

ABSTRACT

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OCCUPATIONAL BOUNDARY-WORK
BETWEEN EMERGENCY ROOM
REGISTERED NURSES

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Occupational boundary studies have addressed divisions among workers by examining the process of creating occupational groups and assigning certain attributes to these groups (boundary work). They have, however, neglected *intra*-occupational dynamics that are also drivers of division and cohesion in the workplace. Using data from participant observation and in-depth interviews in a hospital emergency room with registered nurses, this paper examines the ways that nurses use time management, the ability to be productive while balancing work and breaks well, to distinguish themselves from one another. Using time management, nurses create similarities (cohesion) and differences (divisions) between one another using assessments of a nurse's time management skills. These findings suggests that workplace boundary making may be more dynamic than previous studies have indicated, varying with the status of the person performing the boundary work, the context of the social interaction, and the "audience," in Goffmanian terms, of the performance.

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By

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Chapter 1: Introduction

Divisions among workers have preoccupied sociologists for some time, indeed going back to Durkheim (Durkheim 1984/1933). Sociologists of work have explained these division primarily through aspects of the organizational structure, such as management policies and employee composition (Kalleberg, Reskin, and Hudson 2000; Reskin, McBrier, and Kmec 1999). Occupational boundary studies have taken a more processual approach to studying workplace divisions, emphasizing the relationships between occupational groups. These studies pay considerable attention to the ways that power is maintained and negotiated among members of occupational groups. There has been limited attention, however, to how power is negotiated in workplace interactions. While relationships between occupational groups are highlighted, the dynamics within groups have been largely overlooked. By neglecting intra-occupational dynamics in workplace interactions, studies of occupational groups may be overlooking important aspects of how workers compete for power with others that are similarly situated in the workplace structure. Workers in the same occupation compete for important resources, such as job promotions or preferential treatment, with persons in the same occupation.

In addition to studies of boundaries in the sociology of work and occupations (Abbott 1995; Allen 2001; Bechky 2003; Halpern 1992; Tjora 2000; Vallas 2000), the boundaries framework has been applied to numerous other arenas (Barth 1969; Carter 2006; Gieryn 1983; Lamont 1999, 2000, 2001; Lamont and Fournier 1992; Lamont and Molnar 2002; Newman and Ellis 1999; Pachucki, Pendergrass, and Lamont Forthcoming; Young 1999). Boundaries are what define entities or groups as distinct from others. Unlike division, the term boundary has (1) has a definitional quality that is not

characteristic of all divisions and (2) it implies intentionality. The way that the boundary between doctors and nurses is maintained, rather than the characteristics of doctors and nurses, is the subject of boundary studies. All of the actions that reproduce, destroy, or create boundaries are called boundary work. Boundary work is the beliefs and actions that people take to position persons, entities, or groups relative to one another. These actions can reproduce existing boundaries and they can also challenge dominant existing hierarchies (Allen 1997, 2001; Lamont 2000; Vallas 2000) or create boundaries among entities that may have previously been seen as part of the same group.

Boundaries illuminate important dynamics of power in the workplace, but some aspects of boundaries are underconceptualized. First, there has been less attention to divisions among workers that are potentially a very important source of tension in the workplace – divisions within occupational groups. Second, boundaries are viewed as static while there are signs that boundary work is dynamic. Third, boundaries are often conceptualized as being fixed while there are signs that it is produced in social interactions. One possible avenue, which I pursue in this paper, is to examine boundary work within an occupational group and to view boundaries as being more dynamic and produced through social interactions.

This paper uses intensive case study of hospital emergency room (ER) registered nurses (RN) to examine intra-occupational boundaries. Using the framework of boundary work, I examine how RNs make distinctions between one another and how their status within the hospital emergency room informs the boundary work they perform.

My research question is: How do nurses¹ create intra-occupational boundaries among one another?

In the following section I elaborate on the framework of boundaries and boundary work. Then I review studies of occupational boundaries and two prominent themes in this literature, the structure – agency perspective and the work task perspective. I will then argue for the need for intra-occupational boundary studies. Next I review Goffman’s theory of performance and discuss its utility to studies of boundary work. Then I review my methods for this case study. To provide information about the context of the study, I describe the site where the study took place and the typical day of an ER nurse. In my findings section, I demonstrate how nurses use time management as a way of distinguishing themselves from other nurses. I argue that time management was important to being a good nurse and can be conceived of as a cultural repertoire of ER nursing. I will also argue that ER nurses used the moral claim of time management as a way to distinguish themselves as better nurses and that nurses performed boundary work using busyness differently depending on their status in the ER. Finally, I conclude and propose future areas of inquiry.

¹ From this point forward, when I use the term nurse or nurses, I am referring to registered nurses (RN) unless I specify otherwise. I do not distinguish between registered nurses based on their degree (i.e.; diploma, BSN, etc).

Chapter 2: Literature Review

What are Boundaries and Boundary Work?

Boundaries are all of the ways, sometimes contradictory, that members and nonmembers of groups are defined as distinct from others (Gieryn 1983). Boundary work is the action of assigning attributes to members or elements of a group, which may involve naming a group where an established one did not previously exist, in order to distinguish the group or entity from others (Gieryn 1983). The boundaries and boundary work framework is useful for analyzing how divisions are created and maintained. I will elaborate on the concept of boundary and boundary work and put them in the context of the work of two pioneers in boundary studies, Gieryn Thomas and Michele Lamont.

Boundaries

The intention of boundary studies is to examine macro cultural forms at the micro-level. There are two types of boundaries that are commonly examined, moral boundaries and cultural boundaries. Moral boundaries are supported by moral claims (Lamont 2000, 2001; Lamont and Molnar 2002). Cultural boundaries are supported by claims about knowledge or skills (Lamont 2001; Lamont and Molnar 2002; Vallas 2000).

Lamont and others have studied boundaries in the interest of examining the interplay between macro-level cultural schemas and individual beliefs (Lamont and Aksartova 2002; Lamont 1999, 2000; Lamont and Fournier 1992; Lamont and Molnar 2002; Lamont, Morning, and Mooney 2002). At the micro level, individuals or groups can create alternative ways of classifying groups that challenge the status quo by using different criteria to evaluate themselves (Lamont 2000). In a cross-national comparative study of working class men in the U.S. and France, Lamont analyzes ways that working

class men elevates their self-worth while contradicting mainstream measures of status based on socioeconomic success. Using interviews with 75 U.S. workers², Lamont finds that workers use varied dimensions of moral values to differentiate themselves from others (Lamont 2000). Lamont finds that White working class men in the U.S. emphasize work ethic or “disciplined selves” to distance themselves from Blacks and the poor; and emphasize interpersonal relationships when differentiating themselves from managers and professionals. Black working class men in the U.S. tend to emphasize solidarity and family values, “caring selves”, in differentiating themselves from Whites and middle class persons; and morals in differentiating themselves from the poor. Lamont explains the differences in the moral criteria that these groups use to the differentiate themselves through cultural repertoires, “the cultural resources that people have access to” and “the structural conditions in which they are placed” (Lamont 2000: 7).

Boundary Work

Boundary work is the action of assigning attributes³ to members or elements of a group. Boundary work may reinforce, dismantle, or create a boundary where one did not previously exist (Gieryn 1983). Boundary work can result in the creation of boundaries, but boundary work is primarily about the beliefs or actions taken with the intention of

² For the purposes of this paper, I will review Lamont’s analysis of group relations in the U.S. between Whites, Blacks, and immigrants, paying specific attention to the way that work values is raised in this study.

³ Attributes are also referred to as values, cultural traits, or qualities. I prefer the term “attributes” because it places more weight to the action of assigning characteristics to something that attenuates the implied connection between these characteristics and actions. Also, for the purposes of this study, a nurse talking about themselves as “busy” is more of an assigned attribute than a value per se. Nevertheless, attributes are no less neutral than values. People express these attributes in ways that make explicit the positive or negative meaning/consequences/character of each attribute. In the hospital, for example, when nurses talk about themselves as being busy, they use facial expressions or comments to indicate that a busy nurse is better than a nurse who is idle.

making distinctions. Using boundary work, people divide the world into an “imagined community of ‘people like me’ who share the same sacred values and with whom they are ready to share resources” (Lamont 2000: 3). Since people are more willing to share resources with those that they deem to be similar (Lamont 2000: 3) and justify the exclusion of those that they deem to be different, boundary work tends to complement other social divisions (Barth 1969; Lamont and Molnar 2002). As Barrie Thorne notes, “[e]ven in play, [children] frequently express and enact larger patterns of inequality, by gender, by social class and race, and by bodily characteristics like weight and motor coordination” (1993: 75). People do boundary work, or assign attributes to themselves and others, in order to influence and justify the distribution of power, authority, and resources.

A pioneer in the study of boundary work as discourse, Thomas Gieryn, analyzed the rhetorical strategies that scientists use to create and maintain the boundary between science and non-science (1983). Analyzing speeches and reports written by scientists, Gieryn finds that the qualities that scientists attribute to science vary depending on the non-science they are positioning themselves in contrast to and the particular goals of the scientists (Gieryn 1983: 792). The arguments (boundary work) that scientists use to position themselves in contrast to religion is very different and in some ways inconsistent from the arguments they use to position themselves in contrast to mechanics.

In analyzing the rhetoric of scientists, Gieryn makes a significant shift from an analysis of the qualities of science to the ways that scientists assign particular qualities to science. Barth articulates a similar shift in the study of ethnic groups and culture: “the critical focus of investigation from this point of view becomes the ethnic boundary that

defines the group, not the cultural stuff that it encloses” (Barth 1969: 15). The shift from qualities of a group, the attributes of science or culture of ethnic groups, to the way that group members assign these attributes and define inclusion into a group is central to the concept of boundary work.

Boundary work may take different forms depending on the goals, context, and actors involved. The attributes that people assign to groups varies considerably and can be contradictory, resulting in boundaries that are “ambiguous, flexible, historically changing, contextually variable, internally inconsistent, and sometimes disputed” (Gieryn 1983: 792). Since boundary work is meant to promote an image of oneself in service of a particular goal, some of the variation depends on what one is trying to achieve. Another factor that shapes variation in boundary work is social setting. Social setting, of course, may encompass goals and actors, but in this case it primarily refers to the organization of a setting. For example, Barrie Thorne finds that gender boundaries among school aged children are different in spaces like the playground, classroom, and lunchroom (1993). Despite this finding, Thorne also notes that in the case of children that are stigmatized by race, class, or bodily difference, boundary work is more consistent across social contexts. Thorne’s analysis highlights another explanation for variation in boundary work: the actors involved.

The actors involved in the boundary work equation, especially the groups that people are distinguishing themselves from are significant in shaping the boundary work performed (Gieryn 1983; Lamont 2000). There are at least two groups involved in boundary making, the one that the person identifies with and the group that they present in contrast to themselves. The group that is presented as the contrast group shapes the

specific type of boundary work that people do. If workers are contrasting themselves to managers, they might describe themselves differently from if they were contrasting themselves to their clients. Given these qualities of boundary work, we would expect that workplace boundaries would vary depending on the location of workers, in terms of the literal space and the activities and actors present in those spaces.

While boundary work is commonly conceptualized as a discourse or a set of values, it also involves interactions and the entire context of these interactions, including actors, goals and setting. Boundary work is both discourse and interaction. Thorne eloquently describes the boundary work that children perform to distance themselves from highly stigmatized children as a “shift from acts to imputing the moral character of actors” (1993: 74). It is in marking others with specific characteristics that people draw boundaries between themselves and others. In the following section I will review empirical studies of occupational boundaries that further demonstrate the process of attributing characteristics in occupational disputes.

Boundary studies are a useful frame for understanding the processual nature of divisions. Boundary work is a particularly useful concept for examining the ways that people create “difference” in social interactions. The particular way that these differences are created is informed by the workplace structure yet it is not dictated by workplace structure.

Occupational Boundary Studies

Occupational boundary studies have tended to take one of two approaches to studying power in the workplace. Some have emphasized the interplay between structure and agency whereby structure is continually reproduced by occupational groups. This originates with the “negotiated order” perspective, which analyzes the smooth running of institutions as a continual negotiation. Other occupational boundary studies have emphasized control over work tasks. These studies are rooted in Abbott’s idea of jurisdiction, control over certain domains of work, of occupational groups (Abbott 1993; Abbott 1988, 1995). Both types of studies assume heterogeneity within occupational groups and as a result do not take into account the intra-occupational dynamics that influence running of the workplace and control over tasks. They also do not emphasize the dynamic aspects of boundaries in interaction and pay limited attention to the use of moral claims to create boundaries. For reasons that I will explain in the following section, a study of intra-occupational boundary work may highlight different aspects of how individuals use boundary work to vie for power in daily interactions.

Structure and Agency

Studies of how power is reproduced in the workplace have taken the approach of studying the dynamic relationship between the workplace structure and the workers (Allen 1997, 2000a; Tjora 2000; Vallas 2000). Using this structure-agency model, these studies demonstrate ways the structure of the workplace shapes relationships between occupational groups and the power and authority of distinct groups. In studies of health care workplaces, this dynamic view of the relationship between the institution and the

workers is rooted in the work of Strauss and others (Maines 1982; Strauss and Bucher 1963) on the “negotiated order” of the institution, the dynamic between the “negotiated order” of the workplace and changes within the institution. These studies demonstrate role of actors in creating and responding to changes within the continual process of negotiating the order other of the workplace.

Allen’s study of boundary work demonstrates how the organization of the hospital shapes the boundaries between nurses and doctors, and the ways that nurses do boundary work that influences this relationship (Allen 1997, 2001). In one paper, Allen (1997) argues that the structure of workplaces shape some of the tensions between nurses and doctors. The resolution of these tensions impacts the nurse-doctor boundary. For example, the spatial organization nurses and doctors in the hospital is such that nurses remain on one ward, while doctors work in multiple wards. In order to reduce tension that arises from constantly “beeping” doctors, nurses may save all requests for doctors and give them the requests at one time. Also, nurses will do medical tasks that are in the domain of doctors.

Although Allen treats nurses and doctors as separate occupational groups, she finds variation in the way that nurses perform boundary work. Allen finds that some nurses are more likely to perform boundary-work between themselves and doctors than others. “It was also more common for experienced nurses to blur occupational boundaries than junior staff. Indeed I observed junior nurses asking more senior staff to do their boundary-blurring work for them” (Allen 1997: 512). This suggests that there are internal boundaries among nurses, making some more willing to push the nurse-doctor boundaries and others less willing. Boundary-crossing may impact the entire

group, but it does not happen uniformly among all group members. Interview studies find that when asked about the nurse-doctor boundary, nurses and doctors believe that some nurses, those that are more experience or more educated, are more likely to enter the realm of doctors than other nurses (Snelgrove and Hughes 2000).

In a study situated in a school, Thorne articulates this relationship between organizational structure and boundaries (1993) quite clearly. There are three zones, the lunchroom, the classroom, the playground, each with their own structure that shapes the way that boys and girls interact and the amount of boundary work that they do to distinguish themselves from one another.

In addition to demonstrating the impact of institutions on workers, occupational boundary studies also demonstrate how what workers do shapes the running of the workplace. Occupational boundary studies examine the role of workers, and the formal organization of occupations and professions in shaping workplaces (Allen 1997, 2000a, 2001; Tjora 2000; Vallas 2000). This is an important contribution to the sociology of work, which has viewed work primarily through organizational studies in the past three decades (Abbot 1993; Reskin, McBrier, and Kmec 1999).

To emphasize the relationship between organization and workers, many studies of occupational boundaries situate themselves during moments of structural changes in the workplace that blur occupational boundaries (Allen 1997, 2001; Tjora 2000; Vallas 2000). An example of structural changes is the restructuring of nurse job responsibilities in the United Kingdom in Allen's study of nurses and doctors. Given their emphasis on the dynamic between structure and agency, it makes sense that these studies examine boundary work in times when the structurally formed boundaries are shifting. Studying

workplaces during structural change provides insight into the ways that boundary work by individuals is part of the restructuring process itself; workplace structural change happens at organizational and individual level.

In an ethnographic study of occupational boundaries between engineers and skilled manual laborers in manufacturing plants undergoing automation, Vallas demonstrates how structural changes create instability in occupational boundaries (2000). When managers in manufacturing firms computerize production and hire more engineers, for example, they limit the power that manual laborers have over the production line. Laborers can no longer claim as much specialized knowledge about operations because some of their previous tasks are automated. During these changes, engineers reinforce the structural changes by create cultural boundaries, emphasizing their own technical knowledge, and moral boundaries, questioning the manual laborer's work ethic and commitment to innovation (Vallas 2000). This boundary work reinforces the importance of engineers to automation systems within manufacturing plants.

Despite the importance of changes at the organizational level, Vallas demonstrates that the actions of members of occupational groups also impacts the division of labor within workplaces. The boundary work of engineers allows them increased control over the production floor and ensures their value to the company (Vallas 2000). The boundary work of engineers and manual laborers impact the way that technological changes are implemented and the terrain of engineers and manual laborers in the workplace. In this sense, workers boundary work shapes job responsibilities.

While studies of workplace boundaries emphasize the relationship between structure and agency of workers, they limit their unit of analysis to occupational groups.

The somewhat rigid distinctions between occupational groups, may make for more rigid boundaries between workers since occupational boundaries are in many ways still anchored by institutional structures. It is unclear how power is negotiated in cases where boundaries are blurrier than those between occupational groups such as engineers and manual laborers and nurses and doctors.

One reason it is difficult to examine the blurrier boundaries is that it is difficult to observe conflicts over power in the workplace (Allen 2001). Abbott (1988) argues that boundary conflicts in the workplace are rare and more commonly negotiated in the political or legal realm. As a result, many studies have examined boundary work through analyzing discourse rather than interactions that constitute boundary work (Gieryn 1983; Lamont and Aksartova 2002; Lamont 2000; Newman and Ellis 1999; Norris 2001; Shuval 2006; Shuval and Mizrachi 2004; Snelgrove and Hughes 2000; Timmons and Tanner 2004; Young 1999).

Allen conducts an innovative discourse analysis despite the difficulty of observing boundary work in the workplace. Allen argues that the sharing of “atrocious stories,” stories about dramatic occurrences in the workplace, are a way that nurses perform boundary work between themselves and doctors (Allen 2001). Atrocious stories were shared between nurses, told from the narrating nurse’s perspective, and expressed a moment of tension between nurses and doctors involved in the story. These stories highlight nurses’ superior judgment and sensitivity toward patients’ needs in a work setting where doctors have higher status based on their credentials. Nurses listening to the story adopt the narrating nurses’ perspective and there was consensus about who was right and who was wrong in the event.

While Allen demonstrates the use of atrocity stories to create the nurse-doctor boundary, there is evidence that there are also boundaries between nurses. For example, she mentions that nurses occasionally told “atrocity stories” that involved tension between two nurses. On some occasions, Allen observes nurses sharing atrocity stories that involve tension between nurses of different status levels. Unlike with the stories involving tension with doctors, nurses do not come to a consensus about which person involved is incorrect. This lack of consensus suggests that there are tensions between nurses of different status levels.

Other studies also suggest tensions within the field of nursing, between nurses and support workers, and among nurses themselves. Studies of nurses and nursing assistants find that there is tension between these two groups (Daykin and Clarke 2000; Scherzer 2003). An interview study finds tension between nurses practicing alternative medicine and nurses that practice only traditional medicine (Shuval 2006). There are also reports of bullying among nurses (Stevens 2002), racial tensions during the development of nursing as an occupation (D' Antonio 2007a, 2007b), and tensions between foreign-born nurses and native-born nurses (DiCicco-Bloom 2004). Closer observation of registered nurses may illuminate the nature of boundary work among nurses.

Vallas' study of engineers and laborers also suggests tensions and boundary making among manual laborers. Although intra-occupational boundaries are not the focal point of his study, Vallas mentions distinctions between manual laborers that existed prior to computerization. Vallas does note that prior to restructuring senior operators kept “black books” with notes about production that were sometimes “under lock and key” to preserve their specialized knowledge and keep this information from

other operators (Vallas 2000: 15).

Previous studies of workplace boundaries demonstrate the impact of the negotiation on the running of the workplace. Studies by Steven Vallas and Davina Allen that examine boundary work among workers of different occupational statuses show that workers negotiate occupational boundaries (Allen 2001; Vallas 2000). In these negotiations, workers assert their superior knowledge or judgment in exchange for control over workplace domains. They hint at the presence of boundary work within occupational groups, but this is a peripheral issue in these studies.

In looking at boundary work between groups that are separated through institutional forces, there is a great deal of attention to differences in status between persons of different occupational groups, such as doctors and nurses, for example. These studies assume that the occupational groups are internally non-hierarchical and status within these groups is ignored. Taking a closer look at status among persons who have similar status within an institutional setting, such as occupational title, for example, may illuminate other ways that boundary work happens.

Work Tasks

Some studies have looked to work tasks as a way to analyze occupational boundaries. These studies are rooted in Abbott's concept of occupational jurisdiction, control over domains of work. At least in theory, studies of work tasks at least in theory are dealing directly with the workplace and negotiations that take place in the workplace. Since competitions over the control of work tasks, which Abbott refers to as "turf battles", can happen in the realms of the law, politics, or workplace (Abbott 1988), many

studies are not situated in the workplace (Halpern 1992; Kronus 1976). There is considerable attention to the structure of occupations and the political climate in which occupations develop (Abbott 1988; Halpern 1992). Many studies address political and legal realms rather than the workplace (Bechky 2003).

The status of the task is an important factor in shaping the degree of competition over control over that task. Studies of nurse-doctor boundaries find that there is more disagreement about nurses taking on tasks that are seen as advanced or very specialized (Allen 1997; Norris 2001). In a study of the boundary work of nurse managers, Allen (2000a) finds that the regulation of tasks of the nursing assistant by nurse managers is an important way that nurses maintain power over certain realms of hospital work. In cases where there is overlap in tasks that groups perform, the boundaries become even blurrier and at times result in open conflict between groups (Timmons and Tanner 2004). When the overlap of tasks is informal and performed in ways are beneficial to the group with higher status, this type of boundary blurring can be acceptable, as in the case of nurses performing doctor's duties to alleviate doctors from these tasks (Allen 1997).

Another important feature of control over work tasks is that the meaning, and therefore the status of the task, can change depending on the group performing it. Studies of the boundary work of nurses and nursing assistants demonstrate how the meaning of some patient care duties have shifted (Daykin and Clarke 2000; Nakano Glenn 1992; Roberts 1997), some of these duties being of a lower value than others. In this sense, the tasks the tasks that people are assigned may have a moral aspect as well.

Occupational boundaries are frequently studied within the context of a profession, a group of occupations within the same field. Medicine is a field comprised of different

types of doctors and nurses for example. Using a historical comparative analysis to explain how some occupations were able to dominate closely related occupations, Halpern (1992) articulates the relationship between intra-group dynamics and inter-group boundaries. Halpern argues that in order for one occupation to dominate another occupation, support from other occupations within the same profession is vital to this process. While this study is not intended to emphasize workplace interactions, Halpern argues that workplace dynamics are more prominent in shaping this process than legal or political debates.

Anesthesiology improved its jurisdictional position despite continued lack of control over technicians' professional institutions. Its success cannot be attributed to shifts in public opinion or judicial rule. Between World War I and 1960, neither anesthesiology or nurse anesthesia sought to resolve their disputes in public arenas. Nor did the federal or state governments attempt to intervene. These observations suggest that still other social processes were influencing boundaries between medical specialties and ancillary professions. (1992: 1006)

Halpern then asserts that dynamics in the hospital, between anesthesiologists and other occupational groups shaped the ability of anesthesiologists to control nurse anesthesiologists.

In the early decades of the century, many doctors were quite willing to bypass medical consultants (radiologists, pathologists, psychiatrists, and anesthesiologists) and go directly to technicians for services. Surgeons welcomed nurse anesthetists into the operating room. . . . At issue was both the division of labor among medicine's internal segments and the profession's boundary with a neighboring occupation. (1007-1008)

Halpern argues for the importance of intra-group relations in shaping the way that groups achieve power over other groups.

Also important in Halpern's study is the role of intraprofessional cohesion. In order for anesthesiologists to have dominance over nurse anesthesiologists, there needs to be cohesion between anesthesiologists and surgeons (other doctors). In a study of nurse managers, Allen demonstrates the importance of intra-occupational cohesion and the

ways that the nurse manager tries to create a coherent understanding of the nursing profession (2000a). Part of this process involves controlling the tasks that nursing assistants are trained and allowed to perform. It also involves communicating to nurses a coherent idea of what their work involves.

Taking a more fine-grained interactionist approach, Bechky studies boundary work through workplace artifacts, such as engineer drawings and machines (2003). The drawings and machines represent tasks that are completed by engineers, technicians, and assemblers, however, these workers have varying levels of control over these artifacts in the work environment. Maintaining control over the artifacts, regulating when and how other workers can handle these artifacts and creating the final product, is an important way that workers exercise power in the workplace. Halpern also argues that artifacts can act as symbolic representations of a workers' reputation so that an engineer that produces drawings of low quality may lose credibility among other engineers and technicians. "Individual and group reputations were established on the basis of producing good work . . . Engineers were sensitive about their reputations among members of other groups, as well as their status within in their own occupational community" (Bechky 2003: 741-742). Groups use artifacts as a vehicle to compete for power in the workplace, but also to evaluate group members. Although it is not the intention of the study, this microanalysis of artifacts mediating interaction hints at the way that power is active between and *within* occupational groups.

The two approaches taken by occupational studies, the structure – agency and the work tasks, provide important insights into how people obtain and maintain power in the workplace. An analysis of how members of an occupational group compete for the

power that occupational groups have over their work tasks and in the running of the workplace would provide a more complete picture of power in the workplace. Greater attention to interaction, as in the Bechky (2003) study, and examination of the moral claims used in the workplace.

Why Study Intra-Group Boundary Making?

I suggest that intra-occupational boundary work is a useful site of inquiry because of (1) evidence and theoretical explorations of previous studies (2) definition of boundaries as articulated most explicitly by Andrew Abbott (1995); and (3) particular elements of intra-occupational relations that make it a fruitful site for the study of boundary work.

Some of the early studies of boundaries have demonstrated boundary work in discourse at a distance from the workplace. These studies emphasize the use of boundary work to create distinctions between group of people that “find themselves in relatively similar structural positions” and “lead their lives side by side” – steadily employed working class men (Lamont 2000: 3 and 7). Occupational boundary studies provide a more textured perspective on boundary work by studying boundary work in the workplace between workers. Since occupational boundary studies focus on workers from distinct occupational groups, they may be missing some of the boundary work happens within a group that is of a similar position in the workplace. In fact, some of the occupational boundary studies previously mentioned suggest that there is boundary work happening within occupational groups (Allen 2001; Vallas 2000). While they do not emphasize boundaries between workers within the same occupation, there are signs that

these boundaries exist and are salient in shaping the running of the workplace.

The definition of boundaries makes intra-occupational boundaries important. Andrew Abbott argues that boundaries might come before the categories that they delineate (Abbott 1995). “It is wrong to look for boundaries between preexisting social entities” (Abbott 1995: 857; Vallas 2000) There can be boundaries without coherent social entities or groups. This means that boundary work happens between people that are not completely part of separate groups.

Also, intra-occupational dynamics make for a prime site for boundary work, limiting it to boundary work between groups is incomplete. Given the less formal boundary work at the institutional level, people within the same occupation may be in a position to negotiate and compete for power more fiercely than with persons that are in occupations with more or less status. Goffman also suggests that studying performances within groups of similar status might be useful.

“It may be suggested here that one of the most fruitful places to study realigning actions, especially temporary betrayals, may not be in hierarchically organized establishments but during informal convivial interaction among relative equals. In fact, the sanctioned occurrence of these aggressions seems to be one of the defining characteristics of convivial life.” (Goffman 1959: 205)
Competition between persons in similar occupational groups may be more difficult to capture in interviews.

Studying intra-occupational boundaries may make the boundary work that people perform more visible. Using Abbott’s (1995) definition, an occupation has three features: it includes a particular group of people (that are fairly static); a particularly type of work; and has an organized body or structure capable of some kind of reproduction (such as a school; professional society; certifications). These features make it so that there are

numerous sites for boundary work to happen. In the cases of boundary work between nurses and nurse's aides, for example, boundary work happens on the part of individual RNs, the hospital in creating job descriptions, and organizations like the American Nurses Association (ANA). In a study of boundary work among registered nurses, the boundary work of institutions may be less salient and the boundary work of individual nurses distinguishing themselves from one another more visible.

Studying intra-occupational boundaries is useful because it elaborates on some of the findings of previous studies that remain unclear, it clarifies some aspects of boundaries, and intra-group dynamics are a fruitful site for studying the competition for power that drives divisions. In analyzing of how power functions in social interactions, Goffman's theory of performance is useful because it articulates the role of all of the actors involved in interactions and the relationship between performances and the goals of actors. This emphasis on the goals in Goffman's theory coincides with the intentionality aspect of boundary work.

Social Interaction: Goffman's Theory of the Performance

Goffman's theory of performance is useful because it connects to broader social structures; explains the role of actors in shaping interactions and some of the limitations of what one can perform. In *The Presentation of Self in Everyday Life* Goffman theorizes social interaction as a performance in which actors are simultaneously performing and acting as the audience for one another. While Goffman takes a micro-level approach to studying interaction, the theory of performance is intended to connect to social structure and does through elaboration of role of status in interaction, development of credibility in interactions, and the limitations of a performer's ability to perform.

Goffman's study of performance uses interactions as a site to analyze broader sociological concepts, including social relationships. While Goffman emphasizes the various props that are involved in any one performance, he also states that there are a limited number of possible performances, or roles, that one can play. Since repeated performances tend to constitute a social relationship, the features of a performance can be applied to the social interactions between groups as well as individuals.

Goffman conceptualizes the performance as site to enact larger social values:

“when the individual presents himself before others, his performance will tend to incorporate and exemplify the officially accredited values of the society, more so, in fact than does his behavior as a whole” (35).

The moral values are not what is central for Goffman, but rather the performer himself, the person enacting the moral values, and the audience, the person taking in the performance.

“Sometimes when we ask whether a fostered impression is true or false we really mean to ask whether or not the performer is authorized to give the performance in question and are not primarily concerned with the actual performance itself” (59)

The believability of the performance is not based on the moral values presented, but the person presenting them. Goffman argues that in order for a person to put forth a particular self, the other persons in the interaction, have to believe the self that the performer presents to them. The believability of the performance, he argues, is due to the authority of the performer. Goffman emphasizes the role of the status of performer and audience in shaping interactions and believable presentations of self. Boundary work, like other self-presentations, is contingent on the actors involved in the interaction where boundary work is performed.

Goffman also elaborates the relationship between skill and perceived authority in interactions. He provides the following example:

Medical schools in America tend to recruit their students partly on the basis of ethnic origins, and certainly patients consider this factor in choosing their doctors; but in the actual interaction between doctor and patient the impression is allowed to develop that *the doctor is a doctor purely because of special aptitudes and special training*. Similarly, executives often project an air of competency and general grasp of the situation, blinding themselves and others to the fact that they hold their jobs partly because they *look like executives*, not because they can work like executives. (Goffman 1959: 47) [added emphasis]

While actors are intentional in their performance, part of the authority of the actor is shaped by factors beyond the actor's control.

Goffman delineates factors that shape the believability of a performance for the performer and the audience. If interactions are to even become solid relationships, there must be believability in the self that is presented to the audience. How persons view the performer, prior to the moment when they intentionally perform even, greatly influences the possible performances a performer can perform. The status of the performer varies in importance depending on the issue at stake. Some forms of status are more rigidly policed than others. For example, impersonating a lower status is not frowned upon, but impersonating a higher status is. Also certain types of changes to ones status are more acceptable than others. Goffman uses the following example: "It is felt to be all right for immigrants to impersonate native Americans in dress and in patterns of decorum but it is still a doubtful matter to Americanize one's name or one's nose" (Goffman 1959: 61).

As Goffman demonstrates, there are limitations to what one can perform.

Goffman's theory of performance provides useful insights into the ways that status might influence interactions between members of occupational groups and also the different ways that occupational group members can perform boundary work. The believability of performances can be applied to the believability of boundary work, explaining why some groups perform boundary work differently from others and how the

status of person performing boundary work influences the credibility of boundary work.

Cultural Repertoires, Moral Boundaries, Time Management

Studies of occupational boundaries have not been attentive to moral boundaries in the workplace. Studies of boundary work in discourse, which are not situated in workplaces, emphasize moral claims. In a study of working class men, Lamont (2000) finds that they used moral boundaries to differentiate themselves from people of different racial and class groups; these moral boundaries were based on the available cultural repertoires of the worlds that these men lived in. Studies of occupational boundaries have not sufficiently addressed boundary-making based on moral claims. In some case arguing that “moral boundaries seem more diffusely drawn” (Vallas 2000: 30). Studies of boundaries in the workplace tend to emphasize boundary-making based on formalized training of occupational groups, such as doctors drawing boundaries based on their responsibility in diagnosing patients. There is evidence, however, that occupational groups also have moral imperatives that are highly valued in the workplace.

What repertoires do nurses use to establish themselves as a good nurse? Some of the available repertoires to ER nurses might be caring for patients, skills in emergency medicine, and time management in a fast-paced workplace. I will focus on one, the importance of time management and examine the way that nurses pull from this repertoire to establish themselves as good nurses or better nurses. Time management is a useful and relevant moral claim to use to study boundary work among emergency room nurses for several reasons.

Time management is the ability to juggle many tasks, prioritize, and work quickly and efficiently. Managing time efficiently can be thought of as a cultural repertoire of

hospital life (Allen 2002; Zerubavel 1979) as well as other workplaces (Fine 1990; Hochschild 1997). In choosing the hospital as the site for his study of sociology of time, Zerubavel highlights the moral aspects of time in the hospital.

The temporal order which prevails in hospital life is oriented primarily toward patient coverage and is, therefore, based on fundamental moral considerations and assumptions. The hospital, for example, is one of the few organizations or facilities who operations around the clock, seven days a week, and 365 days a year is dictated primarily by its moral *raison d' etre*, rather than by considerations of productivity and profit. (Zerubavel 1979: xvii)

Time management is an important moral imperative in the hospital. And as Zerubavel argues, this is due to the purpose of hospital work, patient care. Along with these time constraints, nurses are faced with the tensions of managing multiple schedules. “Nursing work involves mediating the polychronic temporal care needs of patients with the monochronic organisation of the hospital” (Allen 2002: 50).

Studies of occupational boundaries have emphasized work tasks and structure – agency in examining the flow of power in the workplace. They have neglected the intra-occupational boundaries, a microanalysis of social interaction, and the role of moral claims in shaping divisions in the workplace. In this study, I use an intensive case study of emergency room nurses to examine the intra-occupational boundaries that shape the way that power was exercised among nurses during the workday. Time management was a salient intra-occupational boundary that nurses used to establish themselves as good nurses. This study contributes to the literature on occupational boundaries by demonstrating another site where power is exercised, and clarifying how boundary work based on moral manifest in workplace interactions.

Chapter 3: Methods

In this section I describe the research design that I used, the selection of my research site, the way that I conducted participant observation (shadowing nurses), my role in the field, and my relationships with the registered nurses and EMTs, and the method I used for gathering and recording data. Next I will discuss how I selected RNs to interview, my response rate, how I conducted in-depth interviews, the types of questions that I asked. And finally I will discuss the way that I analyzed my data.

I selected my site of study on different levels. First, registered nurses are a useful occupational group to study occupational boundary work for several reasons. First, they meet Abbott's criteria of an occupational group (Abbott 1995). The group of people that are called nurses is established and there is a core group that is static; they do a particular type of work; and they have organized structures that reproduce more nurses, including schools, professional societies, and certification institutions.

There are also other features of the occupation that make it useful site of study. Being located in a medical institution, as emergency room nurses are, they work within a highly routinized institution (Zerubavel 1979). In this setting, the tasks that they performed are to some extent routinized and standardized across nurses. In the ER they work independently and in teams with various other health professionals. Unlike workers that have private offices or closed patient rooms, the open layout of the emergency room make it so that most of an RN's work is visible to other workers.

In addition to these features of the institution, the field of nursing itself has undergone numerous changes over the past 30 years (Bowker and Star 1999; Krall and Prue 1995). While nursing is an established occupation, the efforts to professionalize

nursing mean that tasks are still being negotiated. For example nurses have taken on some of the tasks that were previously assigned to doctors and nurse's aides (in this case EMTs) take on some of the patient care that was once assigned to nurses (Allen 2000b).

I selected Grawley Hospital to study intra-group boundary work because there was a sizeable group of Black nurses, hospital staff, and patients. In order to study the way that nurses distinguish between one another, I chose a workplace that is mostly comprised of minorities, Blacks and Asians. About three fourths of the nurses in the emergency room at Grawley were Black and most of the other quarter was Asian. Of these nurses about half of the Black and almost all of the Asian nurses were immigrants⁴. When I was observing there was only one White nurse in the emergency room during the day shift along with a couple of physician's assistants and one of the senior doctors. The composition of nursing administrators, EMTs, and cleaning staff followed a similar ratio. Among doctors and physician's assistants there were slightly more Whites. This is unusual, since only 4.1% of all nurses are Black (Services 2004) , and provides a unique opportunity to study intra-group boundary making among persons in the same occupational group and of the same race.

In order to study divisions among registered nurses, I spent 10 weeks observing and talking to nurses that worked in an emergency room at Grawley Hospital⁵, a hospital located in a metropolitan area. During this time I went to the hospital for two to three hours every two or three days shadowing one of the day shift nurses each time. I

⁴ I initially selected a group that had so many immigrants because I was interested in the relationship between native-born and foreign-born Blacks. As other qualified qualitative researchers have noted (see Geertz 1973; Lareau 2003: 273-274), qualitative research is emergent. The ethnic boundary did not result in my most significant finding.

⁵ Names of the research site and participants are pseudonyms. Since nurses frequently refer to one another by their last names (which are imprinted on their name tags along with their first initial), I refer to them using the part of their name that most other nurses used to refer to them.

shadowed nurses that worked the eight in the morning to the four in the afternoon shift as well as nurses that worked the eleven in the morning to the eleven at night shift. These were nurses that regularly worked together and shared patients during lunch breaks or shift changes. After shadowing eight registered nurses (RN) and a couple of emergency medical technicians⁶ (EMT) once or twice each, I asked nine nurses if I could interview them.

Participant Observations

After I obtained Institutional Review Board approval to observe at the hospital, I spoke with the Director of the Emergency room and the Director of Nursing Administration to obtain permission to shadow nurses. I explained to them that “I want to learn more about the workday of nurses” by shadowing, or following, nurses in the emergency room. I told nurses that I was interested in learning more about their work and what their workday was is like. Even though I explained that I was a graduate student in sociology, most nurses assumed that I wanted to attend nursing school and some found it easier to introduce me in this way to patients, outside administrators, and doctors.

Another way that hospital staff tried to include me in the hospital setting was by encouraging me to wear a uniform. This began when an EMT, Darren, recommended that I wear something “more official” and handed me a light blue contamination gown to wear over my regular clothes. The contamination gown covered me from my collar bone

⁶ In the hospital I observed, the staff members that might otherwise be called “nursing assistants” or “health care assistants” are called “emergency medical technicians”. I use the abbreviation EMT to refer to emergency medical technicians. This acronym was commonly used by nurses and EMTs themselves. Another abbreviation that they used was “tech”.

to the middle of my shins and had an opening all the way down the back that I pulled together by tying a green strip into knot at my lower back. A sticky fastener at the top of my back and elastic bands at my sleeves also held it together. The contamination gowns were available in light blue and lemon yellow and worn by doctors, physician's assistants, and nurses. Although I did not wear one, nurses, doctors, and physician's assistants sometimes wore them along with matching contamination shoes and a contamination cap, when they were working on surgical procedures, usually in the trauma rooms, or with patients that had contagious diseases. In addition to the contamination gown, which I grabbed from the supply area when I arrived every day, I was also required to wear slacks and close-toed shoes. I sometimes wore gloves and occasionally helped nurses with small tasks. For example, a nurse handed me a label and asked me to walk it down the hall and place it a patient's IV bag, another time to bring a patient a cup of water; another time I offered to look for a trash bag when a nurse complained of not being able to find one in the trauma room.

Most of all I think nurses used me as an interested outsider (and in some cases a future nurse) that they could talk to, and more than anything, someone they could teach, someone interested in tasks that they may have considered mundane at this point (Bosk 1979). I took this an opportunity to learn more about how and why they did certain tasks and their perspectives on the way the ER worked; I think that it was also an opportunity to build trust with them. One nurse confided in me about being afraid of needles. Sometimes they told me about their goals; one EMT told me about his plans to start a travel agency and asked me for advice about how he should approach an assignment for a Human Resources course. More frequently RNs gave me career advice. In our first

meeting, one RN gave me a told me about opportunities for making money in nursing and then concluded by telling me that it was stepping stone, and encouraging me to follow my real dream. When I asked her about her dream she told me with a robust laugh that she always wanted to be a powerful business woman in “six inch heels”. Other times they made comments about their frustrations with the lack of supplies in the hospital; insights about patients like how you could distinguish the eyes of a person with AIDS; who was a good doctor and who was not to be trusted; which nurse managers were “ghetto” and which ones were very knowledgeable; and occasionally they used me as a witness to events that had happened and as an ally in light disagreements with other nurses or doctors. I tried to build some rapport with nurses by talking to them in the lounge, offering to get them food from the cafeteria, and once I brought in Wanda on the holiday weekend. On my last day, I brought in pastries and left a thank you card in the employee lounge.

I spent two to three hours at the hospital each time that I observed and I usually shadowed the same nurse for the duration of my visit, except in cases when their shift was ending early. Shadowing meant that I followed nurses around, watching as they spoke to and took care of patients, interacted with doctors and other nurses. It also meant that I went with them to their lunch breaks, sat in and at times participated in conversations that were happening at the nurses’ station, asked questions about procedures and things that were happening at the moment when I felt that they had time to answer them. Since Grawley is a teaching hospital, it was not uncommon for a team of nurses, doctors, medical students, and physician’s assistants to crowd around while a procedure was being performed. It was not uncommon for other people wearing

contamination gowns or white jackets to stand in a patient's room and watch procedures being performed.

The first time I shadowed a nurse, I asked them casually about how they entered nursing, how long they have been a nurse, how they like it, and when shifts they work. I also talked to nurses about things that happened while I was observing. For example while I was there a new administrator, a clinical supervisor, was hired. I asked about her position and what she was responsible for doing. On another occasion there was a hum among nurses about the clinical supervisor yelling at another nurse. I followed the nurse around as she spoke to the nurse involved about this. And then when we were walking around, I asked her further questions about the dispute. The next time I observed and again in the in-depth interview, I asked the nurse involved in the dispute to tell me what had happened in the dispute.

During my observations, I looked for interactions between nurses that demonstrate their evaluation of other nurses or themselves. I also looked for comments that nurses made to themselves, to me, or behind the backs of other nurses. I also looked for evidence that nurses think all RNs are the same or that they use uniform criteria to judge one another. I will also paid close attention to the ways that nurses worked and their disposition when they were not with other nurses and when they were working side-by-side with other nurses.

I did not take notes while I was shadowing nurses, however, I did make notes in my car immediately after my visit. On my drive home, I audio recorded notes about events that happened on the visit. I later transcribed these recordings verbatim. Using

the audio recorded field notes, I included dialogue and descriptions of expressions and body language of people I observed. I then added more detailed field notes to the audio recorded notes within a day of conducting my observations, usually the following morning. In these more detailed field notes, I spent about eight hours writing the details of the previous day's events. I began by writing an outline of the events that occurred during that day's observations and then filled in the outline with more detailed notes. In writing my field notes, I tried to use "thick description" to capture both the events and my interpretation of their meaning within that specific context (Geertz 1973).

Interviews

In my sixth week of shadowing nurses when I felt that I had established rapport with many of the nurses, I began asking them to people to participate in an interview with me. I selected nurses that worked together regularly, at least two or three times in a five day work week. The nursing staff was predominately Black, with about half of them being native-born and half being foreign-born. I conducted half of my interviews with nurses that were born in the U.S. and half that were born in other countries that were well-represented among day shift nurse, three that were born in Ethiopia and one in Trinidad. I interviewed nurses in their homes, coffee shops outside of the neighborhood of the hospital, and in one case a locked hospital meeting room. I conducted all of the interviews in English and with the exception of one participant who was adamantly opposed to the use of the recorder, audio recorded and transcribed all interviews. I reviewed the Institutional Review Board approved consent form with all participants and ask them to sign the form prior to the interview. All nurses seemed comfortable with the consent form and most understood it to be similar to the hospital consent forms.

All of the nurses that I asked for an interview agreed to be interviewed; in once case I asked a nurse for an interview beyond the eight that I intended. Due to his busy schedule and my exit from the field, I was unable to schedule an interview with him. One of the nurses that I interviewed asked me anxiously to turn off the tape recorder very early in the interview. He explained to me once we started without the recorder that his anxiety about tape recorders had to do with witnessing the questioning and killing of family and friends by during Ethiopia's civil wars of the 1990s. He also expressed concerned about violating HIPAA⁷ privacy regulations. He did allow me to take extensive notes while he spoke, however, I do not use direct quotes from this interview.

During the interview I asked nurses about what it is like to be a nurse, what it is like working with other nurses (as supervisors or subordinates), what they consider their work responsibilities and how often they do things that are outside of these responsibilities. I also asked about how cultural differences come up, if at all, between themselves and their coworkers. I ask questions about their own status, such as whom they trust and distrust; and whether they ever feel like others do not trust them. I asked which nurses they admire and specific instances that they consider to be "good decision making" by a nurse. I also asked whom among their coworkers they would trust to take care of their loved ones. I also probed about other topics that the nurses introduced and wanted to discuss. The nurses I interviewed enjoyed talking about the rewards of caring for patients, their own progress as a nurse if they were new to the field, and some of the downsides of working in the ER related to legal liability and treating difficult patients.

⁷ HIPAA is the Health Insurance Portability and Accountability Act of 1996, a bill that requires health care providers to take specific actions to protect the confidentiality of patient information.

Following each interview, I left a thank you note in the inbox of each nurse. I also wrote brief notes about the setting and tone of the interview as well as the disposition of the respondent. I then transcribed the interviews. After reading interview transcripts, I wrote analytic memos about salient themes in the interviews.

In analyzing my data, I used the extended case method approach. I read literature on boundary work and reviewed theories about how people differentiate between one another. I then reviewed interview transcripts and field notes several times, paying attention to salient themes about boundary work. I wrote analytic memos analyzing my findings and I then returned to the literature on boundaries and workplace interactions and again to the data (Burawoy 2003; Lareau 2003). In order to provide a more textured image of my research subjects, I describe Grawley Hospital and a typical day for a nurse working at Grawley and then present my findings.

Grawley Hospital Emergency Room

Grawley is a medium-sized teaching hospital and part of a minority (20%) of hospitals nationwide that are certified as first-rate trauma facilities (Trauma I) yet from the outside it has the appearance of a local hospital, which is it. Most of the patients at Grawley are from locals. Grawley is not visible from the main street a block away. It is not until turning onto Harrison Street to enter Grawley that the purple banners with the Grawley Hospital gold insignia begin proudly announcing the hospital's presence. The brick hospital building stands five stories tall and about 50 yards from the street. The hospital's 1970s architecture are in contrast to the historic buildings surround the hospital, which date back earlier in the century. The neighboring buildings now house a

Bible book store, convenience shop, and a Starbucks. The hospital is buffered from these buildings on both sides by a black iron fence. Leading up to the door is a grassy quadrangle.

In the middle of the afternoon, the area outside the entrance to the hospital is usually filled with people standing or sitting in wheelchairs to wait for shuttle buses or the cars of family and friends that they have made previous agreements with. On the other side of the two automatic doors leading into the main hallway of Grawley, the hospital is usually quiet and patients waiting for care are visible in the maroon and dark green waiting room off to the side. The halls are usually quiet except for an occasional staff person waiting for the elevator to return to their ward from the cafeteria or an administrative office. In the entranceway the concierge sits at a mahogany table awaiting questions. A step further there is a security guard standing at a mahogany podium. Across from the security guard is a black door marked “RESTRICTED ACCESS” that leads into the emergency room.

I used this door to enter the ER on most days. Alongside the card read there was a buzzer that I used to ring the receptionist, who would normally buzz me in without speaking into the intercom. After walking through the door, I went down a short white hallway and came to a set of white double doors and repeated the process of buzzing the receptionist again.

Inside of the ER, florescent lights beamed onto the linoleum floors and off of the large white work station in the middle of the room. Even at a quiet hour of the day, there were more people congregating in the center of the ER than in the main hallway of the hospital. Visible from the door was a receptionist wearing scrubs, the women that handle

the intake of patients wearing collared shirts and navy pants, nurses dressed in blue scrubs and carrying a patient chart on a clipboard, occasionally a doctor and physician's assistant wearing white coats, and an emergency medical technician (EMT) wearing maroon scrubs. Usually a patient in a hospital gown was visible from their hospital bed in the hallway or from the corner of their room. Poking out from behind the work station, fire department EMTs dressed in navy uniforms are sometimes waiting with patients in stretchers.

Instead of solid walls, glass panels that look into patient's rooms border the hallways of the ER. The ER has a rectangular central room and four hallways emanating from each corner; these hallways lead to additional rooms and separate exits. In the center of the ER, there is a large work station that contains a receptionist area where patients check in and check out, incoming calls are received, and ER administrators meet informally. This is also where work schedules are kept, the charge nurse stand to give assignments or page staff members. On the left side of this workstation is a table where several computers and two printers are lined up across from one another. In the middle of the work station is a glass cubicle where nurses and EMTs stand to test blood samples and prepare samples to send to the laboratory. Also inside the work station is where the intake women are stationed; this is also where many of the patient charts, the printer of labels are kept. At the other end of the work station, opposite the receptionist, is the "omnicell", a machine where nurses order medication on a computer screen and retrieve it through a set of miniature drawers. At this side of the workstation patients arriving by ambulance are checked in by the ambulatory EMT crew and an ER nurse. Sometimes this area will have four or more EMT, a paramedic, and two or three patients waiting to

be checked in by the charge nurse.

Along all sides of the work station there are small sections of counter space where workers may stop to write notes; stop to discuss a patient or tell a story; or organize their blood samples or other lab work. The work station is a central pick-up and drop-off station. Not surprisingly, the work station fills most of the central space of the ER; the border between the workstation and the patient rooms the line the four sides of the room is only about four feet.

Where all four corners of the central room would be, there are hallways: one leading to the ambulatory entrance and two trauma rooms; one leading to the waiting room and the main hospital entrance; another leading inside of the hospital; and another leading to four additional patient rooms, bathrooms, the supply room, and the entrance to the pediatric emergency rooms and an intake area called Fast Trak where cases of chest pain and non-emergencies are seen by a nurse practitioner. The emergency room has 14 patient rooms, ten of which surround the work station, three large rooms for trauma cases (trauma I, trauma II, trauma III), and a minimum of eight locations in the hallway where patients are treated from hospital beds. A number of these rooms are specialty rooms, such as the asthma room, the isolation room for patients with contagious conditions or violent tendencies, the gynecology suite. The volume of patients varies considerably, some days patients were in all of the rooms and in beds lining all sides of the work station, all of the hallways, and lined up at the ambulance check in area. Other days there were empty patient rooms and empty hospital beds sitting in the hallways. Like many emergency rooms, Grawley's emergency room received many patients that lived locally and were uninsured (McCaig 2006) as well as patients that were homeless or substance

abusers (Dodier and Camus 1998; Meyer 1992).

The volume of patients did not coincide with the number of staff members working. The number of people present in the emergency room varied considerably from day to day. Some days the ER had ten nurses on duty, two doctors, a resident, two physician's assistants, three EMTs, two transportation staff, two receptionists, and two intake staff, as well as the presence of the Director, hospital administrators, and doctors from other wards of the hospital. Other days there were seven nurses and two EMTs on duty.

A Typical Day for an ER Nurse

On a typical day, a day shift nurse arrives at eight in the morning, clocks in using their employee card, and checks in with the charge nurse. For every shift, one of the nurses is assigned to be the charge nurse. A charge nurse is one of the more senior nurses working on that shift and if there are no senior nurses working, the clinical nurse supervisor, Ms. Peterson, takes that position for the day. The job of the charge nurse is to assign patients to nurses and serve as the go-to person for other nurses. During the check in the nurse finds out from the charge nurse whom she needs to get "report" from. Getting report is when the nurse whose shift is ending explains to the incoming nurse what is going on with the patient, what tasks have been done and what tasks still need to be done and then hand over the patients chart, which is a stack of paperwork on a clipboard that is assigned to that patient. The charge nurse may tell the nurse from the night shift something like, "Give your patient EE to Bebi, and K to Mita" and then the night shift nurse will approach the day shift nurse to hand off the patients. Nurses also receive new assignments as patients are admitted into the ER, in this case the charge

nurse will assign the nurse the patient, tell them what room or bed the patient is in, and hand them the patient's chart.

On some days, nurses are assigned to be primary or secondary nurses for the trauma rooms. When a trauma case arrives, the secondary nurse assists the primary nurse and usually only stays involved for part of the time that the patient is in the trauma room. The two nurses assigned to trauma are on call throughout their shift for any patient that comes into the ER with a serious enough condition to be admitted to the trauma room. Patients admitted into could have symptoms ranging from a gunshot wound to high blood pressure. The trauma nurses can be called away from their own patients at any point to respond to a trauma case. The most typical way that the trauma nurses hear about trauma cases is when EMTs call in to notify the ER of their arrival; these calls come in through an intercom located in the center of the work station. When the trauma nurse is called into the trauma room, another nurse, whom the charge nurse designates, is temporarily responsible for that nurses' patients.

For all nurses except the charge nurse, the day usually begins with the assignment of patients. When nurses are assigned new patients, they usually begin by checking the patient's chart, which has demographic information and the assessment that was made when they were admitted to the hospital. If other nurses and doctors have already seen the patient, it will also contain their notes and list all of the treatments that the patient has received with the signature of the person who authorized the treatment (usually a doctor) and the person that performed the treatment (usually a nurse). The nurse will look to see if there is anything outstanding that needs to be done and bring the necessary supplies into the room. They usually introduce themselves to the patient, ask the patient questions

about their condition and their past medical history. The nurse will then do things like take vital signs, set up an I.V.⁸, administering medication, drawing blood, and ordering or performing tests and x-rays prescribed by the doctor. This may involve several trips to the supply closet, finding a spare machine to take vital signs or an EKG machine⁹, checking in with a doctor about the medication prescribed, inputting requests for lab work or prescriptions into the computer. Once they have completed their assessment of the patient, a nurse may ask an EMT to assist with taking vital signs, putting in orders, or taking blood work. Some nurses are more comfortable delegating tasks to the EMT than others; also depending on how many EMTs are working in a shift, their availability to assist nurses varies. Sometimes patients call nurses for water, a bedpan, or for update on their condition. Nurses sometimes make conversation and joke with them. If they have time, they write up notes in the patient's chart, recording everything that they did, who authorized it, and pertinent observations about the condition of the patient. Usually however, they save notes for after all of their patients have been seen at least once. While they are typing notes, the charge nurse may assign them a new patient, a doctor may interrupt to speak to them about a patient, an EMT may update them on a task they performed or alert them to a new situation with the patient, and other nurses may ask for help finding something or the answer to a technical question, or lean in for a "how are you?" or to tell a story about their day. Since nurses write their notes in open spaces, there are many opportunities for interruptions.

⁸ An IV is "an apparatus used to administer a fluid (as of medication, blood, or nutrients) intravenously". (Source: Medline Plus, U.S. National Library of Medicine and Merriam-Webster; accessed at <http://www2.merriam-webster.com/cgi-bin/mwmednlm?book=Medical&va=IV>)

⁹ The EKG is also called an electrocardiogram and it "is a test that records the electrical activity of the heart.". (Source: Medline Plus, U.S. National Library of Medicine; accessed at: <http://www.nlm.nih.gov/medlineplus/ency/article/003868.htm>)

At eleven, twelve, and one o'clock about two or three nurses take their lunch break at the same time. The charge nurse makes lunch schedules and assigns each nurse's patients to other nurses while they are at lunch. Many nurses explained that this system rarely works this smoothly. Most of the time nurses asked other nurses to cover their patients before they took their lunch break. Some nurses told me that tried to leave their patients in a place where they could be left alone for an hour while they were at lunch. At about two o'clock, nurses were usually typing up or writing notes for their patient's chart. The shift ends at four o'clock and usually at about quarter of they begin reporting to the next shift of nurses about their patients.

After observing nurses during their workdays for ten weeks, I analyzed my data and found that time management was an important feature of how nurses created boundaries between one another. In the following section I will discuss my findings.

Chapter 4: Findings

Using data collected from observations in the emergency room and interviews with registered nurses (RN), I found that there is considerable boundary work among a group of registered nurses. I will argue that time management, being productive while balancing work and breaks well, was important to being a good nurse. Time management can be conceived of as a cultural repertoire, one of the cultural tools or rhetorics, that was available to ER nurses (Gieryn 1983; Lamont 2000). Rather than being a claim about formal skill or knowledge of nurses, it was more of a moral claim about nurses and their work. I will also argue that ER nurses used the moral claim of time management as a way to distinguish themselves as better nurses. Although being busy was recognized by most nurses as significant, nurses performed boundary work using busyness differently depending on their status in the ER.

Before explaining my findings, it is worth mentioning some of the other boundaries that were present in the ER and that I think intervened with the boundary work of time management that I elaborate further on in this section. As others have documented, there were powerful occupational as well as racial and ethnic divisions in the emergency room (Allen 2001; Lamont 2000; Vallas 2000, 2003). One of the more obvious ways that occupation was a boundary is that it was boldly marked with the colors of workers' uniforms. In this sense, the boundaries between the EMT, the nurse, the doctor, the physician's assistant, and the patient were fairly clear just by looking around the room. On my first day observing, a nurse explained to me how the ER is organized using these colors.

Fodor starts by telling me the color-coding of uniforms. She tells me that Turquoise is transport; they transport people around and things. Blue is

Registered nurses. Burgundy, which I did not see anyone wearing at that particular time, are nursing assistants. White, is for doctors, she smiled when she said that and moved her eyes up as if to suggest that it was obvious. She then said that short coats are students and long coats are doctors.

Just by looking around the room, one could get a sense that what occupation one belonged to mattered. The uniform colors were set by higher level hospital administrators and were one of several ways that occupational groups were distinguished from one another. Although these uniforms provided a good indicator of which workers where part of with occupational group, they sometimes betrayed me as an observer. In one instance I mistook a young nurse who I observed for a medical student because she was wearing a pair of faded green hospital scrubs instead of the bright blue nursing uniforms and she was laughing with a medical student. Even though there were some clear rules about the organization of occupational groups in the ER, it was not always clear what everyone's position was and these boundaries needed some clarification for outsiders. Patients, for example, frequently confused EMT for nurses and physicians assistants for doctors. For the workers, however, this boundary was probably more static.

Race and ethnicity was also something that organized nurses during lunch breaks and in some cases, even in how and where they worked on a given day. Even though the emergency room staff was mostly Black and Asian, race and ethnicity are still a rigid boundary. I deliberately chose to study at an ER that was more racially homogenous to attenuate the role of race and ethnicity¹⁰. It turned out that that the ER was still organized along the lines of ethnicity and race (Waters 1999). Ethiopians, Asians, West Indians, and African American take breaks separately; they organize around the work station and chat together; they introduced me to one another. In interviews, nurses spoke

¹⁰ Initially I wanted to study the boundaries between native-born and foreign-born Blacks. This influenced the site that I selected.

of cliques and tensions between racial and ethnic groups. Ms. Peterson, the African American clinical nurse manager, explained it to me early in the interview:

You know the cliques, you notice that they break up into cliques on their own time. I don't think it should be that way. We should all be able to work together. At times it causes problems. We've had conflict after conflict over this clique thing. . . our primary problem was [that everyone was saying] "You all are playing favoritisms with the Filipinos." . . . I have to call in every night to do the schedule . . . now we have to take time out in the schedule to break them up, to make it fair. You still find that if you get one of them to do the assignment [the favoritism happens again]

Ms. Peterson describes to me some of the tensions between ER nurses along racial and ethnic lines. When I asked her to tell me more about the Ethiopian clique, Ms. Peterson look at me hesitantly and burst out with a laugh, "You're not Ethiopian, are you?" We exchanged a hearty laugh about this, but her response indicated how dynamic boundaries can be and that they sometimes need to be confirmed in interactions. In this joke, she also let me know how anxious she felt about these racial and ethnic boundaries.

Despite the presence of these other boundaries, time management was an important way that nurses made distinctions between themselves and other nurses during the workday. Even in cases where there was a great deal of cohesion between nurses, these boundary work based on time management was dynamic and had an important impact on the way that nurses handled their workload.

Time Management in the ER

Given the increasing push for efficiency in health care institutions and the fast-paced environment of the ER (McCaig 2006; Meyer 1992; Robinson, Jagim, and Ray 2005; Schneider, Gallery, and Schafermer 2003), that time management is an important cultural repertoire of the emergency room nurses is not surprising. With nurses being asked to juggle many tasks, including attending to patients and what one nurse described

to me as “giving that tender loving care to the paperwork”, being a busy nurse while still doing the job well is highly valued (Allen 2002). In the ER, time management involves being busy and making good decisions about managing this busy-ness, such as deciding which tasks to complete first and how to take necessary time off during lunch breaks and the end of the work shift. Time management is very important in the ER and was recognized by most nurses and nurse administrators to be essential to being a good nurse. Time management is one of the repertoires that ER nurses had available to them to demonstrate that they were "a good nurse".

In conversations and interviews, nurses spoke about their concerns about completing paperwork adequately¹¹ and how this limited the amount of time they could spend with patients. As other studies of nurses have demonstrated, a major tension in nursing is balancing patient care and required administrative work (Allen 2002). An interaction between a senior nurse, Fletcher-Roy, and a nurse still in his training period, Addis, illustrates the importance of balancing the arena of patient care and administrative work.

Fletcher-Roy, a sixty-something year old woman from Trinidad, is a senior nurse and it is evident in the way she moves around the ER. When she finds something that displeases her, she crinkles her nose and squints her eyes and asks question brusquely - “What is that?” and “What are you doing?”. Fletcher-Roy has been practicing nursing for over forty years and it is rumored that she was originally studying to be a doctor and then switched to nursing. Almost all of the nurses that I spoke with mentioned that

¹¹ Completing paperwork involved documenting all of the task that a nurse completed. This involved creating a record of patient’s treatment that met the guidelines of high-quality care. If a nurse failed to perform a standard procedure, or failed to record it in their notes, this could be grounds for losing one’s nursing certification.

Fletcher-Roy is a very knowledgeable nurse. She has a forceful presence in the ER and when she is in the work station she could be heard speaking loudly to another nurse or a patient.

Addis, on the other and, is a junior nurse about twenty years younger than Fletcher-Roy and lacking admiration from his colleagues. In his forties, he began studying nursing when he migrated to the U.S. from Ethiopia as a way out of working as a security guard. Although he is a junior nurse, Addis also has an air of seniority in that he does not seem concerned with the opinions of others. Other new nurses expressed a great deal of concern about their progress and how they were “catching on”. While he does not yell at patients, he airs on being neglectful and acts as though nothing bothers him.

On an afternoon when there was a steady flow of patients, Addis was attending to a patient in severe pain from his sickle-cell disease when a young African American man approached him in the supply closet with a small baby on his left hip. The two year old boy, who is accompanied by his parents, is Addis’ patient. His parents, having spent the entire night at the ER, are anxious to leave. The father, a young African American man, approaches Addis and explains to him politely that his baby is fussing about his IV and asks Addis if he can remove the IV for them. Addis says “sure” and tells him that he will be by soon to take care of this. After obtaining the rest of the supplies from the supply closet, Addis returns to the sickle-cell patient to give him an injection that will ease his pain. About twenty minutes later, he sits down at a computer in the work station. While there, he asks Fletcher-Roy about where he can find a function on the computer. She tells him where it is located, he continues entering information into the computer, and then

about ten minutes later he picks up his cell phone and places it on his ear. At this point about 30 minutes have passed and both of the parents of the little boy walk to the receptionist's station to ask again for assistance in removing the baby's IV. At this point the receptionist approaches Mary, the charge nurse, and they both shuffle papers around to look up the patient and figure out which nurse is responsible for the patient. Once they determine that it is Addis' patient, the following happens:

The receptionist asks Addis, who is staring at his computer screen and has just hung up his cell phone, whether those patients are being discharged. He says yes and that he is going to discharge them. Mary comes over to him and tells him nicely that they need to have the IV removed from the baby. He says "okay". Mary walks away and [Addis] remains sitting at his computer. Ms. Fletcher-Roy walks over to where he is sitting and leans over the computer desk. She says seriously while peering down on him, "[Addis], time management. You can write your notes later. Take care of the patient first". "Yes ma'am" he replies in a flat tone, while continuing to look at the computer screen. He gets up in about 30 seconds and heads over to the patient's room. Ms. Fletcher-Roy is shaking her head in disapproval.

In this instance, Fletcher-Roy reprimands Addis while explaining to him the importance of time management. While other nurses expressed frustration about Addis being lazy and at times they would inquire about whether he was keeping up with his patients, it was perhaps due to Fletcher-Roy's harsh personality and Addis' position as a new nurse, that she confronted Addis so directly about the issue of time management. It was not common for nurses to question the time management of other nurses in such a direct and condescending manner. Nor was it common for nurses to remind other nurses about the tasks that needed to be done. Nevertheless, this situation expresses the importance of time management as a responsibility of a nurse and some of the consequences of making poor judgments about time management. In this case, the consequence was having the patient approach the receptionist to ask for help.

In the previous example, time management was conveyed from a senior nurse to

one that is less experienced. Another instance in which time management is explained to a nurse explicitly is in an interaction between Monica and Mrs. Harris, the Director of the ER. Mrs. Harris makes the connection between the time management of individual nurses and the running of the organization quite clear.

Mrs. Harris is the Director of the ER, which means that she handles the administration of the emergency room. She is usually in meetings most of the day, but appears in the ER once or twice during the day shift. Mrs. Harris wears a long white coat with two pens clipped to her right side pocket and carries a folder of papers with her at all times. She is friendly, but also serious and very “down-to-business”. Monica is a young African American nurse that has a short trendy hair cut with a blonde streak in the front. One afternoon at a quarter to four, Monica approaches the charge nurse, Betty, who is a middle-aged African American nurse, about taking her lunch break. Since lunch breaks are scheduled for 11, 12, and 1 o’clock, Monica is both asking for permission to take her break and also complaining about not having had the opportunity to take it earlier.

[Monica] walks up to Betty, the African American charge nurse and speaks to her in a whiny voice about needing to take a break. It is now 4pm and the next shift of nurses is arriving. Betty looks up from her papers and begins telling Monica that she cannot go on her break until Agil returns from her break. She ends by saying, “there are rules here”. Suddenly Mrs. Harris [the director] walks up to the front of the line of computers and stands with her hands on her hip[s]. She begins to give a speech. The nurses standing nearby quiet down and she tells Monica, “The bottom of every ER in America would fall at 4pm, if everyone took their lunch break“. She lectures her about the importance of taking a break earlier in the day and finding someone to cover her. Monica’s face looks serious and she is quiet. When Ms. Harris finishes, Monica nods and walks away . . .

In this instance, Ms. Harris reprimands Monica and links her own time management with the running of the entire emergency room. While Monica’s request to take her lunch break at four o’ clock implies that she has been busy, too busy to take her lunch during the standard time, since other nurses view this as being a case of poor time management,

her claim to being busy is not addressed. Not taking ones lunch break on time is one way for a nurse to demonstrate that they are busy, but other nurses and administrators frowned upon it. As Mrs. Harris makes clear in her lecture to Monica, managing ones time well is crucial for nurses.

The importance of time management was not simply a mandate that came from above, from an administrator like Mrs. Harris that was responsible for the smooth running of the ER, it was also an issue that came up among nurses that worked together as peers. An example of two nurses that are peers in the ER is Bebi and Mita. Bebi is an Ethiopian woman in her mid-thirties who recently completed her certification to be a registered nurse after being an emergency medical technician (EMT) for eight years. Bebi is energetic, has a contagious giggle, and by eleven in the morning her face is usually glistening with a hint of perspiration. Mita, who wears a more serious expression and looks a bit older than her 25 years, just completed nursing school after obtaining a B.A. in Psychology. Throughout the day Bebi and Mita get together, at the computer station, in the supply closet, and during lunch breaks which they try to coordinate at the same time each day. If someone is looking for Mita, they will ask Bebi or vice versa. They talk to one another regularly in English and sometimes in their native language, Amharic¹². When I ask Bebi which nurses she can trust, she names Mita first and explains that they all attended the same nursing school. Overall they are close friends in the workplace. In their exchanges, Bebi frequently mentioned the importance of time management to Mita. In the example below, Bebi reprimands Mita for not taking her lunch on time.

While she is writing up her notes, Bebi says to Mita, “I am leaving on time

¹² Amharic is the official language of Ethiopia, where Mita and Bebi were both born.

today”. Mita gives her a weak nod, but does not say anything. In a few seconds, she says, “I have a headache”. Bebi tells her, “You need to take lunch . . . you will learn.” She looks over at me and says, “When its your time, you have to leave. No one is going to tell you to take lunch”. Mita nods weakly.

In times when Mita was not ready to leave, which happened once or twice a week, this exchange was typical. Bebi frequently announced to Mita when she was leaving or taking her lunch. This was in part because they tried to coordinate the same lunch break and if they left at the same time they also walked to their cars together. If Mita was not ready to leave, Bebi would usually give her a short lecture about leaving on time or give her a disapproving glance. The difference in how they approached the end of the day was so dramatic that usually around the end of the day, Bebi had rising excitement about leaving while Mita looked increasingly forlorn. One day at about four o’ clock an incoming nurse asked Bebi why she looked so happy and Bebi replied, “because I’m leaving”. Bebi frequently spoke aloud about leaving on time. When she talks about Mita’s failure to leave on time, she does not attribute it to busyness, but rather to Mita’s inability to manage her time well, something that she must “learn”. Even among ER nurses that are peers, there was significant attention to how well one managed their time.

While balancing ones time is important, it is also very closely tied to being busy. Despite Bebi’s emphasis on leaving on time, she tells me in my interview that she rarely leaves on time because it is so busy in the ER. She explains to me how busy it gets in the ER and asks me, “Have you *ever* seen me leave on time?”. Bebi’s comment to me demonstrates the way that time management itself is a balance between emphasizing busyness and demonstrating the ability to handle that busyness. This example also demonstrates the variation in the moral claims that people make and how these moral claims manifest in the workplace. Boundaries are about ways of distinguishing oneself

and they may not be consistent or even related to behavior in a precise way (Gieryn 1983). Since Bebi thinks about herself as being hardworking, she may talk about herself in ways that exemplify the characteristics of a hardworking person, even if those are not necessarily consistent with all of the ways that she performs hard work in the workplace.

Among ER nurses, time management, was central to being a good nurse. How one managed their time was perceived as important to the running of the hospital and for the individual. Sometimes nurses emphasized their own time management as a way to distinguish themselves from other nurses. While not managing one's time well had serious consequences for the hospital as a whole, nurses often spoke about their own state of busyness as being independent from the hospital.

Time Management as Boundary Work

Nurses used time management to distinguish themselves as exceptional nurses. In other words, nurses used time management to perform boundary work that distinguished them from other nurses. Describing oneself as being busy is a form of boundary work, it is used to demonstrate similarity and difference between nurses. The way that nurses drew boundaries using this important feature of being a good nurse is by establishing themselves as being more busy or more in demand than others.

The emergency room is a fast-paced environment, yet nurses sometimes shrugged this off when I asked them about what it was like working there. Instead, nurses minimized the pace of the ER in general, while highlighting the intensity of their own workload. This means that sometimes nurses are busy even when they tell me that the ER is not very busy.

In the first example that I provide, a conversation between Jessica and Karen,

being busy was used to demonstrate similarity between two nurses. Jessica is a thirty year old nurse with a full-figure and curly hair that she wears pulled back at her nape. She works at Grawley Hospital as a “travel nurse,” which means that she works on contracts lasting three months or more in various hospitals in the U.S. After attending Duke and obtaining a bachelor’s in business, she started a career in marketing, and then left to pursue a nursing degree. Jessica talks about entering nursing because she enjoys taking care of people and likes it that she’s “not sitting in an office all day”. Overall she thinks that nursing is something that she is good at. One way that Jessica talks about herself as being a good nurse is by describing herself as being very busy.

On the Monday of Memorial Day, I shadowed Jessica for the first time. When I asked her about whether the weekend was busy, she explained to me while writing up some notes on a patient’s chart that it was not busy because the CT scanner¹³, a machine that is used to deal with all neurological issues, was broken. Jessica explained to me that this meant they were not getting the usual drunk patients. Grawley Hospital had a reputation among many nurses as being the local hospital where all of the drunks, homeless, prostitutes, and drug addicts were sent¹⁴. She concluded her explanation of the consequences of the broken CT scanner by saying, “It’s not busy, but I am”. She then explained that she had three patients with critically high blood pressure. One patient, a fifty-something year old woman named Ms. Johnson, had a blood pressure reading of 229

¹³ CT scan is computed tomography, which is “a diagnostic procedure that uses special X-ray equipment to create cross-sectional pictures of your body. CT images are produced using X-ray technology and powerful computers.” (Source: Medline Plus, U.S. National Library of Medicine; accessed at <http://www.nlm.nih.gov/medlineplus/ctscans.html>)

¹⁴ Nurses spoke frequently about this. One of the most notable examples happened after a code, an announcement over the intercom of an incoming trauma case, alerting the emergency room staff that here was a patient with the contagious skin virus, Herpes, arriving shortly. A nurse practitioner made the following comment:

An African American nurse practitioner commented “send them *all* to Grawley” and shook her head disapprovingly.

over 140¹⁵ and was bleeding heavily from her nose, which Jessica explained was likely due to her high blood pressure. Despite attempts to slow the bleeding by giving Ms. Johnson medication to lower her blood pressure, the patient continued bleeding profusely and came close to passing out. A doctor and resident specializing in ear, nose, and throat issues treated the patient with an inhalant¹⁶ and a “nose bleed kit” containing gauze to block the bleeding. At the end of these procedures, the floor, side table, and bed sheets were covered in the patient’s blood. Christina cleaned up the room and assisted Ms. Johnson with using her bedpan. All of this required a great deal of running around to retrieve supplies, clean up the room, and assist the patient. During this time, she also juggled her other patients, visiting as she could. With every new activity, the backlog of notes that needed to be written up in the patient’s chart grew longer and longer. The entire time that I shadowed her, Jessica did have a number of tasks to juggle. So while it is the case that Jessica and other nurses *are* busy, being busy is also something that Jessica ascribes to herself independently of the attributes of other nurses. It is well documented that hospitals are understaffed for nurses and nurses are assigned more patients than what quality standards deem optimal (Robinson, Jagim, and Ray 2005; Schneider, Gallery, and Schafermer 2003), yet Jessica still talks about being busy as something that is unique to her own situation. This is what makes being busy a way that nurses do boundary work to differentiate themselves as better nurses than others. Being busy is both a reality of the work life of ER nurses and a tool that they use to set themselves apart from other ER nurses. Busyness, like all types of boundary work, is a product of the structure of the workplace and the goals of workers in positioning

¹⁵ The normal range for blood pressure is at or lower than 120 over 80. (Source: Medline Plus, U.S. National Library of Medicine, accessed at <http://www.nlm.nih.gov/medlineplus/highbloodpressure.html>)

¹⁶ An inhalant is a medication that is inhaled through the nose.

themselves relative to others. Boundaries drawn based on busyness are about the fast-paced environment of the ER and the demands placed on nurses to juggle multiple tasks as well as the competition for higher status among nurses. Thus as Lamont suggests, boundary work is result of structural conditions and available repertoires that people have to evaluate their own status (2000). The way that ER nurses talk about being busy is both about their jobs and their own positioning of themselves relative to their coworkers. Since workers compete for resources, like promotions or preferential treatment, distinguishing oneself as a better worker is important in the workplace.

Being busy was not only a way of explaining her situation on that day, it was also a way that Jessica spoke about herself and nurses that she perceived to be similar to herself. Once Mrs. Johnson's nose bleed slowed down, Jessica attended to other patients and sat down to write her notes. At this point she introduced me to her friend Karen and explained to me that they worked together in their previous job and had jointly decided to take this contract position at Grawley Hospital. She introduced me to Karen as Karen was entering a patient's room. She told me that Karen was as busy as she was, and then added after a moment "maybe even busier". She then she recommended that I shadow Karen if I had the chance. She explained: "She's a great nurse. She *attracts* trauma". When Jessica made this last statement, Karen smiled broadly and nodded proudly in agreement as if to say proudly, "Karen that attracts trauma at your service". The way that Jessica let me know that Karen was a good person to learn from is by comparing her to herself in terms of how busy she is. Being busy, in this sense, is one sign of a good nurse. It certainly is one way that Jessica distinguishes Karen and herself from other nurses. To say that she "attracts trauma" gets at the way that more work befalls good

nurses. Being busy is not only about seeking out more work, but also about having more work assigned to you. Since most of the work in the ER is assigned: either by the charge nurse, who assigns patients to nurses during the shift or temporarily during another nurses' lunch break or by a nurse asking another nurse for assistance in completing one of her tasks or to answer a question. Being busy is about being in demand by ones coworkers. Thus boundary work is heavily interactional; it emerges via one's interactions with other nurses; it is not simply a fixed boundary between occupations.

In addition to talking about herself as busy, Jessica also compares herself to a nurse she admires, also someone who is always busy. In this way, she demonstrates similarity with a more senior nurse and herself. There were also instances where being busy was used to distinguish nurses from other nurses. Jessica implies this when she tells me, "It's not busy, but I am" because she is comparing herself to the hospital as a whole, and presumably other nurses. Sometimes this comparison between the busy and the less busy was more explicit.

Since one measure of busyness was the number of patients a nurse had at one time, since the beginning of their shift, or during an entire shift, it was a common ritual for some nurses was to count the number of patients they had. I introduce an example of one time that this happened between Mita and Bebi in order to illustrate how busyness was used to distinguish nurses from one another. What is interesting about this example is that even though busyness is used to distinguish Mita and Bebi, there were also ways that they were a cohesive group, they shared lunches together, they spoke to one another in Amharic, and they spoke about attending nursing school together, and made references to both being Ethiopian. In this sense, the boundary they share is fairly dynamic,

sometimes being one of similarity and other times of difference, continually created in interactions. In contrast to other studies that depict occupational groups as a unified group, my findings suggest that there are boundaries within groups and that they are dynamic and created in daily interactions.

Interactions between Bebi and Mita demonstrate how dynamic boundaries can be. As I explained earlier, Bebi and Mita are close friends in the workplace. In their relationship, however, there are also boundaries, one of which is based on time management. Bebi prides herself on being able to handle more work than most nurses and frequently compares herself to Mita during their regular conversations. In this case Bebi uses it to differentiate between the two of them, it is a division.

The first time that I shadowed Bebi, I noticed her high level of energy, which she frequently described as “I’m always crazy”. On this first day she expressed to me that she was particularly busy and that it was because she was in high demand.

I followed her into the supply room and asked, “Is it busy today?” She exhaled a breathe and replied, “Not really but today everybody is calling my name”. . . . When we walked out of the supply closet, we encountered a woman dressed in a hospital robe stood holding a tray of food. A charge nurse said, “Bebi, can you ask this woman to sit down”. Bebi gave me a knowing look, “See . . . everybody is calling my name today,” she said as she raised her eyebrows for emphasis. Bebi walked up to the patient and lightly touched her elbow; she said sternly, “Ma’am, please have a seat over there while you are eating”. The woman flinched but did not move. Bebi repeated herself, waited a few minutes, and then shook her head and walked away. . . .

In this case, Bebi is frustrated and conveys to me that she is in high demand in the ER.

She does not credit her workload to the pace of the emergency room in general, but rather to the demands that others are placing on her. Similar to Karen who “attracts trauma,” Bebi describes herself as a nurse that is in high demand at work. Being in high demand means that Bebi has more work than she might otherwise have with her own

patients. This is independent of how busy the hospital is and is more about how Bebi sees her role in the workplace.

Just as Jessica told me about her caseload, it was common for newer nurses to announce the number of patients that they have in conversation with one another. Counting patients is a ritual that Bebi and Mita participated in frequently. Despite having attended nursing school together, Mita was in her early twenties and entering her first profession while Bebi had spent eight years working in the emergency room as an EMT and described herself to a patient as having been a nurse for “a long time”. Bebi performed considerable boundary work that demonstrated her skill in handling a larger caseload than Mita. One way that Bebi expressed superiority in handling a full caseload was through frequently counting her patients. The nurses that I interviewed told me that four patients is a full workload for an ER nurse (Robinson, Jagim, and Ray 2005; Schneider, Gallery, and Schafermer 2003), but that nurses frequently had more than four patients at once. It was common for Bebi to announce how many patients she had in front of Mita and then for Mita to respond with surprise.

When Bebi is in the supply closet, she says to Mita, “I have 5 patients.” Mita says, “five?” surprised. Bebi nods and says “yup” then she continues to grab items from the supply room. Mita responds with enthusiastic surprise and frequently, although not in this case, she would announce the number of patients she had. These exchanges were meant to demonstrate how busy Bebi was during the day. They also served to compare the workload of Bebi and Mita.

This practice of counting patients varied considerably depending on the nurses involved. An interaction between Bebi, Mita, and Jones illustrate this point. Jones, who has been a nurse for 14 years, has decided to work as a contractor to make a higher

salary. Grawley Hospital recently fired all of their per diem workers in an effort to cut costs, but Jones is one of the two nurses that were kept. She also acts as a preceptor, someone who trains new nurses when they first arrive in the ER. Bebi announces the number of patient's that she has had throughout the day in the break room while she is with Mita, her peer, and a more seasoned nurse, Jones.

Bebi says, "I've had 11 patients if they didn't notice." Jones repeats her, "eleven" and her eyes open wide in surprise. [Bebi] then opens the small notepad where she keeps [identification] stickers for each patient she takes each day. She has four pages worth of stickers. Mita checks her book, and says, "I've had 4 four". In this case, Bebi reveals her caseload to two nurses, but only Mita responds by telling her their caseload. Jones expresses surprise, but does not share her caseload with Bebi. As a more senior nurse, Jones does not need to talk about her workload to less senior nurses. Instead she is sympathetic listener while Mita responds by revealing how many patients she has had that day. The different status of Jones and Mita contributes to the differences in the boundary work that they perform. It may be that boundary work is more important in cases were nurse are in closer competition with one another. In the case of Jones, a senior nurse working as a contract employee, competing with two newer nurses may not be as important.

Especially among more senior nurses, being busy was not the only boundary work that nurses performed. They also used boundary work based on skill or knowledge. Many nurses differentiated themselves as caring nurses who were committed to their patients. Others distinguished themselves based on technical skills, like being able to start an IV line or knowing the correct way to administer drugs. This type of boundary work was most commonly mentioned in interviews. The most prevalent boundary work that nurses performed during the workday was being busy. Other nurses did not view

nurses that they thought violated principles of good time management positively.

Although being busy was important for most nurses, there were some exceptions. One of the most glaring exceptions was Addis, an Ethiopian male nurse. Addis was known by other nurses as being lazy and as a result nurses looked down upon him. Jones, a senior nurse, explained to me that she felt that she could talk down to Addis because he would not be bothered by it:

I am the helper . . . So everybody have their own little role that they play. . . [Addis] on the other hand, you know he is lazy and he can take an insult and he wont get upset. . . [Addis], “Oh [Addis] don’t even know what he doing” and Addis won’t yell or anything at you.

In this case Jones expresses that Addis is a lazy nurse and she also demonstrates that she does not have much respect for him. While she does use other ways to characterize nurses, how productive they are is an important feature of how she talks about nurses.

So while being busy was not the only criteria used, it was an important one. Nurses used time management as a way to talk about how they were a good nurse. While time management was an important repertoire of ER nursing, nurse spoke about time management as something that was unique to them and that distinguished them from other nurses. It was used in some cases to demonstrate similarity between nurses and in other cases to demonstrate difference. Boundaries are dynamic and in some cases performing one’s busyness created a tension among nurses that otherwise performed boundary work to demonstrate their similarities. As the exchange between Bebi, Mita, and Jones demonstrates, boundary work also varied depending on who is performing it. I will elaborate on this in the following section.

Being Busy in its Different Forms

As I stated earlier, making claims about being busy is not just about the fast-pace

of the ER. It is a way that nurses demonstrate how good of a nurse they are and being a better worker gives one some power in the workplace. Better workers may be more likely to get promoted and receive more favorable treatment. Yet not all nurses performed busyness in the same way or as convincingly. The variation in how busyness is performed demonstrates the importance of the interaction in shaping the boundary work that nurses can perform.

As one would expect, being busy is important even for those nurses that are not in high demand like Bebi or have a large workload like Jessica. Tenesha, a nurse that has been working in the ER for a year and describes herself as “not catching on as quickly as [she] should,” also understands the importance of being busy in the ER. Tenesha is an African American woman in her mid-twenties with a friendly and open face. She recently graduated from nursing school and told me in an informal conversation she told me that she is considering getting a master’s in public health in order to move into a different field. When I asked Tenesha if I could shadow her, she warned me numerous times that she was probably not the best person. She then added that she thought Mrs. Harris, the Director, might not want me to shadow her because she is not very experienced. After convincing her that I was not only shadowing senior nurses, she continued to tell me about how much she was “behind” from where she should be. In an interview she confided in me that Ms. Harris, the Director, had approached her with concerns about her performance as a nurse. She explained to me that she was trying to catch up by researching medications when she went home each day. This is something that newer and senior nurses talked to me about doing. While I was sitting with her at the work station computers, she opened up a pocket-sized yellow book that she called her

“drug book” and began explaining to me about the use of a drug that a doctor prescribed for her patient. Even while looking through this book to learn more about a medication she is prescribing, Tenesha is conscious of the importance of looking legitimately busy while in such a public space.

[Tenesha is] at the computer station . . . she looks up a narcotic drug in her drug book. After flipping through the book for a couple of minutes, she tells me she wants to look busy and better get up before she gets another patient. We then walk over to her trauma one patient’s room.

Even as she is explaining to me her attempts to improve her knowledge base, Tenesha is also aware of the importance of being busy in the workplace. In this scene Tenesha just had one patient and does not talk about being busy, she does express the desire to appear busy. She does not want people to think that she is idle. Tenesha reveals one way that she performs being busy, by staying out of sight of other nurses. In this case she wanted to appear busy to avoid getting more work. This situation demonstrates that even for those nurses that are not talking regularly about being busy, there is recognition that being busy is important. Some of the things that Tenesha does to appear busy may be different from other nurses. Also, being busy has a more central role than looking studious or informed in this context.

Although most nurses recognized the importance of busyness and tried to use it to gain leverage in the workplace, nurses used it differently. In a conversation about workload between Tenesha and Bebi, it is evident that not all nurses perform busyness the same way. Like in the example of counting patients, being able to claim that one is busy is something that nurses compete for. Not all exchanges about workload are as subtle as the one between Mita, Bebi, and Jones in the break room. Sometimes nurses will compete more overtly about their workload. In these instances, it is even more

obvious how the status of nurses contributes to the way that they interact. In a conversation with Tenesha, Bebi takes a stronger stance on asserting that her own workload is heavier than most. Tenesha has been an RN for a year and also attended the same nursing school as Mita and Bebi. Bebi mentions Tenesha as the other nurse that she feels she can trust when I ask her about this in an interview. Still, their relationship appears to be less close; they spend less time together than Bebi and Mita. One afternoon Tenesha struck up a conversation with Bebi about her workload on a previous weekend.

I had 6 patients all by myself, she told her. Bebi replied blandly by telling her that she had six patients today. Tenesha said, “really” and then added that this was with “no help”. She didn’t have anyone to help her, she told her. Bebi replied that she always had six patients with no help. Tenesha was quiet. They kept on typing on their computers.

In this exchange, Tenesha tries to talk about how busy she was this previous weekend and Bebi dismisses her claim that she was busy by comparing the workload her own. The status of Tenesha, a nurse who has been an RN in the ER for longer, but is not progressing as is expected in the department, is more tenuous than that of Bebi. Tenesha is not able to use being busy to assert herself as a good nurse. As this case demonstrates, busy-ness as a boundary work does not always believable for all nurses (Goffman 1959). Tenesha is not able to create a credible story for Bebi about being busy the previous weekend. So even though she counts her patients for Bebi, she is not able to use it to demonstrate her value as a nurse. Instead Bebi dismisses her claim and asserts her own busyness in its place. Some argue that conflict between workers is uncommon in workplace interactions (Abbott 1988) and that workers resolve many of these conflicts through negotiations that are not face-to-face (Allen 1997). Perhaps because of the similarity of the tasks that they perform, nurses did perform boundary work during the

workday.

In the case of Tenesha, a nurse with a tenuous position in the ER, she demonstrates that she is busy by moving around and by recounting a story to Bebi. For more senior nurses, being busy seemed to be less of an explicit performance. Jones explained to me that she likes to think about herself as being “somewhere in between”. For Fletcher-Roy, a senior nurse, being busy did not involve counting patients or moving around very quickly. Fletcher-Roy has been a nurse for 40 years and every nurse that I spoke with described her as being a very competent and knowledgeable nurse. They also described her as being abrasive, which some nurses justified her abrasiveness by talking about her skills as a nurse. The following scenario provides a sample of Fletcher-Roy’s abrasive attitude, but more importantly, the way that she uses claims to busyness and managing her time. Occasionally nurses will have a patient where it is very difficult to “get a vein,” which means that they have difficulty starting an IV. This happened one day that I was shadowing Bebi; after “sticking” the patient with the needle two times, Bebi decided to get someone to help her with the patient. The following situation occurred when Bebi went looking for help.

[Bebi] goes to nurse Ms. Peterson, who is standing near the receptionists desk, and asks her if she can help her put in an IV. “I can do it,” she says. As she starts to ask her where the pt is. . . Bebi notices Ms. Fletcher-Roy beside her. [Bebi] looks from [nurse] to [nurse] . . . She looks at Ms. Fletcher-Roy and says pleadingly, “Can you start an IV for me?”. Ms. Fletcher-Roy responds in a serious tone, “I can start anything, if I have the time”. Bebi looks defeated, turns to [Ms. Peterson] and asks her again if she can help her start the IV. [Ms. Peterson] says she can and asks where the pt is. Bebi points down the hallway toward Mrs. Nixon.

In this instance, Fletcher-Roy denies Bebi’s request for help using the claim that she does not have time. Although Bebi is offered assistance by Ms. Peterson, the clinical nurse manager that Bebi describes as being a “ghetto supervisor,” Bebi chooses to ask Fletcher-

Roy for her help also.

There is a striking difference in the response of Fletcher-Roy and Ms. Peterson to this request. Ms. Peterson immediately offers her help and then waits for Bebi to take her up on her offer while Fletcher-Roy refuses to help using the excuse that she is busy.

Fletcher-Roy uses being busy to assert considerable control over her workload.

The scene with Bebi, Ms. Peterson, and Fletcher-Roy also demonstrates that busy-ness is not about the actual tasks that one is performing. One does not have to be doing something in the moment in order to claim that they are busy, it is more a moral statement. For example, Ms. Holder Lewis says that she does not have time, but she is not running around. For nurses in lower positions, like Tenesha, being busy does involve moving around, at least out of the sight of others. Performing busy-ness that is believable, and therefore allows one the privileges of a busy person (deserving to take lunch on time; being able to say no to requests) means different things for different people. For those with less authority in the workplace, performing busy-ness is about moving around while for others it involves stating that one is busy.

Being busy was used by most nurses to distinguish themselves from other nurses, however, it had a different meaning for different nurses. The status of nurses greatly shaped how much other nurses accepted that they were busy and the ways that they used the claim that they were busy. Depending on their status in the workplace, nurses were able to use busy-ness in different ways. While most nurses recognized the importance of being busy and enacted it through what they said, their facial expression, and what they did, nurses utilized it differently. For some nurses it was a way to justify taking control over their break time, for others it influenced decisions to help other nurses, and for

others being busy meant missing breaks and being a “helper” to other nurses.

Some studies of workplaces tend to emphasize cultural boundaries, those based on skills and knowledge, in the workplace (Allen 1997, 2001; Tjora 2000; Vallas 2000). In a comparison between cultural and moral boundaries Vallas provides an explanation for this.

Although manual workers seem able to challenge some of the boundary work in which engineers engage (especially constructions of them as lazy or irresponsible), they are largely unable to challenge the legitimacy of the formal knowledge that engineers deploy. Once inscribed within the firm’s opportunity structures, such boundaries tend to institutionalize the privilege of credentialed employees” (Vallas 2000: 5).

I argue that moral boundaries, like being busy or lazy, are also formidable. It is possible that the relatively lower status of manual laborers in the manufacturing plant may be part of the reason that moral boundaries are less effective. Among nurses, possibly because they had similar training and job descriptions, using moral claims to create boundaries was common.

Although nurses recognized the importance of demonstrating that they had good time management, not nurses tried or were able to perform this boundary work the same way. In Tenesha’s case, counting patients was not an effective way to demonstrate her busyness to Bebi. For other nurses, due to their status, it was not necessary for them to perform busyness as actively. For Tenesha being busy involves moving out of a public space while for Fletcher-Roy it did not. The way that boundary work is performed varies considerably depending on the status of the person performing the boundary work.

Chapter 5: Conclusion

Within a group of nurses in a hospital emergency room, there are numerous ways that they distinguish between one another. Time management is an important aspect of ER nursing and nurses used claims of time management to distinguish between one another. Busy-ness was an important form of boundary work for the ER nurses that I observed. Nurses did not use time management uniformly. There was variation in how nurses performed busy-ness and what meaning it had in the context of their workday. The use of busyness may not have been as visible in a study of inter-occupational boundary work, between nurses and doctors for example, because of the institutionalized distinctions between people in these two occupational groups and the differences in the tasks that these groups are formally responsible for. The findings from this study of intra-occupational boundaries suggest that the concept of boundary work can be conceptualized as coming before the entities that they create. As Abbott suggests, we might think of boundaries creating entities. Intra-group relationships are an useful site to study how boundaries begin to create entities.

Previous occupational boundary studies demonstrate the negotiation of power among occupational groups. This process is continual and influences the running of the workplace. I argue that in order to better understand how power is negotiated in the workplace, we need a processual study of intra-occupational boundaries. Just as the boundary work between Bebi and Mita demonstrate, boundaries are dynamic and may sometimes be used to show similarity and other times to show difference. The nurses that I observed and interviewed clearly had groups that they were a part of during their leisure time in the workplace. Even among these groups members, however, boundaries were

dynamic. The work of distinguishing oneself and competing for resources happens between hierarchically arranged occupational groups and within those groups. Since occupational groups are a significant group in the workplace, understanding their internal dynamics is important to studies of workplaces. Occupational groups are the site for mobility and establishing reputation within the workplace. In fields such as nursing, where there is considerable team work and work practices are performed in public and visible spaces, examining how workers make boundaries during the workday may be more fruitful than in workplaces where workers do not work in such close proximity.

The concept of boundaries is useful for studying the tools that workers use to demonstrate their status in the workplace. By examining the way that dynamic way that workers perform boundary work, rather than the characteristics of workers themselves (Barth 1969), the multiple levels where power is negotiated become more visible. This study contributes to boundary studies by examining intra-group boundaries, a possible site for studying boundaries in the making. Secondly, this study examines the way that time management, a moral claim, is used and shapes workplace interactions. And finally, by examining the interplay between the various actors involved in boundary work, this studies viewing boundaries as being dynamic and subject to the position of the performer and the audience.

A future study of how the interplay between intra- and inter-occupational boundary work may yield interesting findings. A study of how the boundary work of nurses and doctors is informed by the boundary work among nurses for example.

Appendices

Appendix 1

Table 1. Participants in Study

Name	Native-born or Foreign-born	Position	Years in nursing	Years in related field	Age	Sex
Jones	Foreign	Per Diem RN	15	15	34	F
Bebi	Foreign	RN (training)	<1	8	37	F
Mita	Foreign	RN (training)	<1	<1	26	F
Ms. Peterson	Native	RN (supervisor)	5	20	44	F
Tenesha	Native	RN (training)	1	1	25	F
Addis	Foreign	RN (training)	<1	<1	34	M
Jessica	Native	Travel RN	2	2	29	F
Karen	Native	Travel RN	12	12	42	F

Appendix 2

Interview Guide – Short Version

First, I would like to know about what it is like for you being a nurse.
What is it like to be a nurse?

When did you first start thinking of yourself as a nurse?

What do you like the most about being a nurse?

Can you think of a day that was great?

What do you not like about being a nurse?

Can you think of a day that was a horrible day?

Next, I want to talk to you about what Makes a Good Nurse

When did you start thinking of yourself as a “nurse”?

In your opinion, what do you think it takes to do well in this job? / How did you get where you are in your job?

Can you think of a time that someday handled something in a way that was wrong?

Can you think of a time that someday handled something in a way that you admire?

In your X years as a nurse, what is the biggest change that you have noticed in the workplace?

Would you ever consider leaving nursing to do something else?

Next, I want to ask you about your daily routine and what it is like working with other professionals.

Besides Registered nurses, what other professionals/people do you work with?

Do you supervise anyone?

Can you think of a time when you were not around – what happens when you call in sick or are not around for some reason?

What have been your experiences working with aids? LPNs?

Can you think of a day when one of the people you supervise called in sick? What was that day like?

Do you ever do things that are outside of your job description? What are they?

If you were in charge of organizing the shifts when you work – put everyone on there that you wanted, who would you select to be on shift with you? (If you could pick doctors, nurses, and other staff to work closely with all/most of the time, who would they be?)

Why these people?

What are they like to work with?

Can you tell me a time that you worked with them in the past?

Who is an important person in your life?

If they were sent to this hospital/your workplace and you could not be there, who would you want to be on staff while he was staying at X hospital?

Who would you **not** want to take care of your <husband/friend/mom>?

(You are from another country and you work with Americans,) I know you work with people from different countries, do you think this changes how they approach nursing?

Are there ways that these differences come up, even in little ways, during the work shift?

Do people treat you like they don't trust you. Why do you think they do that?

Describe to me the last time this happened.

How did you know this was the reason?

Are there people you don't trust? Why is it that you don't trust them?

Do people treat you different from other workers because of your job position?

Describe to me the last time this happened.

How did you know this was the reason?

Do people treat you differently because of your skin color?

Describe to me the last time this happened.

How did you know this was the reason?

Are there any people that you feel inferior to?

In what ways?

When was the last time you felt this very strongly?

Who do you feel superior to?

In what ways?

When was the last time you felt this very strongly?

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