

RESEARCH ARTICLE

“We have to be the link between everyone”: A discursive psychology approach to defining registered nurses’ professional identity

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Funding information

The study was supported by AFA Insurance, Sweden (research grant 170108)

Abstract

Background: The occupational health and safety of registered nurses is unsatisfactory, often including high work demands in combination with insufficient acknowledgement. Implicit expectations influence their working conditions, many of which are set by the nurses themselves. Therefore, we aimed to explore how professional identity was discursively constructed by Swedish registered nurses in research interviews about night shift work.

Design and Methods: Ten semi-structured interviews with registered nurses were analysed using a discursive psychology approach. The Standards for reporting qualitative research guided the reporting.

Results: The professional identity of registered nurses included a theoretical professional aspect as well as a unique experience-based competence. With their overview and breadth of competence, registered nurses constitute the hub of healthcare activities, also mastering tasks in the fields of other health professions. This opacity of professional boundaries is associated with boundless expectations of the registered nurse. Additionally, the professional identity stipulates always putting the patient's best interests first, and one's own needs second.

KEYWORDS

discursive analysis, occupational health, professional identity, registered nurse, work health

1 | INTRODUCTION

For several years, employers have reported difficulties in recruiting registered nurses (RNs), and the global shortage of RNs is recognized (Drennan & Ross, 2019). Difficulties to recruit and retain RNs relates to various aspects of how the work is organized; for example, there is role stress and a lack of financial reward (Flinkman et al., 2010). At the same time, many RNs stay in the profession despite dissatisfaction

with the working conditions. In a study by Cowin (2002), experienced nurses expressed that they found the profession rewarding and fulfilling, in spite of issues of burnout, excessive stress and the perception of a poor public image. Moreover, exhaustion and burnout have followed sickness presenteeism (Brborović et al., 2017), indicating that commitment may be a health risk in an unhealthy work environment. Consequently, it may be necessary to improve nurses' working conditions, not only in order to attract RNs to remain in the profession,

Annika Lindahl Norberg and Jennifer Strand have contributed to the work according to the journal's Authorship policy

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but also to protect the health and wellbeing of those who stay, as convincingly argued by McNeely (2005) more than a decade ago.

The position of a nurse often entails large responsibility and high performance expectations, yet nurses have limited authority and receive insufficient acknowledgement. This combination is a case in point illustrating one of the most well-established models of stress at work, the demand-control model (Karasek, 1979). According to this model, a combination of high demands and low decision latitude constitutes a high-stress work situation. In addition, an increased risk of work stress has been recognized in human service occupations, i.e. occupations whose purpose is to serve people in their role as customers, clients or patients (Aronsson et al., 2019). High emotional demands are assumed to play a significant role in the development of such work stress. Persons in human service occupations are also more likely to experience negative status incongruence, where the status of the occupation is low despite the requirements, for example the requirement to be university-educated (Nyberg et al., 2020). This may partly be explained by the fact that female-gendered occupations, typically involving caring for and developing other people, are generally associated with lower status in society.

Nursing is a vocation with roots deep down in history, yet nursing science was only fairly recently accepted as an academic subject by the academic world, and the precise definition of *nursing science* is still evolving. Consequently, this well-established vocation is at the same time a young profession. Raising the status of nursing as a profession is linked to the development of both nursing science and nursing practice (ten Hoeve et al., 2014). But defining nursing and the nursing profession also involves struggles with the popular image of what it means to be a nurse. More than most other professions, the nurse is a symbol in society. From far back in history, when nursing was regarded primarily as a calling rather than an occupation, this popular image has developed. Although there are a few different nursing stereotypes, one deep-rooted public image typically includes traditional “feminine qualities,” such as subordination, modesty and dependence. Accordingly, this gendered picture directly interferes with the possibility to express competence and independence (Dahlborg-Lyckhage & Pilhammar-Anderson, 2009). This can be illustrated by a paradox only too well known to nurses: the epithet of “Florence Nightingale” is sometimes used derogatorily to depict a stereotype of a submissive and self-sacrificing person—while the real Florence Nightingale was a professional who improved nursing and care through systematic and evidence-based decisions (McDonald, 2020).

In summary, there is a need for additional efforts to improve RNs' occupational health and safety. In the present study, we raise the question whether aspects of the profession itself may provide important information for this purpose. Explicitly, we focus on the RN's professional identity.

The importance of distinguishing one profession from another is not merely an academic matter for profession theorists. It is important also for the working individual, since professional identity is something far beyond a certain level of education, skills and training. Several studies have addressed the professional identity of nurses, and there are several different approaches to defining the concept,

as highlighted by Fitzgerald (2020). Despite a lack of consensus about the precise definition, researchers seem to agree that professional identity forms a crucial part of the working individual's entire set of identities.

In this paper, our perspective on professional identity draws on two partly antagonistic views. On the one hand, we agree with the post-structuralist view that identity is no stable trait but, rather, is a dynamic process that develops along with the individual's immediate social environment (Phelan & Kinsella, 2009). On the other hand, we also agree with the occupational research notion that entirely individualistic analyses of occupation may miss the target (Gerlach et al., 2018). In summary, we see professional identity as something that is shaped in and through the individual's social frame of reference, and yet that is dependent on structural factors relating to the profession and beyond the individual's control. Common structural factors of an occupation allow us to see certain features that recur in the professional identity of different individuals within the same profession.

In the present study, we focus on RNs working night shift. Working night shifts entails a high degree of autonomy and independence for the RN and offers a possibility to display the potential of the nursing profession (West et al., 2016). Therefore, we based our method on the assumption that narratives focusing on night work would provide rich material for an analysis of how nurses construct their professional identity.

The overarching purpose of the present study was to extend the understanding of RNs' professional identity, and thereby identify key ways to improve their working conditions. Specifically, the aim was to explore how professional identity was discursively constructed by Swedish registered nurses in research interviews about night shift work. Our discourse analysis was guided by a discursive psychology (DP) approach (Goodman, 2017; Wiggins & Potter, 2017).

2 | METHOD

The study was carried out as part of a research project entitled “Sustainable working life for night-working health care staff,” whose overall purpose was to deepen the understanding of what night work means for nurses and midwives. For the analyses in the present study, a DP approach was used. The discourse analysis applies a social constructionist view, which assumes that the concepts we use and our way of using language are tools for constructing knowledge. Consequently, a discourse analysis is by definition a product of the researcher's own discourse, as is their interpretation of data. For this reason, it is particularly important that the textual interpretation is structured and mindful. The Standards for Reporting Qualitative Research (SRQR) guidelines (O'Brien et al., 2014) were used.

2.1 | Informants

The main project included nurses and midwives in the Stockholm Region, Sweden. The inclusion criterion was a minimum of 6 months'

experience of having a working time schedule that included night work. The final study group for the main project comprised a total of 29 informants. For the present study, we made a strategic selection of ten interviews with RNs, striving for variation regarding age, years working as an RN and place of work. Their experience of being an RN ranged from 18 months to 38 years, their age ranged from 25 to 62 years. Two of the informants were men.

2.2 | Data collection and processing

Informants were invited by an e-mail sent by the principal investigator (ALN) to all nurses and midwives at a number of departments selected to represent different specialties. Those who agreed to participate responded by e-mail or telephone.

In autumn 2018 and spring 2019, semi-structured individual interviews were conducted at an undisturbed location at the informant's workplace or the researcher's office. The interview focused on the person's firsthand experience of RN's night work and the interview guide included exploring social, organizational and practical/physical aspects as well as expectations from family and/or partner, if relevant. The interviews lasted 45–60 min, were recorded on audio file and were transcribed verbatim using running text with punctuation. For part of the data used in the present study, the transcripts were supplemented with symbols for non-linguistic behaviours.

2.3 | Data analysis

For the analysis, we have largely followed the recommendations for DP by Wiggins and Potter (2017) and Goodman (2017). Discourse analysis is not a uniform method, nor is DP and can be done in different ways. In general, however, it is concerned with rhetoric strategies used in writing or speech, with a focus on how these strategies serve to construct social status and power relationships. A discursive strategy of particular interest is *subject positioning*, in the sense of the term used by that Goodman (2017), which refers to how persons—as the subject—construct themselves and their identity in relation to others. For an understanding of different specific types of linguistic and communicative actions and rhetorical strategies, we have also used the works of Whittle et al. (2008) and Ghee (2010), although they describe discourse analysis in general and not specifically DP.

The first author (ALN) conducted the analysis—coding, interpretations, thematization and formulation of the results—discussing these with the second author (JS) at each step. In the analysis process, we applied the following steps: (a) ALN, who was already familiar with the material through having performed nine of the ten interviews, read all transcripts closely and performed so-called selective coding (Braun & Clarke, 2013). By this is meant a selection of sections from the interviews that were relevant to the study aim, i.e. where the participants talked, in one way or another, about what it is to be an RN. JS performed a parallel coding of one-third of the

interviews. (b) The next step included coding of the selected sections, reading the transcripts in parallel while listening to the audio recordings. In this step, discursive strategies and elements used by the informants to construct professional identity through subject positioning were coded. The following question was asked of the text: *How does the informant talk about what it means to be an RN? Does the construction of professional identity involve defining the interface to other groups or professions?* (c) In the next step the actual analysis started, and the intention was to understand the function of the various discursive elements and their interplay in speech. In steps (b) and (c), the analysis was supported by reflecting on “What is actually being said here?”, followed by “Why do I interpret it that way?” (d) The analysis was then extended to a thematization of the results. Subject positions and discursive strategies with similar meaning regarding the construction of professional identity were grouped into themes. The themes' relevance to the interviews in general was examined and confirmed. (e) The last step included the formulation of the final results in a comprehensive way, yet with the aim to make them easily accessible to the reader, including selection of text excerpts to exemplify the interpretations.

2.4 | Methodological considerations

As DP relies on the researcher's analytical interpretation, it is important to maintain transparency and ensure rigour in the methodological process. To that end, we applied a certain structure through the analysis process, as described under “Data analysis.” The use of text excerpts to exemplify the interpretations adds to the transparency. Moreover, reflexivity is applicable to all research and highly relevant to discourse analysis (Yardley, 1997). Reflexivity includes the researcher's efforts to uncover their pre-understanding of and assumptions related to the research topic, and the possible influence these might have on the data and analysis. What the informants chose to share and how they chose to tell their stories is not a limitation per se, but it needs to be mentioned that the two interviewers were not nurses themselves, nor was the second author. The two authors are Associate Professors in Psychology, and the third person performing one of the interviews was a Professor in Social Work. All three have, as patients and relatives, met RNs as professionals. They have also, as researchers, come into contact with nursing researchers. Moreover, ALN was the primary investigator in the larger research project from which the data for the present study were drawn. In this role, ALN immersed herself in the literature, qualitative as well as epidemiological, about night-working nurses and midwives. In summary, the researchers' professional status and pre-existing assumptions undoubtedly influenced the interviews as well as the analysis, in one way or another. Consequently, the two authors, influenced by their psychological training and practice, had to put extra effort into the analyses, as the traditional focus of psychology is on the essence of phenomena rather than on the rhetorical and discursive strategies by which the phenomena are presented.

Credibility of the analysis also concerns whether the study sample was appropriate to meet the aim of the study. When deciding the sample size, we did not primarily aim for saturation, but rather we aimed to capture a diversity of relevant experiences among the informants.

2.5 | Ethical considerations

The study protocol was approved by the regional research ethics committee in Stockholm, Sweden (approval number 2018/1360-31/5). Participants provided written informed consent, confirming knowledge of voluntariness. The interviewers, one licensed psychologist and one licensed psychotherapist, during the interviews assessed whether the participants needed occupational health care or other support. No such need was detected. All data were kept confidential. Transcriptions were rendered anonymous. The researchers involved in interviewing (ALN and an interviewer) and analysis (ALN and JS) had all several years' experience of handling qualitative data. Careful consideration was given to the presentation of the results so that no individuals could be identified.

Furthermore, discourse analysis with its high degree of interpretation can be unethical if conducted carelessly. The researcher may claim that they have identified underlying intentions, of which the informants are unaware or with which they do not agree. We have handled this ethical dilemma by keeping nurses in general and the informants in particular in mind as recipients of the final report, throughout this work.

3 | RESULTS

The substance of the professional identity of RNs, as discursively staged in the interviews, was structured into four main themes: *Bearer of experience-based competence*; *A qualified profession*; *The hub of the health service*; and *Always the patient first*. Two of these had two subthemes each, with slightly different discursive strategies supporting the main theme. The themes and subthemes are discussed in detail below.

3.1 | Bearer of experience-based competence

The informants described a unique clinical-practical competence, the clinician's eye, which takes time to develop. It is acquired not through education but only through clinical experience. The experience-based competence was constructed as a vital part of the RN's professional identity. Practically all interviews contained descriptions of experience as crucial to RNs' ability to perform their job satisfactorily. In addition, narratives revealed that many RNs took professional pride in their level of experience. In the excerpt below, informant 8 described how the RN's experience-based competence is the link between the patient and the care. Particularly during the

night shift, the RN needs to make a qualified assessment on which the doctor will base their decision.

That's the thing: you need to be able to make a sensible assessment of the patient on your own. And it takes time to get that skill. To get that eye.

(informant 8)

Experience-based competence was generally constructed in two ways, which is further elaborated in the two subthemes below: the positioning against the inexperienced RN and the positioning against the day shift role of the RN.

3.1.1 | It takes experience to manage the night shift

The significance of experience-based competence for the RN's professional identity was in several instances constructed through positioning against the day shift role of the RN. At the end of an interview, one informant was asked to highlight the most important take-home message for a study on night work and emphasized the importance of confidence and experience for the independent nursing work during the night shift:

Well, it's really important to have good experience and feel very confident in your role before you start working nights ... it is very important for patient safety ... and for the individual worker. I would say.

(informant 6)

The RN was described as having enormous responsibility when alone on the ward during the night shift, and the competence needed to accomplish the task was described as being inevitably based on experience.

... even if they're not unstable all the time, these are patients who are seriously ill, and something can happen. So you have to be on your toes and pay attention to them ... like, 'I feel that this patient ... I have to keep an eye on this one.' And that can be a little difficult when you're new and inexperienced, to have that intuition. Because it comes from experience.

(informant 3)

The excerpt above is taken from a lengthy narrative in which the RN's experience-based competence was shown through scene setting, with the narrator as the agent. The understatement "that can be a little difficult" played down the risk of seeming to belittle any inexperienced colleagues.

Moreover, experience-based competence was not only seen as crucial for the RN's professional practice; it may also be the source of joy in the work. When asked what might be positive about the night

shift, the following answer was given without hesitation by one of the informants:

The good thing about working night shift, ... what I think is fun about working at night, is that the patients who need that little bit extra, that I actually may have the time to give it ... if nothing drastic happens. That I'm there for them. Using my clinician's eye, I see beforehand that something will happen, I'm aware of the situation and I inform the doctor well in advance before anything happens. And to be able to arrange my work myself, during the night. Like, I ... I do what I want when I want and when I ... well, in addition to this routine stuff, check out patients and drugs ... /.../ No one sits and tells you what to do and how to do it. Instead you do what you do, and you do it in the patient's best interests. That's what I would say.

(informant 9)

Thus, the experienced RN is fully capable of working independently, if only allowed to do so. In the excerpt, agency was salient and used as a discursive device in several instances: "I see," "I'm aware," "I inform the doctor" and, not least, "I do what I want when I want." This excerpt also reveals frustration at the way the day shift is organized, which does not allow the RN to fully use their experience-based competence. When unobstructed, on the other hand, RN's experience-based competence is allowed to come into its own.

3.1.2 | A registered nurse is an experienced nurse

Another discursive strategy informants used to construct their own experience-based competence was through positioning against inexperienced colleagues. Such constructions of experience were common, although at the same time it appeared problematic to talk about *inexperience*, as if accusing a colleague of not being a real RN. Accordingly, although experience-based competence was constructed in contrast to those who possessed less of it, the explicit word "inexperienced" was rarely, if ever, used by informants to describe themselves or a colleague. In one interview, the interviewer asked whether working with inexperienced colleagues could be stressful or demanding, and the interviewee navigated this balancing act through the answer:

I think it works, I don't think it is a real problem ... I don't feel it is. On the contrary, I can think it's fun to work with ... new people who come up with some new ideas and, and, as a fresh breeze somehow, so I don't mind it ... I can think it's fun, actually ... eh, but in serious situations I can of course see that here is ... it slips a little here, this person doesn't reach all the way and, er, and then I feel that I have a responsibility that may

feel a little stressful ... But it is an exception. I have to say. Yes ... I don't think it's a problem

(informant 1)

At the beginning of the excerpt above, the informant used a number of discursive strategies to convey the message that working with inexperienced colleagues was not a problem. These strategies include repetition and making reference to both thinking and feeling about the issue. However, at length, the statement becomes more ambivalent, uncovering a dilemma. The language is carefully chosen so as not to express disrespect for a young colleague, while at the same time underscoring the significance of experience. In the scene being painted, the young colleague is constructed as vaguely positive, "a fresh breeze," but then the interviewee added that when the working task became more demanding, the young colleague's inexperience, and in consequence, their inability to rise to the challenges of the situation, became noticeable. The experienced informant inevitably had to take over their colleague's responsibility. By not describing a specific event but a generic situation, the interviewee kept the construction global. This can be interpreted as an example of how loyalty towards young RN colleagues can conflict with the way experience-based competence is constructed as the core of the RN's professional identity.

One way to solve the dilemma of maintaining respect for inexperienced colleagues—and, at a higher level, loyalty to the profession—was to recall memories of oneself as a novice. One informant with several years in the profession looked back in time when talking about experience and feeling confident in their role.

Interviewer: /... / what is it like to work night shift being fresh ... ? After 6 months one is still quite new

Informant: Of course it affects how confident I feel in my role to assess the patient clinically and in how to ... in decision making in general. Now I think I myself had quite poor self-insight, and I thought I was very experienced after 6 months ... we are all different there. So I may never actually have felt insecure, but I remember I used to think [laughs], 'Hope no one needs a CPAP [continuous positive airway pressure] because I don't really know if I could handle, how to connect it.'

(informant 6)

Sketching such a drastic situation involving a young RN, who both is inexperienced and lacks insight, can be done safely by describing oneself. The addition of "*We are all different there*" underscores that others may think and act less naively. As it seems, the younger version of the narrator would have accepted the challenge and given it a try without further ado, indicating expectations that an RN is by definition experienced enough to complete all tasks at hand. One issue that lingers in the background is: if the core of the RN's professional identity includes experience-based competence,

then what is the professional identity of the inexperienced RN? The answer did not surface in the interviews and this seemed to remain an unresolved dilemma.

3.2 | A qualified profession

The *profession* aspect of nursing entails that it rests on a fundament of theoretical knowledge and independent professional responsibility. The informants displayed professional pride in this, and often used technical medical terms from their everyday work in a natural and familiar way to describe the RN's assignments and responsibilities. In the following excerpt, the informant described the night shift on the ward. When the interviewer, who had no medical training, asked for a clarification, the explanation was simple and straightforward, but delivered with dignity and professional pride:

/... / it's like the ordinary shift. Like – you receive, you triage, you set a priority

Interviewer: What did you say?

Informant: Triage – that is, you receive a patient, you learn a little about their situation, how long they have had the problem, you take some blood samples, often some vital parameters: pulse, blood pressure. Provide some medicines if needed. You see everyone who comes, and go through that procedure. Make a plan for who needs to see the doctor first.

(informant 5)

Discursive strategies to construct the professional identity of qualified RNs included upwards and downwards positioning. Thus, the RN's identity was constructed by approaching and allying with the doctor, and by distancing from the assistant nurse who is not formally qualified. In this sense, the RN was seen to possess both competence and formal authority, which the assistant nurse does not have, and in some ways to be the doctor's deputy when the doctor was absent, which often is the case during the night shift. This positioning constitutes the two subthemes *The doctor's support and equal* and *Distancing from those who are unqualified*.

3.2.1 | The doctor's support and equal

Registered nursing as a qualified profession was constructed in relation to the doctors, whom the informants collaborated with. Positioning against both young, inexperienced doctors and experienced specialists included agency, typically combined with modesty.

All doctors, but particularly inexperienced ones, were dependent on the RNs. Informant 5 described an episode where an inexperienced junior doctor had a patient who became acutely and severely ill. The doctor was unable to get in contact with a senior colleague and soon found the situation overwhelming. The doctor *“just broke down and cried because she felt she didn't know what to do, and was*

given no help” (informant 5). However, the informant and her RN colleague were able to help her.

So then my colleague had to try to comfort her [the doctor] and I had to try to figure out something myself, like, kind of MacGyver stuff. And I just did, and then I asked her to prescribe everything I had given, afterwards. Because it's like that – often the nurses at night are more experienced than the doctors at night, so they [the doctors] are very dependent on our skills and our help as well ... so that you suggest treatments or ‘well maybe a little more of that’ or something.

(informant 5)

In the above quote, the informant rhetorically plays down the RN's contribution, and at the same time describes a qualified and autonomous effort that resolved the situation. The humble wording of the self-quotation at the end of this excerpt contributes to the construction of a complex relation between the RN and the doctor as part of the RN's professional identity.

In addition, agency was an important building block when positioning was done against the more experienced doctor. During night shifts when there was no doctor in the ward, the RN from time to time needed support in complicated situations, which was usually given on the phone. In the interviews, such encounters were frequently constructed as a talk between equals, where the RN *discussed* the problem rather than simply *asking for help*: *“... when some kind of situation arises, something medical, it's the ICU [intensive care unit] emergency service I turn to and have a discussion with”* (informant 1).

3.2.2 | Distancing from those who are unqualified

Registered nursing as a qualified profession was also constructed through distancing from the assistant nurse who was not formally qualified. The competence and formal authority of the RN, which the assistant nurse lacks, means that the RN can be quite alone with no one to lean on. In the following description, the informant elaborated the burden of being alone with the overall responsibility for the patients' wellbeing. At the same time, she described competence and authority by positioning against the assistant nurse.

As an RN, that's how it is; the assistant nurse is limited, so most often I have to intervene in almost all situations

Interviewer: Mm, what is, what is there that the assistant nurse can do completely on her own?

Informant: Well, basic care. If it is possible for her, she can of course change diapers and help patients to and from the toilet. And ... and get them something to eat, and so on. Plus she can also do, take what we

call controls, which means blood pressure, saturation, heart rate, respiratory rate, and temperature, and measure level of consciousness. Plus the assistant nurse can also – on my instructions – connect the patients to monitoring ... So there's a lot she can do. But as soon as the assistant nurse ends up in a situation where there are medical issues or some kind of assessment of [a patient's] health condition, she must come and get me.

(informant 1)

The discursive strategies in this excerpt included emphatically expressing that the assistant nurse's sphere of activity is associated with basic nutrition and care, while all medical issues are qualified and as such the RN's responsibility. The RN's professionalism is underscored and the dividing line between the RN and the assistant nurse is reinforced by pointing out that certain qualified tasks may actually be performed by the assistant nurse – provided that the RN is supervising.

Constructing the RN's professional identity in relief against an unqualified profession entails that “the other” is presented as somehow less important. This dilemma was generally addressed through the narrator's reassurance that they did not mind assistant nurses as persons and that they did their best. In addition, the assistant nurse was constructed as a valuable resource for the RN to use when carrying out their work. “My assistant nurse” was a frequently used term, indicating traditional hierarchical structures as a discursive device to draw the line between qualified and unqualified.

And then again you might let them do things that they may not actually have formal competence to do, just to make it all work practically. It has happened that I've asked them to run with pain relief to a patient because I was busy elsewhere, although I'm not allowed to hand that over to my assistant nurse. But on those occasions there was, like, no sensible alternative.

(informant 8)

Once again, the RN's independent professional responsibility was constructed through a scene displaying a high degree of agency. In this passage, the narrator is the one who unambiguously possesses the authority and competence to make a qualified assessment of the situation. Even when delegating a task to the assistant nurse, the RN keeps the overall responsibility.

3.3 | The hub of the health service

Health care includes several different professions, which are all essential for the care. The RN, however, often has an overarching role, connecting the various parts. In the interviews, the RN's professional identity was constructed with the RN as the centre of the care machinery, with insight into the variety of activities in the

department. In addition to this knowledge, the RN actually performs tasks, both advanced and simple, within the entire range of patient care. This unique overview was constructed through a general positioning against other professions, which were perceived as lacking such broad competence. The different aspects of this knowledge of the healthcare spectrum were that it is: a key competence, a central part of the action repertoire and a major aspect of others' expectations of the RN.

With an overview of the whole comes the duty to make other professionals, especially the doctor, aware of matters they ought to act on. Particularly during the night shifts, the doctor's work is largely based on the RN's assessments.

... when there is something we worry about that maybe the doctor doesn't think about, and we kind of push it, when we want an examination to be done. Or we think they should prescribe something, and that's a decision maybe that we can't make, but that we may consult a doctor about.

Interviewer: ... and suggest?

Informant: Exactly. And maybe suggest a blood gas [test] or an examination or ... well, decisions they should make.

(informant 2)

In the above quote, the construction of the RN as the pillar of health care is unambiguous. Yet there is a slight touch of despair in the narrator's tone and in the repeated “we worry about,” “we kind of push,” “we think they should prescribe something” as if the responsibility is about to be overwhelming.

In the care of the patient, the RN serves as a hub connecting all the other professional areas, not only administratively but also practically. Informant 7 described the consequences of low staffing during the night shift, and compared this with the day shift:

During the day there can be a bit more to do, [the patients] need stimulation, some need to eat ... if they're awake they need to be washed during the day. And then practice. Exercises. But then you also have the help of the physiotherapist when you need to do these mobilization exercises.

(informant 7)

In this example of constructing the RN as the professional on whom the main responsibility rests, the narrator is the agent who receives help from the physiotherapist even in the physiotherapist's own field.

In addition to defining the RN's professional identity, the description of the broad and varied range of knowledge reveals a permeability of professional boundaries. Entering and moving freely in the fields of other professions is seemingly unproblematic. At the same time, it also entails an absence of a clear demarcation line, which in turn allows others to demand whatever they want from the RN. Thus, the construction is characterized, on the one hand,

by certainty and self-efficacy relating to the RN's competence and overall view and control, and on the other hand it reflects ambivalence about being capable of doing anything and being expected to do everything. However, this ambivalence was not expressed by all informants and it may be of significance that the informant who voiced it most explicitly represented a younger generation of RNs.

I mean, working conditions – that we have to be the link between everyone. I mean, I think the doctors have quite... they have limits for what they should do and not do and that is reasonable. But I feel that nurses have to do everything on all levels. /.../ We take care of all medical equipment, and then we also deal with the communication with the doctors, assistant nurses, physiotherapist, the patient's relatives, care planning with the municipality. Like that. It's pretty ... incredibly wide /... / Well, I think most professional categories have like, 'This I must do, and this I mustn't do.' While we are, like, everywhere. And that's what I mean, it doesn't feel like we're valued: like, why should I stand here spreading sandwiches?

(informant 4)

Here again, the RN's capability of performing all kinds of tasks is rather a truism. Discursively, this is confirmed by the informant's indignation at being used for all kinds of tasks, even simple tasks such as making sandwiches.

In summary, this *doing everything* indeed seems to be part of the RN's professional identity. At the same time, this aspect includes a dilemma, where a broad knowledge and a large capability can entail the risk of being exploited.

3.4 | Always the patient first

In the construction of the RN's professional identity, the relationship with the patient had a particular significance. At the heart of this was the RN's unique, communicative and supportive relationship with the patient. More than any other profession, the RN has a holistic approach to the individual patient, including, but not limited to, their medical condition. Always minding the patient's best interests is therefore crucial not only to the RN's daily tasks, but also to the RN's professional identity.

In the interviews, discursive strategies were employed to excuse and explain the narrator's own needs, such as the need for taking a break. Only once all work tasks were completed did the RNs permit themselves to chat with colleagues, for example. Even professional needs such as turning up the light when examining a sleeping patient were being discursively justified.

Keeping quiet, that's not difficult, because you can talk a little, like, in a low voice. But I think nowadays ...

I notice, like, more in recent years maybe, that I need to have light to see what I'm doing. Some colleagues can dim the light quite a lot in a room, but I feel, no, I have to have a little ... some small light on as well so I see medicine pumps and ... yes. But that comes with age, I would say.

(informant 10)

An act that could possibly be interpreted as egocentric, like turning up the light and maybe disturbing the patient, is here being defended through emphasizing the informant's own imperfection. The fact that this even needs to be defended may be interpreted as a sign that caring for the patient is given great importance.

Moreover, the RN's working assignments during the night shift are compared with those during the day shift, underscoring that care can be truly patient-centred only when the RN is allowed to work undisturbed, as on the night shift.

During the day there are ten other things waiting [to be done] so then it's, like, you just walk in there [to the patient] and think, 'Please stop crying ... I don't have time really' and so you feel, like, unsympathetic. And that wasn't why I wanted to be a nurse, I wanted to be one so that I could sit with those who're crying and have time to sort of take care of them. But then it becomes like a conflict of interest, during the day, that you weigh this patient's needs against everyone else's ... well, against everything else you have to do. So it's a little calmer at night, you simply can do your job better. You are a better nurse during the night shift, I feel, towards your patients, because you can spend more time on them.

(informant 5)

When the patient's medical needs are met, the responsibility of the RN is not over. The RN cares for the entire patient, not only their medical condition. In this description, the informant used weighty discursive strategies in constructing the holistic perspective, for example stating "... *that wasn't why I wanted to be a nurse.*" Supporting a patient in need is so essential that where this is not possible, the informant even goes so far as to question her choice of profession. During the day shift, the continuous demands on and many expectations of RNs—i.e. RNs' working conditions—thus conflict with this central part of their professional identity.

4 | DISCUSSION

The aim of the present study was to explore how professional identity was discursively constructed by Swedish registered nurses in research interviews about night shift work. In brief summary, the results included the following: the professional identity of the RN includes a unique experience-based competence, which cannot be

obtained through education. In addition to the clinical authority of the RN, the RN's competence rests on a combination of theoretical knowledge and independent professional responsibility. Moreover, with an incomparable overview of the care and with a breadth of competence, the RN is the hub of all healthcare activities, also mastering and performing tasks in other professional fields. This opacity of the professional boundaries entails boundless expectations of, and demands on, the RN. Last but not least, the professional identity of the RN stipulates always putting the patient's best interests first, before one's own comfort and needs. We believe that these results provide some valuable clues for the work with RNs' occupational health and safety.

It has been noted that nurses' professional identity develops through experience and socialization in the professional role (Rasmussen et al., 2018). At best, this process is allowed to take its time and includes support from supervisors and experienced colleagues. Urbanowicz (2021), for example, argues for a structured and supervised role transition for the nursing student to grow into the role of the RN—which, however, has not yet been implemented. Nevertheless, experience-based competence seems to be a crucial aspect of being a nurse. If the expectations, both from within the profession and from the context, state that all RNs are supposed to possess solid experience, this may have implications for the occupational health and safety of those who are newly graduated. Stress in the face of excessive demands may be a consequence of not asking for help, when knowledge is taken for granted. Moreover, uncertainty and a lack of confidence per se can lead to stress (Rasmussen et al., 2018), while stress also causes uncertainty and a lack of confidence (Heereman & Walla, 2011). This may develop into a vicious cycle for new RNs who are not expected to be in a learning process. At worst, the invisibilization of inexperienced RNs encourages the development of hierarchy among nurses, with negative consequences both for the individual and for the profession. In addition, our results indicate that young RNs sometimes take unnecessary risks just because they do not want to be seen to be inexperienced. Possibly, high expectations of experience may therefore contribute to a higher risk of accidents.

Nursing is a discipline that covers several different areas. It involves knowledge from disciplines such as medicine, chemistry, physics, biology and the social and behavioural sciences. A breadth of knowledge is crucial to the RN's professional identity. Yet nurses still struggle for the profession to be accepted as a science-based profession in its own right, see e.g. Green and John (2020). Representatives of the profession have argued that even seemingly simple tasks, such as washing and feeding, are parts of the interaction with the patient that gives the nurse important information when assessing the patient's state (Middleton, 2017). Perhaps this very complexity hampers the process of establishing nursing as a well-defined discipline. Rasmussen et al. (2018) have noted an association between confidence in a pronounced role and a well-defined professional identity. Conversely, unclear professional boundaries can possibly contribute to role stress. In addition, uncertainty about what actually are the RN's tasks and what are not increases the RN's risk of excessive workload. Role ambiguity seems to be

related to a risk of demands–resources imbalance (Orgambidez & Almeida, 2020). Beside excessive workload, the demands also include large responsibility. In the face of vague profession boundaries, RNs take on responsibility also where they lack authority and empowerment, a combination that has been pointed out as a major occupational stressor in nursing (Cowin, 2002).

Moreover, expectations to perform all kinds of unqualified tasks serve to sanction a negative status incongruence. Being subordinate to physicians and yet playing an invaluable role in assisting them can be supposed to raise feelings of unfairness regarding the distribution of status, economic compensation and other resources. However, it is worth mentioning that in the present study the discourse depicting the relationship with the doctor was respectful throughout the interviews. Indeed, the hierarchy complicates the RNs' use of their multidisciplinary breadth of knowledge. We found that nurses seem to face a balancing act when communicating with doctors, on the surface conforming with the traditional hierarchy, but essentially violating it by guiding doctors in their work, which is in line with previous findings discussed by Caronia et al. (2020).

Consequently, this breadth of knowledge with its great advantages in combining several different disciplines may paradoxically complicate the definition of the profession, leading to negative consequences for the RN, such as role vagueness and excessive demands. At the same time, the lack of strict professional boundaries may relate to an ambivalence where RNs also benefit from being the hub of the health service. It lies in human nature to be attracted to a role where you are the one that everyone needs.

According to the present analysis, RNs' professional identity was constructed ambivalently in relation to the popular stereotype of the self-sacrificing nurse. There were examples of the RN as a professional who sees to everyone else's interests before looking after her or his own needs. On the other hand, in opposition to this picture, some narrations emphasized that the RN is a qualified professional, and also expressed frustration at being exploited. It is undoubtedly sensitive to construct a professional identity that disconnects from the popular image, and yet does not violate the vital norms of the profession. It is certainly a balancing act to describe respectful and ethical behaviour and at the same time distance oneself from the image of being self-sacrificing. ten Hoeve et al. (2014) posit that since the essence of nursing still tends to be somewhat unclear, a mutual correspondence between the public image and nurses' own professional identity potentially involves a vicious circle. Hopkins (2021), among others, highlights the difficulty of rejecting an iconic status and becoming “just another” profession. As an example, there is the extreme situation of the Covid-19 pandemic when hard-working healthcare professionals were assigned the epithet “heroes” much more often than other hard-working professionals (Hopkins, 2021).

4.1 | Limitations

Certain limitations of this study need to be recognized. Firstly, with regard to the selection of the study group, only RNs with a working

schedule including night shift were invited to participate in the study. This implies that the study group only included RNs working in inpatient care. Hypothetically, the professional identity of RNs at health centres and other primary care units may be constructed differently. Secondly, the focus of the interviews was primarily on the RN's work during the night shift. The results may have included additional aspects of the RN's professional identity if the informants had described their tasks and duties during the day shift in greater detail. However, since the night shift entails a high degree of autonomy and independence, we assume that the results reflect core qualities of the RN's professional identity.

5 | CONCLUSIONS AND RELEVANCE

We believe that the findings may be useful to the clinical nurse as well as the nurse in a managerial position. The study of professional identity deals with the intersection of three aspects, on which organizational improvements are based: the individual, the group and the organization.

Aspects of the RN's professional identity may contribute to remaining in a position that includes potentially harmful working conditions that are taken for granted both within and outside the profession. For example, it may be not only highly rewarding but also self-evident to accept large responsibility although the authority and resources are insufficient, if this is a cornerstone of one's professional identity. Moreover, a certain ambiguity regarding the boundaries for RNs' tasks and responsibilities seems to relate to the way RNs construct their professional identity. In other words, the large breadth of knowledge and the solid, experience-based competence, which in the present study were constructed as central parts of the RN's professional identity, may have unwelcome consequences.

Therefore, when striving to improve RNs' occupational health and safety it is advisable to observe whether the RNs themselves exhibit behaviours and attitudes that contribute to processes that preserve a demands-resources imbalance. Such processes may also act in the conservation of status incongruence, when large responsibility continues to be combined with a low salary and low professional status.

In addition, in the endeavours to create and maintain a good working environment, it is important not to forget the new graduates. A maxim that poses that all RNs automatically have solid experience can make unnecessary demands on those who are yet to acquire their experience-based competence.

ACKNOWLEDGEMENTS

The authors gratefully acknowledge the time and energy contributed by the informants. Thanks also go to Ulla Forinder, of the University of Gävle, Sweden, who performed one of the interviews in the present study.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data (interviews) are not available via any publicly available data repository.

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How to cite this article: Lindahl Norberg, A., & Strand, J. (2022). "We have to be the link between everyone": A discursive psychology approach to defining registered nurses' professional identity. *Nursing Open*, 9, 222–232. <https://doi.org/10.1002/nop2.1056>