professional identity, boundary work, intra-group processes, nurses, temporality, shift work

Introduction

A lack of clear professional identity within nursing is associated with reduced levels of work satisfaction, work performance and staff retention (O'Brien-Pallas et al. 2010). This is of particular concern amid the context of the current nursing staffing 'crisis' (Hayes et al. 2012). In response professional identity is a central research topic within nursing and sociology. The concept of 'boundary work' is key to understanding professional identity as socially constructed in specific social contexts (Gieryn 1983; 1999). However there is minimal consideration of the influence of the temporal dimensions of shift work on these processes.

In this paper I analyse the influence of the temporal dimensions of shift work upon professional identity of a group of critical care nurses (CCNs). I argue professional identity is referenced to similarity and difference between staff associated with different shifts, specifically in terms of politics, personalities and collaborative practice. I conclude that consideration of temporality in analysis of professional identity will extend knowledge on boundary work processes, particularly those at the intra-professional level in professions characterised by shift work.

Professional identity and boundary work

Professional identity is a social identity informed by a 'mandate' of control over a specific group of activities and ideas within a dynamic system of professions based on unique knowledge 'claims' or 'jurisdictions' (Abbott 1988; Hughes 1971). Professional identity incorporates a learned, shared system of actions, language, 'attitudes, values, knowledge, beliefs and skills' (Beddoe 2013:27) that are distinct from those of other professions.

Professional identity is constructed through membership of a social group and the accompanying sense of belonging that is generated from this (Barth 1969). Identity is confirmed, questioned or rejected in relational processes in which performances are assessed by others, based on the similarities of 'in-groups', to which one belongs, and the differences of 'out-groups', to which one does not, in a process termed 'boundary work'(Jenkins 2000; 2014). Boundary work involves performances of difference through promotion of assumed in-group superiorities over perceived inferiorities of out-groups (Barth 1969). In terms of professional identity boundary work involves differences in uniforms (Timmons and East 2011), rituals (Drew 2011) and discursive strategies (Gieryn 1983), such as 'atrocity stories' (Turner 1986).

Social cycles and temporal rhythms

The social dimensions of time and temporality are emphasised by Sorokin and Merton's (1937) conceptualisation of 'social time'. Time and temporality are both socially constructed and are central forms of organisation in the division of labour and identity (Durkheim 1933; 1965; Mead 1934). They are both objective and subjective in that they are measured with reference to an objectively occurring astronomical event, as well as simultaneously experienced subjectively with reference to shared socio-cultural meanings and the activities that underpin them. Analysis of temporal structuring of workplaces has focused on both the

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objective and subjective understanding of time through the concepts of social cycles and temporal rhythms.

Using a hospital as his example Zerubavel (1979) identified 'social cycles' as underpinning the temporal structure of workplaces. Social cycles are objectively measured time periods demarcated by 'rigid temporal boundaries' (Zerubavel 1979:2) in which an ordered series of reiterative arrangements of activities are undertaken. Social cycles are distinguished by 'periodicity, tempo, timing, duration, and sequence' of activities within them. These ideas have been developed (Adam 1990; Fine 1990; Reddy, Dourish and Pratt 2006) to identify workplaces as structured by 'temporal rhythms'. Temporal rhythms are meaningful reiterated sequences, intervals and activities which arise from, and shape the activities of workers, and are attached to specific contextual meanings. Temporal rhythms are classified as large scale or fine grained (Reddy, Dourish and Pratt 2006). Large scale rhythms, such as nursing shifts, are distinct from one another in that they are ordered by different fine grain rhythms such as the provision of basic care, performance of clinical tasks, processing of laboratory tests, the delivery of medication and maintenance of equipment.

While the influence of time and temporality on workplace practices has been explored there seems little empirical focus on nursing's professional identity. Nursing theorists promote consideration of the temporal complexities of nursing as offering insight into its professional identity. However these studies have tended to focus on reviewing the literature with the aim of conceptualising temporality as it relates to nursing care (Caldas and Berterö 2012) and subjectively experienced 'nursing time' in contrast to objective 'clock time' in terms of acknowledging the issues associated with the concepts' development within nursing theory, practice and research (Jones 2010). Thus the focus has been on understanding nursing time in relation to the experience of time spent with patients. However, I agree that focusing on the influence of temporal structure of nursing work, specifically in terms of shift work, at the intra-professional level, could build on our understanding of both the unique features and processes of nursing's professional identity by providing insights into their influence on boundary work.

Methods

In order to explore the meanings that the nurses, as a culture sharing group, attach to actions, language and objects to inform their professional identity from within their everyday practice I utilised a qualitative interpretive methodology, drawing on the principles of ethnography.

I generated data from 92 hours observation and semi-structured in-depth interviews of 13 CCNs across three different shifts within a single publicly funded Intensive Care Unit (ICU) over a five month period. The nurses represented three distinct level of practice; three had less than ten years practice experience, seven had ten to twenty years practice experience, and three had more than twenty years practice experience. I recorded observations as field notes and I transcribed these on a daily basis.

CCNs were allocated to one of four nursing roles for their shifts. These included patient allocation, in-charge or one of two supporting roles, termed access and float. The in-charge role involved administrative and management tasks including coordinating meal breaks and transfers of patients in and out of the unit. The access CCN attended to emergencies outside the unit as part of the MET (medical emergency team), provided cover for CCNs' meal breaks and assisted CCNs if needed. The float CCN provided assistance to CCNs with such tasks as turning patients, checking drugs, organising equipment and covering meal breaks.

I included three working shifts in my observations; thirty-three hours of the early shift (7am-3.30pm), thirty-two hours of the late shift (2.30- 11pm) and twenty-seven hours of the night shift (10.30pm-7am). Between nine and eleven CCNs were rostered on each shift with three or four of them being senior staff (aside from the two regular administrative positions on the early shift). However shifts were differentiated in terms of nursing roles, nursing administration, medical and house services staff. The early shift was characterised by the greatest number of staff, including two senior nursing administrators, up to eight ICU doctors and an array of allied health professionals. House services staff included two ward aides and one cleaner. In addition attendants made second hourly visits to help with turning patients. This was the busiest shift; doctors performed rounds and requested additional treatment orders, allied health professionals attended to treatment, and CCNs provided full personal care to patients as well as performing the routine tasks of observations, medications, management of technology and other clinical tasks.

Late shifts lacked the number of staff of early shift; senior nursing administrative were not present, medical staff was limited to two or three doctors and all allied health staff were 'on-call'. House services staff were all gone by 8pm; the exemption being the attendants who made two-three hourly rounds until 11pm. A central feature of the late shift was the attendance of patients' visitors, and as such, only necessary clinical work was performed until after 8pm when visiting hours ended. If the shift was quiet some access and float CCNs would perform tasks normally assigned to house services, such as re-stocking linen, cleaning equipment and emptying bins.

The night shift lacked a float CCN; the access CCN covered both roles. One doctor (who generally slept from midnight to 5am) was present in the unit and 2 attendants were available between 11pm and 5am if called. While staff performed necessary clinical and regular routine activities, their required workload was generally less than the other two shifts due to limited services within the hospital overnight. While staff often undertook duties of house services staff, there were still periods of enforced inactivity. During these times CCNs, specifically the access and in-charge, would attend to activities associated with professional development, including transcribing data for postgraduate research, working on postgraduate assignments and marking assignments from casual teaching appointments within the School of Nursing.

Findings

Nurses emphasised collaborative practice in their boundary work. The modes of collaboration differed across shifts, with nurses describing differences between night, and the combined early and late shifts. During the early and late shifts inter-professional collaboration readily occurred between CCNs, allied health professionals and doctors; this collaboration between CCNs and doctors also extended to the night shift and was seen as exemplifying CCNs professional identity through ensuring positive patient outcomes. Across all shifts collaboration between CCNs was crucial to the performance of routine nursing activities such as attending to basic patient care and administering medications. The requirement for CCNs to collaborate was expressed by CCN Marcus during his interview,

> *'It's never a one man show, you can't do everything; I can't do everything myself'* (Marcus).

The night shift CCNs highlighted the politics of the other shifts as central reasons for their choices of permanent positions on night shift. This is apparent in the following quote from night shift CCN, Indiana, who explains her shift preferences as we sit in the Observation Area one night shift,

> *'I work permanent night shift. I don't like working days; working nights provides an opportunity to get away from politics'* (CCNI1804).

Other night shift CCNs, such as Karla, identify differences between the early/late and night shift in terms of individual personalities. She expresses this notion as I watch her work at the bedside one night,

> *'I work pretty much permanent night shift…I do it to avoid the stronger personalities that work during the day,' as she pulls a distasteful face* (CCNK 1906).

These excerpts indicate night shift staff contrast themselves against early and late shift staff through separating themselves from such characteristics. This process reflects Barth's (1969) description of boundary work as a process of construction and negotiation of similarity and difference. This notion is foundational in understanding identity processes of culture-sharing social groups, particularly professions (Gieryn 1983; 1999), sub-cultures within professions (Bucher and Strauss 1961) and 'professional tribalism' (Jones 2001). In the case of Karla she clearly indicates her aversion to the 'stronger personalities' of the early shift verbally and emphasises this with her look of distaste. As such Karla's words and actions reflect her negative attitude towards the early shift staff and her perceived superiority over them.

In focussing on the politics and strong personalities night shift members identify the existence of an 'in-group' on the early/late shift. Karla explains this in hushed tones as she moved around the bedspace attending to her patient,

> *'There's a group of older staff here; like a clique… they mainly work during the day as that's where they can show off how special they think they are'* (CCNK1906).

Night shift staff also drew on differences between themselves and the staff from the other shifts in terms of different practice approaches as they highlighted the tendency of early/late

CCNs to avoid intra-professional collaboration and contrasted this with their own collaborative approach. This is reflected by Indiana as she accentuates the collaborative approach of night shift with the autonomy of the CCNs from the other shifts.

> *'People during the day… have strong personalities which can*
> *sometimes mean that you're on your own, even though there are heaps*
> *of people around. Night shift's not like that; there's a lot of teamwork'*
> (CCNI1804).

Intra-professional collaboration occurred across all three shifts. However there were differences in how it occurred between the combined early/ late shift and the night shift. On the early and late shifts senior CCNs were less inclined to collaborate with junior CCNs, while senior CCNs on the night collaborated with all CCNs, with a specific focus on the junior staff. Staff from all shifts readily acknowledged the presence of an 'in-group' within the combined early/late shifts. One of the junior CCNs, Nina, utilises the rhetoric of inclusion and exclusion to distinguish between the in-group and herself in terms of limited collaboration during the early and late shifts. The underlining represents Nina's own emphasis,

> *Some nurses are very independent; they want to do things their way…*
> *and they don't work as well as part of a team. Whereas other people*
> *really embrace the teamwork; I'm one of those people'* (Nina).

Nina's lexical choice reflects the 'us' and 'them' processes that are the characteristic rhetorical strategies of boundary work (Barth 1969), particularly professions (May and Fleming 1997; Norris 2001). This process is a core feature of 'atrocity stories' which are the central from of micro boundary work within the nursing profession (Turner 1986). Atrocity stories are a particular form of narrative that stress the negative practices of out-group individuals from other professions in situations where group identity is threatened. They serve to inform professional group members of the demarcated boundaries between themselves and other professions while confirming the professional identity of the group (Turner 1986).

I suggest that atrocity stories are also performed at the intra-professional level between CCNs associated with different shifts. Night staff CCNs boundary work involves atrocity stories

that discredit the professional identity of the members of the in-group from the other two shifts. Indiana talks about the actions of the members of the in-group as contributing to a negative working environment,

> *'We have a culture of bullying. We have so many new staff who get eaten alive really…I watch a certain group of people who are on. One of them will go and get handover in bed 7; the others will go there as well. I just feel <u>sick</u> for the person that's handing over because you just know they're all just standing there looking down on them; saying, 'oh well did you do this? Did you do that'? Did you do this?' Like they're so belittling and it's awful'* (Indiana).

The night shift CCNs regard collaboration as important within their shift and contrast such an approach with the autonomous tendencies of the early staff members. These shared ideas indicate that night staff constitute a temporally bound culture-sharing social group separate to that of the early/late shifts. The differences of the shifts are readily identified by members of both shifts, but while night staff emphasise politics, personalities and lack of collaboration as negative aspects of the early shift, early shift CCNs do not have the same negative appraisal of night shift. Early shift CCNs see the night shift as a welcome alternative to the daytime environment of the unit. Catrina explains,

> *'Night shifts are really quiet and calm; they're just a whole different dynamic to the day time'* (Catrina).

The different dynamic of the night shift that Catrina alludes to can be understood as arising from the different temporal ordering underpinning each shift in terms of periodicity, tempo, timing, duration, and sequence'. As such the frequency of tasks, speed of performance, organisation and co-ordination of work activities, devotion of time to activities and their sequence is distinct to all three shifts. The differences between the combined early /late staff and night staff's attitudes towards collaborative practice, particularly with junior staff indicates a difference in meanings that the two groups attach to the professional identity. The activities of night staff suggest collaboration, support of junior staff and professional development are meanings that inform their professional identity while the actions of the other two shifts reflects autonomy as a central meaning. This lack of coherence of meanings between CCNs reflects the on-going debate in nursing as to the clarity of its professional identity.

Conclusion

Professional identity is constructed by intra-professional boundary work across the temporal boundaries that separate the distinct collectivites of each shift. This process involves the identification of similarity and difference between CCNs, specifically in terms of politics, personalities and collaborative practice. Each shift represents a distinct aspect of the large scale temporal rhythms that provide structure to the ICU; each is a culture sharing social group who place different perceptions on the importance of collaborative practice as an aspect of professional identity, contributing to its ambiguity. These differences are underpinned by the unique temporal features of each shift which shape the work activities within them. I conclude that considering the influence of temporality on professional identity processes extends our knowledge on boundary work processes, specifically at the intra-professional level. I suggest further work is required in order to more fully understand these processes in terms of institutional and organisational structures in which they occur.

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