



# The meaning of professional identity in public health nursing

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**NÅR DET KJEM TIL STYKKET**

*År ut og år inn har du site bøygd yver bøkene,*

*du har samla deg meir kunnskap*

*enn du treng til ni liv.*

*Når det kjem til stykket, er det*

*so lite som skal til, og det vesle*

*har hjarta alltid visst.*

*I Egypt hadde guden for lærdom*

*hovud som ei ape.*

(Olav H. Hauge: *Janglestrå, Dikt i samling 1980*)

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Working on my dissertation has been an educational journey that I feel fortunate to have chosen. It started with my acceptance to the Nordic School of Public Health (NHV), Gothenburg, and because of the unfortunate closing of that institution; it is finishing at a good replacement, the University of Bergen.

Being a public health nurse myself, with experience in public health nursing education and in practice, I have developed an interest in learning more about the public health nursing profession. After completing my master's thesis on the role of public health nurses, I decided to pursue a doctoral degree so that I would have the opportunity to delve deeper into this area of study and to investigate specifically public health nursing identity.

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Ålesund 14.08.2015

Berit Misund Dahl

## SUMMARY

Because health care is constantly changing, public health nursing is experiencing new and demanding challenges, which can have consequences for the identity of the profession. The overall aims of this dissertation are to help generate knowledge and understanding of professional identity in public health nursing, in order to increase knowledge of how public health nurses (PHNs) are performing their tasks, and of how public health nursing can contribute to improving the quality of life and to reducing health inequality in the population. This study endeavours to generate knowledge and understanding of professional identity in public health nursing by (a) identifying the underlying governmental principles in the curriculum of public health nursing, (b) illuminating the experiences of PHNs in ethically charged work encounters and their influence on professional identity and (c) investigating knowledge and identity in the narratives of PHNs.

*Methods:* Two methods of analysis were applied: Fairclough's critical discourse analysis on the educational curriculum of Norwegian public health nursing (paper I) and the phenomenological hermeneutic method, inspired by the philosophy of Ricoeur, on individual interviews with 23 PHNs working at health clinics for children and young people and in school health services (papers II and III).

*Findings:* Paper I, the analysis of the curriculum, revealed conflicting discourses: (a) a competing social scientific and biomedical knowledge discourse, (b) a paternalistic meta-discourse and (c) a hegemonic individual discourse. The analysis suggests the existence of a dominant disease prevention discourse in the curriculum, thereby pushing the health promotion discourse to the background. Although recent policies concerning public health nursing focus more on health promotion, the analysis revealed that this is not sufficiently explicit in the curriculum text. One interpretation of this finding is that the curriculum is not in line with the policies, which state that PHNs are to implement health promotion and primary prevention strategies.

Paper II, about being in ethically charged encounters, revealed PHNs as follows: (a) feeling responsible and being engaged; (b) being committed and willing to stand up to fight; (c) feeling confident, courageous and trusted; and (d) feeling inadequate and unimportant. The action choices of PHNs had a moral basis, where the responsibility for service users was a deciding factor that could overshadow institutional demands. It seemed as though value conflicts mobilised courage, which is essential in maintaining moral strength. This in turn is important for a strong professional identity.

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In paper III, narratives about knowledge and identity, the following themes emerged: (a) being a generalist and using clinical judgement, (b) being one who empowers and (c) being one who is occupied with individual problem-solving and adherence to guidelines. Time was a deciding factor for the involvement of PHNs and displaced the primary prevention focus. The PHNs had a broad generalised knowledge of their special target group, thereby giving them a 'specialised-generalist' identity. Clarification of this position, in relation to jurisdictional borders, can create a strong public health nursing identity.

*Conclusion:* Discourses in society can influence the constitution of PHNs' identity, and the way in which PHNs describe their practice. How values and knowledge are used and integrated into clinical practice can be indications of how PHNs understand themselves and their identity. This study shows a complex and diverse public health nursing mandate and practice, which can pose a challenge to the constitution of a public health nursing identity. At the macro level, the limited focus on population in both the curriculum text and the practice experiences of PHNs suggests that the government directives stating that PHNs are to promote mental and physical health, good social and environmental conditions (healthy schools and healthy local environments), and to prevent disease and injury on individual and population level were not fulfilled. At the micro level PHNs worked from a moral basis, they were proud of their work, viewed their work as valuable and considered responsibility and trust to be core values. However they were challenged by constraints, such as time, which influence the execution of both macro-level directives and micro-level initiatives. The PHNs could be described as having a stronger identity in relation to personal and professional values (e.g., following up individuals in need) than in relation to institutional values of efficiency and loyalty to policy directives. A clarification of public health nursing as an exclusive working field and an elucidation of public health nursing as a specialised-generalist profession could secure the role of PHNs in relation to jurisdictional borders and strengthen the identity and legitimacy of the profession in their work towards improving the quality of life in the population.

**LIST OF PAPERS**

- I Dahl, B. M., Andrews, T., & Clancy, A. (2014). Contradictory discourses of health promotion and disease prevention in the educational curriculum of Norwegian public health nursing: A critical discourse analysis. *Scandinavian Journal of Public Health*, 42, 32–37.
- II Dahl, B. M., Clancy, A. & Andrews, T. (2014). The meaning of ethically charged encounters and their possible influence on professional identity in Norwegian public health nursing: a phenomenological hermeneutic study. *Scandinavian Journal of Caring Sciences*, 28, 600–608.
- III Dahl, B. M., & Clancy, A. (2015). Meanings of knowledge and identity in public health nursing in a time of transition: interpretations of public health nurses' narratives. *Scandinavian Journal of Caring Sciences*. doi: 10.1111/scs. 12196.

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# 1 INTRODUCTION

This dissertation concerns the public health nursing profession during a time of transition. With its universal service, public health nursing can be seen as a link between the government and the population on the subject of public health. The overall aims of this study are to help generate knowledge and understanding of professional identity in public health nursing, in order to increase knowledge of how public health nurses (PHNs) are performing their tasks, and of how public health nursing can contribute to improving the quality of life and to reducing health inequality in the population.

Over time, the working ideology in public health nursing has developed from an earlier disease prevention strategy with a focus on control and inspections and a ‘top-down’ expert role to a health promotion strategy with a ‘bottom-up’ empowerment role. The changes in public health nursing are reflected in the whole health-care system. These changes affect the health professions with regard to the development of a new organisation and working tasks and a possible change in professional status. The changes are evident from the increased focus on public health and health promotion ideology, the explosion in scientific and technical innovations and the adoption of a management ideology that emphasises efficiency and results (Ewens, 2003; Hjort, 2005; Levin et al., 2008; Winters, Gordon, Atherton, & Scott-Samuel, 2007). Increased attention is being placed on interprofessional collaboration, the flexibility of the labour supply and the neutrality of the professions. Emphasis is being placed on the value of educating health personnel so as to improve their adjustment to future tasks (Ministry of Health and Care Services, 2009b). Challenges related to today’s market orientation, professionalism and academic focus, where professionals are both communicators of scientific knowledge and dialogue partners, have raised questions concerning the meaning of professional identity in health professions (Hansbøl & Krejsler, 2008), and the nursing profession itself is struggling with defining and clarifying its professional identity (Willets & Clarke, 2014).

In health promotion and disease prevention work that is directed at children, young people and families in municipalities, PHNs occupy a central position. Their focus is mainly on improving the health of service users so as to promote personal and social growth, to increase the quality of life, to discover abnormalities, to initiate relevant actions and to refer service users in need to specialised services. They have a knowledge base not only in health promotion and disease prevention but also in nursing care (Keller, Strohschein, & Schaffer,

2011), which includes areas such as medicine, nursing, psychology, pedagogy and sociology.

The present understanding of public health nursing, as revealed from empirical data of the study, is outlined in a historical context of public health. The historical perspective places the profession within a political, organisational and professional development context in the welfare state.

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## 2 BACKGROUND

### 2.1 *The public health context*

Public health nursing has developed in a public health context. The public health concept can be understood as ‘collective action for sustained population-wide health improvement’ (Beaglehole & Bonita, 2004, p. 252). Public health policy has traditionally had a narrow view of public health, based on biomedical knowledge and disease prevention work (Beaglehole & Bonita, 2004); drawing from the biomedical disease model, health is understood as the ‘absence of disease’. This biomedical disease model is based on a pathogen risk focus, with attention given to problem-solving strategies. Disease prevention work can be divided into three levels of intervention: primary prevention, which focuses on responses towards the population that are intended to prevent problems, injury or disease from occurring; secondary prevention, which concentrates on limiting the duration and extent of a problem, injury or disease that has arisen; and tertiary prevention, which focuses on preventing or minimising the sequelae of a problem, injury or disease that has arisen (Caplan, 1964). The problems facing children, young people and families can be both personal and social in character. To fulfil their role, PHNs need to identify these problems. PHNs shall reveal risk factors and health problems at an early stage and follow up and refer children and families with special needs (Ministry of Health and Care Services, 2013) in accordance with primary prevention thinking, as child health clinics and school health services aim to serve the whole child population (Health Directorate, 2014).

Changes to the notion of health are traced back to 1948, when the World Health Organization defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1986). This definition was an individual approach to health, about ways in which to stay healthy and avoid sickness. It can be maintained that the Ottawa Charter for Health Promotion (WHO, 1986) led to a shift in the societal discourse of public health. The Ottawa Charter presented a ‘new public health’, advocating the importance of local communities as arenas for health promotion. As part of the United Nations, WHO (1986) set standards for public health and defined health promotion as the process of enabling people to increase control over the determinants of health, and thereby improve their health. Health promotion, which can be said to be grounded in social science, is focused on building relationships, empowerment processes and health resources, as well as on enabling individuals and communities to choose healthier

lifestyles. Empowerment can be defined as a process by which people are able to gain control over decisions and resources that influence their lives (Laverack, 2009, p. 4).

The Ottawa Charter helped shift the focus to interprofessional collaboration and changes in professional education (and to which it could be expected that the curriculum of public health nursing refers). The new public health ideology was described as the total contribution of society in maintaining, improving and promoting public health. The main concepts included quality of life, substance of life, safety and coping. Important approaches in public health work included the participation of the population and the implementation of empowerment strategies. Individuals and communities were expected to take more control of their own health and to implement ways in which to better their own health, focusing on improving and extending the quality of life and on reducing health differences in the population (Ministry of Health Services, 2003). This form of thinking was recognised in the Coordination Reform (Ministry of Health and Care Services, 2009b), in which municipalities have been given greater responsibility for health services. A new Norwegian public health white paper (Ministry of Health and Care Services, 2013) is aimed at a population with more years of good health and well-being and with reduced social inequalities in health, as well as at a society that promotes good health throughout the entire population. Of especial interest to PHNs is the prioritisation given in this white paper to the further development and strengthening of health clinics and school health services.

Through the passing of laws and the implementation of regulations, the Norwegian government has given the public health nursing profession a mandate, saying that PHNs shall concentrate on health promotion together with the disease prevention strategies (Ministry of Health and Care Services, 2003, 2011c). They are to have a 'health focus', which entails searching for resources and strengthening aspects of public health care and improving children's and young people's coping abilities as well as parents' ability to cope in the role of parent, in line with the salutogenic theory. Antonovsky (1987) developed the theory about salutogenesis, which has had influence on PHNs' health promotion work. The concept of salutogenesis focuses on healthy factors (i.e., how to stay healthy by strengthening positive factors and how to restore meaning and coherence) and is distinct from pathogenesis, which is about pathogenic factors. In his theory concerning Sense of Coherence (SOC), which he maintained must be viewed as complementary to prevention efforts, Antonovsky emphasised coping strategies and coping resources in individuals. Previous research has indicated that SOC is about managing a situation, which is carried out by understanding the situation (comprehension), holding the belief that a solution can be

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found (manageability) and finding meaning in trying (meaningfulness) (Antonovsky, 1987; Eriksson & Lindström, 2006). The theory of salutogenesis is related to the individual level of health promotion work, and can be of importance for PHNs as they work much on individual level.

## ***2.2 The professionalisation of public health nursing***

Sunnhedsloven (Health Act) of 1860 first publicly regulated public health in Norway. An outline of the historical development of Norwegian PHNs (Schjøtz, 2003), show that the precursor of public health nursing can be traced back to the beginning of the 20th century, a point in time when the clinical picture changed with population growth and medical development. Infectious diseases, notably tuberculosis, had become a great problem and were defeated by improvements in housing standards, nutrition, hygiene and medical treatment. There existed an interest in the connection between public health and living conditions, as well as the need for health-care specialists (Melby, 2000). In the beginning, nurses worked together with volunteer organisations and performed prevention work. The volunteer health work carried out by humanitarian and religious organisations occupied a central role in society until the 1970s (Schjøtz, 2003), and it laid the foundation for the development of the welfare state. As early as 1914, the Norwegian Women's Public Health Association established health clinics for mothers and children in Oslo, and the first school health service was organised in 1918. The PHNs had a unique position in fulfilling the public health goals, as they were employed by the voluntary organisations and where the organisations were provided with government funding. The voluntary organisations were working with public health nursing until 1972, at which point the Law on Child Health Clinics and Health Initiatives among Children (Ministry of Social Services, 1971), was implemented, allowing PHNs to be publicly employed. It can be maintained that the PHNs have occupied a unique position as 'health-missionarys' or health educators close to the population, with the responsibility of rebuilding the health-related political goals of the welfare state after 1945 (Schjøtz, 2003).

The development of postgraduate studies in public health nursing education started in 1924, at which time the volunteer associations together with the doctors proposed a nursing education programme of shorter duration and then a 9-month course. However, the Norwegian Nurses Organisation (NNO) demanded a 3-year nursing education programme as the basis for public health nursing education. The NNO, established in 1912, played a central

role in the fight for a 3-year nursing education programme (Mathisen, 2006). The arguments for a longer nursing education programme were to ensure the quality of the education and training and to instil competence in the nursing students. Eventually, the doctors also accepted these arguments in support of a 3-year nursing education programme. However, nursing education was not publicly regulated until 1948. The perception that nurses with postgraduate studies in public health nursing were best qualified to work in child health clinics was supported by the Norwegian Women's Public Health Association (Melby, 2000). As a consequence, the Norwegian School of Public Health Nursing was established in 1947, as a 1-year specialised education programme that was open to nurses who had successfully completed the 3-year nursing education programme. With the establishment of the public health nursing education programme, the nurses' knowledge base expanded from a caring and medical/nursing knowledge base to a knowledge base that included epidemiology and public health strategies (Neumann, 2009).

### ***2.3 Changes in tasks and organisational structure***

In the beginning, community nurses' public health work mainly consisted of disseminating health education on infectious diseases and hygiene and of providing health services in schools and child health clinics. Upon completing the 1-year postgraduate programme in public health nursing, the nurses were given formal responsibility to work as health inspectors and health controllers, which entailed a variety of tasks, such as water testing and inspections of cafés, hair styling salons and camping sites. They were also responsible for performing home visits to mothers and their children and screening controls of all pupils for height, weight, sight, hearing, vaccinations and tuberculosis. The leader of the Health Directorate in Norway, Dr. Karl Evang (1976), named PHNs as the district doctors' right hand (p. 73). Evang was a driving force behind the public takeover of private child health clinics, with the ultimate aim of providing a universal service and a standardisation of services (Jákupsstovu & Aarseth, 1996). A line can be drawn from these universal health services back to the days of Florence Nightingale. She established education for children's nurses, focusing on universal health education and prevention, and home visits to families so as to improve general public health (Nightingale, 1859/1969). With the introduction of health promotion strategies in the 1970s and 1980s, PHNs have gradually changed their role from a 'top-down' expert to a 'bottom-up' model based on empowerment ideology, enabling service users to make independent choices regarding their health and lifestyles (Andrews,

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2002; Dahl, 2004; Tveiten, 2006). Some examples of new tasks are the establishment of maternity groups and parent groups that provide support and guidance regarding boundaries, children's sleep habits and other aspects of the parent-child relationship. In schools, screening controls have been mainly replaced by goal-oriented health check-ups based on knowledge concerning the needs of individual pupils. In new arenas such as high schools, university colleges and health clinics for young people, PHNs communicate with young people on themes such as relationships, sexuality, contraception and physical and mental health. Today, Norwegian PHNs work on the promotion of mental and physical health, the promotion of healthy social and environmental conditions and the prevention of disease and injuries in clinics for children and young people and in school health services (Social and Health Directorate, 2004). The target group is more specific in Norway, with the focus on health promotion and disease prevention, whereas PHNs in other countries often provide both curative and preventive services for the whole population (Philibin et al., 2010).

Governmental responsibility for the public health nursing service first came into effect in 1974 with the implementation of the Act on Child Health Clinics and Health Initiatives among Children (Ministry of Social Services, 1971). The act was important for PHNs, as they got an own County Public Health Nursing Office and an own steering structure both on county- and municipality level. Both the administrative and the professional management of the service were assigned to the PHNs themselves, with the county PHN as a leader of public health nursing in the municipalities. However, only a few years later, the management of PHNs was transferred to a municipal administration through the Municipal Health Services Act of 1984 (Ministry of Local Government, 1982). This change resulted in the closing of the County Public Health Nursing Office and, ultimately, a loss of authority for the PHNs. At the same time, the administrative leadership role in child health clinics and school health services was no longer restricted to PHNs; this role was opened up to members of other professions. The Municipal Act of 1993 (Ministry of Local Government, 1992) allowed the organisation of separate services for children and young people. Some examples are interdisciplinary childhood and youth services, Child Protection Services and Preschool Service, often administered by professionals without a health education background. For PHNs, the new forms of organisation in the municipality meant that PHNs could also lose their close relationship with the health authorities at the municipal level. A legal amendment in 1997 led to PHNs' loss of monopoly for the management of child health clinics and school health services. As a result, both midwives and PHNs were given the opportunity to be administrative leaders of health clinics and school health services



(Ministry of Social and Health Services, 1997). Until recently, the Municipal Health Services Act (Ministry of Local Government, 1982) maintained the responsibility for public health. In 2012, this act was replaced by the Municipal Health and Care Services Act (Ministry of Health and Care Services, 2011a), which also include the former Social Services Act and the Specialist Health Services Act. The new act defines a common value base; as a holistic service, the focus on prevention, collaboration and patient and user participation is emphasised in the act. A new Public Health Act (Ministry of Health and Care Services, 2009a, 2011b) has also given the county administration a legalised responsibility for public health work, including the promotion of welfare and good social and environmental conditions and the prevention of diseases, injury and illness. Tracing the history of the management of PHNs in Norway has revealed different periods with various forms of management and degrees of independence. Initially, medical officers carried out the management of PHNs—albeit with a great amount of independence on the part of PHNs. This was followed by a period during which PHNs were allowed to act as independent administrative and occupational leaders. Today, PHNs have to a great extent lost the administrative link to decision makers (Andrews & Wærness, 2011). However, Jákupsstovu and Aarseth (1996) maintained that this has also made PHNs independent and that they are no longer assistants to doctors.

## **2.4 The research field**

To operationalise the concept of professional identity, and values and knowledge in professional identity, I searched for studies on this topic in data sources such as MEDLINE, ISI Web of Science and SCIRUS. I used the following search terms, alone and in various combinations: *identity, knowledge, nurse, professional identity, public health nurse and value*. A large number of publications were found, and a review of the literature revealed that research on values and knowledge in professional identity in nursing has garnered increased attention in the past decade; however, there is a lack of studies on values and knowledge in professional identity in public health nursing.

Research on professional identity among nurses has suggested that nursing identity was stronger in the past and that it has become more complex and diverse (Harmer, 2010; Tye & Ross, 2000). Health professions have experienced changes in work focus and have had to adapt to working with new service users and in new ways; in turn, these changes and adaptations have challenged their professional identity (Griffiths, 2008; McKenna,

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Thompson, Watson, & Norman, 2006; Scholes, 2008). These developments are also relevant for Norway. Owing to new challenges, the professional identity in nursing groups is blurred (Crawford, Brown, & Majomi, 2008), and nurses can lose their identity when working in skill mix teams as their tasks/responsibilities and individual roles as nurses become less defined (White & Kudless, 2008). The sharing of tasks/responsibilities when working in teams is equivalent to crossing work boundaries, and studies have pointed out that this may result in the loss of nursing identity (Castledine, 2002; Harmer, 2010), which can have consequences for the focus on values and quality in public health nursing work. Adapting work tasks to meet new requirements also represents a challenge for the nursing profession. In light of these challenges, nurses desire a collective nursing identity (White & Kudless, 2008). Lowe, Plummer, O'Brien, and Boyd (2012) defended that clarity about professional identity is needed to strengthen the nursing role. These findings point to the fact that professional identity in nursing groups is under pressure and that focusing on practical experiences can shed light on how challenging working conditions influence the identity of the public health nursing profession.

Values and professional identity are closely related (Fagermoen, 1995), and when actions are not based on values, professional identity is negatively affected. A review of the literature on public sector professional identities revealed that government and institutions disclaim core values, which in turn creates resistance discourses among professionals (Baxter, 2011), and these societal and professional discourses can influence on the identity of the professionals. Clancy and Svensson (2007) studied Norwegian PHNs' feelings of responsibility. Their findings suggested that the essence of PHNs' responsibility towards others was associated with personal responsibility, boundaries, temporality, worry, fear and uncertainty and a sense of satisfaction. They concluded that PHNs' feelings of responsibility for others are personal and have unclear boundaries (Clancy & Svensson, 2007). Fagermoen (1995) found that altruism and human dignity were core values of the professional identity of nurses and that nurses experienced meaninglessness when they could not satisfy the needs of patients. Previous research revealed that both personal and professional values are expressed, that they are important as a knowledge base in nursing work and that they play an important role in constituting professional identity.

In the description of a profession and the constitution of professional identity, the knowledge base is vital (Salling Olesen, 2001). Hurley (2009) studied mental health nurses' identities and found that they had a cluster of capabilities and transferable skills and were 'generic specialists', meaning they constructed an identity that is characteristic of the

perception that no other profession could do what they did. In their study on knowledge, Tabari Khomeiran, Yekta, Kiger, and Ahmadi (2006) found that experience, personal characteristics and theoretical knowledge influenced the development of professional knowledge. A study by Deppoliti (2008) revealed that the successful adaptation of new registered nurses to their profession was influenced by the following factors: the need for continual learning and perfection, the need for balance and support in the practice environment, a sense of responsibility and the development of relationships. Gregg and Magilvy (2001) studied professional identity in nursing groups and developed the concept of 'bonding into nursing', which involves learning from work experiences, establishing one's own philosophy of nursing, receiving positive influences from education, having a commitment to nursing and integrating the role of nurse into the self, which means also being a nurse outside of work. Nurses as role models to other nurses were seen as essential in establishing professional identity as nurses (Gregg & Magilvy). Christensen (2011) found that the advancement of nursing practice was influenced by how theoretical knowledge and practical knowledge were used and integrated into clinical practice. Theoretical knowledge is understood as evidence-based knowledge that can be standardised, whereas practical knowledge denotes skills and clinical judgement in practice situations (Martinsen, 2006). Markham and Carney (2008) studied Irish PHNs and found that they had altered their role and scope in response to societal changes, technological developments and demands for an evidence-based service, which represent challenges related to the quality of care. Although Markham and Carney's study described an Irish public health nursing setting, there are similarities to the situation of Norwegian PHNs (Clancy, Leahy-Warren, Day, & Mulcahy, 2013).

The studies have suggested that possessing theoretical knowledge, practical knowledge and skills, being involved in continued learning processes and developing perfection can constitute and cultivate nursing identity. Possessing an understanding of an exclusive nursing philosophy and working field can be vital to the constitution of professional identity together with the influence of discourses in society, and this knowledge was the basis, when investigating public health nursing identity in the present study.

## **2.5 Aims and research questions**

The overall aims of the dissertation are to help generate knowledge and understanding of professional identity in public health nursing, in order to increase knowledge of how PHNs

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are performing their tasks, and of how public health nursing can contribute to improving the quality of life and to reducing health inequality in the population.

The research questions are as follows:

- (a) What are the governmental principles for how public health nurses should promote health and prevent disease as expressed in the curriculum of public health nursing?
- (b) What are public health nurses' experiences of being in ethically charged encounters, and how can these experiences influence their professional identity?
- (c) How is the meaning of public health nursing knowledge and identity expressed in PHNs' narratives in a continuously changing practice?

The present understanding of public health nursing, as revealed from empirical data of the study, is outlined in a historical context. Thus, the study can give an understanding of who PHNs have been, as described in the historical background; who they are, as illuminated through the empirical findings; and who they can become, as indicated in the Discussion section.

This study does not discuss the development of professional identity among public health nursing students. Obtaining the level of education necessary for a profession is about learning processes, about identifying with a practice field and a profession and about identifying oneself as a professional practitioner (Heggen, 2008). (For a study on public health nursing students' experiences of practice, see Hjälmhult, 2009.) Because almost 100% of Norwegian PHNs are female, a gender perspective is not the focus.

## ***2.6 The structure of the dissertation***

The remaining chapters of this dissertation are organised as follows: Chapter 3 outlines the theoretical framework of the study, which builds on theory of professional development, concepts of values and knowledge, the philosophy of Paul Ricoeur and theory of professional identity. Chapter 4 describes the employed methods, which are critical discourse analysis and phenomenological hermeneutics as well as methodological and ethical considerations. The findings are presented in chapter 5 and discussed in chapter 6; this discussion is based on relevant research, the theory basis, the findings and an awareness of my preunderstanding. Chapter 7 presents the conclusions of the study, describes implications for practice, and provides suggestions for further research.

### 3 THEORETICAL FRAMEWORK

To guide the analysis and shed light on the findings, the following theoretical approaches were adopted in writing the dissertation: professional development, concepts of values and knowledge, the philosophy of Paul Ricoeur and professional identity. These approaches were found relevant, as professional identity is developed in communities of practice and influenced by discourses in society.

#### *3.1 Professional development*

To develop a better understanding of professional identity in public health nursing, a historical perspective on professional development is outlined. The approach to studying the concept of professions is not straightforward. In the 1950s, the traditional structural functionalist perspective asserted that professionals worked in harmonious institutional value communities (Parsons, 1988). This perspective has been criticised for leaving little room for relational professional development, as professionals are managed by institutional values more so than by the values of the profession. Weber (1978) described the development of bureaucracy where professionals have the power to gain a monopoly of a specialised knowledge field. Professions were understood as interest groups with particular privileges, which were not equally distributed. When one profession has a lot of power, the other professions have less power and are dislodged from the privileges of that profession. Weber referred to this as a closure mechanism (Fosse, 2007). There also exists a hierarchy of professions, with the power to prevent others from performing the same tasks (Abbott, 1988; Freidson, 2001; Witz, 1992). A profession has been traditionally defined as ‘a particular, long-lasting formal education acquired by persons who are mainly oriented towards achieving particular occupations, which, according to social norms, cannot be filled by persons other than by those with that education’ (Torgersen, 1972, p. 10).

Abbott (1988) captured the diversity of a profession by describing a profession as an exclusive occupational group that has a particular knowledge base and a particular target group and that is organised under various kinds of jurisdiction. The knowledge base of a profession can characterise and define a profession (Torstendahl, 1990), and scientific knowledge is the basis for professional legitimacy. Professionals have a specialised knowledge and strive for boundaries to other professions; however, these boundaries are not static and can be negotiated (Abbott). One way to characterise a profession is to examine its jurisdictional borders. Public health nursing can be understood as having a particular knowledge base and

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jurisdictional borders to other professions. Jurisdictional borders create a clear distinction as to who is inside and who is outside the profession (Abbott). These jurisdictional borders can relate to a profession's monopoly of particular knowledge and tasks. Abbott distinguished between different types of jurisdiction: full, restricted and intellectual jurisdiction. Full jurisdiction involves a profession that, through legislation, has full control of its working field. Restricted jurisdiction is a division of labour, where a struggle for work tasks exists and where clear boundaries are established as to whom can be incorporated into the fellowship. Intellectual jurisdiction is about different subgroups. One example is consultative jurisdiction, meaning that a profession can receive advice from another profession. Another example is client differentiation, where service users are divided among professional specialisations inside the same profession. The jurisdictional boundary of a profession is not permanent but rather depends on other professions' jurisdictions. The degree of control over working tasks determines how a profession is developing, and jurisdictions related to knowledge and tasks in the public health nursing profession are discussed in this dissertation.

Public health nursing has full jurisdiction of its professional field through legislation. The public health nursing service is regulated by the Health and Care Services Act (Municipality Health and Care Services, 2011a) the Public Health Act (Municipality Health and Care Services, 2011b) and the Act relating to Health Personnel (Municipality Health and Care Services, 1999). Because of their authorisation as nurses, PHNs have a professional authority, and they have a monopoly of public health nursing positions, which gives the public health nursing profession a position that can strengthen its identity in relation to other professions. However, PHNs have a limited jurisdiction in relation to medical tasks, such as vaccinations. In this type of situation, doctors delegate authority to the PHNs.

The specialisation of the public health nursing profession is an example of intellectual jurisdiction. Many PHNs specialise in different fields such as parent counselling and suicide prevention. Discussions concerning specialisation inside public health nursing are in progress (Dahl, 2004). Closure mechanisms and the borders that define the profession can be blurred when specialisations occur in specific fields within the profession and can place the mandate of the profession under pressure.

Professions have been gendered to a great extent. Salling Olesen (2006) explained that professional practices and identities are related to gendered subjectivity, with traditional gender recruitment to professions occurring, such as men to medicine and women to nursing. Witz (1992) argued that gender could be associated with power and closure mechanisms in a

profession. In her research on the medical profession, Witz found that control of recruitment has been within the masculine realm. However, there are now signs of departure from this pattern, particularly in the medical profession, where women are rapidly increasing in number. The gender changes are not as evident in nursing—particularly in public health nursing, which is still mainly a female profession.

Adjustments in society affect certain professions such as doctors and psychologists (Salling Olesen, 2004), and these professions can experience similar changes and undergo similar change processes as those of PHNs. The development of specialist knowledge and restricted areas of knowledge in professions, has led to the loss of monopoly by the classical professions, which in turn has resulted in the emergence of new professions. The existence of professions, in terms of its traditional meaning, has been questioned (Freidson, 2001), however Freidson maintained that despite great ideological pressure on the profession related to market liberalism, professional institutions will continue to exist owing to the need for specialised knowledge. According to Abbott (1988), when competition exists between professionals, it is important for groups of professionals to gain jurisdiction of specific areas. In the past few decades, the knowledge boundaries between professions have not remained static but rather have been renegotiated through professional struggles (Abbott). The renegotiation of knowledge boundaries has also occurred in the nursing profession (Moseng, 2012) and in public health nursing (Neumann, 2009), and which can have consequences for the identity of the profession.

### ***3.2 Professional values and knowledge***

Values and knowledge are fundamental to professional identity. A profession is founded on specific values related to an ideological basis and is more preoccupied with quality than efficiency of work (Freidson, 2001). Public health nursing has a value base in its ethical guidelines (Norwegian Nurses Organisation [NNO], 2011b). Freidson (2001) maintained with the theory of the third logic, that the normative values and ideology of a profession can be more important than the exclusive knowledge of the profession in today's society, where bureaucratic and economic values have a strong influence on professional work. The concept of values can have different definitions. From a management perspective, Busch (2012) presented three common features: One common feature is that values can be understood as latent concepts, or a hidden compass, influencing the thoughts and actions of the professional. A second common feature is that values are general and, hence, may be

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relevant in different situations. A third common feature is that values can exist on different levels—individual, professional and institutional levels. Individual values here refer to personal values, such as trust and respect. Values on a professional level refer to professional standards that provide guidelines for professional practice, for example, quality and participation. Institutional values are bureaucratic and economic values, such as loyalty and efficiency (Busch). Understanding values is also important in public health nursing. The personal values of the professional are individual values, which develop throughout life; these individual values interact with professional values, which are the prevailing professional standards, and with institutional values. Together, they contribute to the value base of the individual practitioner.

The values of nurses are fundamental to their professional identity (Fagermoen, 1995), together with the knowledge base. The ethical code of a profession, which is founded in professional values, functions on two levels: On one level, it functions to secure legitimacy and acceptance of the profession on an external basis. On another level, it functions to secure internal integration of professional ethical values (Busch, 2012). The ethical guidelines for Norwegian nurses state the professional, ethical and personal responsibilities of nurses in the practice of nursing (NNO, 2011b, p. 17). Ethical theories relevant to health professions are duty ethics, virtue ethics and ethics of proximity (Busch, 2012). Duty ethics, which are based on rules, focus on the motive of the person performing the action. Virtue ethics refer to the ethical character of the professional and are similar to good personal qualities and ‘good actions’ described in *The Nicomachean Ethics* (Aristotle, trans. 2004). These are based on the practical wisdom of the practitioner, described in Aristotelian terms as the intellectual virtue of phronesis (Skjervheim, 1996). Aristotle maintained that a value to society is when the result is a ‘good action’ or ‘in the best intentions’. Ethics of proximity are connected to trust in a practice situation. For example, PHNs work in proximity to service users and have a relational perspective. Martinsen (2006) asserted that caring in nursing is a moral practice. Whilst caring for service users, PHNs bring their personal values into the professional field and develop their ethical practice and commitment to work through dialogue and reflection in practice, and this value work is important in constituting the professional identity.

Professional knowledge is specialised and founded on a theoretical, scientific knowledge base (Freidson, 2001). Public health nursing is founded on and is part of the history of nursing knowledge development. The nursing profession has traditionally emphasised empirical knowledge, but with the specialisation of health care after 1945,



nursing science has been developed so as to define and strengthen the nursing profession. Martinsen (2003, 2005) pointed out the significance of situational knowledge other than positivist knowledge and evidence-based knowledge and maintained that *phronesis*, or practical wisdom, and relational competence must be valued above scientific knowledge in nursing. The concepts of evidence-based/knowledge-based practice and evidence-based nursing are used interchangeably, and have their origins in evidence-based medicine (EBM) (Martinsen, 2005; Nortvedt & Jamtvedt, 2009). The following is an oft-cited definition for EBM:

Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. (Sackett, Rosenberg, Muir Gray, Haynes, & Richardson, 1996, p. 71)

This definition has some points in common with the knowledge theory of Aristotle (trans. 2004), who linked knowledge to the character of individuals. Aristotle categorised knowledge under the intellectual virtues of *episteme*, *techne* and *phronesis*, where intellectual virtues mean the knowledge must be used with the best of intentions. The term *episteme* refers to eternally true knowledge—or what can be interpreted today as evidence-based knowledge and theoretical knowledge. The term *techne* refers to practical knowledge; it is about creating and producing, for instance, procedures and techniques. The term *phronesis* refers to situational knowledge, in which clinical judgement is based on both theoretical and practical knowledge. Aristotle introduced the idea of *praxis* when referring to actions that are performed in accordance with a right standard or practical wisdom (*phronesis*). He explained that the action is right when the action is truthful. Through sincere involvement, engagement and mutual dialogue with other people, individuals act virtuously (Martinsen, 2003; Skjervheim, 1996). When PHNs use theoretical knowledge and practical knowledge together with clinical judgement in their interactions with service users, *phronesis* can be developed, comprising the value and knowledge base of the PHNs.

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### 3.3 *The philosophy of Paul Ricoeur*

When reviewing the literature on public health nursing identity, I found the philosophical contributions of Paul Ricoeur to be of great interest, not only his philosophical theory about narrative identities but also his contribution to the phenomenological hermeneutic method of narrative analysis. Ricoeur (1976, 1992) maintained a critical hermeneutic perspective on human action in life and asserted that human action is based on good intentions and a desire for a good society. The aim of this study was to explore the meaning of public health nursing identity in order to strengthen the quality of work so as to benefit the population, as a clarification of professional identity is also a clarification of the professional responsibility towards the population and is related to the quality of work (Freidson, 2001).

Ricoeur's critical hermeneutics was developed from the phenomenological tradition. Phenomenology is about describing phenomena to find their meaning and essence. The philosopher Edmund Husserl, known as the founder of phenomenology, focused on ascribing meaning to human challenges, ahead of reflecting and theorising. However, Husserl has been criticised for having a naïve approach to the lifeworld (Polit & Beck, 2012), as it is difficult to investigate a phenomenon without having any knowledge of it. Unlike Husserl, Heidegger (1962) maintained that the objective of phenomenology is to try to see beneath and behind subjective experiences so as to reveal the genuine nature of 'being in the world' and to try to understand phenomena, not merely describe them. Gadamer (1976) asserted that humans all have a partly unconscious horizon of understanding that is built on their historical existence and from where all understanding is structured. Gadamer introduced the hermeneutical circle and emphasised a dialogue with the phenomenon, a continuous analytical questioning of the possibilities in the parts and in the whole content of meaning, an approach that proved advantageous in the present study.

Ricoeur (1976) used language and the symbols of language to enter the study of hermeneutics. He distinguished the language between an internal organisation and an overarching social growth of opinion, which goes beyond the lifeworld of the individual (Hermansen & Rendtorff, 2002). Ricoeur (1992) pointed out that when individuals narrate, they try to make meaning and sense of a situation. The method inspired by Ricoeur (1976), about phenomenological hermeneutic analysis of narratives was found relevant when illuminating professional identity in public health nursing. The interpretation of PHNs' communication of experiences to me as an interviewer could elucidate ways of working as a nurse. In a somewhat simplified means of explanation, I uphold that whilst a phenomenologist seeks the essential truth in the human lifeworld, many truths emerge

through interpretation, as Ricoeur (1976) suggested, but some interpretations are more probable than other interpretations (p. 79).

### ***3.4 Theory on identity***

To increase the understanding of the mechanisms that constitute professional identity in public health nursing, theories on identity and professional identity are included in the Theoretical Framework section and the Discussion section of this thesis and further related to practical implications. The concept of professional identity is explained in a variety of ways in the literature (Beijaard, Meijer, & Verloop, 2004)—or is sometimes simply not defined (Andrew & Robb, 2011). In general, professional identity is based on the definition of identity. The understanding of identity has developed from a relatively stable configuration, which is dependent on the context and the social environment, to a late modern and a postmodern understanding of identity, which is optional or a reflective project about choosing and changing of identity that is dependent on the situation (Heggen, 2008). Psychological, sociological and philosophical positions can be derived, and can contribute to the understanding of professional identity in public health nursing.

Inspired by Freud, the psychoanalyst E.H. Erikson (1956, p. 57) explained identity as meaning both the sameness within oneself and the sharing of some essential characteristics with others. Erikson maintained that the development of a professional identity in relation to the development of an adult ego was influenced in a systematic way by organised values and institutional efforts on the one hand and by mechanisms of ego synthesis on the other. Erikson influenced Mead, who is often associated with the symbolic interactionist perspective. According to Mead, identity exists in two parts, an 'I' (the self) and a 'me' (the social part). In addition, Mead (1962, p. 164) stated that individuals build their identity through interactions with other people and that a social individual or a self cannot exist without interacting with others.

The late modern perspective of Giddens (1991) asserts that identity is constructed and maintained in reflexive activities, as narratives of earlier episodes. There are no fundamental truths about an identity, just new constructions, and the resilience of an identity depends on upholding a particular narrative (Giddens). The postmodernist tradition maintains that a particular identity is not important; the individual plays different roles, depending on the circumstances (Jenkins, 2008). Criticism can be aimed at the postmodernist direction for being too relativistic and to the fact that identity is not based on fundamental

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values.

Ricoeur (1992), inspired by Mead, emphasised that identity comprises character qualities of the self. Identity is about the identification of characters that are alike from one point in time to another and, thereby, are what constitute the self. Ricoeur, employing a critical hermeneutic way of thinking, maintained that individuals continuously create and interpret identity through cultural narratives. Unlike Giddens, he claimed that historical time is something that is both external and internal to the individual and that it influences identity construction. Ricoeur's identity theory is both about an identical or stable part and a social part, developed by narrating about and reflecting on situations and influenced by the surroundings. Identity can be explained by the Latin words *idem* (sameness) and *ipse* (selfhood) (Ricoeur, 1992). *Idem* is the character, a substantial form; it can refer to the stable characteristics or values of an individual, characteristic that are enduring and identical. *Ipse* involves self-esteem and self-respect; it can refer to acting virtuously despite different settings. The sameness and the self of a person meet and constitute a narrative identity (Ricoeur, 1992).

Through interpretation and explanation of all the surrounding narratives, humans can gain an understanding of what it means to be a human (Ricoeur, 1992). Hence, understanding narration as identity constitution depends on the possession of an understanding of identity as a relational concept (Mishler, 1999). The constitution of an identity can be understood as a mimesis process (Ricoeur, 1984). Mimesis can be defined as an imitation or presentation of earlier experiences. As explained in *Poetics* (Aristotle, trans. 1997), it is because something imitates something else that one can recognise the one in the other. In the present study, the mimesis process was transferred from an individual identity level to a professional identity level, and contributed to explaining the constitution of a professional identity in public health nursing.

### ***3.5 The constitution of professional identity***

In accordance with Ricoeur (1984), the mimesis process in public health nursing comprises three steps. Mimesis I is the prefiguration or basis of action, which is influenced by personal, professional and institutional values and knowledge of public health nursing. Mimesis II is the configuration of the plot, which is the communication of lived experience, and it is during this step that the narratives of the practice experiences of PHNs take place. Mimesis III is the interaction between the narrator and the listener, and it is during this step that the

reflection in practice takes place between PHNs—or, in the present study, between the PHN and the researcher—and that the interpretation process can help find out what constitutes the identity. The interpretation process is important because identity is both lasting and changeable, and the narratives must be interpreted so as to understand the self (Ricoeur, 1992). When, for instance, the PHNs in this study described their practice experiences, the similarities in the narratives, as revealed in the interview and interpretation process can illuminate something general about public health nursing and constitute some characteristics of the identity of the profession.

The concept of identity contains a historical dimension and a situational dimension of the present, and the narrative identity ties the historical and situational dimensions together. When the PHNs described their action choices in practice, their experiences were influenced by the history of the profession. A shift occurred between an understanding of the whole situation according to the parts and the parts according to the whole when the narratives were interpreted; this process was considered to take place in a hermeneutic circle (Ricoeur, 1976). It is a back-and-forth process that occurs between lived life and narration (Sparrowe, 2005). Shifting occurs between the past (i.e., the historical development of public health nursing), the present experiences and the period of reflection afterwards. Taken together, these shifts comprise the mimesis process. The narratives are based on PHNs' personal values and theoretical and practical knowledge, and were influenced both at the micro level and the macro level. The micro level includes service users, colleagues and collaborators, and the macro level is the institutional level (Wackerhausen, 2002, 2009). Both 'significant others' (service users, colleagues) and 'generalised others' (the institutional level) influence the identity (Mead, 1962). Wenger (1998) maintained that distinguishing between the identity of the individual and the identity of the profession can be difficult. The focus must be on their mutual constitution, where the identity of the profession and the identity of the individual intertwine in reflective activities in communities of practice (Wenger). The gathering together of PHNs to narrate and reflect critically on their practice experiences, influenced by social discourses, may result in their constitution of a collective public health nursing identity. In the present study, the narratives provided during the interview process may elucidate the meaning of professional identity in public health nursing.

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## 4 METHODOLOGY

Owing to the nature of the topic and to the fact that the research questions in the present study were related to the meaning of professional identity in public health nursing, the chosen methodology had to contribute in-depth knowledge about values and knowledge in public health nursing. In the subsections of the Methodology section, the qualitative methods that were selected to conduct a critical discourse analysis of PHNs' curriculum (paper I) and a phenomenological hermeneutic analysis of PHNs' narratives (paper II and III) are described and discussed, including data collection, interview method, ethical considerations and methodological reflections. My own position as a researcher is discussed, which is a key aspect in qualitative studies, based on the assumption that knowledge is subjectively constructed (Kvale & Brinkmann, 2009).

### *4.1 A description of the sample in paper I*

The national educational curriculum of Norwegian public health nursing (Curriculum, 2005) was the focus of paper I. The curriculum, which was first formulated in 1998 and then revised in 2005, is produced by the Ministry of Education and Research. It consists of two sections: a general section, which provides a historical perspective and puts forward arguments outlining the continued need for a national curriculum, and a more specific section, which describes the knowledge, function and goals of public health nursing education. The curriculum expresses the governmental strategies for the public health nursing profession, related to underlying knowledge in public health nursing education and creates jurisdictional borders.

### *4.2 Critical discourse analysis*

The method of critical discourse analysis, as developed by the sociologist Fairclough (1992, 2010) was found suitable for identifying underlying governmental principles in the educational curriculum. The discourses in the curriculum can influence PHNs' actions in practice and hence their professional identity. Fairclough (1992) maintained that in discourse, attention must be paid to how society can affect language and how language can affect society. In this study attention was paid to how ideologies could influence the curriculum, and how the curriculum could influence on PHNs' ideological base as revealed

from their action choices, and hence the identity of the profession. According to Fairclough (2010, p. 95), discourse is defined as language use conceived as social practice; it is not merely an individual activity. Fairclough (2010) asserted that the ideology is embedded in the text and that the analysis is about identifying what lies behind the immediate 'common-sense' understanding. The hidden ideology must be seen here in conjunction with the concept of hegemony, which Fairclough (2010) linked to discursive power structures. Throughout the struggle for hegemony in the relationship between discursive and sociocultural practices, power relations are maintained and changed. The ideological discursive struggles contribute to maintaining the dominant relationships.

Fairclough (1992) developed a three-dimensional model of critical discourse. The three dimensions are text, discursive practice and sociocultural practice. This model was used as a tool of analysis in the present study (Figure 1). The different dimensions overlap, owing to interactions between text, discursive practice and sociocultural practice (Fairclough, 1992, 2010).

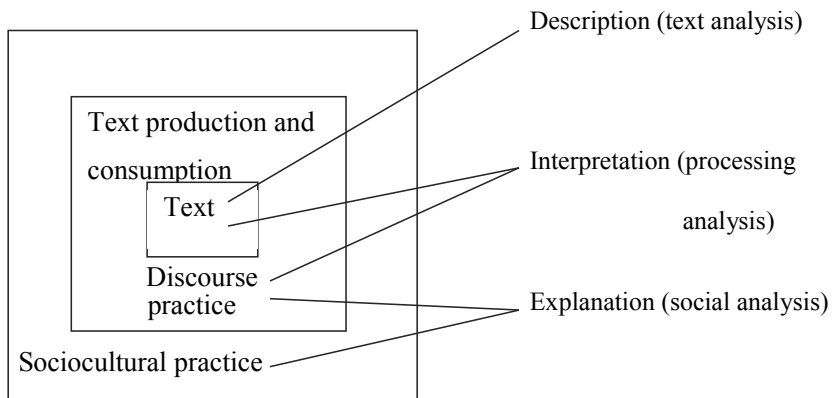


Figure 1 Fairclough's three-dimensional framework for analysis of discourse

#### *Description of the text*

The first analytical step was the description of the educational curriculum text. It revealed underlying structures and a deeper understanding of the text. The text analysis included four areas or levels: choice of wording/vocabulary (individual words), grammar (sentence structure), cohesion (consistency between sentences) and text structure (superior organisation). For example, the use of the modal auxiliary *shall* in the text is of importance

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because it conveyed determination or purpose, thereby strengthening the message of the statements in the text. Another example is the use of chaining of sentences in the text, which indicated cohesion. Yet another example is the use of adverbs like *thus*, which showed the argumentative structure of the text and could be recognised, for instance, as a government document.

#### *Interpretation of the text as discourse practice*

The second analytical step was the interpretation of the text as discourse practice. Discourse practice is the production, distribution and consumption of text (Fairclough, 2010). In this study, discourse practice referred to how various representations of health promotion and disease prevention discourses were expressed, received and interpreted, which can have consequences for the identity of public health nursing. An interdiscursive analysis of various and changing discourses focused on the genre, or the interaction between discourses, which could reveal discourse practices based on earlier patterns. An example from the present study was the possible changing style in the text about the role of a PHN, with contradictions in the text as to whether PHNs have an empowering role or a helping role.

#### *Explanation of the discourses as social practice*

The third analytical step was the explanation of the discourses as social practice. The public health nursing curriculum is produced within a sociocultural framing, in a particular historical period, which it was expected that the curriculum would reflect. Fairclough (1992, 2010) asserted that discourses are relatively stable configurations but that they can be structured through different forms of hegemony and interpreted in different ways. The focus was on revealing discourses with hegemony in the text, which had won the ideological struggle for dominance. In the Discussion section of the thesis, the findings are linked to the constitution of professional identity in public health nursing.

### **4.3 A description of the sample in papers II and III**

Papers II and III were based on interview data from a purposive sample of 23 Norwegian PHNs. Because only female PHNs were working in the selected communities, no male PHNs were included. The inclusion criteria were those PHNs who had been educated as a PHN and were working with children at child health clinics and/or with young people at health clinics for young people and/or in school health services. The following criteria were also included so as to obtain a comprehensive sample: The PHNs should have different



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amounts of work experience and should come from small, middle and large municipalities in two counties in Norway. The included PHNs' practice experience varied from 0.5 to 25 years, with a mean of 11.2 years, and they came from 12 small, middle and large municipalities/districts. The municipalities had 4500 to 625000 inhabitants and were situated in two counties in Southern Norway. There were one to four informants from each location (Table 1). Of the 23 PHNs included in this study, 6 PHNs worked at child health clinics, 7 PHNs worked in school health services and at health clinics for young people, and 10 PHNs worked with both children and young people. In a Norwegian national survey, where 1094 PHNs answered questions about PHNs' competence, 41% answered that they worked in both child health clinics and school health services (Andersson, Norvoll, & Ose, 2006), which is similar to the present study where 43% of the included PHNs worked in both child health clinics and school health services. Thus, the sample can be said to mirror the average of public health nursing work affiliations.

Table 1. Sample Characteristics ( $N = 23$ )

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PHNs in child health clinics	6
PHNs in school health services	7
PHNs in both health clinics and school health services	10
Length of service, years	0.5–25 years, mean = 11.2 years
0.5–5 years of service	7
10–15 years of service	9
16–25 years of service	7
Number of municipalities/districts	12
Size of municipalities	4500–625000 inhabitants
Distribution of informants	1–4 in each municipality/district

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#### **4.3.1 Access to the research field**

Access to the research field was established through verbal and written enquiries to public health nursing leaders in the municipalities. The leaders informed the PHNs, who then established direct contact with me as the researcher. The informants received a written statement about the purpose of the project in advance of the interviews and verbal information at the start of each interview. Before beginning the interview process, I clarified with the leaders and the informants about the possibility of conducting the interviews during working hours so as to minimise the strain on the informants. All interviews were conducted at the workplace of the informants, except for one interview that was carried out in a café. At the end of each interview, I requested permission to contact the interviewee later if I needed supplementary information; all agreed to this request. The interviews lasted from 60 to 80 minutes and were rich in descriptions related to the research questions; hence, the informants were not reinterviewed. One informant wrote me a supplementary e-mail directly after the interview with additional information related to the interview, and this information was included at the end of that transcribed interview.

#### **4.3.2 Data collection**

A semi-structured interview guide, including sequences with open-ended questions to encourage meaningful responses, was formulated. I asked the informants what it meant to them to be a PHN and to describe experiences in which they felt that they had done a good job and those in which they had felt challenged. These questions were selected based on the belief that they would allow the PHNs to describe the essence of their practice experiences, which can be important in elucidating professional identity in public health nursing. The ability to create a good interview depends both on the interviewer and the interviewee, and during the narratives, there was little interruption from me, even in those cases when the development of the story did not seem relevant (Mishler, 1986). I initially created a pilot interview to ensure clarity, understandability and coherence in the interview guide, as well as to receive some indication on the use of time in the interview phase. Testing the interview guide in advance provided me with more confidence in the actual interview situation.

The interviews were tape-recorded and transcribed verbatim. Because the interview situation is a dynamic process, the transcriptions, however, also included characteristics of the situations (Polkinghorne, 1988), with the marking of long pauses (-), enthusiasm (!) and

laughing (laughter). I attempted not to transcribe these characteristics in too much detail because doing so would make the text difficult to read (Ochs, 1999).

#### ***4.4 Phenomenological hermeneutic analysis***

Ricoeur's critical hermeneutics (1976, 1992) was not only relevant as theory for the discussion but also for the method in this study, as the phenomenological hermeneutic analysis of Lindseth and Norberg (2004), which was based on Ricoeur's (1976) theory of interpretation, inspired the analysis of the PHNs' narratives. This method was chosen because it allows the researcher to reveal the lived experiences of the informants, and in the present study, this choice of method was found to be appropriate when elucidating the nature of professional identity in public health nursing.

The analysis involved three steps: a naïve reading resulting in a naïve understanding, a structural analysis revealing themes and a critical reading leading to a comprehensive understanding. The analysis was a dialectic movement between an explanation and a naïve and comprehensive understanding, leading to a text that can open up a way of being in the world (Ricoeur, 1976). The main focus was not on what each PHN conveyed in the interview but rather on the possibilities of living and acting as a PHN that the transcribed text revealed (Lindseth & Norberg, 2004). Based on the PHNs' narratives, are there any clues as to how their practice can be improved?

##### *Naïve understanding*

The first step was a naïve reading of the text, which was carried out repeatedly so as to obtain a naïve understanding of all the interviews in their entirety (Fagerberg & Norberg, 2009; Lindseth & Norberg, 2004). It was important to read the text with an open mind, and the movement was from what the text said to a focus on what the essential meaning of the text was. The naïve understanding was written down and used in guiding the structural analysis (Lindseth & Norberg, 2004).

##### *Themes and subthemes*

The thematic structural analysis focused on identifying meaning units in the text so as to formulate themes. Meaning units are parts of the text that convey just one meaning. A theme is a thread of meaning in part of the text, conveying an essential meaning (Lindseth & Norberg, 2004). The whole text was read again, and meaning units were formed from this

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reading. The meaning units were reflected upon, keeping in mind the naïve understanding. Each meaning unit was then condensed so that it could be expressed in everyday language. Similar condensed meaning units were further condensed and abstracted so as to form and formed subthemes and themes. The themes were reflected upon and compared with the naïve understanding so as to validate or invalidate the naïve understanding. To obtain a valid interpretation, one must seek not only information that verifies but also information that contradicts one's own presuppositions (Ricoeur, 1992). In both papers II and III, the initial reading of the text invalidated the naïve understanding; the whole text was read again, and a new naïve understanding was written down. The process of reading the whole text, determining a naïve understanding and conducting a structural analysis was repeated until the naïve understanding was validated through the structural analysis (Lindseth & Norberg, 2004).

#### *Comprehensive understanding*

The whole text was reread, with the dual aims of striving for an open approach to the text and of keeping in mind the naïve understanding and the validated themes. The themes and subthemes were critically reflected upon in accordance with the research questions, preunderstanding, relevant literature and study context. Thus, understanding and explanation tend to overlap (Ricoeur, 1976, p. 72). The reflection process helped to revise, broaden and deepen the understanding of the phenomena in the text. It was important to allow the literature to highlight the findings and to permit the interview text to illuminate the literature perspective and widen the interpretation horizon (Lindseth & Norberg, 2004) rather than to 'push' the chosen literature of the study on the text. The findings were formulated in everyday language so as to be as close as possible to the lifeworld, in an effort to reveal possible ways of describing professional identity in public health nursing in relation to PHNs' values and knowledge as expressed through narratives from experiences in practice.

#### **4.5 Ethical considerations**

Papers II and III used data material from the personal interviews. I was conscious of the responsibility of protecting the informants when obtaining personal information. There is an ethical dimension in the interview situation, referring to what the research questions can do to the interviewees, what was said and how it was said (Kvale & Brinkmann, 2009; Ricoeur, 1992). The Norwegian Social Science Data Services (NSD) approved the study. In line with

the recommendations from the NSD, the informants received a written statement regarding the purpose of the project in advance of the interviews. At the start of each interview, information about the project was given verbally. The interviews were tape-recorded, and this was clarified with the informants in advance through a consent form.

In accordance with the recommendations of the NSD, the interviewees were informed that they had the option to withdraw from the study at any time and that the given information could be deleted. They were also informed that the data gathered would be securely kept and that the anonymity of each individual interviewee would be ensured throughout the whole process. Full anonymity was achieved through the use of a numeric code for the informants at the transcription stage. The key to the code was locked away, separate from the data material. Some quotations from the interviews were used in papers II and III to illustrate the findings; however, descriptions of the characteristics of the informants and the contexts were kept to a minimum. The informants were from 12 different districts, which helps strengthen the anonymity of the data.

Every transcription, from a spoken word to a written text, involves a number of considerations and decisions. It was necessary to weigh new knowledge against the degree of influence on the integrity of the individual. The anonymity process was thus crucial. A valid research design shall produce knowledge that is beneficial to humans and minimises harmful consequences (Helsinki Declaration, 2008; Kvale & Brinkmann, 2009).

#### **4.6 *Methodological reflections***

The critical discourse analysis used on the curriculum text (paper I) could also have been used as the method of analysis for the interview texts (papers II, III). If linguistic analysis had revealed competing discourses in the interview text, the findings could have been at the expense of in-depth knowledge about experiences and identity in public health nursing; therefore, this method was not considered appropriate for analysing the responses to the research questions. Discourses in society influence the constitution of identities (Fairclough, 2010), and the identity is constituted in a narrative process (Ricoeur, 1992), and thus the two methods complemented each other and increased the knowledge and understanding of professional identity in public health nursing.

The interview process was about negotiating the 'meaning' of the narratives in a dialogic relationship between the interviewed and the interviewer (me). Mishler (1999) maintained that narratives are identity performances; that is, the interviewed tell who they

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are, and from the way they narrate, who they want to be, thus revealing their identity. When the interview text is interpreted, the truth is disclosed in front of the text, in the meeting with the interpreter (Ricoeur, 1976). The interpretations focus on inner consistency and the possibility of competing interpretations of the narratives, with some interpretations being more probable than others (Ricoeur, 1981). As the wording of the research questions reveals, the objective was to find some common characteristics in the narratives of public health nursing experiences or some probable truths about public health nursing identity.

I had a preunderstanding of what I wanted to examine, but it was important to be open to new aspects. Research has shown that individuals are only partly aware of their preunderstanding (Fagerberg & Norberg, 2009; Horsdal, 2012). However, a preunderstanding of the world is considered necessary to unveil the essence of human action, particularly border situations that are difficult to interpret (Ricoeur, 1981). With my public health nursing background and knowledge, I, in my role as interviewer, was (presumably) in a good position to attain a better understanding of the informants and to ask follow-up questions of relevance. However, one must be sensitive to the position and resources that one has when carrying out an analysis (Fairclough, 2001). Hence, it was important to achieve an analytical distance to the data. By employing theoretical perspectives, models and figures, a distance in the research process was achieved. The historical and social perspectives of the research also contributed in creating a distance to my self-understanding of the profession (Moos, 2008). All the interviews and the transcription of the data were carried out by me, which can minimise some sources of error. The co-authors of the papers and I then critically discussed the transcriptions, based on the research questions, so as to reveal the most probable interpretation. An awareness of our preunderstanding contributed to a continued need to revise, question and broaden the critical reflection, as well as, in accordance with Patton (2002), conduct an exploration of rival themes and of other ways of organising the data so as to avoid a biased interpretative process.

The study has sample, context and methodological limitations. Because the sample comprises a small number of Norwegian PHNs, it represents only one group of nurses and can only to some extent be compared with PHNs on a national basis and in other countries. Another limitation is that all the PHNs included in the study were women, which may be related to the predominance of women in (public health) nursing. A focus on male nurses, however, may have enriched the data. Yet another limitation is that only PHNs from Southern Norway were included, thereby reducing the diversity in the sample. There are also limitations associated with concentrating solely on PHNs' individual narratives from

practice. Conducting focus-group interviews, which research has shown creates a group dynamic that yields rich and complex data (Polit & Beck, 2012), could have given the PHNs the opportunity to reflect together about the narratives. However, there is also the possibility in a focus- group interview setting that the PHNs would have been less forthcoming in describing their personal experiences. Interviewing service users and investigating their experiences from practice situations could have also provided valuable insight into the practice field. In addition, the use of field observations may have allowed more accurate data to be obtained about the research questions, thereby increasing the credibility of the findings. Observing public health nursing colleagues as they met in groups to provide narratives of practice experiences and to reflect on these experiences could have given valuable insight into and knowledge of the process of developing a collective professional identity and the content of the collective identity. However, it would not have given the in-depth knowledge about professional identity in public health nursing that can be accessed through the phenomenological hermeneutic method.

#### **4.6.1 The trustworthiness of the study**

The trustworthiness of a qualitative study relates to both the reliability and the validity of the findings. Lincoln and Guba (1985) used the terms *credibility*, *dependability*, *conformability* and *transferability* as criteria for the trustworthiness of qualitative studies. The credibility or truth of the data, understood as a parallel to the positivists' criteria of internal validity, is based on the dependability or stability of the data, which can be related to reliability. The data were derived from 12 different settings and showed variation in the experiences of the participants. This variation can promote the credibility of the data. The conformability or objectivity of the data relates to the interpretation processes, which were described by illuminating accurately what was done. Some of the interpretations are supported by findings in the literature, which can strengthen conformability. In addition to trustworthiness, qualitative studies require authenticity and a critical approach (Whittemore, Chase, & Mandle, 2001). The findings of a qualitative study cannot be generalised statistically; they can, however, be transferred to similar contexts and viewed as arguments in an ongoing discourse (Ricoeur, 1976).

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## 5 FINDINGS

This study is based on three scientific papers, and the main findings of the papers are presented in this section.

### 5.1 Paper I

Paper I analysed the curriculum of public health nursing. Emphasis was put on revealing the underlying governmental strategies for how PHNs shall promote health and prevent disease.

The analysis revealed conflicting discourses (Table 2).

Table 2. Competing and contradictory discourses in the educational curriculum of public health nursing

<b>Discourses</b>	<b>Results</b>
(a) <i>Knowledge</i> : biomedical vs. social scientific discourse	Dominant biomedical knowledge
(b) <i>Ideology</i> : paternalist vs. participation discourse	Underlying paternalist ideology
(c) <i>Level of work</i> : individual vs. population discourse	Hegemonic individual level of work

The analysis showed that substantially more text in the curriculum was devoted to describing work tasks based on biomedical knowledge than on those grounded in social scientific knowledge. The paternalistic meta-discourse, referred to an underlying paternalistic ideology despite a clear focus on user participation, and where PHNs could be identified mainly as discipline agents of the government. The hegemonic individual discourse referred to the fact that there was very little focus on population in the text.

The analysis suggests the presence of a dominant disease prevention discourse in the curriculum. Although recent policies concerning public health nursing focus more on health promotion, the analysis revealed that health promotion is not sufficiently explicit in the curriculum text.



## **5.2 Paper II**

In paper II, 23 PHNs described ethically charged encounters with service users. These narratives contributed to understanding value aspects of professional identity in Norwegian public health nursing. Four themes were identified in the narratives: feeling responsible, being committed, feeling confident and feeling inadequate.

Feeling responsible meant being engaged in the well-being of children, families and young people by showing empathy towards and interacting with them as well as guiding them. Feeling responsible also meant that blurred boundaries could exist between work and private life. Being committed meant that PHNs felt concern when they encountered children and young people in troubled relationships. Being concerned also meant that the PHNs felt compelled to 'stand up to fight' and be advocates for the rights of parents and/or children. Feeling confident meant dealing with conflicting loyalties and coping with ethical dilemmas, such as deciding whether to be flexible and open or to adhere strictly to the regular programme. Feeling confident could also mean being courageous and gaining trust. The PHNs were aware that they occupied a position of power and that they should not abuse their power. Feeling inadequate meant failing to meet expectations, both their own expectations and those of their service users. Feeling inadequate also meant feeling unimportant.

Some common characteristics of their professional identity were a sense of responsibility, a sense of obligation to build trust and a sense of commitment to engage in difficult situations. It seemed that value conflicts could mobilise courage, which is essential in maintaining moral strength, and in contributing to a strong identity of the profession.

## **5.3 Paper III**

The main focus of paper III was on the meaning of knowledge and identity in public health nursing. The sample was identical with that used in paper II. Three themes emerged: being a generalist, being one who empowers and being occupied with individual problem-solving.

Being a generalist meant 'knowing a little about a lot'. Being a generalist could also entail using clinical judgement, which meant knowing what was required in a situation. Being one who empowers meant revealing the resources of service users by engaging in dialogue and focusing on health promotion strategies, in combination with employing effective communication techniques. Being occupied with individual problem-solving meant focusing on individuals with special needs. Some of the PHNs felt that they should be working more with the healthy population, but time constraints meant that they had to

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prioritise those most in need. Being occupied with individual problem-solving could also involve following guidelines and protocols. The PHNs combined individual health promotion activities (based on social scientific knowledge and a relational perspective) with individual problem-solving work (based on medical knowledge and standardised techniques) when giving advice. A challenge facing the PHNs was the time pressure involved in combining standardised procedures with situational clinical judgement during a consultation.

The findings indicate that PHNs can be characterised as generalists, in that they have a broad range of knowledge and skills of normal development. Because PHNs provide supportive, universal, low-threshold health-care services, they can reach groups of people who are not taken care of by other official services. Although PHNs can be characterised as generalists, they work in the specialised field of health promotion and disease prevention. Thus, public health nursing can be considered a specialised service. Based on this line of reasoning, PHNs can be characterised as fulfilling a specialised-generalist role. According to the findings, the PHNs did not consider themselves as specialists in relation to having specialised knowledge. Hence, the specialised-generalist role is a role in which PHNs need to be empowered so as to strengthen the identity of the profession.

#### ***5.4 A summary of the findings***

The findings of the three papers revealed contradictions and duality in public health nursing, as well as challenges with regard to values and knowledge in constituting professional identity and to practice. Contradictions were detected between social discourses in the curriculum text (paper I) and recent policies, which highlighted health promotion and primary prevention strategies at the individual level and the population level. How the PHNs were governed by the discourses of the curriculum and the guidelines was not straightforward, with the results (papers II, III) showing that the PHNs emphasised health promotion strategies but the curriculum text did not. Similar to the curriculum text, the PHNs also emphasised mostly working at the individual secondary and tertiary prevention levels, carrying out problem-solving activities. Their primary prevention work was mostly related to performing statutory tasks, such as conducting regular consultations at child health clinics and screening activities at schools, and not population work related to healthy schools and healthy local environments.

The narratives illuminated dual roles in public health nursing: a disciplinary role and an empowering role. Fulfilling these dual roles could be challenging for PHNs, owing to the time pressure involved (papers II, III). From the way in which values and knowledge are

used and integrated into clinical practice and based on the influence of social discourses, the identity of the profession can be constituted, and this study revealed a ‘specialised-generalist’ identity.

A duality related to values on macro and micro levels was revealed. By endeavouring to remain true to the values of the institution (loyalty and efficiency) and to the values of the profession (quality and participation), PHNs may find themselves in a difficult position (papers II, III). The phenomenon of values revealed that a sense of responsibility, a sense of obligation to build trust and a sense of commitment to engage in difficult situations were common characteristics in the professional identity of PHNs and that these professional values could overshadow institutional values (paper II). The findings showed that constraints (e.g., time) posed challenges for the PHNs (papers II, III).

The findings as revealed from the curriculum text and the narratives related to knowledge base, ideological stand and level of work are summed up in a table (Table 3).

Table 3. Findings as revealed from the curriculum and the narratives

	<b>Curriculum text</b>	<b>Narratives</b>
(a) <i>Knowledge:</i>	Biomedical knowledge	Biomedical and social scientific knowledge
(b) <i>Ideology:</i>	Paternalist ideology	Paternalist and empowerment ideology
(c) <i>Level of work:</i>	Individual level	Individual level

In the following section, I endeavour to discuss these findings from a comprehensive and critically reflective perspective.

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## 6 DISCUSSION

In this chapter, the main findings of the three papers are discussed within the theoretical framework of the thesis, which comprises the theory on professional development, the concepts of values and knowledge, the philosophy of Paul Ricoeur and professional identity, the social discourses and context of public health nursing and relevant literature. The purpose was to present an overall interpretation of the understanding of the meaning of professional identity in public health nursing. This chapter has four sections: the constitution of professional identity in public health nursing, contradictions and dualities in policies and practice, balancing the knowledge base, and the importance of values in professional identity.

### ***6.1 The constitution of professional identity in public health nursing***

In the present study, professional identity is understood by reflecting on how PHNs characterised themselves based on their narratives of practice experiences, which were influenced by social discourses. In accordance with Aristotle (trans. 2004) the constitution of identity is about recognising the unknown in the individual narratives into known categories. The narrative process implied PHNs' preunderstanding or prefiguration, which was the context of a collective history of the profession. These collective histories could be about the changing contexts that have characterised the public health nursing profession, which the individual PHN may have taken part in through education and entry into the profession, thereby possibly implying experiences related to changes from a paternalistic to a more empowerment ideology. When the PHNs described their experiences in this study, this can be interpreted as a configuration process according to Ricoeur (1984, 1992). In accordance with Mead (1962), it can be ascertained that the PHNs' stories had been influenced by service users, by colleagues ('significant others') and by those at the institutional level ('generalised others'). The PHNs were also in the refiguration phase when they interacted with me as a researcher, with the findings being constructed in dialectic process between the interviewer and the interviewee and with the PHNs' values and knowledge being illuminated. Transferred to a practice context, the refiguration phase can be where colleagues meet in communities of practice (Wenger, 1998) and where the identity can be confirmed and developed through mutual narratives of practice situations. A study on newly qualified nurses showed that collegiality was highly valued and that mutually supportive relationship

were important in the adaptation process (Bjerknes & Bjørk, 2012). Developing a professional identity can be about inducing learning processes in the form of critically reflective methods in education and practice. Simulating interactions between PHNs and service users is an example of such a reflective method. Employing this method may clarify the public health nursing role and mandate towards service users. The simulation method has yielded good results when used in previous research on nursing students (Hawkins, Todd, & Manz, 2008; Lasater, 2007).

The narratives illuminated public health nursing values and knowledge that constitute a common public health nursing identity referred to as the specialised generalist (paper III), which is in line with Heggen (2008), who maintained that professionals must support some common symbols of the profession so as to constitute a professional identity, even though they may in actuality practice the role differently. In accordance with Abbott's concept of jurisdiction (1988), PHNs have their main arenas in child health clinics and school health services and have their particular working strategies related to health promotion and disease prevention interventions. The PHNs in the present study could be described as having a stronger identity in relation to personal and professional values (e.g., following up individuals in need) than in relation to institutional values of efficiency and loyalty to policy directives (papers II, III). There is dialectic between following micro and macro level demands, and PHNs' cannot choose to work on just one level, it is important to work on both levels of intervention. The institutional level can have a role in developing effective reporting systems and in initiating PHNs' population work. Public health nursing needs to clarify its professional borders in relation to the individual relational perspective and the population perspective, to develop the identity of the profession so as to fulfil its mandate of information and empowering strategies in health issues towards the population in order to reduce health inequalities. By maximising the possibilities for all service users to take care of their own health, this can benefit personal, social and economic development and, thus, enhance prospects for increased quality of life in the population.

## ***6.2 Contradictions and dualities in policies and practice***

Traces of a hegemonic disease prevention discourse detected in the curriculum text (paper I) were also found in the narratives of the PHNs. In accordance with Fairclough (2010), the discourse practice revealed in the curriculum text can influence social practice, such as learning activities in public health nursing education. The educational perspective is outside

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the scope of this study; however, the PHNs' stories about their practice experiences revealed that health promotion strategies were performed. The limited focus on population in both the curriculum text and the practice experiences of PHNs (papers I, II, III) suggests that the government directives stating that PHNs are to devote most of their attention to all children, young people and families and to base their work on aspects of healthy living and ways of coping with health-related conditions (Ministry of Health and Care Services, 2011c) were not fulfilled. The general aim of government is a healthier population in accordance with the values that form the basis of the Ottawa Charter (Kickbusch, 1997). The Ottawa Charter's health promotion values of equity and enablement (McQueen & De Salazar, 2011) for the whole population—not restricted to the individual level—were professional values that have been recognised in policies. The findings of the present study indicate that the Ottawa Charter's health promotion population focus working towards the society (WHO, 1986) was not well established in public health nursing thinking and strategies, for instance promoting local environment and school environment initiatives and collaboration with the institutional level and voluntary organisations. Fagermoen (1995) maintained that values are closely related to professional identity, and when PHNs' actions are not based on the core values of the Ottawa Charter (i.e., population-focused strategies), this can have negative consequences for the identity of the profession. When PHNs are not fulfilling their mandate, this can be seen as a leader responsibility, but also as a responsibility of each professional, who are facing the dilemmas of prioritising between those most in need and the population work in a context of time pressure. Good routines for reporting deviations to the institutional level can be a way of illuminating the lack of time and resources for population work, and contribute to make visible the need of clarifying the mandate of public health nursing.

The PHNs interviewed in the present study emphasised individual health promotion and secondary and tertiary prevention strategies in practice. By contrast, Norwegian policies (Ministry of Health and Care Services, 2011c) highlight that PHNs are to focus on health promotion and primary prevention strategies at both the individual level and the population level. A study on PHNs in the United States revealed a gap between government-defined public health nursing practices and public health nursing practices in reality (Grumbach, Miller, Mertz, & Finocchio, 2004). Whereas the government-defined public health nursing strategies emphasised health-related issues at the population level (as opposed to individual-focused clinical interventions), the PHNs worked mostly at the individual level. This finding could be explained by organisational and financial constraints that prioritise direct individual-level care and by an educational system that does not equip public health nursing

students with sufficient population health knowledge and skills (Grumbach et al., 2004). A similar situation seems to be described in paper I, where the educational curriculum focused little on the population level of intervention. The findings in the present study indicate that a gap exists between institutional goals for the public health nursing profession and today's public health nursing practices. PHNs do not fully adhere to their own public health mandate of health promotion and primary prevention initiatives at the population level (even though it is their wish to do so) (paper III). Hence, it seems appropriate to suggest that changes be made to the curriculum text so that it adheres more closely to government directives and outlines health promotion and disease prevention ideologies and strategies, arenas and tasks more clearly.

With regard to the institutional or organisational level, a study on Norwegian PHNs (Dahl, 2004) showed that adherence to the mandate of the profession is influenced by the professional backgrounds of the leaders and of those they are to lead. In municipalities where the (female) leader was a PHN who recognised the need for population strategies in public health nursing, the PHNs were more likely to work with primary prevention strategies at both the individual level and the population level. By contrast, in municipalities where the leader had a different professional education background, the PHNs were more focused on individual work. Structural alterations have resulted in the removal of PHNs as administrative leaders of public health nursing. Andrews and Wærness (2011) asserted that after the Municipal Health Services Act of 1982, PHNs have had little control over their own professional field, with new tasks being introduced constantly. There is little room for action owing to a lack of position and a reduction in their jurisdiction concerning power, authority, monopoly of tasks and political influence, which can lead to a deprofessionalisation of public health nursing. At the institutional level, it thus seems appropriate to recommend reinserting professional leaders who may possibly better understand the mandate of the profession they are to lead, though they may still be more occupied with loyalty at the macro level, with efficiency and economic values. Abbott (1988) maintained that establishing new jurisdictional fields results in changes in other jurisdictional fields, and when PHNs are administered by professions with another professional education this can reduce PHNs' jurisdiction, as the institutional level influences the identity of professionals (Wackerhausen, 2009). The population focus can emerge when PHNs share and critically reflect on narratives in communities of practice. The narratives will be influenced by politics and management, values and experiences and can constitute PHNs' identity. A clarification of a defined field of health promotion and disease prevention both on individual and population level can give

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public health nursing autonomy, legitimacy and authenticity, thereby strengthening the identity of the profession.

The PHNs' professional consciousness of their role as important contributors at the population level was evident from the fact that many of the PHNs wanted to work to a greater extent with primary prevention strategies (paper III). However, for most of the PHNs, the primary prevention work was mainly limited to statutory tasks on individual level, such as regular consultations at child health clinics and screening activities in schools. The study showed that their sense of responsibility for those in need made them prioritise individual work (paper II). Thus, there exists potential for strengthening population public health nursing interventions so as to increase the effectivity of public health nursing work. One way of looking at the institutional value of effectivity is to link increased effectivity in public health nursing to the so-called prevention paradox. According to the prevention paradox, population-oriented initiatives, where the risk of disease is low, are as effective as initiatives aimed at individuals with high risk (Beaglehole & Bonita, 2004; Ministry of Health and Care Services, 2013). Based on the findings in papers I, II and III, it can be maintained that health promotion and disease prevention are different ideologies but are complementary in practice. PHNs in this study used both strategies on their individual level of work, and found them to be supplementary.

However, PHNs seemed to be cross-pressured to engage in both primary prevention activities and problem-solving activities (papers II, III). Many PHNs mainly focus on efforts aimed at individuals with high risk of disease and those with established disease, particularly in school health services where they can follow up young people who are in need of treatment. Because they deliver front-line care and services, PHNs are easily available, and for this reason, young people develop relationships with them over time. Many PHNs have obtained further education and specialisation such as in psychological and pedagogical topics. This specialised knowledge gives them a specific qualification within public health nursing. A study on the competence of PHNs (Andersson et al., 2006) revealed that more than 50% of a representative sample of PHNs in Norway possessed one or more forms of postgraduate education but that the demand for more competence, particularly related to psychosocial work towards children, young people and families, was great among PHNs.

Another reason why PHNs follow up service users with established problems over time is that other authorities (both in the municipality and in the specialised services) may lack the capacity to provide follow-up services (Andersson et al., 2006; Clancy, 2010). For example, young people with problems have been known to 'fall between the cracks' of the



first and second levels of treatment. Although PHNs refer service users to specialised services, these service users may wind up returning to them owing to the lack of capacity by second-line services to provide follow-up care.

The PHNs in the present study may experience an ethical dilemma of whether to neglect or to follow up young people with severe problems when they realise that the follow-up authorities lack the capacity to provide follow-up care. The findings indicate that the jurisdictional borders between public health nursing and follow-up services are blurred, which can mean that the work arena is not clearly defined. The increased mental distress among young people calls for PHNs to identify those in need of follow-up services (Myhre Steffenak, 2014). The lack of capacity for authorities to provide follow-up care can be seen as a problem of the welfare state today. Prioritising the follow-up of individuals could weaken the capacity of PHNs to carry out their own work. For instance, if PHNs provide follow-up care, they may have to do so at the sacrifice of other tasks, such as office hours for all pupils at schools. Because of their position in health-care services, PHNs may seem well suited to help deal with the increased psychological problems among young people. Their role in providing this type of involvement may explain why PHNs desire greater knowledge about pedagogical and psychological topics.

A duality was found within public health nursing at the micro level. It concerned balancing a paternalistic role with an empowerment ideology (papers II, III). By fulfilling a paternalistic role, PHNs hold a power position, with the possibility of defining the needs of service users and, thereby, defining the jurisdiction of their practice. However, a contradiction apparently exists in instructing service users how to live in accordance with government health recommendations and in working with health promotion and empowerment strategies aimed at children, families and young people. This duality could be interpreted as the transferring of power from professional to service user and back, which could pose a challenging experience for PHNs. The duality could also be understood as a double agenda of public health nursing (Neumann, 2009). In the early days, PHNs essentially had a paternalistic position, with information and control functions, like control of safe hygiene practices in municipalities. They communicated a national standardisation of public health advice and information aimed at the population (Jákupsstovu & Aarseth, 1996), a monitoring and consultative role at the population level that gave power and influence (Andrews & Wærness, 2011). Table 4 can illustrate the development in public health nursing, where Traditional arenas and strategies dominated the first period of public health nursing, and 'New' arenas and strategies has gradually developed since the 1970 ties (Table

4). The traditional medical focus was prominent in the first period, with the district doctor and the health director acting as spokespersons for not only public health nursing but also volunteer organisations. The PHNs were experts and controllers with regard to individuals (in the form of mother and child), and population, with a pathogenic focus on the traditional arena (Table 4, column (a)). The paternalistic role was also recognised in this study, and is shown in the ‘new’ arena (Table 4, column (b)). However, the new public health empowerment and salutogenic ideology had traditionally only a limited presence (Table 4, column (c)). A macro perspective on the role and scope of public health nursing revealed that the profession has changed owing to social changes (Schjøtz, 2003). The duality in public health nursing has intensified with the changing character of the work arena, as a consequence of increased psychosocial challenges in the population (Ministry of Health and Care Services, 2013). Now PHNs are to work with individuals, families and the population using more health promotion strategies both on traditional and ‘new’ arenas.

Table 4. Changes in the arenas and strategies of public health nursing

		<b>Arenas</b>	
<b>Public health nursing work</b>		<b>Traditional</b> Child health clinics, school health services, communicable diseases, municipality hygiene inspections	<b>‘New’</b> Health clinics for children and young people, groups in health clinics and schools, environmental health, municipal agencies, volunteer sector
<b>Strategies</b>		<b>Traditional</b> Pathogenesis and paternalist ideology -health education -problem-solving	<b>‘New’</b> Salutogenesis and empowerment ideology -relational -holistic
		<b>(a) <u>Restricted disease prevention</u></b> Directed at: individuals, populations	<b>(b) <u>Extended disease prevention</u></b> Directed at: individuals, families, populations
		<b>(c) <u>Restricted health promotion</u></b> Directed at: individuals, populations	<b>(d) <u>Extended health promotion</u></b> Directed at: individuals, families, populations

*Note.* Adapted from *Helsesøsterrollen i folkehelsearbeidet* [The public health nurse role in public health] (p.69) by B. M. Dahl, 2004

In relation to Table 4, this study indicates that PHNs move between and combines the traditional and ‘new’ strategies, depending on the situation. PHNs have lost the traditional municipality hygiene inspections, but are incidentally working on traditional and ‘new’ arenas, still mostly directed to individual and family interventions. When the PHNs practised a paternalistic intervention, it was mostly combined with relational and holistic strategies (paper III).

In fulfilling a paternalistic role, PHNs function as discipline agents of the government who are occupied with identifying risk factors and changing behaviours at the individual level. This position was detected in the curriculum text (paper I). This power perspective of the public health nursing role (paper II) could be about PHNs as contributors to social order by controlling the lives of service users, and a connection could be drawn to Foucault’s (1977) governmentality theory about social control. A more hidden power could also be detected in the PHN role—for example, when they practise supervision and provide support to families at the same time as the control functions are to be carried out. The duality in the intervention is in line with the mandate of public health nursing (Social and Health Directorate, 2004). The tasks that initiated public health nursing to become a key profession, shaped by the welfare state’s ideology and political recommendations, in the reconstruction of public health (Schjøtz, 2003) have been accomplished with the development of the welfare state, and the introduction of new tasks has only to some extent resulted in a reorganisation of the service. A shift in authority has occurred between the professional and the service user, with greater focus being placed on empowerment strategies; however, the professional power can still be said to be present, albeit in a new shape. Laverack (2009) referred to Foucault (1977) by maintaining that it is a subtle but common use of hegemonic power when professionals impose their ‘expert’ ideas of what are important health problems without listening to what service users think are important health concerns. For example, encouraging service users to participate in networks can be done with the best of intentions, but it may not be what they wish for, or desire. The control aspect here was not explicated; it could have existed in a more subtle way. Foucault maintained that hegemonic power is everywhere and is internalised in the individual. Martinsen (2005) pointed out that professionals need to exhibit weak paternalism when interacting with service users. The dominant paternalistic discourse in the curriculum text (paper I) supports findings of previous studies that have attempted to reveal risk factors and to change behaviours at the individual level; hence, these issues still seem to be of central importance (Andrews, 2002). The dominant paternalistic discourse in the curriculum text was not fully recognised in the

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practice experiences of the PHNs. They used empowerment strategies when interacting with service users, and applied dialogue and clinical judgement so as to adjust to the right level of power in the practice situation. The findings showed that combining paternalistic and empowerment strategies may presuppose phronesis, or wisdom with a moral base, so as to increase the possibility of a good result for the service user. Like the empowerment strategy, which also has a moral base in the value of participation, phronesis is also about dialogue with the individual, but is not about transferring of power to the individual. Phronesis is rather about the PHNs' abilities to seeing and acting related to the individual's needs in a holistic knowledge-based practice.

The PHNs in the present study saw themselves as professionals with the power to influence the lives of their service users, and they said that they were aware of the importance of not misusing their power (paper II). It can be maintained that nurses must use their power sensibly (Slettebø & Bunch, 2004), but doing so may not be straightforward. In line with Foucault (1977), who maintained that power and knowledge are inseparably tied together, the PHN will always have an influence on the service user in a direction that is based on the knowledge possessed by the PHN. A subtle power dimension may exist in the empowerment ideology that must be balanced against the more evident disciplinary power dimension in the paternalistic ideology.

A way for PHNs to handle these ideological challenges whilst fulfilling their mandate of working to improve and extend the quality of life in the population can be to clarify and reflect critically together on challenging experiences from practice. During this process of clarification and reflection, PHNs should direct their attention on how to interact with service users in the best possible way, based on the ethics of the profession, so as to protect not only the interests of society but also those of the individual service user. The ethics of the public health nursing profession and clinical judgement can play major roles in PHNs' interactions with children, families and young people, provided that they are based on respect and trust and a relational intervention in practice.

The empirical findings showing a duality between instrumental and relational interventions towards parents, children and young people (papers II, III) suggest that PHNs need to be secured in this dual role towards service users, and by narrating in communities of practice about practice experiences, PHNs' identity can be strengthened. Relational interventions could be in the form of conversation groups with parents, which were introduced by Bogen (1972) in the early 1970s, and which were partly a reaction to failing with biomedical knowledge alone. The present study showed two outcomes in time with

regard to relational face-to-face work: On the one hand, the results of the interventions could be experienced immediately (paper II), and on the other hand, the results could be experienced far ahead in time, in line with prevention logic. The PHNs expressed that immediate feedback provided them with the feeling that they were doing an important job (paper III). The increased public health focus on health policy (Winters et al., 2007) could still involve a redefining of roles and tasks in health promotion and prevention work, which could have consequences for public health nursing. If public health services are to meet today's health challenges, a clarification of the public health nursing role and identity is needed. Critical reflection, innovative thinking and adaptability may be ways in which to clarify the identity and, hence, allow the profession to be at the forefront of primary prevention, as contributors against inequality in the health of the population.

### **6.3 *Balancing the knowledge base***

In the present study, the intentions of public health nursing interventions were to combine and balance biomedical knowledge with empowerment strategies and a holistic perspective. However, constituting a professional identity in public health nursing that fulfils these intentions may pose a problem considering that the curriculum text emphasises mainly biomedical knowledge at the expense of social scientific knowledge. The ethical guidelines for nurses state that the goal for nursing groups is a knowledge-based practice (NNO, 2011b). The curriculum text and the Norwegian nursing organisation focus on scientific knowledge-based public health work (Ministry of Health and Social Services, 2013). Evidence-based knowledge is expanding and has been given increased attention in health care (Fineout-Overholt, Melnyk, & Schultz, 2005; Markham & Carney, 2008) and in public health nursing.

Working in knowledge-based practice involves situations where the best available evidence-based knowledge, experience-based knowledge and client knowledge are used and where service users participate (Nortvedt & Jamtvedt, 2009). Critical voices have emerged against evidence-based knowledge, and Martinsen (2003, 2005) maintains that situational knowledge is another form of evidence-based knowledge that is different from positivist knowledge. A discussion has been taking place about the connection between theoretical knowledge and practical knowledge in the nursing profession (Martinsen, 2005; Nortvedt & Jamtvedt, 2009). The discussion seems to be about which form of knowledge can best develop the profession and aid service users. Double-blind randomised studies, often used in

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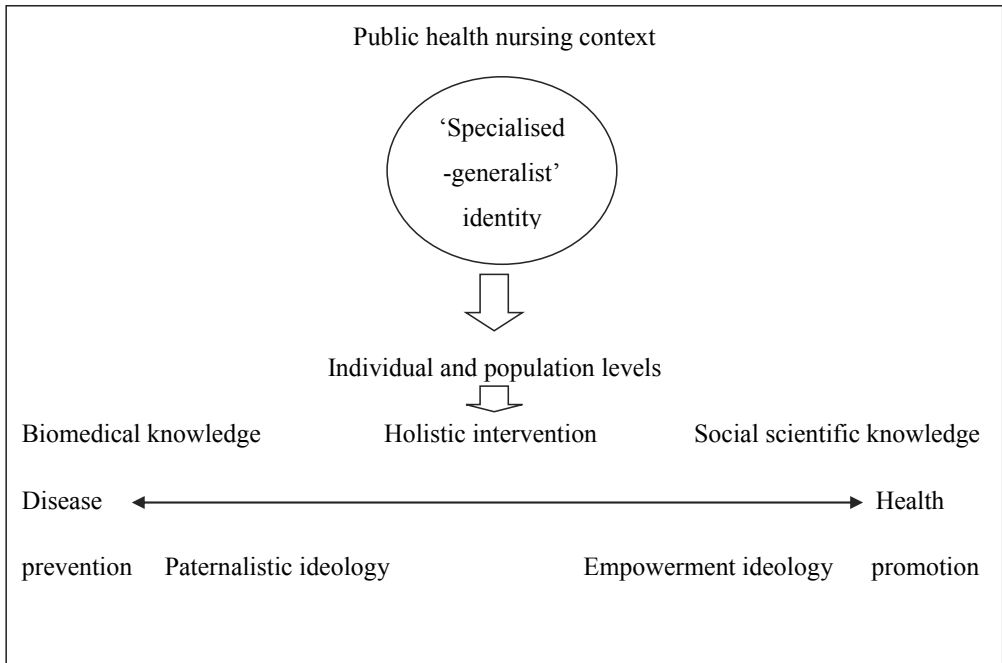
epidemiological and immunological research, are considered the gold standard of clinical research and are ranked at the top of the hierarchy of knowledge in EBM (Sackett et al., 1996). However, in many areas inside public health nursing, there is a lack of research on both positivist evidence-based and situational knowledge, that is, on how PHNs use their clinical wisdom in practice.

Relating theoretical knowledge and practical knowledge forms in public health nursing to Aristotle's (trans. 2004) knowledge categories of episteme, techne and phronesis has been found to be useful in clarifying the knowledge forms within the public health nursing profession. Doing so also makes the profession comparable with other professions that apply corresponding categories to explain their knowledge base. When using episteme and techne knowledge, that is evidence-based knowledge and standardised procedures, the PHNs in this study felt confident in their ability to carry out a consultation (paper III). In their study on Norwegian public health nursing competence, Andersson et al. (2006) advocated for greater use of standardised methods and screening instruments in practice, on the basis that these tests help PHNs to discern when to refer service users to other types of health and social care when borderline deviations are detected. Using standardised procedures and guidelines in consultations can be a suitable tool for revealing deviation from a scale. Standardised practice and knowledge-based practice are connected. The present study indicates that the time PHNs spend on performing standardised procedures can lead to reduced use of their clinical judgement, which in turn can result in less focus on individual needs. Sackett et al. (1996) maintained that every external 'guideline' must be integrated with individual clinical wisdom so as to provide the best level of health care to service users and that a 'bottom-up' approach must be taken with service users. However, standardised knowledge can also contribute in strengthening the professional basis and jurisdiction.

In my research, I described a situation where a tight time schedule made it difficult for PHNs to conduct standardised procedures whilst basing the interventions on situation based clinical judgement (papers II, III), which meant using both screening instruments and dialogue in consultations. On the one hand, standardised procedures can contribute positively in the professionalisation of public health nursing. Because standardised procedures are mainly evidence-based instruments, and the nurses can feel secure in using them. On the other hand, standardisation and institutional loyalties can result in an instrumentalisation of the service (Wyller et al., 2013). There is an increased demand for instrumentalisation in nursing (Scott, 2008), and PHNs risk becoming more involved in gathering and processing data than in interacting with children, young people and families.

The present study showed that instrumentalisation of the service can be increased by constraints such as time; thus, it is important to be aware of this effect when using screening tools. The PHNs in the present study strived to solve problems whilst being resource oriented. Being aware of the needs of others can be as important as carrying out a standardised consultation. Focusing solely on scientific knowledge and not being open to the needs of each individual can jeopardise certain values, such as respect and trust, which can in turn weaken professional identity. It is important for PHNs not only to use appropriate techniques but also to base the intervention on the needs of service users and to listen to the concerns of the service users and empower them to take care of their own health. Benner (1984) maintained that nursing knowledge cannot be put into guidelines and abstract principles. According to Skjervheim (1996), applying an instrumental approach when interacting with service users is not sufficient to obtain a good result. Expecting PHNs to adhere strictly to current evidence based standardised tools does not necessarily harmonise with individual flexible approaches and theories of empowerment and participation.

Public health nursing is a low-threshold universal service that PHNs alone offer. Based on the present study's findings, PHNs can be called nursing specialists within the field of health promotion and primary prevention work for children, young people and families. When PHNs work at the primary prevention level of interaction, they appear as specialised generalists in public health whose objectives are to empower the target group and to detect deviations from normality (paper III). Figure 2 depicts the specialised-generalist identity of public health nursing and the mandate of the profession. The findings of the present study show that the PHNs' work extended along a continuum ranging from disease prevention to health promotion, with a clear distinction existing between the two public health strategies. Public health nursing work was also carried out at the individual level and the population level, but the PHNs in the present study worked mainly at the individual level. The findings suggest that PHNs need to be empowered to fulfil the specialised generalist role. For professionals to be empowered in their role means that they must understand the sources of their own power (Laverack, 2009, p. 43).



*Figure 2 Balancing the 'specialised-generalist' identity of public health nursing.*

The PHNs' range of strategies explicates the 'specialised-generalist' identity. The PHNs had an empowerment and holistic perspective and strived to use clinical judgement when interacting with children, families and young people. However, the present study indicates a contradiction. On the one hand, public health nursing emphasises an empowerment ideology and health promotion strategies with a holistic approach to public health. On the other hand, public health nursing emphasises the need of using evidence-based knowledge and standardised procedures that can be understood as a wish of professionalising the profession, having jurisdictional borders and gaining political influence. According to Sackett et al. (1996), combining both strategies can benefit the population. Sound clinical judgement, is necessary for good results to be obtained for service users. Practical knowledge needs to be accepted as professional knowledge. Previous research has suggested that clarifying the knowledge base of a profession is of importance in developing the professional identity (Hansbøl & Krejsler, 2008). An awareness of the knowledge base of public health nursing can be crucial in constituting professional identity



in a context where PHNs are under pressure from both macro-level directives and micro-level expectations.

#### ***6.4 The importance of values in professional identity***

When illuminating the lifeworld of PHNs, I found nurses who were proud of their work, viewed their work as valuable and considered responsibility and trust to be core values. Public health nursing has a professional ethical basis (NNO, 2011b). According to Freidson (2001), professional privileges can be best maintained by placing greater focus on the particular profession's ethics and morals. Thus, to maintain the profession's symbolic and economic advantage, the profession's ethics are central and must be put on the agenda. Meeting the needs of children, young people and families, in line with the ethical guidelines of the profession, may strengthen the jurisdiction of the public health nursing profession.

However, a consequence of the heavy workload of PHNs could be a blurring of the boundaries between work and private life, resulting in ethical dilemmas (paper II). The interaction between work and home may be a source of stress when the roles are not clear-cut (Majomi, Brown, & Crawford, 2003) and the professional borders are blurred. Ricoeur (1992) maintained that the ethical dimensions of personal identity imply continuity. Hence the social 'ipse' identity of the professional can develop from its basis in the stable 'idem' identity. The sense of responsibility for service users can be considered a stable factor, where professional and personal identities intertwine. Clancy and Svensson (2007), who revealed in a study on PHNs that their experience of responsibility for service users did not stop at the end of a workday, support this finding.

As shown in paper II, a commitment to engage in difficult situations was a core characteristic of the identity of PHNs (paper II). Contradictions were also detected in this study with regard to the factors influencing the PHNs' action choices. Although the PHNs wanted to fulfil their social mandate, their respect for the service users often influenced their choice of action in such a way that their actions in particular situations went in another direction to that of the main recommendations, thereby overruling the standardised system (paper II, III). This ethical level of work is what Freidson (2001) referred to as 'the third logic', where the choice is to follow institutional recommendations or to uphold professional values. Freidson maintained that professional responsibility is established in the ethical regulations for the profession and is related to the quality of work. The value conflicts that were revealed in the present study could be characterised as loyalty conflicts—that is,

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conflicts between loyalty to the needs of the family and loyalty to the health service—which could give rise to moral stress that is difficult to handle. Moral stress can be compared to what Hjort (2005) maintained is the lack of possibilities to work in accordance with ethical standards and competence, which can cause a feeling of disqualification. International studies have indicated that governments and institutions ignore the core values of professions, causing resistance discourses among professionals (Baxter, 2011). The value base may be under pressure in today's professional work, owing to the economic-administrative reforms inspired by the control aspects of the NPM. In Norway, some health professions have protested against the existing market ideology in health care, maintaining that a lack of humanity in the steering systems has generated negative consequences for patients (Wyller et al., 2013).

As values contribute to the constitution of professional identity, a consciousness of the value base among professionals is crucial and has consequences for the integrity and autonomy of the profession. Public health nurses have ethical obligations to ensure the interests of service users (NNO, 2011a), and this position may be threatened by administrative processes, which, in recent years, have displaced the values of professionals (Busch, 2012). To reduce the threat to this position, the political and institutional macro levels have to be held accountable, and together with the professional micro level, they can clarify the professional responsibility and ethical guidelines towards the population. In their study on compassionate care in nursing, Crawford, Brown, Kvangarsnes, and Gilbert (2014) maintained that actions at the policy, organisational, individual and educational levels are needed to incorporate compassionate health-care practices and that this is not merely a responsibility for the individual nurse. The clarification of the responsibility and ethics in public health nursing is also a clarification of professional identity, which means that the way PHNs describe practices can be an indication of how they understand themselves and their identity. This study showed that professional identity is defined by the characteristics that together distinguish public health nursing from other professions. The findings indicate that PHNs need to clarify their action choices in relation to the mandate of the profession, which is to devote attention to health promotion and primary prevention strategies whilst taking a holistic approach to public health. Describing these practice activities in communities of practice helps strengthen the professional identity of public health nursing.

Because experiencing difficult situations may cause feelings of inadequacy and powerlessness, it is important for PHNs to discuss challenging cases with each other and critically reflect on situations in relation to their professional values (paper II). Previous

research has also highlighted how important it is for PHNs to describe their experiences of stress (Majomi et al., 2003). By doing so, PHNs are in a better position to grasp the complexity of their role, which in turn helps prevent burnout, and to fulfil the public health nursing mandate of contributing to improving and extending the quality of life in the population. The identity of professionals is influenced by interventions from both the macro level and the micro level (Wackerhausen, 2009). When the social mandate changes, the professional identities and the social expectations of the profession are affected (Brante, 2005). Dealing with conflicting loyalties could generate ethical dilemmas, as illuminated in paper II, and trigger feelings of inadequacy in PHNs. However, having the courage to deal with value conflicts could work to strengthen their professional identity. If PHNs develop an understanding of public health nursing as a specialised-generalist profession, this understanding can also give legitimacy and authenticity and strengthen their professional identity. When PHNs' action choices are based on a strong collective identity, where their mandate is clarified, PHNs can contribute to improving and extending the quality of life and to reducing inequality in the health of the population.

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## 7 CONCLUSION

This study shows a complex and diverse public health nursing mandate and practice, which can pose a challenge to the constitution of a public health nursing identity. The way in which PHNs described practice and how values and knowledge were used and integrated into clinical practice can indicate how PHNs understood themselves and their identity.

Societal discourses can influence on the constitution of professional identity, and the study has shown a need for a revision of the educational curriculum, as it is not in line with recent policies, which focus more on health promotion. The governmental principles in the curriculum text can indicate the PHNs' action choices with regard to the level of work, focusing mostly on the individual level. The limited focus on population in both the curriculum text and the practice experiences of PHNs indicates that the policies were not fulfilled. Thus public health nursing can need to clarify its mandate and identity with regard to promoting mental and physical health, good social and environmental conditions (school environment and local environment) and preventing disease and injury on individual and population level.

Macro-level demands for evidence-based practice and standardised services pose challenges to public health nursing in the form of balancing time between procedures and clinical judgement in consultations. Increasing the amount of time spent in clinics and schools may improve the quality of their work.

At the micro level, challenges involved the interaction between personal values, professional values and institutional values; the prioritisation of those most in need of services; the institutional value of effectivity; and time constraints. The study indicates PHNs had a stronger identity in relation to personal and professional values than in relation to institutional values of efficiency and loyalty to policy directives. Developing an appropriate system for referring service users with established problems to specialised services can free up more time for primary prevention and health promotion geared towards all children, young people and families.

An elucidation of public health nursing as an exclusive working field and as a specialised-generalist profession, as revealed in the present study, could secure the role of PHNs in relation to jurisdictional borders and strengthen the identity and legitimacy of the profession at a time when health-care policy promotes economic values and increased collaboration.

### **7.1 *Practical implications***

The present study draws attention to the importance of a strong professional identity in public health nursing. A clarified public health nursing role and identity can bring about the need for restructuring in other parts of health care, such as an increase in the number of psychologists and other relevant professions needed in primary health care, and an increase in the capacity of specialised health care. If these types of changes are implemented, PHNs will be better able to fulfil their main mandate, which is to use their resources to help children, young people and families to cope with their everyday lives and to detect and refer deviations from normality. By effectively fulfilling their main mandate, PHNs help improve and extend the quality of life in the population.

For PHNs to participate actively in constituting their own professional identity, it is important that the institutional level facilitates the existence of learning environments in communities of practice. The gathering together of PHNs on a regular basis gives them an opportunity to narrate and reflect critically on their practice experiences and to discuss the public health nursing mandate. One positive outcome may be an enhanced action competence based on a common understanding of the value and the theoretical and practical knowledge base of the profession, which in turn may constitute strong individual and collective public health nursing identities. This type of approach to constituting identity can be transferable to comparable professions that also face challenging restructuring processes.

This study shows that the time allotted for public health nursing consultations leaves little opportunity for a holistic perspective. One initiative could be to lengthen the duration of consultations at child health clinics from 20–30 minutes (today) to 45 minutes. This study also indicates that an increase in the time available in school health services is needed. Health promotion work and holistic thinking require, as shown in the present study, a combination of techniques and procedures with clinical judgement in consultations, which can be time consuming.

The knowledge gained from this study may be of interest to nursing education institutions, to the public health nursing profession and to the government that controls the profession. The findings of this study may also contribute to the dialogue on the quality of public health nursing.

## **7.2 Further research**

This study emphasises the importance of stories about practice situations in creating a basis for the development of professional identity. However, further research is needed to understand fully the processes related to the development of professional identity. One related topic that was not explored in this thesis concerns how and to what extent PHNs share stories about their practice experiences with one another.

Because collaboration is the mantra for today's health-care system, critical research on the consequences of increased interprofessional collaboration, particularly on the development of professional identity, is of importance. Whether (and, if so, how) professionals defend their jurisdictional borders is a related theme that needs to be investigated further so as to illuminate how professions develop today.

Widening the gender perspective on public health nursing may provide enriched data and new insights about processes in the profession and about consequences for the population. Further research is recommended to illuminate these conclusions.

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