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An analysis of time conceptualisations and good care in an acute hospital setting

Jan Dewar ⓘ | Catherine Cook ⓘ | Elizabeth Smythe ⓘ | Deborah Spence ⓘ

Department of Nursing, Faculty of Health and Environmental Sciences, School of Clinical Sciences, Auckland University of Technology North Campus, Auckland, New Zealand

Correspondence
Jan Dewar, Department of Nursing, Faculty of Health and Environmental Sciences, School of Clinical Sciences, Auckland University of Technology North Campus, 90 Akoranga Dr., Northcote, Auckland 0627, New Zealand.
Email: jan.dewar@aut.ac.nz

Abstract

This study articulates the relationship between conceptualisations of time and the accounts of good care in an acute setting. Neoliberal healthcare services, with their focus on efficiencies, predominantly calculate quality care based on time-on-the-clock workforce management planning systems. However, the ways staff conceptualise and then relate to diverse meanings of time have implications for good care and for staff morale. This phenomenological study was undertaken in acute medical–surgical wards, investigating the contextual, temporal nature of care embedded in human relations. The study interviews involved 17 participants: 11 staff, 3 previous patients and 3 family members. Data were analysed iteratively to surface the phenomenality of temporality and good care. The following constituents of the data set are explored that together illustrate the relationship between the conceptualisations of time and the accounts of good care in an acute setting: patient time as a relational journey; patient time, sovereign time and time ethics and time, teamwork and flow. The findings are clinically significant because they offer a contrasting narrative about the relationship between time and care quality. The experiences of giving and receiving good care are indivisible from how temporality is experienced and the social relations within which care is embedded. Healthcare staff experience temporality differently from patients and families, a point that healthcare participants in this study appeared to comprehend and accommodate. For all parties involved in providing care or being the recipient of care, however, the capacity to be present was valued as a humanising ethic of care. Our study reinforces the importance of not creating presumptive binaries about which temporal structures are more or less humanising—there is a place for a fast-paced tempo, which can be experienced as being in the flow of human relations with one's team and on behalf of patients.

KEYWORDS
good care, health professionals, hospital care, nurses, phenomenology, temporality, time

1 | INTRODUCTION

In contemporary healthcare, the predominant discourses about time relate to time-on-the-clock, focussed on efficiencies (Bendix Andersen et al., 2018; Katzman et al., 2020). However, in practice, healthcare workers and the recipients of care may have multiple implicit understandings of time and its relationship with the perception of good care or the lack thereof (Ihlebæk, 2021; Lövgren et al., 2010; Mohammadipour et al., 2017). The organisational capacity to provide quality care is primarily calculated according to hard data such as nursing staffing levels and skill mix using workforce management planning systems, such as TrendCare (Drennan et al., 2018). However, there are increasing calls to harness soft intelligence about the components of good care (Martin et al., 2015). The overarching narrative currently informing healthcare organisations is that workplace time pressure can be resolved by simply calculating staff-to-patient ratios, including appropriate staffing with an adequate skill mix. We are not dismissing the logic of safe staffing. However, our data provide soft intelligence highlighting that the ways staff conceptualise and then relate to time have implications for good care and for staff morale.

2 | CONCEPTUALISATIONS OF TIME

Phenomenology is concerned with discerning meaning rather than informational content. Heidegger's phenomenology is hermeneutic, it is interpretive (Walsh, 1996). According to Heidegger (1996), hermeneutic phenomenology requires researchers to dwell on the language of participants to reveal what may be hidden or forgotten in the everydayness of life. A Heideggerian view contributed to theorising the relationship between time and good care because Heidegger's view enables researchers to illuminate the everyday, which often goes unnoticed. Heidegger (1996) posited that for humans to know about time, we must have a sense of mortality. Our experience of time only gains meaning once we know what we are set against. Davies (1996) referred to this cognisance as embodied time, a concept Lövgren et al. (2010) explored in relation to the experiences of people living with inoperable cancer. For Heidegger (1996), time is a series of events where some aspects are visible and others are shadowed by a concealed reality. We only see part of a picture that comes to the fore; we can never fully see the whole. For example, an emphasis on clock time may foreclose noticing other time conceptualisations.

2.1 | Temporality

Time is a major part of how we experience our world. The term, temporality, is closely related to the concept of time and encompasses our subjective relationship with time. Caldas and Berterö (2012) note that temporality is experienced differently between nurses and patients, which may lead to patients' experiences of suffering. Caldas and Berterö (2012) give the example of a period of

20 min flying by for a nurse, but for the patient waiting to receive care, this timeframe is substantively longer. Other theorists have usefully contributed to understanding the practice implications that can be extrapolated from conceptualisations of time. Suddick et al. (2019) note that while studies tend to focus on literal time efficiencies, temporally meaningful moments were significant for staff caring for people recovering from a stroke when staff organised their care in ways that privileged accommodating patients' preferred schedules and pacing. Patients also have a qualitative experience of time. A study by Mohammadipour et al. (2017) similarly highlighted that when patients experienced the nurse's full presence even in brief moments of receiving care, the felt sense of having received the nurse's time differed substantively compared to if the nurse was distracted.

2.2 | Nursing/medical/clock time

Although nurses in clinical practice may not have ever engaged explicitly with education pertaining to the philosophy of time, Caldas and Berterö (2012) use a body of nursing literature to highlight clinical nurses' acute awareness of temporality. Waterworth (2003) notes that nurses report time debt, which connotes the dissonance between the time the nurse has and the time needed. Ihlebæk's (2021) study uses the concept of temporal structures and demonstrates how nurses engage with temporality, as intermediaries between what the author calls medical time, patient time and hospital time. Medical time is time defined and scheduled by clinicians and may create relationships of dependency where future options are prescribed by clinicians based on familiar resolutions to health issues, rather than the needs and wishes of patients. Patient time is conceptualised as a journey, where the time things take is not prescriptive, but rather is relational, accommodating a flexible approach to time. Hospital time has equivalence to clock time, with a focus on time optimisation and cost reduction with the detrimental effects of not shaping care around people's complexities. Ihlebæk calls for temporal reflexivity, where senior staff within organisations recognise and influence temporal structures shaping care, rather than passive adaptation. Ihlebæk's study uses exemplars to illustrate nurses' agency in knowing which temporal structure to prioritise for a particular situation.

2.3 | Fast and slow care

Temporal structures compete in clinical settings. Fast care, where the focus is on organisational needs, such as processing the timely throughput of patients and meeting targets, is important but can result in care delivery that is misaligned with patients and families perceiving they are cared for. Rushton et al. (2016) draw attention to the significance of slow care, where the focus is on cultivating the quality of relationships, optimising both the patient experience and staff satisfaction.

2.4 | Sovereign time

The stress of clock time can be ameliorated significantly when staff are able to determine the rhythm of care. Sovereign time pertains to the amount of discretion and flexibility employees have over aspects of their role. Egede-Nissen et al. (2013) developed the concept of time ethics, which emphasises caregivers' sovereign time use in determining how best to care for people who have lost their perception of time through cognitive impairment.

2.5 | Process time

Caregivers' willingness to be present relationally to the specific context of a person's care needs requires experience, flexibility and the ability to tolerate uncertainty. Davies (1994) differentiates this way of engaging outside of clock time, using the term process time. Davies (1994, p. 280) argues that the notion of process time '…emphasizes that time is enmeshed in social relations …. process time is on many occasions not measurable or at least hard to measure'. Process time is a fluid, relational measure of the time taken to care for another. An example of process time is a nurse giving a person living with dementia their medications, which the person accepts, where they have previously refused medications from other caregivers. The nurse who succeeds may have engaged in an extended timeframe of caring actions that have iteratively built a relationship of trust that makes the moment of pill-taking happen. The nurse may have also reflected with colleagues, deliberated on the way to work, drawn on practice wisdom or consulted the literature about how best to succeed in this activity. In this example, it is not possible to separate the task from the relationship nor is it possible to quantify accurately the clock time taken to achieve this outcome. Time ethics (Egede-Nissen et al., 2013) links well to the related concept of process time, as both entail a fluid, relational measure of the time taken to care for another person.

2.6 | Plurotemporalism

Binaries that reify process time over clock time or vice versa are unhelpful. In acute clinical settings, optimal care relies on the ability of staff to switch between clock time and process time (Rushton et al., 2016). Davies (1994) considers that both times weave together synchronously. Rushton et al. (2016) draw from Nowotny's (1992) concept of plurotemporalism, which blends these typically polarised conceptualisations of time and includes both the symbolic and the real. Rushton et al. (2016) apply this concept and proffer the notion of person-centred time. These authors suggest options such as slow streaming could be used to prioritise process time over clock time where fundamental safety is not compromised.

2.7 | Crip theory

The area of critical disability studies has contributed significantly to a critique of the relationship between clock time and normative bodies. Pertinent to the current study, crip theory broadly deconstructs social pressures and norms, challenging neoliberal prioritisation of efficiencies and instead privileges body-mind unpredictability and the related temporal variations. Kafer's (2013, p. 27) argument has synergies with the notion of slow streaming: 'Rather than bend disabled bodies and minds to meet the clock, crip time bends the clock to meet disabled bodies and minds'. Katzman et al. (2020) note that built and social environments are created to fit the temporality of able-bodied people. Environmental obstacles thus constrict the lives of those living with disabilities more than the disability per se and impact significantly on differing temporal perceptions.

2.8 | Time and good care

Our research seeks to make visible conceptualisations of time in relation to the experience of good care from diverse perspectives: care recipients, including families; care providers and those witnessing care and staff in auxiliary roles, whose job description may not formally include care responsibilities, yet they routinely make decisions to provide care. This article is in part a response to Rushton et al.'s (2016) call for research that revises the concept of time and encompasses nursing practice and research, in acute settings. The research question that guided our overarching study is as follows: What are the experiences of good care in a general medical-surgical hospital setting? The following question informs this article: what is the relationship between the conceptualisations of time and the accounts of good care in an acute setting? The research was undertaken in Aotearoa, New Zealand and includes experiences of Māori (indigenous people of New Zealand).

3 | DESIGN AND METHODS

The foundation study from which this article was drawn is informed by phenomenology, investigating what is familiar and everyday in being human. Heidegger described the self, being in the world, as Dasein. Dasein for Heidegger means 'the self as the there (Da) of being (Sein), the place where an understanding of being erupts into being' (Davis, 2010, p. 44). Thus, this Heideggerian concept provides an opportunity to examine face-value assumptions and to consider what possibly lies behind individual staff or patient responses to temporal situations. A phenomenological approach yields stories of lived experience. This article however moves to a more hermeneutic analysis, where insights from the original study are brought into conversation with research from a wider methodological base.

3.1 | Recruitment and participants

Senior colleagues and the Māori health team assisted with participant recruitment, passed on the recruitment flyer to potential participants. Past patients who were community dwelling also responded to information on a church noticeboard. Participants were given study information and researcher contact details if they wished to participate. Nursing staff were excluded if they operationally reported to the lead researcher. There were 17 study participants: 11 staff members from nursing, medicine, physiotherapy, chaplaincy, occupational therapy, social work, cleaning services, food services and health care assistant groups; 3 recently discharged patients and 3 family members. There were 5 New Zealand Māori, 10 New Zealand European, 1 Irish and 1 Chinese participant. Thirteen women and four men participated. Pseudonyms are used for all participants.

3.2 | Data collection

After gaining informed consent, interviews were conducted by the lead researcher in a private setting, agreed upon by the participant. The conversation was recorded and transcribed. Through the interview process, participants were encouraged to tell stories and elaborate on how they felt. Interviews were approximately 1 h in length. Examples of staff interview prompts are as follows: tell me about a recent situation you were involved in that positively impacted good care; tell me a story that stays in your mind about care that was outstandingly good. Interview prompts to patients and family members included the following: tell me about what made you/your family member feel you were receiving good care; who were the people providing care and what did they do? These stories were then transcribed using the intelligent verbatim approach, removing repetitions and hesitations (Crowther & Smythe., 2016), and were returned to the participant to check that the transcription reflected the intended meaning.

3.3 | Data analysis

Data analysis was undertaken with reference to Gadamer's (2004) and Debesay et al. (2008) hermeneutic circle. A synthesis of the researchers' understandings, the ideas expressed by the participants and the environment in which care occurs all influenced our thinking. Through a fusion of patient and staff voices and the philosophical notions of temporality informed by a wide range of literature, this written work was constructed to illuminate the understanding of how time may impact or enable good care (Norlyk & Harder, 2010). Working with the data was a process of writing, reflecting and rewriting to produce a hermeneutic interpretation of the text. Throughout this process, rhetorical movement occurred, correcting and modifying existing fore-structures to gain understanding through the hermeneutic circle of interpretation (Debesay et al., 2008). By the researchers understanding their positionality alongside the text, the text was illuminated to form new horizons of understanding (Bradshaw, 2013; Gadamer, 2004).

3.4 | Ethical considerations

The study received ethics approval from the Auckland University of Technology Human Ethics Committee 18/337. The committee was satisfied that the lead researcher was well-placed to undertake these potentially sensitive interviews with her clinical expertise in facilitating dialogue about care quality. The participant information sheet provided information about accessible, free services if the interviews triggered significant emotions. No participants were significantly uncomfortable with the interview process and appeared to appreciate making a contribution.

4 | FINDINGS

The data set provided abundant exemplars from which we have drawn quotations to illustrate an array of tacit conceptualisations of time that informed practice and the patient experience. The overarching findings were that practitioners who appeared to experience high levels of job satisfaction were able to switch dextrously from the fast care of acute clinical care into the slow care of person-centredness and made deliberate choices to do so. Practitioners did not necessarily view fast care as inherently problematic; they reported times of being appropriately under pressure, for example, in managing clinical crises, and experiencing a sense of being in the flow, especially when good teamwork was involved. A striking feature of the data set was healthcare workers' repeated use of the journey metaphor to conceptualise the time frame of an illness experience for patients and families. Patients and families identified that, in effect, person-centred time was not necessarily about the length of time spent but rather the experience of being seen and the quality of comportment and presence of the healthcare worker within the time spent. The following constituents of the data set are explored that together illustrate the relationship between the conceptualisations of time and the accounts of good care in an acute setting: patient time as a relational journey; patient time, sovereign time and time ethics and time, teamwork and flow. We acknowledge that to illustrate these time concepts as constituents distinct from each other, we have made demarcations in the authorial commentary. Our purpose in so doing is to further illustrate and make accessible the extant terms used in the theoretical and empirical literature (see, e.g., Davies, 1994; Egede-Nissen et al., 2013; Ihlebæk, 2021; Rushton et al., 2016) to present time conceptualisations beyond the ubiquity of neoliberal clock time efficiencies.

4.1 | Patient time as a relational journey

The use of the journey metaphor appeared to highlight healthcare workers' awareness that although their lives intersected with patients

and families, the temporal experience differed vastly. This awareness appeared to elicit compassion and tolerance in their responses. In the following quote, a senior nurse used the journey metaphor combined with the analogy of a long-haul flight to indicate an appreciation that, in effect, an extended illness erodes patients' and families' capacity to comprehend the experience and the importance therefore of clearly summarising key information:

> I think about it [making sense of illness] a bit like a long-haul flight. You start off fresh, and by the end of it you don't even know where you've put your passport ... you know you're just wrung out and I think I go from a functioning human being at the beginning of the long flight journey to, 'phew', and that whole emotional roller coaster .... sometimes I have to say to patients, 'we actually don't have any more information to give you, we're not keeping anything from you, we need these tests it's information gathering, that's where we're at, at the moment'. And, focussing on what we do know, for now rather than, what we don't know and speculation ... that 'everybody's working really hard to try and get you that information as quickly as possible and some tests can't be rushed'. (Lisa, senior registered nurse)

The above quote has synergies with Davies' (1996) concept of embodied time, with the nurse identifying the whole-body experience of endeavouring to tolerate an extended illness journey. In the following quote, a healthcare assistant described her first experience of metaphorically stepping into the temporal experience of her patient, who was living with dementia and had a past career as a teacher. The staff member used the journey metaphor and additionally emphasised the metaphor of jumping on the patient's bandwagon to signal her fullhearted willingness to share her patient's temporospatial experience:

> I get to really know them as real people. And, to me, it's a journey that I can share .... we start talking and all of a sudden, she'd wander [cognitively]. And it must have been because she was a teacher, she started telling the children to go and sit here or you know, 'stop playing'. I jumped on her bandwagon, and I talked to her like I was one of her children. And she used to talk to me like, 'Where is that book? I told you to bring that book'. Things like that she'd say to me, so I'd have to look around for a book. She goes, 'That's better, now I want you to do that story again'. And, to me, that was the most beautiful thing I've ever seen in my life to be able to get on a bandwagon, that was the first time I've ever experienced that. (Aroha, health care assistant)

The above quote echoes Egede-Nissen's concept of time ethics, whereby the healthcare assistant exercised time sovereignty in deciding how best to spend time with this resident. In so doing, she reported an intense feeling of satisfaction being able to spend time relationally. In the following quote, a doctor used the journey metaphor to highlight the importance of humanising care and resisting the pressure of time debt and hospital time that so readily slide practice towards depersonalised care:

> Things about hospital culture, unfortunately, have developed into this numbers game where you see patients as something to get rid of, almost from the hospital to get your list down because it seems like you're winning. You've taken a number, you've done something with them and you get them home and then they come off your list. We've got into that culture where we see discharging patients as winning some kind of strange game. And I think one of the most important things for good clinical care is to try and ignore that gut feeling of that adrenaline rush you get when you cross something off a list, to remind yourself that this is a human being with genuine problems and that you are seeing them at a very vulnerable part of their life. At the end of the day, that's why we're in this profession not to cross people off a list for a discharge. But to be involved in their journey as much as possible and make it as palatable as possible. (Andrew, doctor)

It is interesting in the above quote that the participant was aware of his physiological response to time pressure, as well as a strong institutional culture that readily prioritised speed, and nevertheless reported the capacity to draw on deep values about relationships of care that created a sense of choice.

In the following quote, an occupational therapist described how she had to come to terms with the understanding that what she wanted for a person's stroke rehabilitation programme may differ from what the person wanted. The person's priority may be to go home as soon as possible rather than stay for further investigations. The journey metaphor in this instance appears to be used as an acknowledgement that a person's decisions arise from the past and the imagined, preferred future and are not only linked to what is happening currently around a health issue:

> I think that's for me that just comes back to that kind of context of someone's life journey and their values and what's important and what's not important and all that kind of thing. This [rehabilitation process] is important to us because we see it every day and we know the research and we know all that kind of stuff. But does it sit in their world as a big thing? (Sam, occupational therapist)

The above quote serves to portray Heidegger's (1996) argument that the human awareness of life's finiteness gives meaning to time. A

recurring feature of healthcare workers' use of the journey metaphor was the capacity to comprehend others' temporospatial experiences as related to and different from their own and to contextualise the patient's life and priorities beyond narrow biomedical goals. The metaphor's use was associated with examples of humanising care and affirmation of preferred care values.

4.2 | Patient time, sovereign time and time ethics

The data set highlighted that even within an unrelentingly busy acute hospital context, healthcare workers were able to harness moments where time was not always clock-based. The following quote is illustrative of a practitioner's conscious decision to shift from fast care to slow streaming, with a person-centred goal of attuning to the other person:

> When I come into a space, someone might see me run up the stairs but I will consciously still myself and walk slowly, so that I enter a space slowly and I'll try and keep my movements slow and not throw my hands around because I can throw my hands around when I talk …. it's entering, it's moving in a way that is in tune with a still sense of presence. Like if you rush in and somebody's an older person and they're frightened, it's only going to exacerbate that. This is kind of interesting in this environment because everybody's rushing and everybody's making a noise…. I try and actively be still, I still my heart, I still my soul, I still my brain. (Robyn, spiritual care coordinator)

The above quote can also be seen as an exemplar of sovereign time, with the practitioner making decisions about how best to meet the person. The following quote is used as an exemplar of what Davies (1994) termed process time, whereby the daughter of a patient recounted the surety she and her relative had that even when absent, staff continued to be mindful of patient and family concerns and would return to address any outstanding issues. This confidence led the participant to affirm that they were not just a number to be dealt with in hospital time:

> Anything that you asked them they had the questions answered right there and then. If they couldn't answer them then they'd go away and find out. And if it took half an hour it would take half an hour but they would be there and then they would come back and make sure that you understood before they left. Like you're not just an appointment time. (Marama, patient's daughter)

In the following quote, the participant recounted that as a patient, one practitioner stood out as providing what she termed 'caring care', which she distinguished from 'good technical care'. It appears that she had the felt sense of experiencing in effect the doctor's comportment, the capacity to shift from medical time to patient time:

> He seemed to have a lot of time. You know they, maybe that's an old historic thing but I just expect the doctors on rounds you always heard how busy they are and how they're rushing to get from one place to the next but I was surprised how long they actually stayed and talked about what was going on…. Dr [name] taking the time to explain, he that was not making me feel like, 'I'm too busy for you', like he just really took the time and that was lovely… But, they all gave good technical care so there's technical care and then there's caring care. (Debra, patient)

An occupational therapist reflected on how time can be misspent in the fast care of a hospital, in effect by focusing on an agenda that does not match with the patient's preferences and circumstances. The practitioner drew on the notion of choosing wisely and the concept of narrative reasoning to highlight how to decide how time is best spent. The quote reflects what Ihlebæk (2021) calls temporal reflexivity, where the staff member adapted the clinical agenda to the person's life:

> I think the difficulty with the fast pace of the wards is that often, we don't necessarily get the opportunity to [make an in-depth assessment] and we focus on some of the wrong stuff, that 'choosing wisely' kind of philosophy. Are we having all these things done that actually do make any difference or do transfer into somebody's real life. Are we focussing on the right stuff?…. I guess like I say the philosophy of ours is how is this going to impact this person's everyday life whether it's what medications they're on, when they have to take them, how they have to take them, who's going to be with them, whether it's support they need at home, whether it's package of care it's like so where does this sit in the context of this person's narrative? If you use narrative reasoning and say who is this person and why you're doing what you're doing how does that fit with their narrative you know? (Sam, occupational therapist)

In the following quote, a registered nurse (RN) in effect described a blend of time ethics, sovereign time and process time in the description of engaging with a patient who had dementia:

> I start my day by saying good morning to her and seeing if she actually remembers me from the day before and she doesn't. She's normally not in a good space in the mornings so I know just to leave her, she wants her curtains pulled, she doesn't want to look at

us. I'm just trying to get that relationship going quite early in the day so that the rest of the day can go a bit smoothly…. she has high anxieties about everything. She worries about her worries really. I've been having to spend a lot of time with her. Yesterday we played cards and I got her interacting with me we played 'Memory' and she did really, really well. She's also quite obsessed about [imagining] hot chilli peppers that are in all the food that's coming from the kitchen and it's also been in her pills and things like that so, having to do a lot with her, I'm with her a lot, more than anyone else. I remind her where she is and that I'm a nurse, I'm here to look after her, not here to hurt her. All of that it, it's every day that's what I do. (Moana, registered nurse)

The quote illustrates the impossibility of a nurse necessarily determining how much time has been dedicated to the care of one patient. In this example, process time is evident in the way the RN intentionally wove relational care throughout the day, with micro-moments as well as longer care segments. The nurse's knowledge of the patient informed the shape of care, rather than the hospital routine.

4.3 | Time, teamwork and flow

Although persistently busy, time-pressured workplaces are often associated with care erosion and psychological distress. Participants in this study repeatedly highlighted the ameliorating effects of good teamwork, so that the fast pace was experienced as a type of flow, rather than a time deficit. In the following quote, a cleaner foregrounded collegial relationships and beneficial outcomes for patients rather than the repetitive nature of her work. The quote appears to be evidence of this worker's temporal reflexivity, where rather than feeling driven by hospital time, the pressured time frame is imbued with relational meaning:

> Mostly teamwork and because I see a lot of the nurses, sort of buddy up if they have too much work or someone wants extra help. The care assistants, we buddy up and we get something done. If the nurses need the room for a patient, an isolation room, me and the care assistant will get in there, get everything done, work together. Get it done fast because a patient from downstairs is coming up. You help the nurses out and they help you and we work as a big team to cater for the patients….intertwined or whatever you call it we just all seem to know our roles. And a lot of the times I'm just happy about doing things and I'm just pleased because I'm doing it for patients and for the ward, for the nurses and for everyone else and myself and I get it sorted. (Maia, cleaner)

This sense of quality teamwork, which appeared to ameliorate the pressure of the fast pace of hospital time, was also reported by an RN. Rather than passive relinquishing to time pressure, this temporal reflexivity about the significance of teamwork in a busy environment altered the meaning of time pressure. The quote is illustrative of Davies' (1994) point about the enmeshment of time in social relations:

> We know how to work as a team and, maybe that's because we are so busy but, we just get on really well. We work together. There's no one, you know how you get the odd bullying here and there, there's nothing like that in our ward. It's just awesome. Talking to bureau nurses they don't like coming to our ward because of the heaviness of it but they love coming to our ward because of the people and so that makes it okay because they know they're not going to be on their own. (Moana, registered nurse)

Fast care is not necessarily in opposition to patient-centred time. In a similar vein to the above quote, another RN described with pride and joy how fast-paced teamwork, aided by a new protocol, enabled the successful treatment of a patient who required thrombolysis after a stroke:

> We had a lady, probably six weeks ago who, was a code stroke down in ED, code stroke assessed really quickly, ED promptly escalated us to come down. Rapid assessment and we thrombolysed, gave her a bolus of her emergency treatment in CT [CAT scanning], so because we had the expertise of the [senior medical officer] there we door-to-needled-her in 21 minutes which is amazing. That was not just a quick scan. That was a CTA [CAT scan with dye injected into the blood vessels] which takes time so probably 10 minutes of that was the scanning, and we assessed her for clot retrieval and she went to [tertiary hospital]. She was our first one sent so it was really good in terms of the working relationship with the duty nurse manager, the retrieval team, and [city tertiary hospital]. It all lined up beautifully and we were able to test our pathway here which was really good. I learned quite a bit from that and we were able to then use that learning to improve our documentation. She went home the next day. Independently so actually that was brilliant. That was great, that's the magic moment you talk about when you go home. What's your good points, what's your bad points? Well you can't beat that, it was great! (Lisa, senior registered nurse)

Again, the above example shows the relationship between social relations and time, whereby even 6 weeks later the sequence of

events was conceptualised as a 'magic moment' rather than time poverty. Nowotny's ([1992](#)) concept of plurotemporalism is useful for identifying within this example the blending of commonly polarised time conceptualisations, where medical time blends with person-centred time, focused on the best outcome for the patient. It is interesting to note that in the above example, the nurse appeared to report a sense of agency within the time scarcity for a successful outcome.

An RN described an experience on the night shift where a patient was becoming increasingly distressed with what she perceived to be a misplaced nasogastric tube. She negotiated with the patient that she would replace the tube immediately, which led to instant relief for the patient. This is a striking example of the nurse's ethics in the way she related to the patient's and her colleagues' time, which informed her action:

> I try to be proud of all my care.... It [timely intervention] does give you those moments where you think actually, I smashed that, I assessed it, I made a plan.... And I try on night shifts not to be that nurse that says, 'oh well, the morning staff can sort it out'. My colleague who I was on with said, 'Oh don't worry about it, the team will just sort it out in the morning', but I said, 'But this patient's really uncomfortable and he's doing everything like he was doing laps up the hallway, he was doing everything that I had [told him], he was rubbing his stomach the right way and he was trying his hardest to do all the things that he could do, but it just wasn't working....'. Problem-solving in the middle of the night isn't always the best idea but sometimes actually it is something you can do, you don't have to leave it to the day staff.... (Jenny, registered nurse)

In the above quote, the nurse rejected her colleague's proffering of a medical time solution that privileged staffing workloads and instead appreciated the time ethics in alleviating the person's suffering as a preference. In so doing, the nurse prioritised attending to the patient's temporal experience of suffering and was agentic in acting according to her values about teamwork.

5 | DISCUSSION

This article highlights a plurality of time conceptualisations including and outside of linear, sequential notions of clock-time-orientated time management. Although within healthcare, clock time is applied ubiquitously to organise care arrangements (Bendix Andersen et al., [2018](#); Katzman et al., [2020](#)), the data set provides rich evidence that, at least tacitly, both professional and auxiliary healthcare staff drew on a range of time conceptualisations. This study contributes to examining the relationship between time and accounts of good care in an acute setting. The article builds on the extant literature in arguing that workforce management planning systems do not capture the processing time that real care takes, nor

the patient and family experiences of medical time, hospital time and patient-centred time. We concur with Martin et al. ([2015](#)) that hard data, what is reported and recorded, is not a neutral scientific endeavour. Our study highlights that conceptualisations of time matter because they have ethical implications for everyone involved in healthcare and appear to have significant implications for staff morale in terms of finding work meaningful. Bridges et al. ([2013](#)) note that staff disengagement from care results from moral distress. This occurs in part due to a lack of time and imposition of routines that prioritise managerialism and patient throughput over addressing complexities, including people's social issues.

The data set of the current study demonstrates that healthcare staff recognised that patients and families experienced temporality differently due to the ways illness shaped embodied experiences of time. Therefore, the focus of care, including education and goals, needed to be adapted accordingly and individualised. This point about disrupted temporality is vividly illustrated in Moskalewicz et al.'s ([2021](#)) study of women's experiences of undergoing chemotherapy for ovarian cancer. The researchers use the term chemo-clock to indicate the dominating role of the cyclical chemotherapy experience, which desynchronised women from conventional clock time and biological rhythms. The impact of chemotherapy also resulted in disruption to social temporality. Instead, their lives were experienced as both accelerated, with the sense of time running out, and slowed down due to the impact of the treatment. Moskalewicz et al.'s ([2021](#)) study has synergies with Kafer's ([2013](#)) call for 'crip time'—flexing dominant temporal parameters to include non-normative bodies.

In the current study, a number of staff used the temporal metaphor of a journey to characterise the illness experience for patients and families and emphasised the importance of alleviating uncertainty where possible. Hommerberg et al.'s ([2020](#)) analysis of metaphors used by people living with advanced cancer also identified that although the journey metaphor can indicate a transition to new meaning and growth opportunities, it can also be used to express a passive sense of being transported through an isolating experience. Lövgren et al. ([2010](#)), in a study of people living with incurable lung cancer, also identified that patient uncertainty was exacerbated when there were long periods of waiting, especially in an information vacuum. Their participants were acutely aware of the finiteness of their embodied time and experienced time delays in access to healthcare staff as wasting the now limited commodity of the clock-time they had left to live. Of importance, Lövgren et al.'s ([2010](#)) participants reported that even when they had a typically brief time with health professionals, they did not feel seen, but rather perceived that they were being processed through the system as a medical case rather than a human being.

Therefore, as highlighted in the current study and the wider literature, it is not only or not necessarily the clock time spent but the sense of presence patients experience that contributes to a felt sense of quality time. This point is emphasised by Caldeira and Timmins ([2015](#), p. 2355) that care moments are enhanced when nurses perceive time as opportunities for meaningful connection through presence, '...being able to see more than just look, and being able to listen more than just hear'. Mohammadipour et al. ([2017](#)), in their qualitative study exploring

patients' experiences of nursing presence, identified that presence included embodied practices of active listening, making eye contact and speaking calmly and empathically. Assing Hvidt's (2022) study also noted that patients perceived a qualitative difference in having allocated time with a doctor, contrasted with the doctor's apparent presence during that time, which participants valued most and referred to as being 'given time'. Ellingsen et al. (2013) recommend adopting a slower, flexible rhythm in care when people are dying, what these researchers call a rhythm of harmony. An inability to fit in with the norms of clock time renders people living with severe illnesses to the position of outsiders, which diminishes dignity. In the current study, the limitations of clock time were evidenced within the data set, particularly when caring for people with complex needs. In these instances, Davies' (1994) concept of process time was pertinent in making visible the warp and weft of time and social relations and in highlighting how problematic it is to try to allocate discrete units of time to various procedures. We concur with Rushton et al.'s (2016) argument for new metrics compatible with person-centred time.

Another contribution this study makes is drawing attention to the morally sustaining effects for healthcare workers in exercising sovereign time and patient-centred time. In the current study, participants reported that when they were able to be present for patients, these experiences reinforced their preferred values and were a source of pride and joy. Nursing participants in Suddick et al.'s (2019) study considered that their efforts to be present for patients recovering from a stroke were compromised through system-focused clock time that prioritised auditing and fast throughput as care measurements and noted that while technology can positively mediate care, its presence can also detrimentally impact patient-centredness. Healthcare participants in Scerri et al.'s (2015) dementia-care study referred to the importance of 'quality time' with residents, which was not about proximity per se but rather about engaging with genuine interest with the person with dementia. By contrast, for family members in this study, quality care pertained to care 'in time'—the timeliness of care provision or lack thereof counted more than the quality of time spent per se. Again, this finding highlights that patients and families experience temporality differently from healthcare workers.

Significantly, in the current study, fast care was not necessarily spoken of by healthcare participants as being in opposition to patient-centred time and may be entirely appropriate. The examples in the current study were wide-ranging, from an instance of patient care involving stroke clot retrieval to expediting a ward's capacity to transfer patients in from the emergency department. Even in clinically pressured contexts, committed teamwork led to a focus on and pride in social relations with colleagues for the benefit of patients, an example of Nowotny's (1992) concept of plurotemporalism and Zerubavel's (1981) notion of temporal synchronicity in teams. Waterworth (2003) argues that nurses' experiences of time, referred to as temporal reference frameworks (Zerubavel, 1979), are not a matter of individual conceptualisation necessarily but are associated with implicit shared understandings of temporality inherent in teamwork. Drawing on Waterworth's argument, Pedersen and Roelsgaard Obling (2020) caution against leaping

to presumptions that temporal structures are inherently more or less humane, for example, not assuming that standardisation is necessarily inhumane. The current study demonstrates that good care is typically a synthesis of temporal structures.

6 | CONCLUSION

The experiences of giving and receiving good care are indivisible from how temporality is experienced and the social relations within which care is embedded. Healthcare staff experience temporality differently from patients and families, a point that healthcare participants in this study appeared to comprehend and accommodate. For all parties involved in providing care or being the recipient of care, however, the capacity to be present was valued as a humanising ethic of care. Studies that address only the impact of clock-time and workforce management systems fail to capture the nuanced appreciation staff have, at least tacitly, about the importance of process time, and the capacity staff have, even in pressured contexts, to experience sovereign time and patient-centred time. Our study reinforces the importance of not creating presumptive binaries about which temporal structures are more or less humanising—there is a place for fast care that can be literally lifesaving, and this fast care can be experienced as being in the flow of human relations with ones' team and on behalf of patients. Our study, therefore, confirms the utility of the concept of plurotemporalism, of considering that in any given situation, there are multiple socially constructed temporal 'realities'. The exploration of healthcare workers' and patients' experiences of plurotemporalism potentially unlocks a door to comprehending what contributes to ethical comportment and the reduction of burnout. Studies that focus solely on staff experiences of clock time are likely to only report time poverty and stories of inadequate staffing and skill mix as if these currently insurmountable problems must be sorted before good care can prevail. While our study does not dismiss the enormous pressure under which healthcare staff currently work, through a hermeneutic approach, we have demonstrated that accounts of good care are unevenly linked to clock time and are much more aligned with the capacity of staff to engage in temporal reflexivity, including an appreciation that the temporal structures shaping the experiences of patients and families differ from their own.

CONFLICT OF INTEREST STATEMENT
The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT
The data that support the findings of this study are available on request from the corresponding author. The data are not publicly

available due to privacy or ethical restrictions. (This statement pertains to data sovereignty issues as some of the participants are indigenous Māori.)

ORCID

Jan Dewar https://orcid.org/0000-0002-6081-292X
Catherine Cook https://orcid.org/0000-0003-3976-6858
Elizabeth Smythe https://orcid.org/0000-0002-0714-7908
Deborah Spence https://orcid.org/0000-0002-6796-9487

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