Research article

The construction of contemporary nursing identity from narrative accounts of practice and professional life

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ABSTRACT

Objective: To explore the contemporary narrative of nursing identity in Spain.
Method: This qualitative study was conducted between 2018 and 2020. Eleven registered nurses were interviewed. The conversations were recorded in audio, were semistructured, and held in a mental health clinic affiliated with a Catholic institution. Narrative analysis of the data was carried out.
Findings: Two themes were identified: How do I construct my professional life?, with the subthemes 'Training and initiation in care practice', 'Ways of living the professional care experience', 'The sculpting of care' and 'Self-image and future projection'; and What do I know about my practice?, with the subthemes 'Nursing experience: shift, days, years', 'Strategy in the field of nursing care', 'Some foundations of caregiving practice', 'The specificity of the gesture of care' and 'Voice and recognition of nursing within the institution'.
Conclusion: Contemporary nursing identity is built in reflections on the epistemology of care, confronting the weight of tradition and breaking into new modes of self-image where the profession is legitimized and projected from historical consciousness. This claim can be used to support reflective practice in academic and healthcare settings as well as to promote a paradigm shift.

1. Introduction

We can consider that professional identity is related to history, with the experiences lived within the practice, with the concept of oneself as a person and as a professional, with personal and family history, with self-esteem, with education, with beliefs and with respect for the legitimacy of the discipline [1]. Thus, we can argue that the concept of nursing as a profession has become increasingly important, including responsibility, specificity and precision of tasks, decision-making power and autonomy, the level of knowledge and the contribution to maintaining and promoting a healthy society [2, 3, 4, 5].

Nursing is the science concerning professional care of the sick and injured, as well as other tasks of clinical and health care, and the promotion of health and prevention of illness. Nursing belongs to the group of the so-called Health Sciences, nursing professionals operating with a degree of autonomy and independence, yet being part of a multidisciplinary team. The nursing profession comprises the care of people of all ages, family status, group or community filiation, whether suffering an illness or not, and whatever circumstances their lives may be surrounded by [6, 7]. The history of the nursing discipline supports two fundamental profiles in relation to the understanding of care: technical care and humanistic care. Currently, the modernization of care and specialization and the protocolization of health activity are the engines of the development of the hospital social world and constitute the universe in which the process of socialization of contemporary nurses occurs. As such, the time dedicated to building rapport with patients is decreasing in favour of applying procedures, which eventually materializes in professional unease, ranging from anxiety to burnout syndrome and lack of life satisfaction [8, 9, 10, 11].

In general terms, the study of nursing identity is articulated in research on care experiences, aspects of role and gender, but there is no current exploration around the concept, value or legitimacy of the profession that diachronically collects the attributes of its history. To carry out an epistemic reflection from the nursing identity, narrative resources enable the understanding of the profession in the storyline of the story of its history [12, 13]. Thus, narrative theory is presented as a model of interpretive understanding in which, the subject articulates different elements, linking in a single story the meaning of his or her life [14].

The study of contemporary nursing's identity would affect current and future practice's effectiveness, giving new approaches to disciplinary autonomy and the independence of one's knowledge. Thus, we believe that a nursing profession's portrait would serve as a renewed understanding of contemporary nursing [15, 16, 17]. Deepening nurses' lives would also be a space for reflection that would benefit the profession in the healthcare, academic, and political spheres. It would contribute to the fight against the lack of institutional visibility and recognition [18, 19]. Additionally, this research's relevance arises when considering the historic moment that the nursing profession is going through, materialised in the global campaign *Nursing Now*, which seeks to value and empower professionals in the face of the health sector's challenges [20]. We understand that discussing the construction of the nursing professional identity can still contribute essential elements that would aid in achieving this campaign's results, particularly concerning the objective of improving education and professional development [21].

Nursing care professionalisation begins in a turbulent context in Victorian England, starring F. Nightingale and her epidemiological studies, which decreased mortality in the country and among the Crimean War soldiers. Scutary (Turkey) was the place where nursing and epidemiologic work was carried out by F. Nightingale. Religious creed of F. Nightingale was Protestantism and Kaiserwerth (Germany) was the place where she was trained in nursing skills. This nurse established the first nursing curriculum, which would then be collected by successive nursing training schools in Spain and the rest of Europe [10, 22]. Although we cannot affirm that nurses' training in the world has a direct relationship with Catholicism, we can say that it has had a historical relationship with religion and the institutions that made it possible since the Middle Ages (convents, monasteries, orders, and congregations) [23, 24].

Before the professionalisation of nursing care we already find relevant historical figures, such as João de Deus (John of God) within 16th C. Catholicism (mainly in Italy and Spain). Also, in the 19th and 20th C. we find important figures, associated either to the Catholic or the Protestant creed, such as Marianne Cope, Dorothea Dix, Ethel Gordon Fenwick and Hildegard E. Peplau. Their work involves a turning point in the development of the nursing profession, especially in regard to theoretical, political and management aspects [25, 26, 27, 28].

The institutionalization of nursing care occurs within Christian culture, redirecting the trajectories and conflicts of identification of caregiving practices in history, especially since the split of Christianity. Until the end of the 19th century, people who provided care in Spanish hospitals were mainly nuns, while the technical activities related to medical treatment were carried out by practitioners under the supervision of the doctor. In addition, from its beginning to the present, religious institutions are those that provide greater support and continuity in care for orphaned children, poor women and widows, and mentally ill individuals [10, 29, 30].

However, Christianity does not condition care practices in the same way in the Protestant environment. Nursing is developed in a more sophisticated way at a technical and procedural level, where it is officially professionalised among both lay and religious women [31, 32]. There is still no history of nursing that integrates Western and Eastern European countries. Nonetheless, there is an argument that supports the professional evolution of nursing care from F. Nightingale to the present, with its legacy being the reason for the existence of the nursing identity at the international level [33]. In Asia, nursing care is related to other religions such as Buddhism and Taoism, although Christianity has also been the predominant religion here [34]. For example, the first school for training nurses was established in India in 250 BCE [35].

Moreover, the professionalisation of care has gained international relevance because of the historical moment in which some women who administered it began to empower themselves and participate politically. They participated without renouncing the component of spirituality. For example, F. Nightingale was a woman of strong religious convictions, and her plan of studies required morally good women [36, 37]. Taking into account the historical development of the nursing profession, our initial research question was: 'How do nurses construct their professional identity?'

From the historiographic level, the influence of religious values on professional identity is inescapable, in the sense of preserving the character of dedication, self-denial, and unconditional nature within its science. But this is not strictly true in all instances. In the 19th C. in the United Kingdom nursing was regarded as a lowly job, and usually paid with alcoholic drinks and shelter [10, 38, 39, 40]. In light of the documentary testimonies, little has been written about the knowledge of religious nurses, who also did not formally submit to medical strategy. Over time, the male doctor and the religious nurse represent the foundations on which, in Western culture, the hierarchy in modern hospitals is articulated. For the most part, religious institutions affiliated with a hospital are dedicated to the care and treatment of mentally ill patients, keeping nurses among the staff hired for the practice of nursing. Religious orders also assist maternity, children and the elderly. Additionally, religious men and women who, without renouncing the charism and hospitality, become interveners in decisions bordering the professional nursing activity [10, 41]. The objective of this work is to explore the contemporary nursing narrative identity in Spain.

2. Materials and methods

2.1. Design

Narrative and interpretive study by analytical induction. The theoretical-methodological approach responds to qualitative research from the narrative perspective of identity, conceived as the construction of a coherent historical and experiential account [42].

We could say that within the qualitative movement, we find the narrative strategies needed to generate knowledge, although we could regard these strategies as going well beyond the paradigmatic qualitative outlook. Knowledge-generating narrative modes attempt to bestow meaning upon our surroundings, through connections between events in time, adopting the form of a story; they constitute a dynamic approach for an understanding of human identity and the process by which we bestow meaning upon our ever-changing world [43].

The hermeneutic turn in philosophy and social sciences allows narrativity to acquire the status of a primary form by which meaningfulness is granted to human existence. Likewise, a central tenet within the conceptual framework of narrative philosophy and narrative psychology is the understanding of life as a text (whether in mind yet to be uttered, written or spoken). Human beings attain their identity and their idea of self by employing a narrative configuration, totalising their existence, comprehending it as the expression of a story being revealed [42, 44].

Narrative research, as a branch of interpretative research, shares some of the general methodological principles of qualitative research, especially the hermeneutic stance whose objects are, mainly, texts. However, narrative research introduces a fissure in traditional qualitative research: lived experience is not something to be apprehended by research; it is in fact, rather, itself being created in the very research process, and this results in the problem of the relationship between text and experience (a crisis of representation) which we try to address with the re-elaboration of a coherent story, characterised by sequentiality, plot and social dimension [43, 45].

2.2. Selection of informants

The Sisters Hospitaller of the Sacred Heart of Jesus, a pioneering hospital in providing care to people with mental disorders in Spain, was accessed through a care center located in Madrid's Autonomous Community. A letter of introduction and information was distributed to potential informants.

The inclusion criteria were professional practice, currently or in the past, in a psychiatric and/or Catholic healthcare institution. Purposeful sampling [46] and snowballing [47] were performed for maximum

experiential, age, and gender variations. Eleven interviews were conducted (Table 1).

2.3. Data collection

Eleven nurses were interviewed. All participants were fully qualified nurses. However, not all of them had obtained the specialisation in mental health. Out of a total of 11, 6 of them had obtained the specialisation certificate and 5 had not. Semi-structured interviews were conducted. The conversations were recorded and transcribed. Literal and interpretive notes were taken during the interviews.

The data were collected by the principal investigator. The interview guide was built with open questions, based on the literature review and the professional experience of the researchers themselves (Appendix 1). The philosophy of understanding consisted of an approach to the perspectives that informants have regarding their lives, experiences or situations, as expressed in their own words [48, 49].

For audio recording, a digital recorder was used. The total length of the interviews was approximately fifteen hours, with a variation of 60–90 min; the variation was related to the uniqueness of each participant in terms of how they express their ideas and experiences. The testimonies were fully transcribed in a Word text editor.

2.4. Data analysis

We opted for narrative analysis, which included the following strategies: holistic-categorical (the text as a whole), categorical content (the thematic or categorical units extracted from the text) and holistic form (the storyline or global structure of history). Microanalysis of text segments was carried out, that is, reading the contents line by line, word by word, and extracting the meaning by generating interpretations [42].

With the analysis carried out, *images-concepts* were generated: concepts sensitive to each subtheme and, in turn, to other inflections of the polyphonic story, ultimately building a matrix of interrelations; terminological matrices with reference to each subtheme and, in turn, to other inflections of the polyphonic story, ultimately constructing a matrix of interrelations. In addition, the presentation of the story adopted a particular format, congruent with the narrative and interpretative epistemology in which it is based: using experiential synthesis, in the third person, to describe the subthemes; and using the voices of the nurses, in the first person, to contribute to the sustainability and credibility of the entire text. The *image-concept* is the element, at the same time sensitive and reflective, the basic structure on which the model of nursing identity understanding is constructed [50].

The actual themes and subthemes emerged from a thematic and interpretative analysis, consistent with data collection. Informants begin at the start of the experiences and, after probing and enquiring on the part of the interviewer, they describe their modes of practice, how they see themselves and how they project themselves from their learned and practiced modes of care. The first theme emerges from the convergence of these subthemes, but as informants attach importance to experience and practice, a second theme arises; we can narratively break it up into a discourse on time and work strategies, foundations from reflexive practice, attempts to define the uniqueness of nursing care, and professional visibility and recognition.

The cross-sectional analytical exercise was to construct a story consistent with the objective of the research, that is, to reflect the dynamics of nursing identity in contemporary Spain. Appendix 2 shows the analytical strategy developed, with a partial and exemplary sample of the total.

2.5. Ethical aspects

The conduct of the research and production of the report met the criteria established in the *Consolidated criteria for reporting qualitative research* [51]. Research consent was obtained from the corresponding bodies: Research Ethics Committee of the Faculty of Medicine of the Autonomous University of Madrid and Research Committee of the Sisters Hospitaller.

The letter of information was handed out to potential informants by a gatekeeper who was also an informant and by the main researcher himself. An informed consent form was also handed out, thus ensuring confidentiality of personal data at all times throughout the research process. This document asked informants whether they consented in taking part in the study or not, and specified that consent could be withdrawn at any point with no effect whatsoever on their work situation or job status. The informants signed the informed consent form after receiving instructions on the purpose of the investigation. To preserve the confidentiality of the participants throughout the research process, acronyms were assigned*.

Interviews were carried out in rooms belonging to the care centre, minimising the possibility of being interrupted. In some cases, interviews were carried out in the informant's place of residence and in offices of the university building. Likely interruptions were minimised by warning in advance staff working in the area (clerical staff, care management staff, professionals on duty in the corresponding shifts). Moreover, all conversations were held outside informants' working hours, so as not to condition care responsibilities. The head of the care centre facilitated the carrying out of the research, but did not in any case compel informants to participate. Question appropriateness was dependent on conditions of actuality and factuality, that is to say, oriented towards a gradual understanding of nursing identity, adapted to the informants' degree of emotional and discursive openness, and without ever losing sight of their well-being.

At the beginning of the research process we could already notice a difficulty on the part of the informants to keep an open conversation as soon as they were informed that the study included the exploration of the identity and meaning of the nursing profession, or even the description of an ordinary day of work in professional care. Therefore, the initial information was merely interest in and curiosity about what a nurse normally does, and once a link was established and certain openness developed, we could gradually introduce a repertory of questions on identity without violating the ethical principle of beneficence and nonmaleficence.

2.6. Rigour

Methodological rigour was guaranteed by the criteria described by Denzin and Lincoln [52], and Silverman [53]. With regard to research rigour we took into account the bases of intersubjectivity, flexibility and

Table 1. Defining characteristics of the informants. Autonomous Community of Madrid.

Informant	Sex	Age (years)	Professional experience (years)
M	Female	31	9
J	Male	39	16
F	Male	34	11
E	Female	28	6
JJ	Male	41	17
V	Female	28	5
G	Female	29	6
VI	Female	28	5
P	Female	23	1
B	Female	55	28
Y	Female	64	42

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* Acronyms: (1) Initials of the name; (2) Sex: female (F)/male (M); Age (years); Professional experience (years).

the dynamism in the research process and in the findings, always seeking clarity and methodological consistency.

With regard to the findings, through an interpretative process and a process of abstraction, researchers sought to attain originality, credibility, pertinence, transferability and reproducibility. The strategies to guarantee rigour were as follows: credibility (isomorphisms and differences between informants, and between informants and researchers); transferability (applicability based on knowledge of the context); dependability (consistency, accuracy and progress in understanding); and confirmability (confirmation of conclusions by reviewers external to the study).

Data saturation was reached, since from data collected and analyses performed no new themes or ideas emerged. To arrive to this methodological turn, the main researcher, after a thorough analysis of all transcribed interviews, passed on his reading to the other two members of the research team. After two more readings of the transcriptions, thematic diversity was discussed and findings were triangulated, thus arising the themes and subthemes mentioned in the text. Table 2 shows the theoretical-methodological decisions, from the research objective to the epistemological framework.

3. Findings

The age range of the nurse informants was 23–64 years, and the range of professional experience was 1–42 years. The findings consisted of two themes: subthemes and matrix threads (*images-concepts* that start with a certain theme and reappear in the rest of the story). In this sense, the contemporary nursing story was as follows:

3.1. How do I construct my professional life?

Exercise of reconstruction of the life trajectory in relation to the profession, from its beginning to the present, seeking transcendence in personal life.

3.1.1. Training and initiation in care practice

This subtheme constitutes a biographical-experiential matrix that nurses refer, with considerable dilation and reiteration, from the *images-concepts* «training» and «the beginning»; followed, with more latency, by «courage» and «fear».

Nurses' professional lives are represented, from the beginning, by an academic doctrine based on ethics and the good of the other and vulnerability and sacrifice from the beginning of care. Emphasises the will to face a lack of resources (economic and experiential), which improves over time but remains in the memory.

There were always real examples and a lot of practicums […] Working is the best way to learn. My first assignment as a nurse was mental health […] My main difficulty was the fear of making mistakes and harming someone […] Nursing carries a lot of responsibility. You are involved in many fields and many pathologies, it is impossible to know everything... (M_F_32_8). *I thought about leaving in the third year of my career, but I ended up deciding to finish it. I had very good shifts, and others not so much […] maybe my emotional state*

influenced it a little (VI_F_28_5). *My training, at the theoretical level, as well as in the specialty, can be improved. Often due to the lack of training or experience of the teachers themselves. The best was practice, being able to expose myself to reality. Perhaps I lacked greater supervision at times […] My greatest difficulties were wanting to be seen by the rest of the team as a professional and not as a student* (G_F_29_6). *My training as a nurse was not easy […] Because of the various money problems we had in my home, I had to make many sacrifices […] I remember that at the university our professors were very strict about what we wore* (B_F_55_28).

3.1.2. Modes of living the experience of professional care

This subtheme represents a biographical-experiential matrix that nurses construct with relative homogeneity from the *images-concepts* «knowledge», «the future», «significant experience» and «self-knowledge».

Nurses place the focus of their learning in practice, where their own lived experience of care invites ethical reflection (beyond technique). Professional growth is articulated in difficult contexts and with few resources. Over time, nurses build a professional life with first-person care, deciding what is appropriate or not for others' good, regardless of resources and their emotional state. Thus, nurses perceive that they are building a professional life of continuous self-improvement regarding their knowledge but are more critical about the subordinate task of administering pharmacological treatment.

I could not prioritize […] I have learned from all my colleagues […] Even, from those who, in my opinion, did not do it well, I have learned a lot to not repeat their way of working. Above all, I mean dealing with the patient, more than techniques or knowledge […] (M_F_32_8). *The most useful things I've learned about my profession have been from places with fewer resources and in psychologically hard services. One's own experience is what usually gets you out of most trouble at work […] However, in general, I've learned most from those people so involved with their work they try their best even on their worst days* (G_F_29_6). *Connecting with patients. Experience makes you learn that fixed notions about certain situations are not so fixed after all and can be somewhat flexible […] not everything is so black or white […] you learn what you want to be and what you don't want to be in the profession. We have forgotten that touch with the patient and our reason for being... […] Nursing has become a profession of only applying treatments […] the doctor does not value our autonomy and theoretical body; therefore, despite having trained in a career of vocation and service, I feel that I am simply here to accept the orders of a doctor* (B_F_55_28).

3.1.3. The sculpting of nursing care

This subtheme constitutes a biographical-experiential matrix that nurses construct in a delicate and implicit storyline, which only timidly expands through the *images-concepts* «servitude» and «growth».

The culture of care is gestated from the university and the first care practices: they refer to a climate of humanisation and a need to train constantly. However, at certain moments in their professional career, the impotence of having sacrificed too much (in training and care work) and the implied personal exhaustion are manifested.

Table 2. Theoretical-methodological decisions. Qualitative consistency in The Construction of Contemporary Nursing Identity from Narrative Accounts of Practice and Professional Life.

Research objective	Scientific aspects	Analytical stance	Data sources	Epistemological framework of reference
What do nurses consider important as regards their professional identity?	We are interested in the themes that matter/appear most in nurses' discourse.	Analysis of thematic content.	In-depth interviews.	Constructivism.
	We are interested in the way nurses construct a narrative account of their experiences.	Narrative analysis.		Social Constructionism.

How your co-workers accept you at the beginning is key, in my case I have only words of thanks to them for everything they taught me and the patience they had with me […] I am always in training, it cannot be otherwise. There are always new things to learn […] In all cases, they have helped me learn, to grow professionally, but, above all, grow personally (J_M_39_16). *The truth is that it is a profession that burns you out, it wears you out mentally; it is not valued… Honestly, I have no idea why I didn't become an engineer […] The help, honestly, was really good from my colleagues. I have done training courses, especially online, and they have served me little…* (F_M_34_11).

3.1.4. Self-image and future projection

This subtheme refers to a biographical-experiential matrix that nurses construct through the *images-concepts* «protocol» and «procedure».

Having no time for reflection and no time for oneself can put immense stress on nurses' professional lives that can lead to low self-esteem. Nurses demand more experiential care time, more time outside the procedural processes and fixed guidelines: more human care and less automatism.

As soon as I finished my degree, I started working in two public places and a private one, and the money really very sweet. I stopped my master's degree, which was intentional; I do not regret it, but, at the same time, I should have done more training […] Mediocre, I value myself as mediocre. I do not know how others think […] It is clear that things turn out when interpersonal relationships are good; it's proven. This is in a team, with which we must reach a consensus […] I would be motivated enough (although it sounds somewhat materialistic, but today with this vocation you do not live or travel) an increase in salary (F_M_34_11). *Professional training does not make you a good person […] we have had colleagues who do not have any type of vocation or humility for the profession, however, they do it because they know the technique […] I think that professionalization should be accompanied by vocation, because we must practise this career with mysticism […] it was born from maternal care historically…* (Y_F_64_42). *I think I still have a lot to learn […] There are things I know that work badly because of how the patients are. Something that could change in my typical work is trying to spend more time with patients* (G_F_29_6).

3.2. What do I know about my practice?

Exercise of reflection on practice as a universe of acts of identification and legitimization of the profession.

3.2.1. Nursing experience: the shift, the days, the years

This subtheme constitutes a biographical-experiential matrix that nurses hold in the *images-concepts* «the script», «the rest: what remains» and «the first contact».

Experiential time is the time that defines the meaning of the profession. Nursing time works as an adapter to events, and it depends on the intensity, the affectation and the surpassing (beyond) of the given time. The nursing time always depends on the nurse's personal status and the amount of work to be done, and in this experiential time, the speed of performing procedures is experienced as a problem. Nurses feel that they cannot care as they would like or for as long as they would like: they typically function with an anticipatory and preparatory disposition, expecting the unforeseen, while following a certain established organization.

It depends on the professionals who work that day, the number of patients and each one's situation. My attitude changes depending on the patient, the workload, the number of guards that week, since the psychological fatigue builds up and you're not at 100% every day, although you always try […] I do not prepare any type of script before arriving at the unit, because I didn't know what kind of patients I was going to find, nor the number, nor the pathology, nor if I know them from other admissions. Based on the first contact, I develop a strategize for my shift (V_F_28_5). *Every day is different […] I think it is necessary to think ahead, as much as possible, reflecting on issues that we know we will have to deal with the next day, to bring the most thought-out ideas, and not have to make panicked decisions, without time to think about*

them (J_M_39_16). *From the therapeutic bond […] Sending them a message of help and encouragement, inviting them to a space in which they can express themselves […] It is important to think ahead, it helps you in stay organized in your tasks* (E_F_28_6). *Stressful, you run and there are things that should be done more calmly […] We have a script, then each one moulds it to his or her person. I think it is better to arrive a little earlier so that the colleague can calmly tell you the shift* (JJ_M_41_17). *A spiral of emotions […] we can go from extreme peacefulness to an emergency that merits the presence of all team members […] Our participation is as important as that of the doctor, however, we are always at the rear […] Thinking ahead, in some cases, is productive; in others it is not, because we are always prepared for the unexpected* (B_F_55_28).

3.2.2. Strategy in the field of nursing care

This subtheme represents a biographical-experiential matrix that nurses construct, with more prominence, in the *images-concepts* «prioritization» and «record».

Prioritisation and data recording are conditioned by experience, sensitivity, and theoretical knowledge. However, registered care is an annex to the medical record and is notably contingent on medical records. Again, the importance of care (sensations and emotions) is not usually reflected but is felt with more or less intensity.

Each patient is unique. If something happens that should be worked on above others, I try to address it as a priority and urgent (VI_F_28_5). *Our notes are attached to the clinical history of the patient, which is a legal document […] We also make these observations verbally […] The nursing team coordinates the process of patient care* (Y_F_64_42). *Despite the existence of protocols, the most experienced nurses teach us how to solve problems quickly […] this experience enriches the team and provides a certain hierarchy within the nurses, although all are respected* (P_F_23_1). *Depending on my experience and training and the capacity I feel. It depends on the situation of each patient, and those that generate the most distress for me would go first. To be always there to sustain, in the limit of the impossible, as if death always lurks and life was going away in that event* (V_F_28_5).

3.2.3. Some foundations of caregiver practice

This subtheme constitutes a biographical-experiential matrix that nurses reduce and persevere in the *concept-image* «self-care».

The foundation of care ends up being the individualisation of human needs and the intimate experience with the person in need. For this reason, nurses have a more internal than external meaning because of its difficult definition. The care experience is also an exercise in professional self-care, to the extent that it remains humanised (with the time really necessary) and not very close to procedures or control.

I listen to know exactly what happens to them. If I can solve it, I do it, and if not, I refer it to the professional who can do it […] If there is no protocol, I use common sense. Based on previous experiences (G_F_29_6). *When there are no protocols in the unit, you rely on the protocols of other units or even on experience* (V_F_28_5). *Some patients are more complicated than others, but care is essential […] No matter how much work plan we have, sometimes patients do not recover and everything changes unexpectedly* (Y_F_64_42). *The protocols help you establish the framework, but the most subtle has to be individualized. Each patient is a different person, and there are no common solutions that are valid for all […] It is necessary to first know the patient, know the goals that the team has set, and not least, not make decisions alone, always rely on the rest of the team* (J_F_39_16).

3.2.4. The specificity of the gesture of care

This subtheme refers to a biographical-experiential matrix governed by the complexity and relationships between its *images-concepts* components: «disproportion» and «religious».

This section explains the unconditionality, symptomatological indifference, preposition, and overexposure to the nurses' vulnerable events. Time is particularly critical to care; indeed, it is relative and difficult to measure, since it is always beyond it, it is projected into an improvement; that is why it is disproportionate. In this particularity of care, a technique

escapes science, confuses science (the measurable) and religion (the transcendent). The need for more time, in essence, means that you have to take care of the non-measurable: the unforeseen, the different, the unstructured.

Special nursing care needs require more time […] The sickest users need more time (V_F_28_5). Lack of resources, time and space. The day-to-day, the group and/or general tasks occupy a large part of the shift, and leave little space […] You can look for moments in which to see a patient alone, in unstructured spaces (garden, hallway). We must listen more to the patient; otherwise, we will not be attending to their individuality (J_M_39_16). I like to care for my patients as I like to be treated […] Maintain comprehensive care where rights are respected […] We apply the process of care to the letter and strive to fulfil it […] As a nurse, there is no distinction between people when they pass through doors (B_F_55_28).

3.2.5. Voice and recognition of nursing within the institution

This subtheme constitutes a biographical-experiential matrix that nurses construct, in a more recurring manner through the *images-concepts* «values» and «recognition», followed by «the role», «the silence» and «subordination».

The nursing voice represents, corporately, unease; as a lack of intrinsic recognition of her work impregnated with femininity, technicality, daily life and intimacy. Nurses report that healthcare institutions prioritise the finance over care needs. However, they are forced to continue providing top-quality care without being involved in important clinical or institutional decisions.

It is a public unit, and we have great freedom of action […] The voice of Nursing, half […] We are heard when it interests them (G_F_29_6). The values of the institution play an important role, since they mark the dynamics of the day to day […] There is a general feeling of lack of team when working. Only to improve economic indicators, reduce working hours […] The current management of the centre is focused on the financial and strategic part of health and is far from the care required by patients […] The patient who needs care is not linked to management and consumption indicators […] he only needs health services (V_F_28_5). These are human values that every professional should have regardless of which institution they work in […] The team must be a single voice. Unfortunately, nursing at the institutional level is underrepresented, as there is no representative on the board of directors, the highest management and decision-making body of the clinic. Many programmes and goals are handed down to us. However, there is always the capacity to adapt and redesign these larger goals within a margin (J_M_39_16).

4. Discussion

The findings represented in this work are in tune with studies that, in general terms, allude to the identity conflict of the profession in the course of its history (lack of uniformity and historical awareness) [54, 55]; the charitable-technological dichotomy of care as the essence of its current practice [56]; and institutional, sociological and professional role constraints in light of the contemporary predominance of the female gender in the collective [57, 58].

In light of the available literature regarding the construction of nursing identity, we can identify, fundamentally, two lines of work: on the one hand, that qualitatively oriented to the description of the field, collecting nursing discourses and analysing them from sociological dimensions, but, without having a philosophical viewpoint [59, 60, 61, 62, 63]; and, on the other hand, that which is quantitatively oriented through questionnaires [64, 65]. At present, the latest trends in the approach to nursing identity maintain historiographic and narrative resources and are theoretical. However, in our opinion, they stop at the epistemological limits of understanding those who participate. Nurses have a spiritual and philosophical professional dimension with a great future to explore [66, 67, 68, 69, 70, 71].

The theme 'professional nursing life' traces back a life trajectory in relation to professional practice. The subtheme 'training and initiation in

care practice' tunes up with the findings of many works, both at national and international level, which gather the experiences of nursing students [8, 72, 73, 74, 75]. In some of the studies focusing on the experience of nursing practices, references to self-image and professional future have also been identified [76, 77]. In this regard, we have also found studies differing in terms of the exploration of professional nursing life. Thus, we have found research works describing and analysing the ways in which nurses carry out professional care, but these works do not highlight the ways in which nurses experience professional care as part of their lives, as reflections which condition the theoretical and practical consistency of their knowledge. That is to say, even though we have found references to how professional practice is experienced as years go by, and to how scarcity of resources is experienced (with some consequences, such as professional burnout), we have not seen these experiences put in connection with the opportunity for self-improvement and self-reinvention prompted by a situation of collapse [78, 79, 80, 81, 82, 83]. Precisely the subtheme 'the sculpting of care' allows us to see that traditional attitudes of commitment and unquestioning loyalty keep a link with a deeply rooted spirit of humanisation; that the reigning technological paradigm becomes, in a sense, a hindrance for the preservation of such a professional culture and fullness.

With respect to the theme 'professional nursing life', the story is revealed in its most genuine dichotomies, contrasting the sense of remaining and reflecting on the limits of the human experience, in its full vulnerability, and of going beyond the professional, that is, reaching the borders of the personal, sacrificing life itself in an attrition, in a certain sense necessary, to enable and strengthen self-improvement and growth. In this sense, compassion fatigue and burnout are symptoms of the physiological installation of the Christian germ of unconditional help to others in the midst of the technological impregnation of care contexts: surrender and self-sacrifice are transfigured, they become a necessary sacrifice for asceticism and professionalization promised by the capitalist and Protestant paradigm [74, 84, 85, 86, 87]. In relating, with time as an instance of identity construction, the *images-concepts* «sacrifice», «fatigue», «reflection» or «procedure», we find a compensatory time, roughly articulated in professional growth and a relationship with self-improvement through capital and labour.

Thus, we analyse the relationship that the history of the profession prescribes and proscribes between femininity and temporality as structures of care. We use the conjunctures regarding the female gender as an agent of care in the now to demand, no longer an egalitarian recognition, of social, institutional or sexual justice, but a professional justice from the indices of its history.

In contrast, we do find a wide range of studies which incorporate in their interpretations the question of nursing time and professional practice [88, 89, 90, 91]. In this regard, building a discussion around professional practice in the light of the findings in this study could open some interesting lines of research. We have found many studies dealing with nursing practice, in different areas and in different academic and professional contexts [92, 93]. We have also found research work analysing and providing current strategies in the field of nursing care [94, 95]. However, we have not found the positing of a link with temporality as a defining structure/function of "being a nurse" from a narrative analysis of professional practice. That is to say, the present study emphasises and commits itself to the analysis of the professional meaning of nursing from the philosophy of its practice.

In the theme 'nursing practice', the story is constructed on a *forced hermeneutic* in the emergence of a space of philosophical reflection that assumes a poststructuralist reading of metaphysics, that is, of tradition. The «self-care» *image-concept* is precisely the juncture of this conflict, of this rupture between the classical world and Christianity, the seed of that deep-seated feeling of disproportion, of that provisional excess of care for the other from the reflection of oneself: the other is understood as a journey back to one's own origin. The autonomy and decision-making of nurses are associated with the regulations of institutions. This issue translates into the fact that institutions share the values of care, but

frequently, the regulations on the expenditure of supplies and medications - the imperative of efficiency - as well as the periodic meetings for the review of goals, frustrate the fact that the raison d'être can be the practice. Nurses try to develop autonomous practices; perhaps, like no other profession, it has desired and invested efforts to be a scientific discipline. Assuming these movements entails the need to provide them with ways to develop [96].

We attempt to show a commitment to *a time-driven reading of nursing identity from its practice*, because we think that it makes sense from a contemporary understanding of life and human being as projects subjected to change. We also think worth highlighting the relevance acquired by professional self-care, in linking care for others to the conditions to be able to carry it out in an autonomous, free and satisfactory way: a nurse needs to care for herself or himself in order to care for someone else [97]. Somehow related to this consideration, we have found studies containing non-structured, non-pharmacological or non-protocol-abiding interventions which would tune in to the subtheme 'the specificity of the gesture of care'.

This recovers, as part of the construction of nursing identity, the reality of gender. The nursing discipline supports a profession mainly made up of women; for this reason, it is classified as a female profession. This analysis of the profession allows us to know and respond to certain situations and conflicts in which the profession is involved during its evolution [98]. The nursing profession is related, from its first historiographic explorations, to stereotypes that, at present, resonate sexist and stigmatizing and to a socially discredited image in the context of comparison with the dominant or traditional structure - the most visible, the highest paid - of the male and the condition of masculinity. Thus, the nursing story coexists with the vocational disposition while reproducing the majority representation of a profession associated with the traditional female role [2]. Nurse identity refers to a multifaceted phenomenon that is fundamentally due to the different roles that nurses assume in a plural and variable society under continuous review [99]. In social memory is the recording of a discipline that *is for women* - and that we consider today to *be for women:* at least, femininity and the affinity of care for this structure are necessary.

Belonging to this series of ideas we can understand the subtheme 'voice and recognition of nursing within the institution' as one on which hinge the two main themes of this study. This subtheme is in turn related to the subtheme 'self-image and future projection'; thus, we find that nurses' idea of themselves depends in principle on the social imagination, university education, early experiences in care, motivation and self-growth, and that this idea changes throughout their professional life. Nurses see themselves reflected in the duty to be fulfilled, in the practice, in their principles (ethical, experiential, or coming from the years of their academic training) and in a certain overstrain and fight. This is, in our view, an index of their self-overcoming and their wisdom and philosophy of life as a unique body of knowledge.

Currently, there is a growing awareness of the possibilities of developing the nursing discipline. The need for an effective integration between theoretical conceptions and their projections on practice is evident [100]. The future presents challenges for the profession, which will support a scientific and thinking body that, for the time being, knows no limits from within, if it is a profession that goes beyond technique, the instrumentalization of its knowledge, beyond the mechanization and the subordination of its possibilities.

4.1. Recommendations

Along the lines of themes and subthemes that emerged from nurses' narrative accounts, and in the light of the interpretations made by the researchers, we recommend going on exploring and deepening the knowledge of nurses' lives and their professional conflicts, of their construction of an identity increasingly in conformity with undergone experiences and the opportunities offered by their visibility, policies and timing; a unique timing which articulates their sense and survival, worthy of a whole philosophy of life. We are committed to an identity which hinges on a new and renewed version of the nursing profession, from the modes in which nurses give a narrative account of their own stories.

4.2. Limitations of study

With respect to the limitations of this research, the necessary trust and rapport took a long time, having to ignore data sources that were not accessible again and assuming laborious analytical work simultaneous to the data collection. In this sense, the sampling was more intentional than theoretical and limited to a single area.

It is important to point out that this research was carried out in a single care centre, with links to the Roman Catholic Church, where informants where not necessarily religious people or professing any particular faith. Findings in this research need not be extrapolated to other institutions of its kind (Mental Health care centres linked to the Catholic Church) in other countries, since each different culture and social history would also condition and single out professional nursing identities and their modes of envisaging the future. Therefore, it would be interesting and enriching to compare the present analysis with those carried out within Roman Catholic environments in other territories, as well as with Protestant or even non-confessional environments, so that more widely-reaching threads in culturally diverse nursing identities could be explored and identified.

This research had a strong and necessary subjective component which, although it favoured the theoretical and interpretative development of the study, questioned at times its consistency with the main objective of the study. The reason for this is that the study turned out eventually to be more interpretative than descriptive.

5. Conclusions

The professional identity of contemporary Spanish nurses is manifested as a variable, diverse and transmutable function that resists uniformity and opens constellations of understanding, as it gains voice and visibility. The nursing discourse survives, conflictively, the subordination to medicine and fidelity to the hospital tradition governed by issues of gender.

The contemporary Spanish nursing identity functions in two different and permeable themes: professional nursing life and nursing practice. A story projected in the active change and philosophy of nursing care.

Professional nursing life hinges on the following subthemes: 'Training and early care practice', 'Modes of experiencing professional care', 'The sculpting nursing care', and 'Self-image and future projection'. These encapsulate the important aspects of nursing professional life according to the narrative account of nurses.

Nursing practice hinges on the following subthemes: 'Nursing time - shift, days, years'; 'Strategies in the field of nursing care', 'Some foundations of care practice', 'The specificity of the gesture of care' and 'Voice and recognition of nursing within the institution'. These encapsulate the reflections regarding nursing practice and its underpinnings.

The storyline of the identity story of contemporary Spanish nursing travels from a certain prescriptive morality, going through repression and institutional and social interception of gender, to the claim of a different culture, which makes sense in the sensitivity and in the organic, feminine and matrix of time. This claim can be used to support reflective practice

in academic and healthcare settings as well as to promote a paradigm shift.

Declarations

Author contribution statement

Ginés Mateo-Martínez: Conceived and designed the experiments; Performed the experiments; Analyzed and interpreted the data; Contributed reagents, materials, analysis tools or data; Wrote the paper.

Maria Carmen Sellán-Soto, Antonio Vázquez-Sellán: Conceived and designed the experiments; Contributed reagents, materials, analysis tools or data.

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Data included in article/supplementary material/referenced in article.

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The authors declare no conflict of interest.

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