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Received: 8 April 2023 | Revised: 4 July 2023 | Accepted: 10 July 2023

DOI: 10.1111/nin.12584

ORIGINAL ARTICLE

# Nurses' ways of talking about their experiences of (in)justice in healthcare organizations: Locating the use of language as a means of analysis

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## Abstract

Nurses have their own ways of talking about their experiences of injustice in healthcare organizations. The aim of this article is to describe how nurses talk about their work-life experiences and discuss the discursive effects that arise from nurses' use of language regarding their political agency. To this end, we present the findings garnered from a study focused on exploring how nurses deploy their political agency to project their idea of social and political justice in public healthcare organizations and how they face the challenges and uncertainties of (re)thinking their institutional order when it does not resonate with their professional ethos. We then discuss the implications that nurses' use of language has in relation to their ability to deploy their political agency to oppose the forms of injustice they face in their daily practice. We conclude by stating that careful attention should be placed on understanding the discursive implications of nurses' use of language on their individual and collective emancipation in healthcare organizations.

KEYWORDS

critical discourse analysis, epistemology, language, nurses, political agency

## 1 | INTRODUCTION

Nurses face a tangle of systemic difficulties to perform their professional roles freely and fully in healthcare organizations (López-Deflory, 2022; Martin, 2015; Skinner et al., 2018). These difficulties have to do with the distributive elements that make up nurses' working conditions. These factors include the scarcity of time they have to enact their roles (Vinckx et al., 2018), the physical and mental (over)load they take on (Govasli & Solvoll, 2020; Hochschild, 2012; Selberg, 2013), as well as the lack of physical spaces and material resources to which they have access (Souza et al., 2017), and the low salary they perceive to receive according to the responsibilities they assume (Gonçalves et al., 2015). They also have to do with nurses' lack of recognition or misrecognition in the microcontext where their relationships with other healthcare professionals and patients are established and maintained, as well as in the macrocontext where the economic, political, social, and cultural elements that make up organizations' institutional status quo operate (Allen, 2015; Khademi et al., 2012); and nurses' voices lack of representation or misrepresentation both in and outside healthcare organizations (Aberese-Ako et al., 2014; Drenkard, 2015; Skår, 2010; Sundean et al., 2017; Weston, 2010).

An analysis of the most recent literature on nurses' work-life experiences reveals that researchers interested in this phenomenon focus on the analysis of the thematic content of the participating nurses' discourses. However, the analysis of the formal content of

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their analysis often goes unaddressed in nursing research. The formal content of discourse refers to the way in which a speaker expresses himself or herself about a certain topic. In other words, it is the set of considerations of presentation, organization, and appearance accompanying speech, which has nothing to do with its thematic content, but which implicitly provides information about it (Fairclough, 1992).

We do not intend to downplay the contribution that researchers focusing on describing the thematic content of nurses' discourses around their work-life experiences make to illustrate nurses' alienation in the healthcare system and to claim for a social transformation, which would interrupt injustice (re)production in healthcare organizations. Instead, we suggest that the analysis of the formal content of discourse as an orientation of analysis supplementing the analysis of its thematic content should be raised as a method of analysis with added value.

A critical analysis focused exclusively on the thematic content of nurses' discourses is incomplete. It fails to capture hidden findings beyond "what is said," that is, findings housed in the "how it is said." This angle also runs the risk of contributing to the reproduction of some long-standing issues in nursing. As a result of these analyses, nurses are often portrayed as mere informants of their work-life experiences. They are constructed as simple observers of the world they inhabit that can do little or nothing to transform it. Considering nurses as agents is mostly forgotten in this context (Lunardi et al., 2017; McMillan & Perron, 2020; Ray & Turkel, 2014). An analysis focused simultaneously on the formal content of nurses' discourses would, to some extent, overcome the aforementioned limitations. This dual orientation considers, in fact, nurses' acts of reporting their work-life experiences as a form of action with potential transformative effects. This statement is in line with the approaches of linguistic anthropology, such as that of Duranti (2004), according to which it is possible to study the different degrees of individuals' capacity to act, subjectivity or autonomy through the analysis of the semantic role attributed to agents in linguistic practices.

A concomitant analysis of "what is said" and "how it is said" would enhance knowledge to aid in the construction of nurses as subjects who, seeking to achieve specific purposes, mobilize forms of agentivity through their use of language. Thus, nurses embody not only informants of the realities of which they consider themselves victims but also agents who, through their speech acts, shape these realities while also shaping their political agency to transform them.

The aim of this article is to critically explore the discursive effects that emerge from how nurses, as research participants, use language to describe their work-life experiences. To this end, we begin by describing the methodological considerations of a critical discourse analysis study we conducted. We then report the most salient findings of this research, specifically focusing on those arising from the analysis of the formal content of the nurse participants' discourses. We finally discuss the value of the dual thematic/formal content analysis in the framework of critical discourse analysis.

## 2 | THE STUDY

We introduce below a general overview of the study that has led us to raise the value of the dual analysis of thematic and formal content in qualitative nursing research.

### 2.1 | Purpose

The purpose of the study was to explore how nurses deploy their political agency to project their idea of social and political justice in public healthcare organizations and how they face the challenges and uncertainties of rethinking their institutional order when it does not resonate with their professional ethos. In this article, we focus on the presentation of the findings that, as part of this larger study, allow us to understand how nurses use language to report on their experiences of (in)justice in healthcare organizations.

### 2.2 | Design

An ethnomethodological design of critical discourse analysis was used in this study. Ethnomethodology is a branch of sociology that aims to reveal the nature of social orders through the study of how people try to make sense of the world around them through words and actions in their stories (Garfinkel, 1991). Critical discourse analysis is a process of social research focused on the study of speech and texts. In other words, it is the study of language as a means to discover the ways through which discourses construct and mediate the naturalized sociocultural and political reality of a given social and historical context (Fairclough, 1992, 1995). Ethnomethodology and critical discourse analysis are used together in this study as a new avenue for in-depth analysis of the interrelationship between social life and language. The integration and mutual complementarity of both methodologies allow for combining field study in institutional spaces and critical analysis of the discourses that shape how individuals act in them. This allows us to understand in greater depth how injustice is (re)produced in a given context to make it prevail therein or how it is transformed to promote social emancipation (Krzyzanowski, 2011).

### 2.3 | Sample and participants

The contexts chosen for study were the public healthcare organizations in Majorca (Balearic Islands, Spain). They included hospitals, centers for primary care, and nursing homes. The study participants were divided into two groups: the central voices and the peripheral voices. The central voices included those participants on whom the research focused: nurses. These were split into six profiles: (1) nurses in clinical practice, (2) middle nurse managers, (3) nurse managers, (4) nurses in political and/or collegiate positions, (5) nurses in union positions, and (6) nurses in mixed positions (between clinical and

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management). Although the research was not specifically interested in them, the peripheral voices included those participants on whom the central voices spontaneously relied as a discursive and dialogical resource through which they understand themselves, the world around them, and the position or status they occupy within it (Musaeus, 2017). Peripheral voices' narratives thus become useful to better understand central voices' narratives and the context in which they are produced. Regarding justice in healthcare organizations, the inclusion of peripheral voices in research is of great interest since the construction of fair environments depends not only on those who experience injustice the most but also on those who contribute with their actions or inactions to shape these experiences (López-Deflory, Perron, et al., 2022). These peripheral participants were split into two profiles: (1) physicians in clinical practice and (2) healthcare organization managers. All participants had to meet three inclusion criteria: (a) be working at a public healthcare organization at the time of data collection; (b) have at least 6 months of work experience at a public healthcare organization; and (c) voluntarily agree to participate in the study and sign the informed consent form. Participants were recruited using intentional sampling through key informants, direct access, and snowball techniques (Denzin & Lincoln, 2017). Table 1 summarizes the composition of the final sample of participants taking into account their segmentation by sex according to the data provided by the official professional associations regarding the representativeness of women and men in each of the participants' professions.

**TABLE 1** Final sample of participants.

| Voices | Profiles | Sex: Female | Sex: Male |
|---|---|---|---|
| Central voices | Nurses in clinical practice | 11 | 4 |
| | Middle nurse managers | 3 | 1 |
| | Nurse managers | 3 | 2 |
| | Nurses in political and/or collegiate positions | 3 | 0 |
| | Nurses in union positions | 1 | 1 |
| | Nurses in mixed positions | 1 | 1 |
| Peripheral voices | Physicians in clinical practice | 2 | 2 |
| | Healthcare administrators | 0 | 1 |

## 2.4 | Data collection techniques

Data collection was conducted between November 2019 and March 2020 by the first author of the article through in-depth individual interviews that lasted 90 min on average. The interviews sought to address issues related to nurses' identities, the forms of injustice they felt they faced in healthcare organizations, and the forms of action through which they deployed their political agency to fight against these forms of injustice. The interviews were audio-recorded to later undergo transcription and analysis. Data collection techniques also included a sociodemographic questionnaire and the researcher's field diary.

## 2.5 | Data analysis

The analysis of verbatim transcripts was carried out following the critical discourse analysis method developed by Norman Fairclough. This three-dimensional approach to discourse understands discourse as text, as discursive practice, and as social practice (Fairclough, 1992, 1995).

Each interview was read several times to elaborate codes linked to verbatim fragments that were grouped into subcategories and later into categories. Three categories were elaborated: (1) *ways of thinking*: a baggage of socialization that precedes, is nourished by, and impacts healthcare organizations; (2) *the recognition of the axes of injustice*: an analysis of the position occupied and to be occupied in healthcare organizations; and (3) *the emancipatory yearning*: an ethical and political movement symbolized in gazes, words, and actions.

The findings included in each category were organized into three intertwined sections: a preliminary section, a central section, and an impact and transition section. The preliminary section collected the findings that allowed us to understand how the participants approached the topics included in each of the categories by focusing on the study of the linguistic characteristics of the textual corpus. The central section collected the thematic findings directly and explicitly linked to each of the categories. The impact and transition section collected findings that indirectly and implicitly revealed the effects arising from the findings included in the central section.

## 2.6 | Rigor

Methodological rigor strategies included adherence to criteria of validity, reliability, and generalization potential defined by Morse (2015). In addition to the above criteria, reflexivity has been applied throughout the research process. All the researchers who have conducted this study and who are listed as authors in this article are women, nurses, researchers, and academics trained in the critical paradigm of qualitative research. Our positionality must be acknowledged to understand the orientation of the formulation of the aims and the analysis and interpretation of the data generated in this research (Berger, 2015).

## 2.7 | Ethical considerations

This study obtained ethical approval from the Research Ethics Committee of the Balearic Islands (reference number: 4013/19 PI) and was conducted in accordance with the principles of the Declaration of Helsinki. All participants were given verbal and written

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information about the study and signed a written informed consent before being enrolled as study participants.

## 3 | RESULTS

We present below the results of the preliminary section of the second category of data analysis. We have decided to focus only on this category of data analysis, leaving aside the other two developed categories, because the results included in its preliminary section are the ones that contribute to the main argument of this paper. They specifically shed light on the linguistic features identified in nurses' recognition of the axes of injustice within healthcare organizations, allowing us later, in the discussion section of this paper, to address the meaning of these results regarding nurses' political agency.

In this vein, during the analysis of the formal content of nurses' discourses, we identified five discursive strategies that nurses undertook to report their experiences of (in)justice in healthcare organizations. These included the use of the second grammatical person, the division of the plot of the stories into narrative planes, the rhetorical transformation of reality, the inclination toward anecdote, and constant comparison. We explain and illustrate each of them below.

### 3.1 | Use of the grammatical second person

Participants tended to portray themselves as second-person storytellers to discuss the economic, political, social, and cultural elements that they considered to shape the institutional order of healthcare organizations. The patterns identified in the relationship between the use of "you" and the thematic content of nurses' speech acts suggested two main discursive effects.

On the one hand, through this linguistic feature, the participants made the most of their involvement in the study to engage in a reflective dialog with themselves. They did not speak to themselves using "I," but using "you." They temporarily dissociated from themselves. They contemplated themselves as if they were someone else. They did so when expressing individual and collective experiences that were controversial, delicate, sensitive, painful, or uncomfortable to acknowledge. This allowed them to escape identifying with the reality they were narrating and which they would have preferred not having to narrate.

> For me being a nurse … (silence) Ugh … I don't know. It involves many things: a lot of personal sacrifice, a job that then changes your way of living or perceiving illness and health … I think it's a job … All jobs have their own thing, okay? I am not saying that other jobs are not difficult, complicated, but on a personal level I believe that nursing does change you eventually. You go through many situations that, although you do not want them to affect you, in the long run they do, or at least in my case they have affected me. (…) I have changed my way of seeing things or feeling them as a result of being a nurse. (…) So, I don't know … For me "nurse" is sacrifice (silence and thinks) and lots of stamina (sighs). (Nurse in clinical practice 1, woman)

On the other hand, through this linguistic feature, the participants acknowledged some recipients of their stories. The interviewer was the main recipient. The participants sought to intercept and engage her emotionally so that she would become aware of their experiences and even make her feel the events.

> The ward is a factory. (…) You get there at 8:00 a.m. and check everything. You check the agendas. You review the treatments. You prepare the machines. At 8:25 h everything has to be ready because the patients have to come in. You have 7 minutes to connect the patients to the machine and the same time to disconnect them (…). On a good day you have 35 minutes for lunch. On a bad day, 15-20 minutes. You eat and go back. You start the afternoon shift and do exactly the same thing. That's my shift. (Nurse in clinical practice 2, man)

The individuals toward whom the nurses intended to direct the criticisms of their working conditions were also recipients. The participants addressed the researcher as if she embodied the physicians with whom they established tense relationships, the nurses with whom they did not share the same paradigmatic vision of the profession, or the managers of healthcare organizations by whom they feel misrecognized. Thus, the results suggested that meetings with the researcher allowed participants to safely express opinions that they would not express in front of their actual recipients.

> (Regarding nurses' misrecognition by physicians) You can't discuss these issues with physicians. You can't because you'll get them angry (…) There's also risk involved. You're knocking a powerful collective, so… Say goodbye to the good life—if you've ever had it! (As if talking to a physician) If you are able to understand it, your life will be much more uncomfortable because you cannot (pauses story, thinks) be in a situation of power because those below you are screwed, because you are privileged. No, that's not compatible. Either you're in that situation and you're aware of it and you like it or you get down from there. (Nurse in clinical practice 2, man)

> I've never gone up to the replacement nurse to say, "Look, this shouldn't be like this …" Because who am I to say anything. (…) It's exhausting to have patients

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> with monthly appointments to take their vitals, to control blood pressure, get weighed … (As if talking to a nurse) You are creating needs for patients. It is not because I don't want to work, but if the patients are well controlled, if they are within normal parameters, why do you see them every month? Shouldn't you make the most of that time to do other things? These are things you inherit (laughs). (Nurse in clinical practice 3, woman)

> What I see are problems I have on a daily basis. If they haven't been solved, it is because no one wants to solve them. I believe that our problems are not a priority. (…) More and more is spent on equipment. (As is she were talking to a manager) Having equipment is fine, but you need bricks! You're going to build the roof first and you're missing bricks! What you need is the people at the bottom, nurse assistants, nurses … You can have all the equipment you want, but if you do not have your bases covered, it's no good. Well, that's what I think. (Nurse in clinical practice 1, woman)

### 3.2 | Division of the plot of the stories into narrative planes

Participants reported a complex working life in their stories. An analysis of the formal content of their discourses suggested that untangling it was a challenge for them. The beginning of the textual corpus was chaotic and anarchic. The flow of the participants' ideas was not orderly. Multiple topics were addressed simultaneously, and they quickly skipped from one to another. The nurses had a lot to say. Gradually, they ordered their stories by arranging their story in two narrative planes. Consequently, the middle and end of the textual corpus appeared more structured. This arrangement reflected the shaping of the sense of nurses' experiences.

The participants were in the foreground, that is, they expressed themselves first about the experiences reflecting the most idyllic facet of their working lives. They first embraced their most positive and venturous reflections. They took a back seat, that is, they took second place regarding experiences that reflected the most unpleasant facet of their working lives. They postponed sharing their most negative and unfortunate reflections.

> (After reflecting on the most comforting issues of being a nurse, switches to a hopeless tone of voice), but everything around us … (prolonged silence). Everything around the nurse and everything that has to do with how we are looked at or how we are cared for by organizations … (sighs). That leaves much to be desired (puts the accent on “that” by adopting a derogatory intonation). (Nurse in clinical practice 1, woman)

The participants also divided the second narrative plane of their stories into two subplanes. Analysis of the participants' nonverbal language was useful in this regard. In the first subplane, they reflected on issues that were easier for them to convey. These were more concrete and could be common to the experiences of other professionals. The time they had to carry out their work, the (over) load of work they take on, the physical spaces to which they had access, the material resources they could use, and the salary they received were the addressed topics. They expressed themselves in an asserted, confident, and bold manner in this respect.

> Professionals ask for time. They ask for time and resources. They tell us, “I don't have the time to do the job as well as I know I could.” That's a common complaint in nurses in general, isn't it? They tell you, “I know I should go further, but during work hours I can't.” (Nurse in a political position 1, woman)

In the second subplane, they reflected on issues that were more difficult for them to define and portray. These were more abstract and specific to the nurses' realities. Professional recognition and representation were the addressed topics. They expressed themselves in an uncomfortable and even repressive way in this respect.

> We have to value our work and we have to show that it is necessary because if not it is not considered necessary (Pauses story and adopts an upright position) I don't know if I should tell you … Well, it doesn't matter, you'll cut it (says before relating a personal experience where the organization she works for demonstrated a lack of recognition of her work). (Nurse in clinical practice 4, woman)

> (Referring to the treatment received by the organization) I believe that this is a massive lack of respect and not so much towards us, but towards patients. This recording will not be heard by anyone, right? (Nurse in clinical practice 5, woman)

### 3.3 | Rhetorical transformation of reality

Participants tended to transform their working realities into realities different from the original ones. They used four resources for this objective: metaphors, abstract entities, summary, and humor. Analysis of the thematic and formal content of nurses' discourses suggested that these resources were seen as a shell that helped nurses not only relate their experiences of injustice but to deal with them on a daily basis in healthcare organizations.

In this way, nurses often interrupted the correspondence between the actual conception of their working conditions and their fictitious description. Metaphors seemed to be crystalized resources in the language of the participants. They used metaphors

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linked to war, sport, theater, or health to describe their work-life experiences.

> This struggle goes on and on and on … We still have to prove how capable we are to others, but we also have to prove it to ourselves because there are those still among us who do not believe in it, you know? (Nurse manager 1, woman)

> This is like football coaches, isn't it? A coach gets to a new team and the team has to prove it's changed, right? Well, middle managers believe that nursing is the same. A middle manager arrives at the care unit and the unit has to change and show something's changed (laughs), even though there is no reason for it to change. (Nurse in clinical practice 2, man)

> The committees where decisions are made (concerning nurses' working conditions) are pantomimes. Pantomimes! We all know where negotiations are made is in an office somewhere. (Nurse in union position 1, woman)

> Some nurses aren't fussy about working in one unit or another. They do their job and go home because it's their obligation. They do not value what nursing is (…). They are the virus of nursing: the people who do nothing to keep nursing moving forward. (Nurse in clinical practice 6, man)

The nurses tended to dispense with the "who" in their syntactic constructions, especially when they made negative judgments toward other individuals or structures. We coin these absent *who* as "abstract entities." The abstract entities manifested themselves in the participants' accounts through the use of personal pronouns without prior reference to the subjects to which they referred, of general and nonspecific entities and of impersonal sentences. Abstract entities point to a faceless person who was unlikely to be recognized if the interviewee did not expressly ask for them.

> I believe that we are not being asked enough to do the groundwork properly. We are asked to show that we can do lots of things (…) but we are also not very clear about what the institution asks us to do, what we are for the system (…) They order you, they dictate tasks… But sometimes there are things that … (leaves sentence unfinished). I think the system needs to pamper nurses a little more and tell them clearly what it expects from them and give them the tools to do it and to do it well because patients will benefit from this. (Nurse in clinical practice 7, woman)

The nurses would also give a narrative summary of the events in which they were involved. They were selective with the information they transmitted. They simplified the narrated events by ignoring some of their details, left their sentences unfinished, and assumed that the interviewer was aware of the outcome of the events. The simultaneous analysis of the thematic and formal content of the participants' reports suggested that nurses put these strategies into practice, especially during the reporting of their most negative experiences.

> (After addressing nurses' social recognition) I think the imbalance between what we contribute to society and the value that society attributes to us is unfair, you know? This sums it up, basically. (Nurse manager 1, woman)

The nurses finally also showed a tendency toward humor in their narration of events. They used laughter, irony, or sarcasm to cope with a tense face-to-face with their working conditions. The annotations such as "(laughs)" or "(adopts an ironic tone of voice)" in the illustrative verbatims chosen to present the results of the study have shown the recurrence of this resource in participants' accounts.

> I believe that all this (referring to the identified forms of injustice) has consequences in the same direction: towards the patient. (Pauses story) Yes I am badly treated, because in the end this is abuse, I think (laughs). (Adopts a lower tone of voice) What I'm saying is very serious, but it is the truth. This affects the patient (exclaims)! (Nurse in clinical practice 5, woman)

### 3.4 | Anecdotal inclination

Participants shed light on their experiences of (in)justice in healthcare organizations from a situational and contextual perspective. This fact anchored them in the microstructural space where the macrostructural political, economic, social, and cultural elements that makeup healthcare organizations practically converge to constitute the order of things. Thus, moments of theoretical abstraction aimed at endowing their experiences with meaning were unusual.

Anecdotes played a fundamental role to bring listeners closer to nurses' experiences. Expressions such as "I don't know how to explain it to you," "look, I'm going to give you an example because if not, I don't know how to explain it to you," or "I'll give you an example and you'll understand it better" were recurrent in their accounts.

> There is no decision made by nurses which pushes what the physician decides to second place. I'll give you an example because if not I don't know how to explain it to you. (…) For example, we screen patients who are candidates for peritoneal dialysis. However, if the physician considers that the patient is a candidate, even if you have made an assessment and see that he or she cannot be a candidate due to circumstances other than

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biological, your assessment will not count towards the final decision. (Nurse in clinical practice 1, woman)

### 3.5 | Constant support in comparison

Participants sought to acknowledge what united and made them equal as well as what separated and differentiated them from the other professionals. Comparison became a common practice among nurses as a means to understand their own status in healthcare organizations. Most of the comparisons were made in relation to the salary they receive.

Nurses compared themselves to a *plural other*. They placed on a vertical axis of comparison the professionals they considered to have a higher professional status than their own. These included physicians but also other nurses holding positions considered hierarchically superior. They also compared themselves, although to a lesser extent, with professionals whom they consider to have a lower professional status than their own. These mainly included nurse assistants and orderlies, but also professionals from non-healthcare fields.

> Physicians have acquired rights. I don't know if we can even call them "privileges" (…) We don't know why they have them, but they have them compared to us and they have them everywhere. (…) That's life … . (Nurse in clinical practice 3, woman)

> If I look at myself and ask myself: "What's the money like?," "Yes, I get paid well" (…) But if we as professionals compare ourselves with nurse assistants and orderly, by scale of responsibility … (grimaces) (…) An orderly has no responsibility, a nurse assistant has no responsibility, you get to the nurse and we have a lot of responsibility. Why is there that gap, you know? That's something I don't understand. (…) If I look at it that way, I think I'm getting too little for what I do. (Nurse in clinical practice 2, man)

> If you look at the basic salary … (Thinks) If they take away the complements, you earn more working at a supermarket (laughs) hardly any responsibility, you know? It's not that I'm saying that other jobs are well paid. I'm no one to say that. Every job implies taking on certain responsibilities, but if you take a closer look, you say to yourself: "Well, then I am not so well paid." (Nurse in clinical practice 8, woman)

The participants placed on a horizontal axis of comparison their more immediate other. That is, nursing colleagues who had the same position as them in the same or another healthcare organization and/or who worked at different levels of healthcare (primary, secondary, and elderly care).

> If I compare my work in hospital care with that done by a colleague in primary care (laughs) the issue is much bloodier. I mean, I don't … (thinks) I am not going to discredit the work of my primary care colleagues. I love it and I would love to do it. If I can, I will try to opt for it. But if you compare their work and mine, I don't understand why they get paid "so much" more than me, or even more than me. Why are there differences between a nurse in hospital, primary and social care? (Nurse in clinical practice 2, man)

Nurses also compared themselves and their colleagues on a temporal axis. They sometimes compared themselves to their individual past selves, that is, they analyzed their work-life experiences matching their current working conditions with their past ones. The analysis of the thematic content of the nurses' accounts suggested that these comparisons helped them to express the changes in meaning they attributed to the nursing profession. They felt that their work-life experiences had led them to lose their affection for the nursing profession.

> Being a nurse for me was one thing and now it's something else. (Pauses story and thinks) As a nurse, I understood "always being able to help," right? Being able to help others, feeling good helping (…) And now, over time, I have become frustrated because I have seen that being a nurse is this, but I can't do this … I can't because I don't have time to do my job well (sighs). (Nurse in clinical practice 5, woman)

However, participants mostly compared themselves to their collective past selves, that is, with those nurses that came before them. The analysis of the thematic content of nurses' reports suggested that these other comparisons helped nurses better understand why they are the way they are today. Through them, nurses encountered a sense of relief given the improvements in the status of nurses in healthcare organizations. In this regard, utterances such as "nurses have changed" and "the past and present of nurses have nothing to do with it" were common among participants. However, signs of progress as professionals quickly became illusory and dashed nurses' hopes for an emancipated future.

> (Referring to nurses) They have been made visible, an attempt has been made to empower them, but they are merely the managers' puppets. They are not autonomous. They are going through a still significant process of subordination. The healthcare system has a structure of deep patriarchal ideology and… It is true that it has made a lot of progress (…) But when it comes to practice, we are still practically at the same point. We don't help the physician with his gown, or bring him coffee—thank God—but we don't have a political or managerial voice. (Nurse in clinical practice 9, woman)

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## 4 | DISCUSSION

The results of the analysis of the formal content of nurses' discourses in this study supported the thesis that they do not give meaning to their daily work experiences solely through the thematic content of their narratives. They give them meaning simultaneously through the particular use of language in their speech acts (Dahlke & Hunter, 2020). This finding suggests the need for researchers to report not only on the thematic content of the narratives analyzed but also on their formal content.

In our study, the analysis of how nurses approached the description of their work-life experiences worked as an object whose study contributed to different aims. This contributed to a holistic understanding of the thematic content of the discourses analyzed. The way nurses expressed themselves during the interviews, including their verbal and nonverbal language, added meaning to their experiences of injustice in healthcare organizations. This enhanced meaning did not always occur in the same direction as the meaning arising from the thematic content of the participants' speeches. The work-life experiences that the nurses shared with the researcher pointed out that they fell into relationships of alienation from themselves, others, and the world and that these relationships were irremediable (Ceylan & Sulu, 2011). However, the way in which they reported them suggested something different.

The analysis of the formal content of the participants' reports suggested, unlike what is common in nursing literature, that nurses did not always manifest themselves as victims deprived of the capacity to transform their working conditions or as subjects whose only capacity for action was to reproduce the institutional status quo that maintained their subordinate status in healthcare organizations (Lunardi et al., 2017; McMillan & Perron, 2020; Ray & Turkel, 2014). The analysis of the formal content of the participants' narratives revealed the existence of discursive gaps from which nurses' political agency manifested itself through language. These discursive gaps allowed nurses to create microspaces of emancipation from which they inhabited in a different way the norms that prevail in the institutional status quo of healthcare organizations (Leeb, 2017; Marignier, 2015).

The boundary between the subordinating effects and the emancipatory effects generated in the participants' discourses was continuously redefined during the data analysis process. While relating their work-life experiences, the maintenance and the challenge of the order of things overlapped. Subsequently, beyond the hopeless thematic content about what it was like to be a nurse today, there was a language that possibly contributed to keeping the institutional status quo stable, but that possibly also contributed to opening spaces of freedom within it. Under this assessment, the results of our study are discussed below.

The use of the second person suggested that nurses continually sought to dissociate themselves from who they were, what they were doing, and what they experienced in healthcare organizations. They hid their "I" behind a "you." This made nurses spectators of their own realities. They recounted their own vulnerability by protecting themselves from it. Some participants explicitly corroborated this interpretation of the results. "(As a nurse) you have to depersonalize yourself or step an unreal distance away from what is happening or … (grimaces and leaves sentence unfinished)," explained the Nurse in clinical practice 2, man. Although through this way of approaching their work-life experiences, nurses seemed not to assume themselves to freely express their opinions in the first person. Thus, endowed with protective armor, their opinions were agentially presented.

The division of the plot of the stories into narrative planes suggested that nurses felt more or less entitled to express themselves about certain working conditions. They first addressed those issues that they considered objective, such as time availability, exposure to workload, access to space and material resources, and salary. They later addressed those issues they judged more subjective, such as professional recognition and representation. This created a hierarchy in their working conditions. Some participants explicitly corroborated this finding. In the first part of the interviews, they expressed themselves according to what they considered the basis of their working conditions. "Nurses need to have their bases covered. (…) The basic things for them are their free time, their leisure, their leave, their salary. If they weren't guaranteed, the job wouldn't work," explained the middle nurse manager 1, woman. The attention on these issues left social, cultural, and political issues influencing nurses' daily practice out of reach. This also affected nurses' perception of their own capacity for transformative action on their working conditions. Participants felt that they could do nothing to improve nurses' recognition and representation in healthcare organizations. They blocked their political agency prematurely. However, when they reported (on) their working conditions in different narrative planes, they did so strategically. They constructed their labor claims in a way they perceived that they had a better chance of being heard. Some participants stressed this respect, as did the nurse in clinical practice 1, woman, in that "(managers) see numbers and economics. If they don't see this, they don't attach much importance to it." They shaped their speeches to what others could value. This finding highlighted signs of agentivity in the participating nurses as the literature suggests that claims aimed at greater nurses' social recognition or representation in decision-making positions are not often heard (Briskin, 2012).

The rhetorical transformation of realities suggested that nurses avoided the act of reporting them. The resources used with this purpose, that is, metaphors, abstract entities, summary, and humor, were used by the participants to deal with difficult-to-face professional experiences. The nurses chose to confront artificially constructed realities. This left their current realities intact. However, some of these resources, such as metaphors or humor, simultaneously allowed for the expression of nurses' political agency. Participants strategically used metaphors to generate meaningful accounts and awareness of them (Zannini et al., 2015). They made their realities more familiar to the interlocutor because they considered others could not understand them as they had not experienced them firsthand. "People who are not inside (the profession), I think they do not understand, do not live these things

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so closely," explained the nurse in clinical practice 1, woman. The nurses also strategically used humor as a mechanism to manage the tension experienced when reporting the harshness of their working conditions. Participants showed difficulties in narrating their experiences through a more serious speech. While studies have traditionally focused on the study of humor in the context of the patient–nurse relationship (Beck, 1997), some studies approach humor as a coping strategy for nurses themselves (Adams, 2007; Bartzik et al., 2021). The use of humor should, however, be taken with caution. This risks fostering a culture of nurse resilience and trivializing nurses' work-life experiences while generating the idea that no transformative intervention is necessary (Traynor, 2018).

The inclination toward anecdotes suggested that nurses did not link their working conditions to the economic, political, social, and cultural structure that could give them a systematic explanation. This aligned with nurses' patterns of socialization. Nurses are trained to focus on the intimate sphere in which patient–nurse interaction occurs and build a territory of alienation around it (McMillan & Perron, 2020; Rudge, 2013). This led participants to propose ideas for change that did not involve a radical transformation of the forms of injustice they faced in their daily practice. In contrast, they proposed superficial and microcontextual remedies to them. These remedies led to injustice being (re)produced. However, nurses' capacity for a thorough analysis of "what is contextual" could be developed in another direction that considers the bigger picture where their working conditions are framed. Microcontextual remedies represent a necessary first step for macrostructural remedies that are able to strengthen individuals' progress toward their own emancipation (Fraser, 2013).

Constant comparison suggested that nurses needed others to better understand themselves. This way of reporting their work-life experiences contributed to the discursive construction of nurses as dependent on others (Dove et al., 2017). However, comparison also manifested itself as a strategy that participants used to ensure that the arguments to denounce their working conditions were not systematically dismissed and to renegotiate the power of other professionals and the power they themselves exercise in healthcare teams (McMillan & Perron, 2020).

In short, the results of the analysis of the formal content of the participants' discourses suggested that by only carrying out an analysis of their thematic content we lost the opportunity to stop considering nurses as mere nonpowerful and enforcers agents of the institutional status quo oppressing them (Lunardi et al., 2017). The analysis of the way in which the participants reported their work-life experiences allowed for the consideration of nurses as subjects with the capacity to deploy their political agency. Therefore, nurses' political agency manifested itself through the actions they undertook individually and collectively in healthcare organizations to make them resonate with their professional ethos, but also through the language they used during interviews. Thus, in this study, language was considered a form of action (Duranti, 2004; Hardin, 2001).

The results of the dual analysis of the thematic and formal content of the participants' accounts also allowed us to question the unnuanced approaches suggesting that a given action can only reproduce or challenge the institutional status quo. The acknowledgment of the tense boundary between these two effects would contribute to enacting tangible interventions aimed at tilting the balance toward challenging the order of things. How nurses report their work-life experiences reflects how they behave toward them in healthcare organizations. Being aware of this opens opportunities to devote efforts to the development of nurses' political skills that, embodied in language as a form of exercise of power (Buresh & Gordon, 2013; McMillan & Perron, 2020), would contribute to the deployment of nurses' political agency not only intended for the patient but also for themselves (Perron, 2013).

### 4.1 | Limitations

Limitations of this research respond to the impossibility of generalizing its results due to our reflexivity and positionality and qualitative approach. On the one hand, our reflexivity and positionality as researchers have shaped the orientation of the analysis of the results of this study. Researchers holding other social positions, personal experiences, and beliefs would have, perhaps, generated different results from ours (Berger, 2015). On the other hand, formal content analysis results of nurses' discourses are dependent on the context of the study. The language used by the nurses participating in this study may vary from nurses from other contexts. Replication of this study with participants from other cultural settings could generate different results (Wodak & Meyer, 2009).

## 5 | CONCLUSIONS

This article has aimed to raise the analysis of the formal content of discourse as an object of study. With this objective in mind, we have presented the results of this strand of analysis from a study focused on how nurses deploy their political agency to transform healthcare organizations into fairer environments and resonate with their professional ethos. The results of this study suggested that exploring the formal content of nurses' discourses sheds light on findings related to political agency hidden beneath the thematic content of nurses' discourses.

The analysis of how nurses report their experiences of injustice within healthcare organizations through the study of the most salient linguistic features in their speech acts thus has implications when considering nurses as political agents. Nurses reveal themselves, far from the traditional conception of powerless subjects, as subjects capable of transforming the spaces they occupy not only through the deployment of political actions in healthcare organizations but also through the way they report their experiences of injustice to others. Analyzing both the thematic content and the formal content of nurses' speeches becomes a perspective that needs to be considered if we aim to fully understand how nurses encounter injustice and how they challenge the organizational status quo to uphold justice for themselves and the patients they care for.

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The methodological value of dual approaches to discourse generates the need to devote research efforts to developing a tool to guide researchers in the holistic and critical analysis of the results of their study. This may be particularly necessary for those researchers whose expertise is not found in the linguistic features of the language. The analysis of the thematic and formal content of discourses should be considered if researchers truly intend to discover meaning beyond words. In nursing research, this also has the potential to contribute to the discursive construction of nurses as subjects with the capacity to exercise their political agency and transform the world around them so that it resonates with their professional ethos.

## CONFLICT OF INTEREST STATEMENT

The authors declare no conflict 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.

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**How to cite this article:** López-Deflory, C., Perron, A., & Miró-Bonet, M. (2023). Nurses' ways of talking about their experiences of (in)justice in healthcare organizations: Locating the use of language as a means of analysis. *Nursing Inquiry*, e12584. https://doi.org/10.1111/nin.12584

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