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Time to care - An ethnographic study of how temporal structuring affects caring relationships in clinical nursing

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ABSTRACT

This article explores how temporal structuring of clinical activities affects nurses' establishment of caring relationships with patients, based on an ethnographic study in a Norwegian cancer ward in January–June 2017. By drawing on practice-based perspectives on time and care, the article shows how 'medical time', 'patient time' and 'hospital time' represent three distinct but interconnected clinical rhythms affecting caring relationships. In this way, the article provides insights into how caring relationships are established in nurses' intermediate role as temporal agents, accommodation various temporal structures associated with the biomedical and person-centred care models. Second, it contributes insights into how caring practices are temporally structured and reproduced in a hospital context. Finally, the article describes factors that influence different ways of structuring time, emphasising the need for temporal reflexivity and flexibility in meeting patients' care needs, and the role time to care plays in facilitating this.

1. Introduction

> Nursing is about … It depends of course, but here at the cancer unit, I'd say that in addition to technical procedures it's mainly about being there, observing and assisting patients with basic needs, but also helping them to cope with the uncertainties of the future […]. It's about time actually, and that's a growing concern for us, you know, having enough time. Time to care.

This ethnographic study explores temporal dimensions of nurses' caring relationships with patients in a Norwegian cancer ward. As stated in the above quote by a cancer nurse, good nursing requires time to be with patients and to address their individual needs. However, expectations to treat more acutely ill patients more rapidly while cutting the cost of care provision have been said to lead to a discrepancy between the traditional nursing mandate as a caregiving profession and what nurses actually do (Allen, 2015; Latimer, 2000). Thus, the nurse's concern about lack of time to care concurs with a prevalent critique in the literature that current profit-oriented care policies are insensitive to the time and space needed to explore requirements of situated care, which cannot be prescribed and measured (Cohen, 2011; Davies, 1994; Gherardi and Rodeschini, 2016; Kleinman and Van der Geest, 2009; Schillmeier, 2017).

This critique forms part of a wider concern about recent transformations in healthcare claimed to rationalise and dehumanise caring relationships through objectification, commodification and standardisation (Timmermans and Almeling, 2009). In this literature, holistic patient-centred care is contrasted with and seen to suffer from bureaucratic control, optimisation through efficiency standards, and the emergence of evidence-based medicine, treating patients as objects of medical manipulation (Clarke et al., 2003; Diamond-Brown, 2018; Felder et al., 2016; Timmermans and Almeling, 2009). Thus, the proclaimed crisis of care seems to involve more than lack of time, representing also a shift in orientations to, and valuations of time, related to notions of what care is and should be in a modern hospital context. Temporality is, however, rarely treated as a research object in its own right in studies of healthcare organisations and caring relationships (Habran and Battard, 2019; Pedersen and Roelsgaard Obling, 2020). This study contributes to the literature on the current condition of care by exploring the temporal structuring of caring practices among nurses on a Norwegian cancer ward, and emphasising the need to rethink why and how time to care matters.

Cancer care involves tending to patients coping with and recovering from severe, acute and sometimes lifelong medical, physical, psychosocial and practical complications and constraints (Cancer Research UK,

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2020). At the study hospital, the focus on patients' medical urgency and immediate risk, combined with increased pressures regarding efficiency and patient throughput, implied an emphasis on medical events and a clock-based structuring of nurses' caring activities. Nurses' daily care for individual patients' complex medical responses and situated care needs, however, often resulted in disruptions of the pre-determined framework for treatment and recovery. This predicament made the cancer ward an interesting context for examining how the meaning of time to care goes beyond the problem of lack of time, encompassing the intertwinements between different clinical rhythms and care tasks in nurses' patient-related work. More specifically, the paper explores how temporal structuring of clinical activities affects nurses' establishment of caring relationships with patients.

To address this issue, the article applies a framework by Rowell et al. (2016), outlining how practices encompass temporal patterns, conceptions and orientations, and how these interact in guiding practice performance. Thus, drawing on a dynamic perspective on time, it discusses how caring relationships emerge through temporal structuring that connects activities and events in an organisational context (Ancona et al., 2001; Elias, 1992; Hernes and Schultz, 2020; Orlikowski and Yates, 2002; Reinecke and Ansari, 2015; Rowell et al., 2016). Furthermore, the article builds on a practice-based perspective on care as an emergent, situated and collective competence, and caring relationships as relationally constructed within different care models (Gherardi and Rodeschini, 2016; Liberati et al., 2015; Mulligan, 2017; Tanenbaum, 2015). The biomedical and person-centred models, embedded in practices aimed at 'caring for' and 'caring with' patients, are used as analytical categories to differentiate between different modes of valuation and ways of structuring time in nurses' caring practices (Habran and Battard, 2019; Mol, 2008; Tomkins and Simpson, 2015).

The findings are presented as three analytically derived ethnographic vignettes (Humphreys, 2005) to describe how 'medical time', 'patient time' and 'hospital time' represent three different ways of constructing time, evident as various rhythms in clinical practice. The article also shows how these observable patterns are underpinned by deeper conceptions of time as event-based and clock-based, and by various temporal orientations in tending to patients' complex needs. Furthermore, it reveals how the three rhythms produce dependency, partnership and reliability as distinct but interrelated constituents of caring relationships.

In this way, the article contributes new knowledge on how temporal structuring matters in meeting care requirements in modern hospital contexts, emphasising the need to enable conditions that ensure temporal reflexivity and flexibility in clinical practice (Rowell et al., 2016; Orlikowski and Yates, 2002). The article argues that by exploring temporal dimensions of caring relationships, apparent contradictions between objectifying biomedical interventions, holistic patient care, and reifying care policies are refined and nuanced, providing evidence of the complexity of situated care (Felder et al., 2016; Timmermans and Almeling, 2009).

1.1. Temporal structuring

Within dynamic perspectives on time, temporal structures are seen as socially constructed and enacted phenomena, reflexively reproduced and reflectively transformed in practices (Erickson and Mazmanian, 2017; Hernes and Schultz, 2020; Orlikowski and Yates, 2002; Pedersen and Roelsgaard Obling, 2020; Rowell et al., 2016). In order to explore the complex intertwinements of clinical rhythms in care practices and how these affect caring relationships, this article builds on the notion that temporal structuring takes place in the relation between three mutually reinforcing levels of temporal structures that, according to Rowell et al. (2016), interact and work to guide practices.

The first level is 'temporal patterns', which are the observable pacing, speed and timing of events (Zerubavel, 1979, 1981). The second, deeper level, 'temporal conceptions', refers to the properties ascribed to time, such as event-based and clock-based, enabling actors to comprehend and act upon time (Ancona et al., 2001). Finally, 'temporal orientations' denote the way time is valued and attended to, being embedded in activities, such as an emphasis on past, present or future, a focus on process or outcome, and time as a resource (Hernes and Schultz, 2020; Reinecke and Ansari, 2015; Rowell et al., 2016). These levels work to reproduce practices by imposing moral and cognitive constraints on practice deviation, "moderated by the extent to which they are tied to the meaning of a practice and shared across practices" (Rowell et al., 2016, 304).

The literature on time in organisations has been characterised by the schism between notions of time as an objective versus a subjective phenomenon (Orlikowski and Yates, 2002). Clock-time is described as consistent with a mechanical view of the world, associated with an emphasis on time commodification. It is the dominating temporal conception in Western contexts, used synonymously with time itself and treated as objective, external and linear (Orlikowski and Yates, 2002; Zerubavel, 1981). Time within this perspective is valued as a resource possible to own, manage and manipulate, thus engendering a set of values and norms about how time is best used in particular contexts (Ancona et al., 2001; Erickson and Mazmanian, 2017; Reinecke and Ansari, 2015). In contrast, event-time is conceived as qualitative and dynamic, inherent in processes and events and defined by the experiences of organisational members (Ancona et al., 2001; Jacques, 1982; Orlikowski and Yates, 2002; Starkey, 1989; Zerubavel, 1981).

This dichotomisation has also been prevalent in the literature on care, used to explain tensions and conflicts in care work (Cohen, 2011; Davies, 1994; Kleinman and Van der Geest, 2009; Schillmeier, 2017). Recent research has outlined how different care models imply variations in how time is conceived and attended to with implications for how it is constructed (Habran and Battard, 2019; Tomkins and Simpson, 2015). Habran and Battard (2019) show that practices aimed at 'caring for', based on the biomedical care model, create a temporality described as impersonal and abstract. The focus is on the past and present in prescribing the future on the clients' behalf, treating care recipients as passive objects of care. In contrast, person-centred models aimed at 'caring with' construct time by joining patients' journeys and facilitating an exploration and co-construction of future uncertainties (Habran and Battard, 2019).

In the present study, the notion that temporal structures not only take place in time, but also embody deeper temporal conceptions and orientations, is used in the analysis of how nurses accommodate and manage multiple temporal structures simultaneously to meet the complex challenges of hospital care. In this way, this article adds to previous research by aiming to avoid an 'a priori' normative stand on particular temporal structures, exploring and discussing how practices are reproduced, and the conditions that affect different ways of structuring time (Pedersen and Roelsgaard Obling, 2020; Rowell et al., 2016).

2. Methodology

2.1. Research context

In Norway, cancer care has since 2015 been organised in standardised pathways to meet the requirements of the government-initiated "Coordination reform – Proper treatment - at the right place and right time" (Norwegian Ministry of Health and Care Services, 2008–2009). In order to ensure efficiency and predictability in cancer care, diagnoses and treatments are provided by state hospitals, while rehabilitation takes place in primary healthcare (Norwegian Directorate of Health, 2016). In cancer patients, acute and long-term side effects of the disease and its treatments do, however, often coincide and might be difficult to differentiate. The formal sequencing of the cancer trajectory is therefore not always clear-cut, and many patients are frequently re-hospitalised. This makes a Norwegian hospital cancer ward an interesting context for exploring the complexity of care and how the managing of various

temporal rhythms and horizons affects nurses' caring relationships with patients.

The hospital studied is defined as a large emergency hospital with about 5000 employees and a catchment area of over 300 000 inhabitants (Norwegian Ministry of Health and Care Services, 2017). Two years before the study, the hospital had been relocated and reorganised, with increased emphasis on patient safety and participation, and extensive use of information technology to ensure time optimisation according to set efficiency standards. This was also reflected in the physical structure and organisation of ward activities, with universally designed work sections, each serving nine single-patient rooms. The cancer ward had three work sections and 27 patient rooms. At the time of the study, 45 nurses worked in the unit, including two men.

2.2. Creating data

Fieldwork was conducted from January to June 2017, and involved participant observation of nurses and informal interviewing (Spradley, 1979). The ten nurses with whom I paired up during shifts were selected by snowball sampling after an introduction from the senior charge nurse at the study outset, ensuring variety in length of experience and involvement with different patient groups. Participating nurses were aged 25–50, with two to 25 years' experience, and had positions ranging from 60% to full-time.

The nurses were mainly attached to one section with a typical patient profile, and I observed all three sections, mostly attending entire 7-h shifts. With time, I was entrusted to perform tasks such as fetching food for patients and assisting them with personal care. This provided access to varied situations in everyday ward activities and interactions with patients, relatives and other clinicians. During the fieldwork, my roles ranged from complete observer to active participant, negotiating my way into the field (Spradley, 1980; Wind, 2008). The ethnographic approach taken in this study thus builds on the premise that data are created through participant observation as a performative practice (Gherardi, 2019, 2).

The fieldwork was followed by formal semi-structured interviews with nine of the ten nurses with whom I had already developed some rapport through observations, allowing for a free flow of information (Spradley, 1979). The tenth nurse was not interviewed due to illness. Based on field observations, the interviews explored the nurses' experiences of establishing caring relationships with patients, focusing particularly on temporal dimensions in the structuring of clinical care, such as optimisation measures, timing, and temporal orientations. The interviews were conducted in a hospital meeting room and were audio-recorded; they lasted about 60 min on average.

2.3. Ethical considerations

Appropriate ethical approval was obtained from the Norwegian Centre for Research Data. All ward nurses were informed about my role in the ward. None refused to participate in the study. Names and ages were anonymised to ensure internal and external confidentiality. All participating nurses signed non-disclosure agreements and gave informed consent. Oral and written information on the study goals was provided, and preliminary findings were discussed with the nurses throughout the study. The nurses worked as gatekeepers to patient encounters and all accounts of conversations involving patients have been anonymised in the analysis by producing 'typical' patient stories, altering age, sex and diagnosis.

2.4. Data analysis

The data analysis began immediately upon entering the research setting and was thus inductive, using temporality as a sensitising concept to orient my ethnographic gaze in the field (Blumer, 1954). In line with the first step of thematic analysis (Braun and Clarke, 2006), I then proceeded by thoroughly familiarising myself with the written field notes (Emerson et al., 1995), searching for interesting observations. Preliminary ideas formed the basis for inductively identifying and coding features in the data according to several temporal dichotomies such as process versus outcome orientation, scheduled versus unscheduled caring practices, and experiences of time as a resource or a journey. These initial categories were used to structure the interview guide, which contained open-ended, descriptive questions (Spradley, 1979). The interviews were transcribed verbatim and re-read in a search for additional ideas to enrich the observational data (Braun and Clarke, 2006). Field notes and interview transcripts were translated, with minor grammatical and aesthetic adjustments.

In the analysis of the entire empirical data, performed in NVivo 11 (QSR International, Brisbane), I started reviewing the literature on temporality and care in organisations, following the next steps in thematic analysis, i.e. generating, reviewing and naming overarching patterns of responses concerning the research question (Braun & Clarke, 2006, 2019, 2019). The framework of temporal structures of Rowell et al. (2016) was used as a theoretical lens in the analysis of caring practices, according to the categories 'caring for' and 'caring with' (Habran and Battard, 2019; Mol, 2008). The framework was also used in the analysis of how different temporal structures were balanced and combined through nurses' reflexive engagement with time in situated care (Erickson and Mazmanian, 2017; Orlikowski and Yates, 2002; Rowell et al., 2016).

In this abductive process, allowing empirical observations and existing theorisations to enhance each other (Tavory and Timmermans, 2014), three overarching analytical categories was identified to illuminate the temporal complexity in clinical cancer nursing: medical time, patient time and hospital time. The ways these represent different but interconnected clinical rhythms and how they affect the construction of caring relationships will now be presented in three ethnographic vignettes (Hammersley and Atkinson, 2019; Humphreys, 2005). The vignettes represent typical situations condensed from the analysis of the data and allow for contextual richness and a vivid presentation of the findings (Felder et al., 2016), supplemented by quotes from the formal interviews.

3. Findings

The first two vignettes describe the case of Mrs Doe, a patient who had stayed in the ward for some time, recovering from heavy chemotherapy. They outline three daily situations showing how medical time and patient time represent two different ways of structuring caring practices and how they affect nurses' caring relationships with patients. First, the pre-round meeting between doctor and nurse, discussing patient cases. Next, the doctors' patient round accompanied by the nurse, and finally, a nurse-patient care situation. The third vignette zooms out, contextualising these events in the hospital's clock-based schedule, outlining nurses' experiences of a new distribution of tasks to 'in-nurses' and 'out-nurses' and its effect on caring relationships.

3.1. Medical time

> The nurse meets up with the doctor in the haematologists' shared office space. They start going through the patient list. "Let me see," the doctor says, opening and studying the chart and medical notes of the first patient on the computer. "Positive indication of complete remission," he states, looking up at the nurse and adding, "How's she doing?" "The readings this morning were fine," the nurse replies, adding, "No fever or other signs of infection." "What about her intake?" the doctor asks. "Well, that's still the problem, she hasn't started eating yet," the nurse replies. She is about to continue when they both suddenly stop. An alarm is activated. The doctor opens the door. "It's a cardiac arrest," he states. They both run towards the

room marked with a cone as the cardiac arrest team arrives and starts the compression, regularly switching turns. It's hectic but everyone seems to know their role. I hear some nurses in the corridor murmuring: "Why isn't he under a do-not-resuscitate order? He's old, and incurable. It's unethical, really". The patient could not be saved.

The doctor and nurse return to the office. "Whew … That was a bit shaky. Well, where were we?" the doctor asks. The nurse looks at her notes: "Mrs Doe … She feels extremely nauseous and has difficulty in holding on to whatever she manages to eat," she adds. "Okay, that will be the main subject today then," the doctor says, adding, "No effect of the antiemetics?" "She claims that they work, but when she feels the texture of the food in her mouth, she starts retching," the nurse replies. The doctor makes some notes. They then discuss other patients before the round.

We enter Mrs Doe's room. The doctor stands at the end of the bed, the nurse stays in the background leaning against the window sill, while I remain closer to the door. The doctor asks Mrs Doe how she is feeling and whether she has been able to eat anything. She replies quietly that she cannot manage even the smell of food. The doctor looks at the diet list on the bedside table, and points out how essential food is for her recovery, explaining how the treatment has set her back and that almost like a child she needs to get used to all the different flavours and textures of food again. "Start by eating neutral food and add in cream and nutritious smoothies," he says, glancing over at the nurse. "We'll also try another anti-sickness medicine for your nausea. I'm afraid gaining full appetite could take months. Try to comply with the diet list," he continues. Mrs Doe nods quietly as we leave the room and hurry to the next patient.

Numerous observations of such pre-round meetings during the fieldwork revealed that their main purpose was to define the most pressing issues and necessary immediate or future interventions, and decide how to communicate and discuss these with the patient. They thus involved framing a patient's complex condition according to what medical means were available, which should be implemented, when and by whom. This motivated a particular temporal patterning of subsequent caring activities based on the nature of the problem at hand as defined by clinicians. The sudden emergency of the cardiac arrest also reveals how even medical events that cannot be scheduled are prepared for, based on knowledge of the actions needed to save lives, triggering trained and coordinated responses.

The pre-round situation further shows how such understanding was established in nurses' and doctors' reflective engagement with time embedded in aggregated knowledge of the diagnosis and patient group, and the patients' timeline, as evidenced by their individual experiences and responses. The doctor evaluated the patient's past and recent developments, documented in the patient record and the medical chart, while the nurse provided clinical observations and experience with the patient concerning the relevant medical parameters. The nurses' role in constructing a medical understanding of the patients' complex treatment and recovery process, and how time spent with patients was an essential factor, also became evident in the interviews, as the following quote illustrates:

You know many of our patients [haematology patients] are at risk of developing sepsis from their treatment. This is indicated by altered mental status, fast respiratory rate and low blood pressure, and perhaps a rising temperature. So, if we find for instance that a patient becomes absent-minded and his blood pressure drops, we must inform the doctor. That's information they wouldn't get elsewhere. Because they don't spend as much time with patients and don't really know them as we do. We make up a team with the doctors, in fact, and I find that they [the doctors] depend on us, you know, our clinical evaluations.

Field observations showed how nurses gained knowledge of such clinical indicators through frequent and scheduled patient encounters, such as daily measurements, providing food and medication, tending to wounds and administering catheters. These activities aimed at 'caring for' patients could be plotted into the nurse's schedule as manageable tasks defined by doctors or nurses themselves. Thus, the medical care model as a mode of ordering events structured doctors and nurses' time with patients, informing them about who to see first, the frequency of visits, and what indicators or interventions to focus on in engaging with their problems.

It also became evident during patient rounds how the medical care model determined patients' future actions. In the visit to Mrs Doe, the doctor addressed nourishment as the major worry, authoritatively explaining her situation, and outlining the measures she needed to take to restore her diet based on evidence of what works. Such instructions were comforting to many vulnerable patients, who expressed gratitude for good care. Furthermore, while talking to the patient, the doctor also communicated to the nurse, glancing over at her and using the term 'we', which indicated that the information provided was to be attended to, ensuring different anti-sickness medicines and nutritious food according to the diet list.

Medical time, then, defined and scheduled by clinicians, imposes a dynamic and flexible rhythm, patterning caring initiatives according to the problem at hand and focusing on how the present and familiar can be used to achieve particular outcomes. By determining future activities to ease patients' suffering, ensure their recovery, and save lives, caring relationships built on dependency are thus created. Sometimes, however, medical time was not in the best interest of the patient, as evidenced by the nurses' questioning of the ethics of performing cardiopulmonary resuscitation on the old patient. At other times it did not have the expected effect or countered patients' bodily rhythm and explicit wishes and needs, leading to a broadening of the temporal horizon.

3.2. Patient time

"Good morning!" says the nurse, as we enter the patient room. "How are you doing this morning?" "As usual," Mrs Doe replies, "Not too well, I suppose." After the morning checks of temperature, systolic blood pressure and oxygen saturation, the nurse sits down next to her. "I know I promised not to go on about this, but still I have to," she says, pointing at the diet list on the table. "Just seeing that list makes me nauseous," says Mrs Doe. The nurse replies that she knows. "I'll put this out of your sight, then," she adds. For a while, nobody speaks. "Remember we talked about how there might be more to this than just the food? From what you've told me, you've been going through a lot. Have you thought about talking to someone?" the nurse asks. Mrs Doe replies that she could talk to her sister, but doesn't want to burden her. The nurse suggests that they can help her apply for home nursing for a period if she would like that. The patient nods. "You know, there are professionals out there that can help you work through everything that's been going on in your life these past years," the nurse suggests. Mrs Doe agrees, saying, "I think that could be a good idea." More silence. The nurse adjusts the sheets and fetches some laundry from the bathroom. She returns to the bedside. "Still, I'm afraid your first step to get out of here is to start eating," the nurse smiles. "Is there anything you might feel like having?" "You never give up, do you?" Mrs Doe replies, smiling faintly back and agrees to try porridge and some fruit.

As we return to the section office we find another nurse just finishing a call. There is a problem with a patient who has completed her treatment and is to be discharged. She refuses to go to the nursing home where she has been accepted for personal reasons, and does not trust the home care nurses. Her family wants to pay for her to stay in another home under the neighbouring local authority but that is impossible because of local policies and financial arrangements. The

patient's daughter was on the phone, exhausted after having to take care of her mother 24/7 for some time, asking the nurse for help. "I don't know how to get this patient on board. This has taken days," the nurse sighs.

These situations demonstrate that establishing caring relationships with patients go beyond the medically scheduled to-do list described in the first vignette, while still being closely entangled with the activities involved. One nurse explained in an interview: "It's like when I enter the room to administer a catheter or whatever and find the patient's upset, I like to have the time to ask how they are, what they need, and to listen to them. I never ask if I know I haven't got time to listen". Thus, giving the patient a voice, while performing other more tangible care interventions, means being committed and having the time to address whatever needs were expressed, also those outside medical issues.

In the case of Mrs Doe, entry into a more boundless space where a whole life was brought to the table and needed 'caring with' was initiated by an experienced lack of effect of medical treatments. Prior to the situation described in the vignette, both doctors and nurses had for some time aimed to deal with the non-compliance of Mrs Doe's sick body with the scheduled interventions and their expected outcome. Aiming to understand and solve this problem based on previous experience, the nurses seemed discouraged with the doctors' preoccupation with nutrition as a mere medical problem with prescribed and scheduled solutions, like antiemetics and diet lists. In a conversation between nurses, one explained, "We don't need screening to see when a patient's undernourished. What these patients need is some peace, and time to recover. They'll eat when they're ready".

The other patient case described in the vignette illuminates how patient time was also initiated by relatives, or by patients who were reluctant to accept solutions defined and decided on their behalf. Such cases could be considered time-consuming or troublesome by busy nurses, but also sometimes provided information useful to subsequent treatments or care interventions. One morning a visiting son informed a nurse about his recently admitted mother: "She probably won't tell you this, but she sleeps most of the day, and hardly eats. She thinks she's fine, but she's not". This information set the stage for the patient encounter and led to various examinations, starting with blood tests.

In all these patient cases, the structuring of caring activities involved building trust over time and establishing a partnership, where nurses included both the 'patient' and the 'person'. It meant attending to the process more than a defined outcome, exploring the patient's past and future anticipations in aiming to reach a common understanding of the complexity of their present situation. It also involved acknowledging disruptions to the nurses' fixed schedules, allowing for a flexible patterning of caring activities according to the patients' rhythm, representing a journey where things took the time that they needed to take. In cases like Mrs Doe's, the nurses aimed to open a space for a dialogue about life in its diversity to define other solutions than tablets and foodstuffs. Other cases involved responding to and guiding patients who openly expressed their wishes and needs, sometimes counteracting their own good.

Thus, while opening up for subjective experiences in exploring the unknown involved extending the temporal orientation beyond the scope of medical interventions and the caring relationships established on the cancer ward, it was not altogether detached from these. This demonstrates how nurses continuously needed to reflect on and balance the inherent tensions between medical time and patient time, keeping up with scheduled activities, dealing with requirements of situated care, and allowing for patients' responses and requests. The final vignette will present how this balancing act was also affected by the nurses' busy work schedule and their continuous race against the clock.

3.3. Hospital time

7 a.m.: The morning shift starts as the first oncoming nurse enters the ward. She logs in to the computer while getting brief oral updates from the night shift nurse.

7.30 a.m.: The remaining two morning shift nurses arrive. After quickly skimming through the patient record, the in-nurse starts preparing and distributing medication. This often elicits new requests. One patient needs painkillers, one wants juice, another needs toileting assistance. As we rush back and forth between patients and the section office, tasks are delegated to the out-nurses busy with morning care that needs to be completed before the doctor's round.

8.00 a.m.: We hurry on to the morning meeting where nurses from all three sections meet up to evaluate the patients' status. The charge nurse informs about a number of incoming patients, suggesting a swift dismissal for patients to be discharged. She later states that the ward has been obliged to cut costs. "All overtime must be recorded and accounted for. It must be reduced," she says.

8.15: The in-nurse rushes back to the section, "It's always time and money," she sighs, preparing medication for the remaining patients. One patient is optimistic and talkative, ready to go, and needs help packing. Another is in shock, having received devastating news about the progress of his disease. He has relatives visiting. Others request results from blood tests. Mrs Doe is feeling nauseous. No time to dawdle.

8.45: The charge nurse arrives at the section office where the in-nurse sits at the computer to cross off the tablets provided. She says that one of the incoming patients is waiting in the corridor. "I'm the in-nurse, shouldn't the out-nurses deal with that under the new arrangement?" she replies. "Well, now you know!" the charge nurse says and leaves. An out-nurse runs past to greet the new patient.

9.20 The nurse glances at her watch and realises she should have attended the pre-round meeting 10 min ago. She hurries along the corridor, while stating worriedly that she has had no time to update herself on the patients. "I'm sorry I'm late, busy morning," she says as we enter the doctors' office.

This final vignette, zooming out from the case of Mrs Doe, provides a glimpse of a typical busy morning, and the structuring of nurses' caring activities according to the clock, embedded in the hospital's 24-h shift system. Measurements were to be taken, meals served and medication provided at set time slots each day. Ward meetings were timed relative to each other, with the pre-round succeeding the doctors and nurses' separate morning meetings, which all led up to the patient round. Then, nurses from each section aimed to meet up for a brief report, coordinating tasks prescribed by doctors.

The system of in- and out-nurses had been implemented to enable a swift and more effective fulfilment of these obligations, while ensuring continuity and quality in patient care. Previously the three nurses operating a section split the responsibility for the nine patients between themselves, thus performing all required tasks for their patients, including measurements, daily care, medication and patient rounds. This was time-consuming for doctors who then came to the ward for separate pre-rounds with all nurses, and made upcoming requests from patients difficult to coordinate during rounds for nurses. However, the newly installed division of tasks also seemed to have its drawbacks.

On the one hand, nurses claimed that it had made their responsibilities clearer, with defined duties that could be patterned and managed according to a set time schedule and then crossed off. "A good day's work is when I have completed my duties, like when I know everyone got their medication on time, or, as out-nurse, that I've changed patients' bedsheets, tended to catheters, managed the antibiotics, you know, the medical and technical stuff," one nurse explained in

an interview. This was also relevant to patients, who became anxious if daily routines were obstructed, such as lack of medication at the scheduled time.

On the other hand, nurses felt that the new arrangement prevented an overall understanding of the patients' situation and the interventions planned for them, due to an experienced loss of flexibility and hence a lack of control. The in-nurse found that when she arrived at the pre-round meeting, she had only spent a brief moment with patients, with no time to read notes or confer with the out-nurses. "It's not a good feeling to meet the doctor without updated knowledge of patients. It feels unprofessional, like we're not able to do our job, and it also affects how doctors can perform theirs," one nurse explained in an interview.

The out-nurses, on the other hand, lacked the insights provided by meetings with doctors in rounds and pre-rounds, which could be used to inform and explain and thus ease patients' worries. They also had responsibility for more patients than before, which meant constantly having to prioritise between tasks, as seen in the following quote: "Pain always comes first, but when someone's sad or just needs to talk, and we know others haven't been washed or they're waiting for tests … it's difficult".

Finally, independent of roles, nurses discussed how they felt squeezed between patients' need for time and stability and demands for time optimisation and reduction of costs. One nurse exclaimed: "When management start going on about encouraging patients to leave, and we know they're not ready, we protest! They're ill and vulnerable and need time. We end up sending patients home on a Friday, knowing they'll return on Monday. It doesn't make sense!" Another agreed: "I understand they have their financial considerations, but we must speak up for the patients! I'll spend an extra 5 min with a patient, and I'd rather work unpaid overtime to finish the report".

Thus, the structuring of caring activities according to a clock-based conception of time, conceived as an objective and measurable quantity and valued as a resource, established a task-oriented rhythm in nurses' caring practices. Hospital time then ensured a systematic and efficient patterning and distribution of care to patients, essential to their survival and recovery. Thus, it created predictability in caring relationships according to who was doing what, and when.

The focus on efficiency, however, involved less flexibility for nurses in managing tasks to be solved. Furthermore, loss of flexibility influenced the information flows essential for the construction of both medical time and patient time, and for reflective engagement with the inherent tensions between them. The resulting risk of losing sight of the whole picture was considered particularly worrisome for patients with complicated and composite diseases, for those whose conditions were undiagnosed, and for patients at particular risk of swift deterioration, such as haematology patients like Mrs Doe.

4. Discussion

This article adds to the literature on the conditions of care and caring relationships in modern healthcare by exploring how temporal structuring affects nurses' establishment of caring relationships with patients, an under-researched field (Habran and Battard, 2019; Pedersen and Roelsgaard Obling, 2020). The study shows how 'medical time', 'patient time' and 'hospital time' emerged as three different clinical rhythms, creating dependency, partnership and reliability as essential constituents of caring relationships. Furthermore, it illuminates tensions in hospital care that required an openness to other ways of structuring time. Finally, the study reveals factors that influenced complementarity or conflict between ways of structuring time and thus nurses' establishment of caring relationships with patients (see Table 1).

Based on these findings, the study's contribution to the literature is threefold. First, it develops prevailing understandings of the interplay between biomedical and person-centred care models by showing how nurses operate as temporal agents, reflexively accommodating several temporal structures simultaneously in the establishment of caring relationships. Second, it contributes insights into how temporal structures are reinforced and reproduced in a hospital context where predictability is emphasised over flexibility. Finally, the study adds to previous research by showing how a broadened understanding of what 'time to care' means can nuance existing notions of the conditions and complexities of care in modern healthcare contexts. These contributions will now be further developed and discussed.

4.1. Temporal reflexivity and nurses' role as temporal agents

The existing literature on time in organisations has stressed how temporal reflexivity involves organisational actors having the capacity to identify, analyse and change temporal structures that guide and reproduce practices (Orlikowski and Yates, 2002; Reinecke and Ansari, 2015). Thus, it implies the articulation and discussion of a shared understanding of 'what time is' in particular organisational contexts (Rowell et al., 2016). This article contributes to such reflexivity among practitioners and managers by identifying medical time, patient time and hospital time as three co-existing and interdependent clinical rhythms, which therefore need to be considered to reach a common

Table 1
Clinical rhythms, their effects on caring relationships and conditions affecting their intertwinements.

Temporal structures, effects and influencing factors	Clinical rhythms		
	Medical time	Patient time	Hospital time
Temporal conception	Event-based (defined by carer)	Event-based (lived by patient)	Clock-based (objective/linear)
Temporal orientation	Past/present to prescribe the future Focus on outcome	Past/future to grasp the present Focus on process	Time valued as a resource Focus on tasks
Temporal patterning	Dynamic according to biomedical evidence and clinical knowledge	Fluid according to uncertainties of lay experience and patient knowledge	Rigid according to what is manageable and measurable
Ways of valuing time in care models	'Caring for' (Biomedical)	'Caring with' (Person-centred)	Care efficiency (Care policy)
Effects on caring relationships	Dependency	Partnership	Reliability
Risks	Objectification	Relativism	Reification
Status in the organisation	Silent politics. - Closely tied to the meaning of main activities. - Widely shared among all staff.	Hidden and informal. - Loosely tied to the meaning of main activities. - Confined to carer-patient.	Loud and visible. - Organising principle for all activities. - Universally shared.
Tensions that require openness to other temporal structures	The medically unexplained and lack of response to/inadequacy of medical treatments	Lack of insight into one's own medical condition/unrealistic expectations for future trajectory	Means to ensure predictability in contrast to medical needs and holistic care
Factors that influence complementarity/conflict between rhythms	Recognition/lack of recognition for uncertainty and patient experience	Recognition/lack of recognition for the medically known and the manageable Temporal reflexivity and flexibility Time to care	Facilitating/lack of facilitating for uncertainty/fluidity in holistic care

Time to care – an ethnographic study.

understanding of time in a hospital context.

Furthermore, the article adds to existing research on the factors influencing care in modern healthcare by nuancing prevailing understandings of the interplay between care models and their effects on caring relationships. In this literature, dependency and partnership have been described as opposing outcomes of the biomedical and person-centred care models (Habran and Battard, 2019; Tanenbaum, 2015). While these are often normatively depicted as representing authoritarian versus inclusive interventions, treating patients as objects or subjects of care, both are also associated with risks if they become naturalised as automatic and default responses to care needs (Habran and Battard, 2019; Mol, 2008; Tomkins and Simpson, 2015).

The biomedical care model potentially leads to objectification by enacting a temporality experienced as abstract and impersonal to patients, while person-centred care, on the other hand, can lead to the notion that 'anything goes' by transforming abstract time into care recipients' time (Habran and Battard, 2019; Mol, 2008). What then constitutes 'good' or 'bad' care depends on the context, and must be empirically investigated. This ethnographic study of how temporal structuring affects caring relationships in clinical nursing illuminates how tensions and limitations associated with the two care models require an openness to other temporal structures, and how they can be made to complement each other in the care of patients with complex needs.

Tracing nurses' activities in pre-round meetings, patient rounds and various care situations demonstrated how nurses operated as temporal agents, accommodating multiple temporal structures simultaneously in their clinical work with patients (Rowell et al., 2016). The case of Mrs Doe shows how the medical framework and its prescribed interventions, such as a diet list, were sometimes inadequate, requiring an openness to lay experience and individual responses and timelines. In other cases, the relativist notion that 'anything goes' was balanced by nurses' advice to patients on the necessity of medically structured and prescribed interventions.

The study thus reveals how nurses enacted a temporal reflexivity in knowing when particular temporal structures were required and how to implement them in their ongoing and adaptive responses to care needs (Rowell et al., 2016). In this way, the article emphasises the essential role played by nurses in countering the risks of naturalisation of care models (Tomkins and Simpson, 2015), allowing the potential pitfalls of dependency to be balanced by the advantages of partnership and vice versa, as distinct but interrelated aspects of caring relationships. As will now be discussed, this was an ambivalent dynamics.

4.2. Predictability versus flexibility and the reproduction of temporal structures

A second contribution of this article is the insights it offers into the processes through which particular temporal structures becomes reinforced and reproduced in a hospital context. According to the framework on temporal structuring outlined by Rowell et al. (2016), temporal structures work to reproduce practices by imposing moral and cognitive constraints on practice deviation, moderated by the extent to which they are tied to the meaning of a practice and shared across practices (Rowell et al., 2016). In this article this framework is applied to explain how medical time gained prominence over patient time, affected by the emphasis on predictability over flexibility in the structuring of caring activities.

Medical time can be said to constitute the "silent politics of time" (Das, 1991) in hospitals, accepted as the main organisational principle of activities and events. Its dynamic and event-based conception of time as owned and managed by the carer was closely related to the main purpose of hospital activities to cure diseases and save lives and thus widely shared among hospital staff (Rowell et al., 2016). As communicated by the nurses in this study, deviations from medical time were experienced as both unprofessional and unethical, potentially putting lives at risk, and were thus morally sanctioned.

Implemented to meet defined and measurable outcomes, medical responsibilities and technical procedures were consequently incorporated into the formal schedule of hospital time, which represented a loud and visible rhythm with its universally shared clock-based conception and commodified valuation of time (Orlikowski and Yates, 2002). Adherence to or deviation from the set time schedule for medically defined tasks was thus also associated with norms such as punctuality and lateness (Zerubavel, 1981).

The study has shown how the resulting task orientation ensured a certain predictability in caring relationships, making the performance of multiple caring responsibilities manageable for nurses and reliable for patients, preparing them for what to expect, when and by whom. The focus on efficiency did, however, also make caring relationships prone to commodification and standardisation.

By reducing both in- and out-nurses' time with patients, but also their flexibility in managing caring tasks and the flow of information between professionals, the focus on efficiency affected the temporal structuring of both medical time and patient time. Furthermore, it influenced the intertwinement between care models with potential consequences for the balancing of dependency and partnership in caring relationships. Thus, it potentially worked to both objectify and reify patients, preventing a holistic understanding of their situations (Cohen, 2011; Gherardi and Rodeschini, 2016).

To counter these effects, nurses often prioritised a few extra minutes with patients, despite 'lack of time' and the risk of being reprimanded for working extra hours or deviating from the medically prescribed schedule. If not associated with medical immediacy, such patterning of caring activities represented a "temporal rebellion", stepping out of time to act according to the patients' rhythm (Erickson and Mazmanian, 2017). While experienced as agentic by particular nurses and as empathetic by patients, this modest revolt did, however, not shift the dominating and underlying conceptions of time as organised according to the clock. Impossible to prescribe, standardise or measure, deviations from patient time were thus only sanctioned by nurses' moral obligations towards patients, and remained a hidden and informal rhythm, used to balance predictability with flexibility in nurse-patient encounters.

5. Conclusion: time to care and caring relationships

This study has aimed to present a broadened understanding of what 'time to care' means in contemporary healthcare contexts, by exploring how temporal structuring affects caring relationships. This is important because the proclaimed crisis of care seems to involve more than 'lack of time', representing a shift in orientations to and valuations of time based on different notions of what care is and ought to be, and what types of care can be afforded (Cohen, 2011; Davies, 1994; Schillmeier, 2017).

Building on previous research on temporality in care (Davies, 1994; Habran and Battard, 2019; Pedersen and Roelsgaard Obling, 2020; Tomkins and Simpson, 2015), the article presents an analysis of the tensions and complexities in the construction and managing of different clinical rhythms and care tasks that can work to nuance prevailing notions of the effects of bureaucratic control and evidence-based medicine in healthcare (Felder et al., 2016; Timmermans and Almeling, 2009). This is achieved by providing insights into some of the factors affecting different ways of constructing time and their interrelationship, emphasising the role time to care plays in enabling temporal reflexivity (Orlikowski and Yates, 2002; Rowell et al., 2016).

The article argues that providing clinicians with the capacity to critically reflect on 'what time is' in a hospital context, the dynamics between different temporal structures and their effect on caring relationships requires, first, that the role of temporal agents in the structuring of caring practices is recognised and facilitated. Second, this does not only require time with patients but also time for clinicians to meet to discuss patient cases among themselves. Thus, it depends on a temporal patterning of caring activities that coordinates the enactment of various

temporal conceptions and orientations (Rowell et al., 2016).

Finally, this patterning needs to involve a certain flexibility. This is vital in allowing informal rhythms to complement formalised time. It is also facilitated by entrusting practitioners with the autonomy to define and time care interventions according to individual patients' complex acute and long-term care needs in ways that are medically justifiable, meaningful to patients and organisationally acceptable. Thus, time to care matters in hospital care because it enables a temporal structuring of caring practices that safeguards patients' inevitable dependency, accommodates partnerships and secures reliability as essential constituents in caring relationships in modern healthcare contexts.

5.1. Limitations and research opportunities

This study draws on data from a particular social, professional and organisational context, and the analysis is therefore dependent on the specificities of the case. More studies are needed on the role of temporal structuring in the establishment of caring relationships, exploring how temporal patterns, conceptions and orientations interact and reinforce each other in different contexts of practice and from different perspectives, including experiences of care recipients and the use of communication technology.

Credit author statement

Corresponding author is the only author of this article.

References

Allen, D., 2015. The Invisible Work of Nurses: Hospitals, Organisation and Healthcare. Routledge.

Ancona, D.G., Goodman, P.S., Lawrence, B.S., Tushman, M.K., 2001. Time: a new research lens. Acad. Manag. Rev. 26 (4), 654–663.

Blumer, H., 1954. What is wrong with social theory? Am. Socio. Rev. 19 (1), 3–10.

Braun, V., Clarke, V., 2006. Using thematic analysis in psychology. Qual. Res. Psychol. 3, 77–101.

Braun, V., Clarke, V., 2019. Reflecting on reflexive thematic analysis. Qual. Res. Sport Exercise Health 11 (4), 589–597.

Cancer Research UK, 2020. About Side Effects of Chemotherapy. https://www.cancerresearchuk.org/about-cancer/cancer-in-general/treatment/chemotherapy/side-effects/about.

Clarke, A.E., Mamo, L., Fishman, J.R., Shim, J.K., Fosket, J.R., 2003. Biomedicalization: technoscientific transformations of health, illness, and U.S. biomedicine. Am. Socio. Rev. 68, 161–194.

Cohen, R.L., 2011. Time, space and touch at work: body work and labour process (re) organisation. Sociol. Health Illness 33, 189–205.

Das, T.K., 1991. Time: the hidden dimension in strategic planning. Long Range Planning 24 (3), 49–57.

Davies, K., 1994. The tensions between process time and clock time in care-work: the example of day nurseries. Time Soc. 3, 277–303.

Diamond-Brown, L., 2018. "It can be challenging, it can be scary, it can be gratifying": obstetricians' narratives of negotiating patient choice, clinical experience, and standards of care in decision-making. Soc. Sci. Med. 205, 48–54.

Elias, N., 1992. Time: an Essay. Blackwell, Oxford.

Emerson, R.M., Fretz, R.I., Shaw, L.L., 1995. Writing Ethnographic Fieldnotes. University of Chicago Press.

Erickson, I., Mazmanian, M., 2017. Bending time to a new end: investigating the idea of temporal entrepreneurship. In: Wajcman, J., Dodd, N. (Eds.), The Sociology of Speed: Digital, Organizational and Social Temporalities. OUP, Oxford.

Felder, K., Felt, U., Penkler, M., 2016. Caring for evidence: research and care in an obesity outpatient clinic. Med. Anthropol. 35, 404–418.

Gherardi, S., 2019. How to Conduct a Practice-Based Study: Problems and Methods, second ed. Edward Elgar Publishing, Northampton, MA.

Gherardi, S., Rodeschini, G., 2016. Caring as a collective knowledgeable doing: about concern and being concerned. Manag. Learn. 47, 266–284.

Habran, Y., Battard, N., 2019. Caring for or caring with? Production of different caring relationships and the construction of time. Soc. Sci. Med. 233, 78–86.

Hammersley, M., Atkinson, P., 2019. Ethnography: Principles in Practice, fourth ed. Routledge.

Hernes, T., Schultz, M., 2020. Translating the distant into the present: how actors address distant past and future events through situated activity. Org. Theory 1 (1), 263178771990099.

Humphreys, M., 2005. Getting personal: reflexivity and autoethnographic vignettes. Qual. Inq. 11, 840–860.

Jacques, E., 1982. The Form of Time. Heinemann, London, U.K.

Kleinman, A., Van der Geest, S., 2009. Care' in health care: remaking the moral world of medicine. Medische Antropologie 21, 159–179.

Latimer, J., 2000. The Conduct of Care: Understanding Nursing Practice. Wiley.

Liberati, E.G., Gorli, M., Moja, L., Galuppo, L., Ripamonti, S., Scaratti, G., 2015. Exploring the practice of patient centered care: the role of ethnography and reflexivity. Soc. Sci. Med. 133, 45.

Mol, A., 2008. The Logic of Care: Health and the Problem of Patient Choice. Routledge.

Mulligan, J., 2017. The problem of choice: from the voluntary way to Affordable Care Act health insurance exchanges. Soc. Sci. Med. 181, 34–42.

Norwegian Ministry of Health and Care Services, 2009. The Coordination Reform. Proper Treatment - at the Right Place and Right Time. Retrieved from. https://www.regjeringen.no/contentassets/d4f0e16ad32e4bbd8d8ab5c21445a5dc/en-gb/pdfs/stm200820090047000en_pdfs.pdf.

Norwegian Directorate of Health, 2016. Pakkeforløp På Kreftområdet [Cancer Pathways]. Retrieved from. https://www.helsedirektoratet.no/pakkeforlop/generell-informasjon-for-alle-pakkeforlopene-for-kreft/pakkeforlop-pa-kreftomradet.

Norwegian Ministry of Health and Care Services, 2017. Sykehus [Hospitals]. https://www.regjeringen.no/no/tema/helse-og-omsorg/sykehus/id10935/.

Orlikowski, W.J., Yates, J., 2002. It's about time: temporal structuring in organizations. Organ. Sci. 13, 684–700.

Pedersen, K.Z., Roelsgaard Obling, A., 2020. 'It's all about time': temporal effects of cancer pathway introduction in treatment and care. Soc. Sci. Med. 246, 112786.

Reinecke, J., Ansari, S., 2015. When Times Collide: temporal brokerage at the intersection of markets and developments. Acad. Manag. J. 58 (2), 618–648.

Rowell, C., Gustafsson, R., Clemente, M., 2016. How institutions matter "in time": the temporal structures of practices and their effects on practice reproduction. In: Gehman, J., Lounsbury, M., Greenwood, R. (Eds.), How Institutions Matter! Emerald, pp. 303–327.

Schillmeier, M., 2017. The cosmopolitics of situated care. Socio. Rev. 65, 55–70.

Spradley, J.P., 1979. The Ethnographic Interview. Holt, Rinehart & Winston.

Spradley, J.P., 1980. Participant Observation. Holt, Rinehart and Winston.

Starkey, K., 1989. Time and work: a psychological perspective. In: Blyton, P., Hassard, J., Hill, S., Starkey, K. (Eds.), Time, Work and Organization. Routledge, London, UK., pp. 35–56

Tanenbaum, S.J., 2015. What is patient-centered care? A typology of models and missions. Health Care Anal. 23, 272–287.

Tavory & Timmermans, 2014. Abductive Analysis : Theorizing Qualitative Research. University of Chicago Press, Chicago, Ill.

Timmermans, S., Almeling, R., 2009. Objectification, standardization, and commodification in health care: a conceptual readjustment. Soc. Sci. Med. 69, 21–27.

Tomkins, L., Simpson, P., 2015. Caring leadership: a Heideggerian perspective. Organ. Stud. 36, 1013–1031.

Wind, G., 2008. Negotiated interactive observation: doing fieldwork in hospital settings. Anthropol. Med. 15, 79–89.

Zerubavel, E., 1979. Patterns of Time in Hospital Life: a Sociological Perspective. University of Chicago Press, Chicago, IL.

Zerubavel, E., 1981. Hidden Rhythms: Schedules and Calendars in Social Life. University of Chicago Press, Chicago, IL.