

Perceptions of public health nursing practice On borders and boundaries, visibility and voice

Anne Clancy

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The Nordic School of Public Health

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Sweden

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Abstract

Aim: The aim of this comprehensive thesis is to explore different perceptions of public health nursing practice. The intention being to contribute to developing the service, theoretically and practically, in throe with current and future public health needs.

Methods: The thesis comprises five studies. Public health nurses, young people, parents and decision makers are interviewed and share their perceptions of public health nursing practice (studies I, II, III and IV). Consultations at local child health clinics, clinics for young people and at school health services are observed (study III). A cross sectional study amongst a sample of doctors, public health nurses, midwives and child protection workers is carried out (study V). The first four studies have an explorative, descriptive design. Study V, with its focus on interprofessional collaboration, is based on the results of studies I, II, and IV.

Findings: Study I, a case study, provides a backdrop for the remaining four studies. It focuses on changes the nurses have faced during the period 1984-2005. The results point to issues of visibility and that respect is more important for the nurses than authority or status. Study II is a philosophical study based on interviews with public health nurses. It gives an introduction to the philosophy of Emmanuel Levinas and develops a novel theoretical and practical understanding of aspects of responsibility in public health nursing. Study III shows the importance of relationships with service users in public health nursing practice; and that not only pleasantness but also honesty and openness are important. This study has contributed to further developing models of public health nursing interventions. Decision makers in study IV point to the challenges public health nurses face regarding collaboration, visibility and boundaries. Study V is a cross sectional questionnaire study that focuses on interprofessional collaboration. The results show that size of municipality can influence frequency of meeting points and views on issues relating to collaboration; and that mental health services are those most missed in collaborative relationships. The findings warrant further research and should be of interest when organising municipal health- and social services in Norway.

Conclusions: The thesis concludes that service users and decision makers are satisfied with public health nursing services, but that public health nurses face challenges related to collaboration, to boundaries for knowledge and involvement, and in making their health promotive function visible.

Key words: boundaries; children; Emmanuel Levinas; interprofessional collaboration; interpersonal relationships; Norway; parents; perceptions; public health nursing; visibility; young people.

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E-mail: anne.clancy@hih.no

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Sammendrag på Norsk

Denne doktorgradsavhandling: *Perceptions of public health nursing practice - on borders and boundaries, visibility and voice*, fokuserer på ulike oppfatninger av helsesøsters praksis.

Helsesøstre, ungdom, foreldre, samt lokale politikere og administratorer er intervjuet om deres syn på helsesøstertjenesten. Konsultasjoner på helsestasjon for barn, ungdom og i skolehelsetjenesten er observert. Et utvalg av samarbeidspartnere har svart på et spørreskjema om samarbeidsforhold. Avhandlingen består av fem studier. De første fire studier har eksplorativ, deskriptiv design. Studie V er en tverrsnittsstudie som bygger på resultatene fra studiene I,II, og IV. Avhandlingen har til hensikt å løfte frem områder som respondentene mener fortjener oppmerksomhet og som kan ha praktiske og teoretiske implikasjoner for utvikling av tjenesten.

Studie I, en case studie danner et bakteppe for de andre studiene. Den fokuserer på endringer i helsesøstertjenesten i perioden 1984-2005. Resultatene fra denne studien peker på helsesøstrenes opplevelse av usynlighet og at respekt er mer viktig for helsesøstre i studien enn autoritet og status. Studie II er en filosofisk studie basert på intervjuer med helsesøstre. Den gir en introduksjon til Levinas' filosofi og utvikler en dypere forståelse for teoretiske og praktiske aspekter av etisk ansvar i helsesøsters praksis. Studie III peker på betydningen av relasjoner i helsesøsters praksis. Det var viktig at konsultasjonene var hyggelige for helsesøstre og brukerne, men ærlighet og åpenhet var også vesentlig for gode relasjoner. Beslutningstakere i studie IV peker på utfordringer helsesøstre har når det gjelder samarbeid, usynlighet, samt grenser for deres kunnskap og involvering. Studie V er en spørreskjemaundersøkelse som fokuserer på samarbeid. Resultatene viser at kommunestørrelse har betydning for hyppighet av møtepunkter og syn på samarbeid og at psykiske helsetjenester er savnet mest i samarbeidsrelasjoner. Disse funn burde være av interesse i fremtidig organisering av helse- og sosialtjenester.

Avhandlingen konkluderer med at foreldre, ungdom og beslutningstakere er fornøyde med helsesøstertjenesten, men at helsesøstre står overfor viktige utfordringer i samarbeidsrelasjoner, i forhold til grenser for involvering og i å synliggjøre deres helsefremmende funksjon.

Nøkkelord: barn; Emmanuel Levinas; familier; folkehelse; grenser: helsesøstertjenesten relasjoner; tverrfaglig samarbeid; synlighet, ungdom

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Original articles

This doctoral thesis is based on the following original papers. They are referred to in the text by the corresponding Roman numerals:

Study I

Clancy, A. (2007). A profession under threat? An exploratory case study of changes in Norwegian public health nursing. *International Nursing Review*, 54(2), 197-203.

Study II

Clancy, A., & Svensson, T. (2007). "Faced" with responsibility: Levinasian ethics and the challenges of responsibility in Norwegian public health nursing. *Nursing Philosophy*, 8(3), 158-166.

Study III

Clancy, A., & Svensson, T. (2010). Perceptions of public health nursing consultations - tacit understanding of the importance of relationships (accepted). *Primary Health Care Research and Development*.

Study IV

Clancy, A., & Svensson, T. (2009). Perceptions of public health nursing practice by municipal health officials in Norway. *Public Health Nursing*, 26 (5), 411-419.

Study V

Clancy, A., Gressnes, T., & Svensson, T. Public health Nursing and interprofessional collaboration- a questionnaire study (Submitted).

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“For it seems as though experience first gave contents – forms, solidity, roughness, color, sound, savor, heat, heaviness, etc. – and then all these contents were animated with meta-phors, receiving an overloading through which they are borne *beyond* the given.”

Emmanuel Levinas

Basic Philosophical Writings (1996, p. 34)

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Introduction

The purpose of this doctoral thesis in Public Health is to describe and interpret perceptions of Norwegian public health nursing practice in order to contribute to understanding and developing the service in accordance with current and future needs. My interest in research on the profession has grown from a curiosity about a service, which I was part of for eighteen years, into what I hope is a critical mature reflection. It can be argued that it will be impossible for a researcher who has spent so much time within the professional fold to achieve a mature, unbiased reflection. Can distance in time and the advantages of hindsight enable an “insider” to become an “outsider”? Choosing different perceptions as a focus can alleviate, but not necessarily remove issues of bias, as perceptions are always grounded in personal experience. My tacit presuppositions can impose challenges pertaining to the overall design, the choice of methods and the use of relevant theory when writing up this thesis. I will therefore, in the course of my writing, pay special attention to these issues.

Norwegian public health nursing was described by Oslo’s Chief Medical Officer, Melby in 1989 as the most important general prophylactic service after the Second World War. Public health nursing today remains the core profession at local health clinics and school health services. According to Andrews (2002) views on core welfare services in Norway have changed and new attitudes to authority and knowledge have influenced the way professionals work, creating new dilemmas for professionals. Public health professionals are always situated in a context. It would be utopian of the author to view the profession isolated from its historical, cultural and professional context. This thesis explores and illuminates the public health nursing service from different angles. It includes the nurses’ own reflections, the opinions of decision makers, service users and collaborators. Qualitative and quantitative methods are used to answer the research questions. Perspectives on health, public health and public health nursing as well as theories on the development of professions provide the reader with a background for understanding this public health nursing service. Emmanuel Levinas’ (1906-1995) fundamental ethical philosophy guides this exploration, and mediates with the author throughout the thesis.

Public health has been described as being both a science and an art (Beaglehole & Bonita, 2004). Public health research is a scientific endeavour that can require creativity in capturing

essences and in presenting thoughts and reflections. According to Levinas, where language falls short the arts can say what cannot be said (Levinas & Aarnes, 1998).

At different points in the thesis I will incorporate reflections on the challenges of research; these phenomenological reflections are metaphors to the visual arts. The metaphors or analogies illustrate my thoughts, as an amateur artist and researcher, on the challenges of describing and interpreting reality. These metaphors are framed “word pictures”; embodied impressions that enable expression and give form to my thoughts.

Metaphor: From impression to expression

In cubism the artist breaks up, analyses, unfolds and reassembles objects two-dimensionally in abstracted form. The intention is to depict the subject from different viewpoints in order to show the theme in a greater context. In a cubist painting the flat surfaces seemingly intersect at random angles giving a shallow picture with no sense of depth. The artist if asked could inform that the angles are in no way random; they have a function but their depth may not always be apparent. The author of this text unfolds and reassembles public health nursing within a greater context. The resulting picture remains only a picture, an attempt at interpreting reality.

Exploring a public health service

Smith describes public health nursing as a nursing speciality that combines nursing and public health principles (Breslow, 2002, p. 998). The focus in the thesis is on public health nursing, in a context, with an awareness of the complexities of public health and an understanding of the need to look at the profession as an integral part of public health services. The very nature of public health as defined by Winslow (1923) is preventing diseases, prolonging life and promoting physical and mental health through organised community efforts (Beaglehole & Bonita, 2004). Mæland (2005) and Tones and Tilford (2001) write that collaboration and integration are the only ways to achieve public health goals. The important theoretical perspective guiding public health nursing is the public health model and there is a need to develop knowledge of public health nursing within the sphere of public health (Elo & Calltorp, 2002). Exploring aspects of a professional public health service can throw light on the profession and generate knowledge that can improve and develop the service. Referring to

public health nursing, Ellefsen (2001) maintains that descriptive studies are necessary in order to develop, advance and if necessary change the service that is delivered. Further research should address the question of changes and patterns in health visiting work* (Ellefsen, 2001). Being part of a public health service provides challenges for public health nurses (PHNs) in areas such as knowledge development, conduct and how they present their service (Neumann, 2007).

Ideas for developing the services come from many sources. Wiegersma (2005) writes that a variety of professionals is necessary in public health. He suggests new roles for PHNs; suggesting that they perform tasks normally held by physicians. A Norwegian parliamentary politician has even suggested that local health clinics should widen their remit and now give health services to grown ups (Dolonen & Østby, 2008) entailing new tasks for the nurses. Before new roles are assigned to public health professionals existing ones should be examined. Concern for and interest in the quality and content of the service provided is the underlying reason for this scientific research.

The five studies in the thesis

The thesis comprises five studies numbered I to V. Study I illustrates important changes that have influenced PHNs' role and function during the past 20 years, and provides a backdrop that helps contextualise public health nursing today. The study discusses the public health nursing profession's changing role regarding collaborators, tasks, leadership and authority/status during the period 1984-2005. Study II shares the nurses' reflections on the challenges of responsibility they face in their work. This study illustrates the challenges the PHN faces in her work and provides the reader with an understanding of Levinas' philosophy. Study III describes and reflects upon how PHNs' nurse, and on how the nurses and their service users experience public health nursing consultations. Study IV discusses how a sample of municipal decision makers perceives the service. Collaboration is vital in public health, the theme of collaboration was an important focus in studies I, II, and IV. Study V is a cross

* Different nursing titles are used in the dissertation as public health nursing duties and titles vary from country to country. Despite different titles (health visitors, community health nurses and public health nurses) there are little differences in their aims, tasks and methods (Craig, 1998)

sectional questionnaire study that illustrates how a sample of PHNs and their collaborators view collaboration issues related to public health nursing in different sized municipalities.

After this introduction the author will provide the reader with background information on public health nursing. An introduction to the philosophy of Levinas will be given followed by thoughts on the theoretical concepts of health and public health and relevant knowledge on professions in public health. The aims and research questions will be presented before detailing the methods used in the five studies in the thesis. Ethical and methodological issues will be discussed before the results and subsequent discussion are presented.

Historical background

Community nurses in Norway were traditionally concerned with caring for the sick. School health services were introduced with the implementation of the School Act in 1860 (Ellefsen, 2002) and the first mother and child health clinic was opened in 1911 (Schiøtz, 2003). The first courses for PHNs were started in the 1920s/1930s and in 1947 the first school of public health nursing opened its doors. These nurses have existed in Norway from about the middle of the 1920s but the professional service is described as primarily a post war phenomenon (Schiøtz, 2003).

Einar Andersen, district doctor and Chief County Medical Officer worked for years to establish a public health nursing service that would spread the message of health to all homes and provide information on hygienic principles (Schiøtz, 2003). Preventive work was to be the PHNs domain with focus on infants, young children and school children. Local health clinics, school health services as well as offices for mental hygiene were to be centres for this work. Anderson wrote in 1938 that even though the services should have an element of control; the PHN was not to behave like a detective sergeant but be pleasant, helpful and courteous. Andersen saw the potential in a workforce that worked closely with the community and that could gain insight into which areas to prioritise in preventive work (Schiøtz, 2003).

In 1945 the Minister for Health Karl Evang created a five year plan for the improvement of public health in Norway. Public health nursing was an important part of Evang's plan and he repeated time and time again the profession's important role in public health. The Act

concerning public health nursing was passed in 1958; establishing that PHNs should assist local doctors in the prevention of diseases (Schiøtz, 2003). Norwegian PHNs and local doctors had a key role in building up public health services and enacting the welfare state's policy after 1945 (Schiøtz, 2003).

District doctors were quite alone as health professionals in their districts, and had difficulty prioritising prophylactic work (Schiøtz, 2003). As the need for prophylactic services grew the doctors were active in establishing positions for PHNs in order to help them carry out this work. PHNs were looked upon as vital partners in public health work. Clancy (2004) interviewed PHNs who presented reflections from their practice from the 1950s to the present day. Their stories create a picture of what it was like to work as a PHN in the period after the Second World War. A retired nurse describes public health nursing in the nineteen fifties in the following way:

There was a great need for PHNs, there was no nurse here. School health services were nonexistent (...). We had no welfare office. There was only one doctor in the whole municipality. We started with the school health services and set up a clinic for babies, children and expectant mothers. There was a lot of sickness in the community. Many had tuberculosis and some were sent to the sanatorium, also children. Four children had the disease and had to be admitted. The hunt for tuberculosis was interesting (...). I carried out hygienic inspections; I went to the community hall and discarded all the chipped crockery. I instructed the local shopkeepers not to stand on drawers, where they had flour and raisins, in order to reach the top shelves. I inspected all the drawers. Many a time I felt ill at ease (...). I knew they thought I was strict (...).

(Clancy, 2004, p.2 appendix 5)

In many communities the public health nurse and doctor were the only public health professionals until the late seventies. Other health and social professionals with specialised tasks and functions have since then entered the field of public health (Schiøtz, 2003; Vallgård & Krasnik, 2007). A PHN described nursing in the seventies in the following way:

I went to public health nursing school in 1976. My first job was in a small community spread over lots of small islands. My work was partly done in people's homes because they didn't have clinics on all the islands. I got to know the whole family, the old granny in the attic as well. I had a very holistic view.

Reflecting on public health nursing in the 21st century the same nurse continued:

We have lost a lot, yet we still have a multitude of tasks and a lot to keep an eye on. We have to be watchdogs in many areas, but I feel that we have lost good collaborating partners. Health reforms and privatisation of doctors' services have created a new situation. It is difficult to carry out preventive work based on a "pay by item" system. We don't have a framework for meeting points any more.

(Clancy, 2004, pp. 9, 11 appendix 5)

The political and organisational changes that came with the Norwegian Municipal health services Act (1982) caused several radical alterations in the role and function of the PHN. From previously being in close partnership with doctors, they now had to share tasks with a host of new health and social professionals, such as; psychologists, occupational therapists, physiotherapists, dental hygienists, child protection workers, engineers and technicians, to mention a few. Focus on principles of empowerment and user participation entailed that PHNs' focus changed from being "expert" advisor to supporter and enabler.

According to Skaset (2003) the closer we get to our own time the more difficult it becomes to give historically correct data, due to the wealth of details and the difficulty in gaining an overview. Study I in this thesis looks closer at the period of change from 1984-2005 and illustrates specific changes and challenges PHNs face regarding tasks, leadership, collaboration and authority/status. Norwegian municipalities were now required by the Norwegian Municipal Health Services Act (1982) to carry out preventive and health promotive work. The intention was to increase decentralisation; to improve collaboration amongst professionals and to achieve increased utilisation of local resources (Skaset, 2003). The increased number of professionals, on the one hand, and community health promotion ideologies of community empowerment, on the other, required that interorganisational and interprofessional collaboration came to the fore. These changes influenced the roles and functions of all health and social professionals in the community.

Public health nursing today – its relevance to public health

Public health is concerned with the promotion of health for all citizens (Cordeiro, 2001). Practitioners, programs, policies and the general public are all important factors in achieving public health goals. The World Health Organisation (WHO) has stressed nurses' role in public health and sees the need to focus on family health and community health nursing (WHO, 2000). In child health services parental counselling is a way of promoting health and preventing illnesses and protecting children (Bremberg, 2001). WHO recognises nurses as a force for health and points out that nurses and midwives have increasingly important roles in tackling public health challenges, in ensuring continuity of care and addressing peoples needs (WHO, 2000). WHO's document is directly relevant to Norwegian PHNs; they are the largest special interest nursing group in the country, they are community based; they follow up families over time and focus on family health.

Public health nursing has evolved alongside the public health movement. The main reasons for its development have been individual and population needs for health services and as a force against inequality, disease, poverty, environmental pollution and infectious diseases (Edgecombe, 2001). PHNs in Norway today are authorised nurses who have an additional one year qualification in public health nursing (KITH, 2002). The aim of the education is to educate and enable nurses to carry out health promotive and illness preventive work with children, young people and families. Per definition, a public health professional focuses on population level health (Gebbie, Rosenstock, & Hernandez, 2003). The PHNs' population based role entails a focus on populations and is carried out by primary preventive measures and by charting and conveying knowledge of local health issues to policy makers and to other sectors and participating in municipal health planning. PHNs are also a standby flexible workforce prepared to respond to immediate public health challenges and threats such as natural catastrophes, epidemics and pandemics.

Edgecombe (2001) differentiates between the generalist public health nursing role and the specialist role of the PHN who is involved in maternal and child health; maintaining that the population focus of the generalist PHN is central to its role. The Norwegian PHN can be defined as having a specialist role. The PHN is specifically involved in child and family health at individual and group level and due to the universal nature of her services is in a position to monitor the health of her target population.

PHNs' work does not involve hands on nursing. The nurses are usually assigned a geographical area as their district; their areas of responsibility can also be confined to school health services or local clinics while some PHNs' work is restricted to certain population groups; for instance young people, refugees, and the elderly. The PHNs' mandatory services at local clinics and school health services will be the focus of this thesis.

Even though PHNs have an independent role, they do not work alone. Central professionals at local clinics and school health services are PHNs, doctors, midwives and physiotherapists. Other professionals can also provide additional services. Doctors have the overall medical responsibility, whereas each professional is responsible for the services they provide.

The public health model is a general model that focuses on the relationship between host, agent and environment. The model applies public health science and an epidemiological approach, but gives no theories on the causes of specific health problems (Elo & Calltorp, 2002). The public health model is an important theoretical perspective guiding public health nursing practice (Elo & Calltorp, 2002) as is the nursing perspective. According to Elkan, Blair, & Robinson (2000a, p. 1318) the public health model contains strong elements of professional dominance and control. Nursing is an approach that focuses on relationships, on care and on strengthening each individual's resources. According to Glavin, Helseth, & Kvarme (2007) the individual/family based approach is the PHNs' strength and PHNs have been criticised for not becoming more engaged in public health work at a community level. Some nurses may favour the client centred model over the population model without understanding the difference between them; "In areas of diminished funding the population model needs to be protected" (Edgecombe, 2001, p. 10). Helseth (2007) explicates, however, the continued importance of the PHN's direct contact with individuals and groups.

Elkan et al., (2000a) describe different models of health visitors' interventions and have created a synthesis of these models. The synthesis comprises two groups: the disease based model dominated by medical and epidemiological concepts and a model that emphasizes participation and empowerment at individual and group level. The strength of the first model is that it allows the PHN to focus on a single problem, attempt to identify its causes and assess the effectiveness of interventions. The model has also its weaknesses in that it may focus on

the nurse as an expert with the necessary expertise to deal with complex problems; problems that in reality are not easily solved. The second structural model emphasizes PHNs' working in partnership with clients and acknowledges the necessity of their being aware of the wider social and economic context and complexities within which families live their lives. Radical models that focus too much on structural issues have also weaknesses, in that they underestimate the importance of one to one relationships in facilitating change. Robinson's relationship centered model (a less radical structural model) emphasises participation and the empowerment of individuals in face to face relationships (Elkan et al., 2000a).

Empowering individuals whilst at the same time recognising and reporting patterns in the health panorama can promote the health of populations. An integration of relevant models that promote health and prevent diseases and empower individuals and groups must surely be the goal for all PHNs. Populations comprise individuals and the goal in public health is to promote the well being and health of all members of the population. My knowledge of the field allows me to assert that the PHN's face to face meetings with a multitude of parents, children and young people gives her knowledge of local populations and puts her in a position to feel the pulse of the community and monitor trends and patterns in the public health of local populations.

Nordic perspective on public health nursing

There are similarities in the public health nursing services in the Nordic countries even though their titles, tasks and remit differ. The counterpart for the Norwegian public health nurse (Helsesøster) is the "Sundhedsplejersken" in Denmark, the "Hälsövärdare" in Finland, the "Distrikssköterskan" in Sweden and the "heilsugaesluhjúkrunarfræðingur" in Iceland. The similarities in practices are grounded in a joint philosophy based on WHO's guidelines (Bjälming & Ek, 1991). Historical development of the services has followed the same pattern in all Nordic countries. But in the early days the service in Finland was considered to be more advanced and well developed (Hilli, 2007). Nordic countries, in contrast to other high income countries, offer universal home visits to families with new born babies; providing a better foundation for further interactions with public health nurses (Hjälmhult, 2009).

PHNs in the Nordic countries work closely with their fellow citizens and can become aware of needs and trends in society at an early stage and take steps to help (Bjälming & Ek, 1991). There are some differences in how services are carried out in the Nordic countries. Denmark does not offer services at local child clinics but relies solely on home visiting. Immunisation programmes are not within the Danish nurses' mandate. PHNs in Norway, Sweden and Iceland carry out immunization programmes and provide both a domiciliary visiting service and a service at local child health clinics.

In Denmark and Norway the nurses work mainly with young children, families and school health services and do not partake in hands on nursing; whereas in Iceland, Finland and Sweden a public health nurse can work with all ages and with both counselling and hands on nursing. These universal services are free of charge in all Nordic countries. Public health nursing practice in the Nordic countries has changed with changing needs in society and focus is now more on psychosocial problems (Schjøtz, 2003).

PHNs' societal role

PHNs are societal agents for carrying out public health work and their area of responsibility is regulated by the Norwegian Municipal Health Services Act (1982) and the Norwegian Communicable Diseases Act (1994). Their remit (pertaining to health promotive and preventive services at health clinics and school health services) is further detailed in regulations (Helse- og omsorgsdepartementet, 2003) and guidelines (Sosial- og Helsedirektoratet, 2004). The purpose of the services provided at local clinics and school health services is to accommodate the needs of the target group (Helse- og omsorgsdepartementet, 2003). The nurses perform home visits, immunisations and carry out developmental screening; they also counsel and give advice to individuals and groups. Home visiting is an important health promoting intervention and it allows the nurse to get to know families in their own environment (Jansson, 2003). Early child development is defined as a social determinant of health and health inequalities, and is a priority focus for PHNs (Cowley & Bidmead, 2009). A health visiting service is a key requirement for tackling health inequalities so that all children and families who would benefit from early intervention can be identified. Public health nurses promote health and work mainly with primary and secondary preventive strategies. The nurses' role in primary disease prevention is carried out through

immunisation programs, and by health education. Secondary disease prevention is defined as discovering problems at an early stage and entails setting in measures to prevent further negative development. The complex nature of many health and social issues necessitates that PHNs must collaborate with other health services, schools, child protection services and the police in order to carry out their work. Tertiary prevention entails preventing further negative development of an existing problem, such as those experienced by children with chronic illnesses and disabilities, and their families.

Hagestad (2003) refers to the local child health clinic as a gateway to a healthy life for the growing population. These clinics provide a universal service and almost 100% of families avail of the service. The school health services can be seen as a continuation of the clinics' services. The PHN has office hours at the school and is available for pupils, school administration and collaborators at certain times of the week. School nurses are there for pupils and are responsible for keeping broader issues visible to administrators, teachers, students, families and communities (Abrams, 2005). The fact that PHNs are the health professionals who have the most contact with children, young people and their families establishes them as central actors in performing health promotive and disease preventive work for their target group (Glavin et al. 2007).

Health promotive and preventive work with children, young people and families remain PHNs' core function with an increased focus on mental health and responsibility for coordinating of services for children and families with special needs. Due to the nature of preventive and promotive work it is difficult to measure the effects of PHNs' work.

A review of the literature

Search in "Bibsys", medline, Cinahl and "academic search elite" databases with the search words "public health nurse", "health visitor", "community nurse" and "helsesøster" for the period 1995-2007 shows few studies that have a broad focus on changes and challenges in public health nursing. Some studies have been carried out on employees at local health clinics in Norway (Bild, 1995; Finnvold, 1996; Paulsen, 1990). Reports have also been written about the clinics; they do not focus on the daily activities but mainly on evaluation of projects and new enterprises; the studies have been basic and do not have a strong theoretical base

(Helsetilsynet, 1998). A Scottish study (Craig & Smith, 1998) on health visitors' role in public health illustrated challenges in defining the role. The study does not conclude with a clear definition but illustrates possible models from a public health perspective.

An English study showed that ordinary users of the health visiting service are content with the service (Bowns et al., 2000). Peckover's (2003) study showed that in situations when family violence occurred, PHNs often fall short in giving sufficient support and adequate advice on other supportive services. A Finnish study showed the necessity of having a qualitative good public health nursing service in order for service users to be content with the PHNs' health promotive role (Uosukainen, 2001). Bodil Ellefsen (2001, 2002,) published comparative studies on public health nursing in Scotland and Norway. Her studies showed similarities in issues related to prioritisation, lack of time, strain and insecurity. The differences between the two countries were mostly in management matters and organisational structures. A systematic review of international studies on domiciliary health visiting and a selective review of the British literature (Elkan, R., Kendrick, D., Hewitt, M., Robinson, J. J., Tolley, K., Blair, M., et al. 2000b) suggests the continued need for a flexible universal service rather than a service targeted solely to high risk groups. The review also shows that there is little systematic research on health visitors' relationships with individuals and families.

According to Baggens (2002) the ways which nurses establish, pursue, change and develop joint work relations with parents and children have not been studied to any degree. Andrews's doctoral thesis on changes in local Norwegian health clinics (Andrews, 2002) showed that the profession has become more resource orientated but that the nurses encounter a series of dilemmas when they try to tone down their role as "experts". Andrews and Wærness (2004) study on deprofessionalization of public health nursing discusses changes in the nurses professional status, tasks, leadership and collaboration. Andrews discusses tensions and dilemmas in a changing practice that implements health promotion ideologies but continues to hold on to traditional contrasting values (Andrews, 2002, 2006).

Tveiten's (2006, p. 18) review of the literature shows that there is limited research on PHN strategies and interventions. Tveiten's doctoral thesis describes and interprets supervision in public health nursing, mentioning time, competency and cooperation with clients, as important issues. Tveiten (2006) interviewed nurses about their perceptions of supervision in

public health nursing and analysed audiotaped dialogues sent to the researcher by the nurses in the study. Neumann (2007) interviewed both nurses and parents at local clinics and carried out observations at the clinics waiting rooms, with the intention of examining normality and deviation; and to look closer at what PHNs see and do not see in mother and child relationships. The fact that almost 100% of families avail of public health nursing services can, according to Neumann (2007), show their unique and specific knowledge of children, child health and family circumstances in their districts. The PHNs' trusted status in communities can put them in a position to reach and help many parents and families, but their focus on the concept of normality can influence their approach; making it difficult for PHNs to discover children who are victims of abuse and deficient parental care (Neumann, 2007).

Activities in school health services have been charted to some extent (Helsetilsynet, 1998; Kristiansen, 2003; Wistoft, Bruun Jensen, & Roeseler, 2005). Sollesnes and Tønjum (2008) have written about retired nurses' perceptions of school health nursing from the 1960s to the present day, and conclude that these PHNs had an independent, clearly defined role that focused on vulnerable pupils who strived with problems at school or in their home environment. Borup's (2007) Danish study demonstrated the effect of the health dialogue with the school nurse; her study concludes that school nurses play an important role for pupils in susceptible situations. A Swedish study reveals that 15 year old pupils feel that trustiness, attentiveness, respectfulness, authenticity as well as accessibility are the most important factors in promoting a good health dialogue with the school nurse (Johansson & Ehnfors, 2006). Tinnfält's (2008) doctoral thesis on young people's perspectives of mental health revealed the importance of the school nurse and showed that trust, respect, authenticity and respectability as well as continuity and accessibility were important for health promoting mental health dialogues. Claussen's (2008) doctoral thesis showed that public health nurses have a deep knowledge of schoolchildren's health that is not used to its full potential.

Jentoft (2005) carried out a study on health clinics for young people. The purpose of her study was to find out how adolescents perceive the service. The study showed that the young people trusted both the service and the health professionals working there. Trust was the analytical focus of the study.

There are certain gaps in the field of knowledge development pertaining to: PHNs daily practice, her strategies and interventions (Tveiten, 2006) and in the ways which nurses establish, pursue, change and develop joint work relationships with service-users (Baggens, 2002). Neumann (2007) refers to the lack of critical studies on the public health nursing profession that are applicable to Norwegian conditions. There is also a paucity of research on collaboration issues (Ødegaard, 2008). This thesis narrows the knowledge gap on these issues by providing perceptions of public health nursing practice using empirical data from observations, interviews, and a questionnaire survey.

Aims and research questions

The main purpose of this thesis is to increase knowledge and understanding of public health nursing by describing and analysing perceptions of public health nursing practice. The main research question reads as follows:

How do PHNs, their service users, collaborators and decision makers perceive public health nursing practice?

The scope of the main research question is broad in order to identify changes and challenges in the role and function of the PHN; in interpersonal relationships and in interprofessional collaboration. The thesis is limited to five studies that answer the following specific research questions:

Study 1: How and why has public health nursing changed regarding: tasks, status, leadership and collaboration over the last 20 years? This study provides a backdrop for, and contextualises the remaining studies. By exploring selected documents and the nurses' own views, the study aims to gain a greater understanding of the role and function of the PHN today.

Study II: How do experienced PHNs reflect on their practice? This study aspires, through Levinasian philosophy, to gain a greater understanding of how PHNs experience ethical responsibility in their work.

Study III: How do PHNs and their service users experience consultations? This study aims to gain a greater understanding of what goes on in public health nursing consultations and to give an understanding of how nurses and their service users experience these meetings.

Study IV: How do municipal decision makers perceive public health nursing practice? Local decision makers make priorities that can influence the public health nursing service. This study gains knowledge of decision makers' perceptions of the service.

Study V: How do PHNs and a sample of their collaborators view issues that can influence interprofessional collaboration? Collaboration emerged as an important issue in studies I, II, and IV. This study explores the issue further.

The societal and scientific relevance of this thesis

The paucity of research on PHNs' daily practice that is applicable to Norwegian conditions necessitates this research. The focus of this thesis is broad, the argument for this is that investigating a public health service that has diffuse boundaries and a multitude of tasks requires an open and discovery orientated approach. The purpose and intent of this study is the recognition of the need to gain insight into how PHN practice is perceived by others. Perceptions can seem to defy the objectivity and logic of Science. This thesis is within a humanistic context and thus lays claim to different views on objectivity and logic. Levinas (1969) is clear that we are all situated in the world; there is no view from nowhere.

The review of the literature has shown that there are gaps in the field of knowledge development pertaining to the PHNs' daily practice. My being present at PHN consultations provides data on these sessions that former Scandinavian studies do not. Levinas provides a novel philosophical frame of reference for studying the role and function of the PHN.

It can be argued that the subject of this thesis should have been justified by a theoretical goal. This is, however, an explorative, descriptive study, and not primarily a theoretically driven one. The broad focus "perceptions" allows the different themes from the empirical data to come forth. Discovering issues and topics that deserve further attention can elucidate the service and provide important themes for further research. In this thesis, findings from the first investigations (studies I-IV) furthered new questions about collaboration (study V). Examining perceptions of public health nursing practice by both "insiders" and "outsiders" will add to knowledge development in the field. An explorative descriptive study of a public health service, using new data, has a scientific and practical value in its own right. Examining what people think, what they expect and how they experience a service can when analysed systematically provide relevant scientific data.

Studying other people's perceptions, through my own perception necessitates that I must be analytical and critical to what comes forth. The thesis does not attempt to evaluate the service in a scientific sense as this would have required an entirely different approach. Outcomes of public health nursing and health visiting can only with difficulty be measured using statistical methods. A practice needs to be described and interpreted. Critics of scientific evaluation methods such as randomised controlled trials (RCT) advocate flexibility in both design and methods arguing that the outcomes of health visiting cannot be viewed as effects resulting from causes but as the end result of more complex interactions (Elkan et al., 2000a). Qualitative approaches are necessary in the study of persons. By orienting ourselves towards people's ideas about the world; we can help make visible the different meanings they ascribe to a situation (Marton, 1982), and in this way form knowledge of phenomena.

It is imperative for professionals to listen attentively to a variety of perceptions of their practice in order to detect new understandings of their work. These understandings can promote relevant changes in the services they offer to their clients. The search for interpretations and understandings in this thesis requires a critical appraisal and awareness of my own presuppositions as a former PHN.

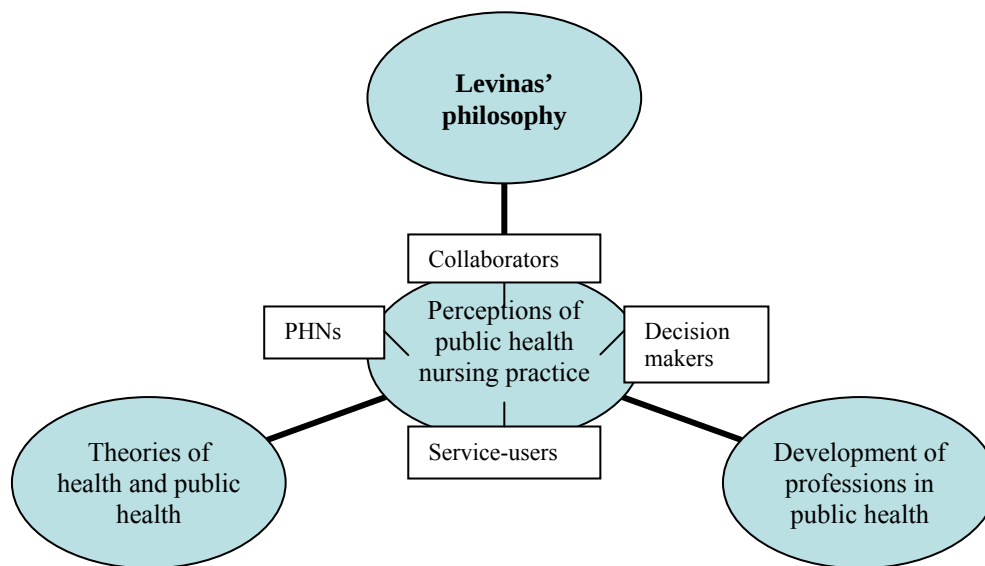
Metaphor: Changing perspective

The hard working naturalistic sculptor has now become a conceptual artist. The idea of this new art form is "concept", not product. Will she manage to leave the practical world of stone and mortar, and change purpose and perspective?

Theoretical frame of reference

Perspectives on health, public health and public health nursing as well as theories on the development of professions and Levinas' philosophy provide the conceptual frame of reference for this doctoral thesis in public health (Figure 1). Levinas' philosophy serves as a reminder throughout my work that ethical responsibility and focus on the Other can provide a solid foundation that can unite philosophy, science and the practical world of public health nursing.

Figure 1: Conceptual framework for the thesis



The philosophy of Emmanuel Levinas

According to Douglas Weed public health with its core focus on prevention, community, methodology, disease and health will benefit from philosophical enquiry (Bremberg, 2001). Public health emanates from ethics, and from commitment to humanity (Weed, 2001). The theme of ethical responsibility, broached in Levinas' philosophy is fundamental in public health nursing. Responsibility for others is what carries the discourse of science and philosophy (Levinas, 1991). *Responsibility, alterity and encounters with the Other* are corner

stones in Levinas' philosophy. Responsibility is about response, it entails being open to the call of the Other and implicates a response(ibility). The responsibility is mine; I cannot make reciprocal demands on the Other. This responsibility is not something I choose, it is something I am given, but at the same time cannot contain. It transcends the boundaries of the factual relationship in time and space, the boundaries of language and the boundaries of knowledge. Even though Levinas writes about intersubjective dependency, his concept of alterity recognises each person's separateness, existential loneliness and humanness. Recognition of the seemingly contradictory forces of dependency and separateness is relevant in the study of relationships between PHNs and the people they meet in their work.

Levinas is primarily concerned with the Other in relationships but he is also concerned about the third party: others we never meet nor see, but who need our help. The insistence on the "one self" in face to face meetings can be a threat to others who are not present to make their demands (Levinas & Robbins, 2001). The trace of something recognisable in the face of the Other is what appeals to me and calls out for my compassion and response. This trace can also serve as a reminder of the others whom I have not and maybe never will meet.

Levinas is clear about personal responsibility and describes it as the demand it is, not what it ought to be, as laid down in ethical codes. The public health nurses' ethical code is based on the fundamental values of respect for life and human dignity and addresses the professionals ethical norms and each individual nurse's ethical responsibility (ICN, 2006). Grimen (2008) refers to the professional community's societal mandate and political foundation as being the basis for their moral practice. According to Grimen (2008) a profession's moral standards must be carried out within the boundaries of universal moral values and religious standards but are not directly derived from them. Ethical codes are normative. Codes of ethics would not have existed without the political legitimacy of a profession. Levinas' ethics of responsibility can be defined as a primary fundamental ethics built on a concept of a pre-existing ethical responsibility for the Other. Levinasian ethics can provide a basis for understanding PHNs' reflections on ethical responsibility in public health nursing practice.

According to Levinas (1991) justice remains justice only when there is no distinction between those close up and those far away. Collective and individual responsibilities are keywords in public health. Levinasian ethics can help to give insight into the pull between closeness and

distance that public health nurses experience in individual meetings with service users, in prioritisation and in collaboration. Levinas' demands for justice and responsibility seem impossible to reach. The nurse can feel the proximity and insistence of the one "Other" in face to face meetings with parents, children and young people; whilst at the same time being aware of Others who need her help but are not present to make their demands. Responsibility for the Other cannot be avoided, ignored or transferred. Levinasian ethics can help decision makers understand that even though nurses are faced with and not forced into responsibility, they are not free to choose how they experience ethical responsibility.

Levinas (2003) writes about asymmetry in relationships and points out the double asymmetry in our personal responsibility for the Other. His thoughts on asymmetry are not about one sided power structures as we know them; with the health professional as expert and the patient in a subordinate position. He takes the asymmetry a step further by regarding the responsible helper as a hostage with total responsibility for his keeper (the Other). How can a hostage assume responsibility for his keeper? The idea of having the power to help but at the same time being a powerless prisoner is a challenging concept that seems insurmountable. Public health nurses can experience a personal responsibility for their clients; they have the power to help, but can at the same time feel helpless. Even though we do not always put the Other before ourselves, Levinas (1987) maintains that we are chosen to do so and that it is a value we can always strive for.

Levinas does not discuss responsibility in general terms, nor does he give advice on how to deal with our burdens of responsibility; he reminds us of the necessity of openness and that our focus should always be on the Other person. According to McQueen & Kickbusch (2007), most theories of health promotion fall short of adequately describing health promotion as a field of study and practice. Levinasian ethics and his insistence on our focus on the Other can provide an important reminder to acknowledge health promotion's primarily ethical base. The ideology of health promotion is built on responsibility, equality and ethics (Tones & Tilford, 2001).

Levinas (1987) opens up for the use of different perspectives. He reminds us of the alterity of each individual when studying relationships, and the objectivity of justice which is called upon to compare unique and incomparable others. Even though Levinas' philosophy can be

difficult to understand, Levinas (2001) announces his ethics in the everyday language of “Here I am! What can I do for you?”

The concepts of health and public health

In order to contextualise public health nursing further it is important to take a closer look at the concept of health and public health; and the role of professions in general. WHO’s Ottawa charter in 1986 broadened the definition of health to include psychological, environmental and political determinants, where all sectors in society contribute to public health (Fosse, 2007). Public health has been defined in many ways, but all definitions have in common that they focus on entire populations, rather than individuals or a specific framework or body of knowledge (Beaglehole & Bonita, 2004).

Andrews discusses the problems of a broad definition of public health; the “public” in public health comprises individuals, whose lives can be viewed from many perspectives (Røiseland, 2002). The definition of public health must be broad enough to encompass activities other than those of the medical care system and must recognise the social, economic and cultural determinants of health and disease (Beaglehole & Bonita, 2004). The broad definition of public health is relevant for PHNs; their focus is mainly on promoting health and carrying out primary and secondary prevention strategies for individuals, groups and local populations.

Totality or holism as a frame of reference for health

There is no one agreed upon definition of the concept of health. Antonovsky’s (1996) salutogenesis perspective on health can give us an understanding that health is a mystery that needs to be unravelled where a sense of coherence is central. According to Hugaas (2004) health can be described as a process, a state, a diagnosis, a task or assignment, an answer, a goal or a form of capital. It can be defined as theoretical, practical, active, passive, objective or subjective (Hugaas, 2004). In practice there are as many definitions as there are subjective interpretations of health. Health can be viewed from a holistic or reductionist perspective (Wulff, Pedersen, & Rosenberg, 1990). The reductionist perspective is based on a medical model of health with a biomedical foundation. Understanding health as absence of disease puts focus on disease, objective criteria for diagnosis and on the appropriate treatment. This

reductionist view does not give room for the fact that we are always healthy in some aspect, that health is not static, not a constant. The holistic viewpoint attempts to obliterate the dichotomy between health and disease, it sees health as more than just absence of disease. Hugaas (2004) writes that human life is diverse and can be viewed from a myriad of perspectives, but that despite its diversity it has fundamental similarities (it is fundamentally the same).

The holistic approach also encompasses individual experiences of health and illness, within a context, and looks on health more as a continuum (Antonovsky, 1996). Antonovsky's definition attempts to include social, cultural and historical influences on health and proposes that putting each of us on a dis-ease/ health continuum at a given point in time is a more accurate conception of reality than a health/disease dichotomy (Antonovsky, 1996, p. 14). In a holistic view, health is referred to as a person's ability to reach their goals and feel happy (Nordenfelt, 1995). Professor Peter F. Hjort, an important advocate for community medicine, writes that health is having the energy to meet the challenges of everyday life (NOU, 1998).

The holistic model has its advantages as it attempts to include human life's diversities and differences. The concept of holism, understood as form of totality, has limitations. The concept of totality can give the impression that there exists a whole, a background or framework which the subject fits snugly into, enabling a type of objective analysis. We need to be reminded that there is no position on the sideline that allows us to analyse a whole, we are always situated in a social, cultural, and historical context. Our focus is limited and our access to a holistic view likewise.

Levinas (1969) writes that even though our lives are totalities from birth to death, they exist in an infinity that has no beginning and knows no end. Due to our situatedness and each individual's separateness we can never claim to have a holistic view. The past can act as a framework and enlighten us about certain experiences. The future, which we cannot control, can give promise of possibilities but also create uncertainties. The possibility of a holistic view seems impossible. Even though the concept of holism can be deemed utopian it is however something all public health workers should strive for. The concept promotes an understanding of the importance of context, participation and dialogue and is in accordance with the ideals of health promotion. Looking at health as a resource provides the basis for the

theory of health promotion. Health promotion seeks to promote this positive view of health. In health promoting nursing relationships ethics are implicit and cannot be separated or applied as a type of knowledge to a given situation. According to Tranvåg & Kristoffersen (2008) there is a need to develop holistic nursing interventions in which care, health promotion and dialogues play a part. Health promotion is a core principle for PHNs' services. There are difficulties in putting this ideology into public health nursing practice due to the abstract nature of the concept (Baggens, 2002) and the conflicting "expert focus" discourse (Andrews, 2006). Nurses should in principle act as both experts and enablers (Andrews, 1999). Baggens (2002) found that the nurses in her study did not actively use the parents' knowledge and experience and that the nurses did not always act in an empowering way. Andrews (2006) discusses the struggle between rationalities of caring and technical rationalities and the difficulty in clarifying whether the relationship between the PHN and parents can be said to be supportive and caring. In this author's view the concept of holism is more a goal to be aimed for in public health than a realistic state.

Metaphor: The challenges of attempting to capture a holistic view

Painting mountains from a distance can be a straightforward task for the artist working during the dark winter months in the north of Norway. The mountains have clear contours. Details become blurred, obliterated due to lack of light. The artist is not distracted by a magnitude of colours, shadows and surrounding details. The palette can be limited to shades of blue and grey. The mountains steady, defined shapes emerge as two-dimensional almost geometrical figures.

Painting the scene in full daylight is a different story. The light, the magnitude of colours, the enormity of detail make other demands on the artist. It becomes impossible to capture the whole scene. Giving all the details equal attention would be a utopian feat. Should she include the poppies in the surrounding meadow, the ladybird on a leaf in a nearby tree? The landscape owns its own truth, but the artist chooses what to concentrate on and what to ignore. The finished painting will be her interpretation of what she sees from her position in the landscape, within the limits and the possibilities of her framework of understanding, her expertise and her chosen method.

The development of professions in public health

Do we know enough about how professions contribute to public health? According to Beaglehole and Bonita (2004) public health professions have a low profile, are not sufficiently engaged in public debates and their contribution to public health is often overlooked. The period after 1945 was the period for the development of professions in the Norwegian welfare state (Willumsen & Breivik, 2003). There are many ways of defining what a profession is. Freidson (2007) maintains that professionalism is about the occupational rather than the managerial control of work and that it is a type of logic that is not well worked out in theory. What professionals must, could and should do, as well as when and how, are to a large extent controlled by professional standards. According to Abbott (1988, p. 8) “Professions are exclusive occupational groups applying somewhat abstract knowledge to particular cases”. According to Meads, Aschcroft, Barr, Scott and Wild (2005) professional identity is not fixed, it is a product of history and culture and is under continual development. Public health professionals’ roles and tasks have changed; doctors were initially the core profession that set the standard for professional jurisdiction (Fosse, 2000). From the 1800’s they were leaders of public health committees; they worked with other professionals: engineers, town planners and veterinary surgeons. Old established professions had power and were looked upon as experts; whereas new professions do not necessarily have the same status. Newer professions have received tasks from existing professions; doctors have given tasks to nurses and nurses to nurses’ assistants. The tasks that were “handed over” were never core function tasks but tasks that bordered onto neighbouring professional jurisdictions.

PHNs entered the stage in the 1920s and especially after the Second World War became important professionals at local health clinics and school health services (Kildal & Elvbakken, 2006). Nurses have had a more subordinate role than doctors but have as time has passed been given jurisdiction over their own territory (Abbott, 1988). PHNs have health promotion and preventive work as their speciality (Fosse, 2000; Hatling, 1991). Hatling (1991) maintained that PHNs had the most advanced view on prophylactic health work when compared to district nurses and district doctors. Even though these nurses have expertise on prophylactic and promotive health work, they have not been given formal authority on these issues.

Public health work has been described as a “borderland” for many professions (Fosse, 2007) but for PHNs it has always been a core function. It has been said that it is difficult for a

female occupation to be given status. Witz (1992) describes the use of closure mechanisms in relation to the medical and nursing profession and discusses exclusion strategies that decide who should be allowed in and demarcation strategies that define who does what within the boundaries of the profession. The fact that Norwegian PHNs and midwives can now prescribe contraceptive pills to teenagers can indicate a weakening of demarcation strategies between the medical and nursing professions and indicate increased control by the state on all professional projects.

Fosse (2000) refers to problems attached to defining preventative medicine as a professional area of responsibility, and that a strengthening of preventative work as a concern for professions can result in removing it from the public sphere into the professional. According to Abbott (1988) prophylactic work/preventative medicine has not been a prioritised area for doctors. The diminishing role of social medicine can also be a cause for concern in public health work (Clancy, 2005).

Public health work is an organised work effort not limited to health and medical professionals. Noack (2005) writes that public health experts need to inform the public and advise political leaders on how to sustain and develop public health. This is an interesting thought and gives rise to an important question: who are the public health experts or professionals of today? In the health promotion tradition of “the new public health” individuals are seen as experts on their own lives. Discussing professional expertise in public health can lead to diminished focus on the empowered individual; as Le Grand (2007) points out, “people” not “pawns” are involved. Service users are not just passive recipients of interventions but active participants in shaping their own outcomes (Elkan et al., 2000a). At the same time there remains a need for professional expertise and a satisfactory coordination of public health services to address public health needs.

Professionalization strategies are a contrast to strategies for developing collaboration (Fosse, 2007) and it can be argued that there is an element of dissonance associated with promoting professional interests on the one hand whilst simultaneously being clearly focused on public health issues. Professionals can however also be looked upon as the linchpin of public health. Giving voice to professions need not only be associated with improving professional status. Professions can voice trends, needs, values and visions in public health issues and in such a

way provide a necessary counterweight to society's current and at times dominant focus on market values. Freidson (2007) discusses the need to promote alternative opinions of professions: that they are not only motivated by professional interests but also by a genuine concern for their service users.

Debates on the nursing profession have also occurred within the profession. Schiøtz (2003, p. 463) writes about how Norwegian nurses' "enfant terrible" Kari Martinsen caused uproar in the 1970s and 1980s when she criticised those who one sidedly focused on theoretisation and professionalization of nursing within a medical discourse. Martinsen maintains that care and professionalization are two conflicting discourses. Martinsen's critique was a necessary contribution to the debate on the development of the nursing profession. Martinsen writes that nurses have focused too much on the evidenced based criteria of medical science and not enough on care and vulnerability (Martinsen & Eriksson, 2009). The furore the critique caused is understandable. It illustrates the dilemma of nursing, a predominantly female profession with diffuse boundaries. Nurses wished to be freed from the yoke of oppression, hold on to traditional, fundamental nursing values and at the same time gain professional status.

Public health nursing: a woman's profession

Realities are produced along with the statements that report them. Gender is an aspect of public health nursing that must be mentioned. Macdonald (1995) writes that there is an eloquence attached to the omission of women from early professional discourses. Authors both ignore the efforts of women to enter professions and the patriarchal approach to keep them out. Witz (1992) suggests that discursive strategies influence social closure and that there is a link between concepts of ideology and closure practices. The majority of PHNs are women, with only a handful of men. Dahle writes that from nature we have been given our biological gender which again places us in one of two social categories; we live in a gendered society that influences how we understand the world we live in and how others understand us (Alvsvåg, 1997, p. 217).

Bodil Ellefsen (1995) did a comparative study of three municipal nursing services, among them the public health nursing service. Her doctoral thesis showed that all nursing services

had power and influence but that factors such as gender, context, tradition and work-processes could explain differences in power and influence regarding decision making. Even though all three services are female occupations, the thesis showed that administrative leaders had more influence on public health nursing services than other municipal nursing services. Vike (2007) writes that control systems need correctives but that women in primary care have little influence; speaking out can be interpreted as “whining”, leaving it to the goodwill of decision makers to act on their pleas.

Levinas has been criticised for his views on women. Beauvoir (1961) refers to Levinas (1987) in order to prove her point about how woman is categorised as Other and man as absolute. It can be argued that this is a misinterpretation; that Levinas puts the Other in an elevated and not a subordinate position. Irigaray (1985) points out that it is precisely this categorisation and presentation of women as other (an alterity) that reduces the feminine to sameness (Critchley & Bernasconi, 2002). This can be interpreted as an undermining of one of the corner stones in Levinas’ philosophy: the unique alterity of each individual. Levinas emphasises individual responsibility and places ethics as first philosophy. Irigaray admonishes loyalty to philosophy and encourages us to challenge what she terms: the discourse on discourses (Critchley & Bernasconi, 2002). Irigaray’s admonishments can make us aware of the shortcomings of all philosophies, in their ability to capture reality, and remind us to be wary and always do what philosophy commands- to constantly search and research. There is no doubt that categorisation of women as other, secondary, apart, dependent and subordinate can be seen in both the history of philosophy and the history of professions.

Relevant discourses and mode of description of public health nursing services

Mode of description can influence the development and status of a public health profession. Discourses are not only speech and text acts. They are also abstract theoretical forms that do not exist in reality; but are constructed in order to illustrate how the topic of analysis is presented in a text, speech act or other presentation. Silence on a topic is an aspect of discourse, in the same way that doing nothing is a kind of action (Macdonald, 1995).

Portraying the world in a certain way can ensure the relevance of certain topics and render other topics irrelevant and out of the question (Jørgensen & Phillips, 2006, p. 151). We do not know enough about how professions contribute to public health. As mentioned earlier, public

health professions have a low profile are not sufficiently engaged in public debates and their contribution to public health is often overlooked (Beaglehole & Bonita, 2004).

Policy documents guide policy. The content, form and mode of description of issues in policy documents can influence society directly and indirectly. Van Leeuwen (1996) refers to a policy document as being a document in the public domain, produced by government officials and directed at the public and other government bodies in order to provide knowledge and inform government policy (Koller & Davidson, 2008). The Norwegian Health Personnel Act (Helsedepartementet, 1999) was among other things intended to quell the dominance of professional interest groups and focus more on the interests of the public. In Report no. 16, (Stortingsmelding, 2002-2003) the role of professions is toned down. This is illustrated by the following quote: "It's important to focus on what has to be done in the municipality- not on who does it" (Helsedepartementet, 2003, p.77). Stenvoll, Elvebakken and Malterud (2005) compare this report with a similar public health document from 1993 and conclude that the focus on preventive institutions, such as child health clinics and school health services as well as professions working there, has been weakened. Focus in the current report is now more on each individual's personal responsibility for their health. The latest report to the government on public health work, (The coordination reform), focuses on coordination of services and not on professional groups (Ministry of Health and Care Services, 2009).

Discourses on health promotion and prevention can influence how public health nursing is understood. Health promotion empowerment ideologies wish to narrow the gap in knowledge and power between professional and lay person (Andrews, 2003). Empowerment strategies are based on democratic ideals and entail shifting the balance of power from the expert to the layperson; grounding the relationship on dialogue, equality and participation. The health promotion discourse promotes that the professional does not present herself as an expert but takes a back seat, a fact that can tone down and marginalise their expertise to a certain extent (Wistoft & Jensen, 2006). School nurses view health promotion as being more flighty and less connected to medical or factual knowledge than prevention (Wistoft & Jensen, 2006).

Current discourses can indicate that there is a focus on the empowerment of clients at all levels and a weakening of professional power. This can illustrate scepticism not only towards professional power but also as to where professional interests truly lie.

Interprofessional collaboration and interpersonal relationships

Every member of the public health professions bears a responsibility for and commitment to public health practice (Weed, 2001). Public health nursing is an independent occupation with diffuse boundaries. The lack of rigid boundaries and the independent nature of public health nursing can pose challenges in issues related to interprofessional collaboration and in interpersonal relationships with both service users and collaborators.

Boundaries can be seen as points of separation; they limit, hold together, protect and provide a sense of security for professionals and the people who avail of their services. Boundaries can also be seen as points of connection (Ashcroft & Meads, 2005). This is an interesting thought; can it be that a profession with diffuse boundaries will experience difficulties finding points of connection in collaboration? Fleetwood (2007) writes that in order to collaborate professionals need to go outside their own boundaries by moving them or creating new ones. A rigidly defined role for the public health nurse can be an impediment to collaboration (Chaudry, Polivka, & Kennedy, 2000)

Benny Hjern writes that collaboration is an important aspect of professionalism in modern organisations (Axelsson & Axelsson, 2007). The collaborative approach is, however, not without problems; with the rise of inter-professional team-working the traditional hierarchical type of decision making has been toned down and new patterns have emerged. According to Fosse (2007) the service providers may collaborate but the organisational structures do not always support collaboration. Coordinating services, adequate funding, creating forums for dialogue between decision makers and professionals, and amongst professionals are challenges that need to be met. The public health report (Helsedepartementet, 2002-2003) encourages collaboration, it is focused on consensus and does not bring forward conflicts of interest between different professionals, administrative levels, sectors and social groups; likely occurrences if existing funds are just relocated and no extra funds allocated to health services (Kildal & Elvbakken, 2006). Not focusing on core professional actors and possible conflicts of interest can hint at consensus; if the tasks are first elucidated, they can then be performed and clarity and coherence will reign. Collaboration is, however, complex and conflicts do not disappear by not being mentioned. Previous studies have shown that relational, capacity and structural issues influence collaboration (Willumsen, 2006). According to Pettersen and Johansen (2007) successful collaboration requires a balance

between relational and structural issues as well as accessibility, continuity, capacity and competence.

The PHN establishes and develops relationships over time, continuity in public health nursing practice entails being there (over time) should the need arise. In public health nursing relationships the nurse must be attentive to the needs of the Other person and show willingness to look, see, listen and respond. In first time meetings the Other presents himself as a stranger, a person outside of myself, unknown to me. Repeated meetings establish relationships. We must, however, remember that, as subjects, we are separate, different and can never be melted together as one (Levinas, 1993).

Working alone in a job with diffuse boundaries can add to PHNs' feelings of personal responsibility in interpersonal relationships with children, parents and young people (Study II). There are no clear boundary markers for nurses or anyone else in ethical responsibility. Empowerment ideologies attempt to wipe out traditional power structures as we know them, and favour a redistribution of power from the professional to the lay person (Andrews, 2003). Levinasian ethics do not attempt to obliterate these structures; merely reverse their order and keep them intact. As the subject, the responsible professional is both subordinate and infinitely responsible for the other person. We can only go so far in our crusade to help; attentiveness to "The face of the other" should always restrict our involvement (Levinas & Aarnes, 2004).

Empowerment, as defined by Rappaport (1981), aims at enhancing the possibilities for people to control their own lives. Empowerment ideologies can refer to intrapersonal, interpersonal and group relationships. Interpersonal empowerment involves the power or lack of power that is displayed in face to face encounters and is of vital importance in professional client relationships (Svensson, Müssener, & Alexanderson, 2006). Ryles (1999) concept analysis of empowerment in nursing promotes an understanding that it is what people share and recognise of themselves in others that is crucial to promoting empowering relationships. Levinas not only writes about this recognition but mentions "substitution": the ability to put oneself in the place of the Other, enabling sensitivity, compassion and an understanding of vulnerability and suffering (Levinas, 1991). Substitution is not only about putting oneself in the place of the Other in order to feel what he feels but also in order to comfort him (Levinas & Robbins,

2001). Whether the reference is to Levinasian ethics or empowerment principles, the decision to become involved or remain detached is always up to the Other and this requires attentiveness from the nurse in all relationships. She must meet the pull between personal closeness and involvement on the one hand and the use of general rules and regulations on the other.

Methods

The different methods used in the thesis are presented here. According to Bowling (2002) public health research uses knowledge from different disciplines in order to generate and create knowledge. The focus in research should not be on whether to choose quantitative or qualitative methods; it should always be on quality (regardless of design) and on the insight the research process and the results can provide. Both qualitative and quantitative methods are used in the thesis. The first four studies in the thesis are qualitative, the fifth is a complimentary quantitative study based on themes from the first four studies. Triangulation entails using different methods to answer a research question, even though the data defy comparison, they provide at the same time different segmented views of a whole (Barbour, 2001). The four first studies seek to understand public health nursing by asking questions related to the respondents' experiences and from observed data. Themes raised are elaborated on using relevant documents and literature. Qualitative research is a systematic process that carries out an in depth analysis of a research topic in order to receive a greater understanding of the phenomena (Silverman, 2005). Data are often derived from small samples; data is generated more than generalised (Sandalowski, 2004). The fifth quantitative study uses numerical data. All studies seek to generate knowledge and bring forth relevant questions and new themes for further research.

Metaphor: On the limitations of materials in capturing reality

How can the landscape artist capture a life essential such as "air" with the limitations of the materials at hand? Techniques and materials are tools that can help the artist create interpretations of reality: the palette knife can create one effect, the brush another. What does the artist see? Is it air in motion, are the trees swaying in the wind? The materials have their limitations. Maybe the finished painting can do no more than give associations to air. Maybe a portrayal of something completely different could give even stronger impression of air and space: depicting people under water without air can give an even closer association to this life sustaining element that remains unnoticed and taken for granted. When the motive is chosen, the artist must do her best to interpret; that requires loyalty, creativity and a command of the materials.

Overview of the five studies and their methods

Before detailing the method used in each study an overview of the studies in the thesis is given (Table 1). The empirical data for study I was collected in 2006, for study II in 2002, for study III and IV in 2006 and 2007 and for study V in 2008 and 2009.

Table 1: Overview of the studies

Study	Aim	Participants	Data collection and analysis
Study I	To provide a backdrop for the remaining studies and create an understanding of the role and function of the PHN today	5 PHNs that had worked during the whole of or most of the period 1984-2005	Focus group interview (3 nurses) and two individual in depth interviews Qualitative Content analysis
Study II	Through Levinasian philosophy, provide an understanding of ethical responsibility in public health nursing	5 experienced PHNs	Individual in depth interviews Hermeneutic phenomenology
Study III	To gain a greater understanding of how nurses and service users experience consultations	7 young people 7 parents 8 nurses	Field observations and in-depth interviews Qualitative content analysis
Study IV	To gain knowledge of how decision makers perceive the service	11 municipal decision makers	Individual in depth interviews Qualitative content analysis
Study V	Collaboration was an important issue in studies I, II and IV. This study explores the issue further	849 PHNs 519 child protection workers 115 midwives 113 doctors 1596= Total 93 persons (drop out specifications)	Questionnaire survey Descriptive and inferential statistics

Method study I: A case study

Case study methodology

Case study methodology is chosen to study a case, or cases with real boundaries (Creswell, 2007). The boundaries help to limit the case and can be phenomena such as: time or place, an event or a single program. Yin (2004) writes that case study methodology is ideal to study on-going phenomena in their real life context. Multiple sources of information are used and can

include interviews, observations, audiovisual material and documents and rapports. It can be difficult to define real boundaries and the researcher may have to work with contrived ones (Creswell, 2007). The “boundaries” of the case involve situating the case in a given setting.

The methodology used in study I is based on Yin (2003). The study sets out to look at a contemporary ongoing phenomenon in its real life context. A single case, embedded case study design with four sub-units of analysis is chosen. The embedded sub-units reside within a main unit. The main unit in this single case study is: changes in Norwegian public health nursing 1984-2005, the sub-units of analysis are defined as collaborators, tasks, leadership and authority/status. The intention was to include the viewpoints of a sample of PHNs and a former leader of their professional interest group and simultaneously examine a selection of existing documents and literature in the field.

Data collection

The sample was strategic as the author wished to interview nurses that had worked most of, or all of the period from 1984 – 2005. Permission was obtained to carry out all the interviews. The focus group consisted of three PHNs, the researcher was the moderator. Two single interviews were carried out; an in-depth face to face interview and a telephone interview. All three interviews were unstructured, the sub-units of analysis and the research questions being the guidelines. The group interview and telephone interview were based on notes whereas the in depth individual interview was taped. The possibility of contacting the respondents, if there were issues that needed to be validated, made the approach a feasible one. The researcher availed of the possibility and contacted two of the respondents by telephone in order to validate statements when transcribing the data. The notes from the focus group were read to the group before terminating the interview. The former leader of the professional interest group read the notes from the telephone interview and filled in and elaborated further where she felt her viewpoint had not come across clearly enough.

Data analysis

Case study analysis is the most difficult stage of doing case studies (Yin, 2003). Data is collected from different sources and there are different ways of analysing the data. In this

study the strategy for analysing the data is an analysis of the specific aspects of the case as defined by the sub-units of analysis. In the presentation of findings relevant information from literature and policy documents, regarding changes in public health nursing, is presented to contextualise the nurses' statements and comments. The data from all three interviews were content analysed by identifying, describing and sorting the data into the pre-designed categories defined by the sub-units. The data from the interviews, literature and policy documents were then were then studied to reveal variance and similarities. Yin (2003) reminds the researcher that it is important to attend to all the evidence. If alternative evidence is discovered this should be presented as a rival explanation. The aim is to build a description and explanation of the case. Theoretical propositions are not provided at the outset of this study but rival explanations emerged from the empirical data collected.

Study limitations

Yin (2003) reminds us of the limitations of a single case while Cresswell (2002) maintains that multiple case studies can dilute the overall analysis. The empirical material in the study is limited. According to Merriam (1988) a case study entails interviewing, observing and analysing. It can be questioned if grounded theory could have been a more suitable explorative method to answer the research question. However, as the units of analysis were already defined at the outset and data was mined from documents and literature, case study methodology based on Yin (2003) was deemed the correct approach. The documents analysed comprise legislative documents, a document from the professional interest group and relevant literature.

A final analytical challenge is to bring a case study to a conclusion, especially if it is a single case study and the case is still ongoing (Yin 2004). The purpose of this study was not to reach conclusions, but to discover issues and topics that deserve further attention. Despite the limits of this single case study it gives insight into topics that were relevant for the remaining studies. The depth of the empirical material generates interesting topics for further research. Even though lack of visibility is an important issue, the voices of this small number of nurses can appear to dominate the findings. It can be argued that more critical theory could have been applied to the case.

Method study II: A hermeneutical phenomenological reflection

Hermeneutic phenomenology

Hermeneutic phenomenology is the method chosen to look closer at the nurses' reflections on their practice. It is a discovery orientated method that is both descriptive and interpretive in its form. Rich descriptions provide the basis for interpreting lived experience (Van Manen 1990). Van Manen (1990) recommends interviews as a suitable method for gaining access to a deeper and richer understanding of our lifeworlds. Lifeworld is described by Merleau-Ponty as the world we live our everyday lives in, the authentic world of our experiences; where we experience our first wood, meadow or river, a world we are inseparable from (Bengtsson, 2001). Conversational interviews should be open, but must have a clear purpose Fog (2004). The open interviews in the study gave rich descriptions of the PHNs' lifeworlds. The nurses' descriptions of their work provided the basis for reflection and interpretation of the phenomenon of responsibility in public health nursing. The purpose of an open interview is to procure empirical material on how the persons being interviewed describe themselves and their experiences. The purpose is to capture their perspectives on their lifeworld and that comprises their descriptions of that world (Fog, 2004).

Data collection

After receiving permission from their leader and an administrative review by the regional ethical committee, five experienced nurses were interviewed in depth. The nurses were asked to share stories about situations that had made an impression on them or to describe situations where they felt inadequate. An open theme guide was used in order to keep focused on the topic during the interviews. The nurses' stories were taped and transcribed verbatim. As the theme of ethical responsibility emerged it became apparent that the themes from the nurses' stories could be interpreted within the framework of Levinas' philosophy.

Data analysis

Interpretation requires creativity but at the same time loyalty to the empirical descriptions. Van Manen (1990) describes several approaches to thematising a text: The "selective

highlighting approach” as described by Van Manen (1990) was applied to the empirical data which comprised five narratives based solely on the PHNs’ stories. The approach entails highlighting sentences, phrases or words that can bring forth the essence of the phenomenon. The themes that emerged were: personal responsibility, boundaries, temporality, being alone, worry, fear and uncertainty; and a sense of satisfaction; resulting in a main theme: ethical responsibility.

Study limitations

Even though the study is small and the number of respondents limited it provides insight into a fundamental theme: the challenges of ethical responsibility in public health nursing. It can be argued that a Levinasian reflection is a limited one. In accordance with my understanding of the fundamental position of ethics, I argue that this is not the case. This study can provide a fundament for understanding the philosophy of Levinas, which is an important perspective in the thesis, and give insight into how nurses’ experience and respond to “the ethical call of the Other person”. It can also be argued that had the focus been on ethics at the outset the results could have been even more ample. At the same time Lindseth and Norberg (2004) remind us that posing questions on ethics does not necessarily reveal ethical issues encountered in practice.

Method study III: Observations and interviews

Data collection

Two supervisors were contacted and asked to recruit PHNs who were willing to allow the researcher to participate at consultations and interview both nurses and service users after the sessions. Eight nurses responded and agreed to take part in the study. They, in turn, contacted twelve service users who gave the researcher permission to participate at a public health nursing consultation and interview them after the session. All participants signed consent forms. The data was collected over a period of seven months from November 2006 to May 2007. The methods used for data collection are a combination of field observations and interviews. The first author participated at twelve consultations and interviewed eight PHNs

and fifteen service users (three couples). Table 2 gives an overview of the eight site visits and the participants in the twelve consultations. The interviews took place directly after the consultations. Single interviews of the eight PHNs were conducted: two single interviews with mothers, seven individual interviews with young people and three interviews where both parents participated. This gave a total of 20 interviews.

Table 2: Overview of the field observations and interviews

The child health clinic		The clinic for young people	Nurses' office at school
Researcher present at five consultations		Researcher present at six consultations	Researcher present at one consultation
10 interviews		8 interviews	2 interviews
2 individual interviews with parents	Mother and 9 month old baby boy Mother and 15 month old boy	4 Individual interviews with 17 year old girls	Individual interview with 17 year old girl
3 interviews with couples	Mother, father and 8 month old baby girl Mother, father, twin babies 7 months and 2 year old boy Mother, father and 6 month old baby boy	1 individual interview with 19 year old girl 1 individual interview with 17 year old boy	
5 individual interviews with nurses	Individual interviews with: 3 nurses > 10 years experience 2 nurses < 5 years experience	2 individual interviews with nurses with between 5 and 10 years experience	

Field observations

Patton (2000) writes that it is necessary for the researcher to describe the activities and events that take place in order to enable the reader to enter into and understand the situation described. A description of the physical settings makes it easier to visualize and understand the setting (Strong & Dingwall, 2001). Drawings from the site visits and the textual descriptions of the setting were important in order to recall and separate the uniqueness of each site visit. The drawings show the bodily postures of the nurses, parents and children and serve to illustrate a relaxed atmosphere and not a strict ceremonial order at the child health clinic and school health service. The observations from the clinic for young people reveal a more ordered structure.

All field notes were transcribed and supplemented with reflections after each site visit. According to Schensul, Schensul, & LeCompte (1999) the challenge is to transcribe the observations into field notes whilst being aware that all observations are filtered by the researcher.

The choice of participant observation and taping the consultation was chosen as the author wanted to be present at each consultation in order to be prepared with questions for the subsequent interviews with the public health nurse, parents and young people. I consider “being present” a form of participation, even though I was not an active participant during the sessions. The interviews took place immediately after or shortly after each consultation. Focus on life-world existentials and specifically on the public health nurse’s approach guided the observations. The researcher’s attention was fixed on describing the setting, following the activities in progress, making drawings and taking notes from the setting as well as writing down thoughts and spontaneous questions that arose during the consultations. The wealth of all the data from the observations cannot be included in the thesis and will be the focus of a forthcoming study. The following is however relevant. The observations gave the researcher close contact with the field and provided detailed information not available in previous Norwegian studies on public health nursing practice. The scanned drawings (Figure 2) from the different site visits are frozen snatches of moments in time. Drawings are supportive sources of data, the midpoint between the lived experience and the verbal expression (Dahlberg, Nyström, & Dahlberg, 2008). The data from the observations promote understanding and provide the basis for themes and questions in the subsequent interviews, such as: Why did you spend so much time on the floor with the baby? Why did you reach out to hold the baby? How did you react to the nurse’s comment on your weight?

The following passages and drawing (Figure 2) are excerpts from the researcher’s notes from the site visits and illustrate the different setting and their focus:

The child health clinic

I feel comfortable here, the waiting area exudes comfort, the walls are yellow, there are two big comfortable red chairs, lots of toys, and a little play house. Two mothers sit and chat; whilst one breast feeds her baby, they discuss vaccines and their side effects and share personal experiences on the issue. The bodies in the nurse’s office are not stationary. All positions seem natural. Crawling, kneeling, squatting on the floor, sitting on chairs, walking, standing, and lounging. The occupants are busy and often focused on the baby.

The clinic for young people

The waiting area is small; it's in the corner of a huge hall with lots of doors. Several sofas in contrasting colours fill the space. Two are occupied; two girls sit in one and three in the other. This is a hectic place full of activity, people constantly on the move in and out of offices. Two girls seem to be watching a film on a PC; others chat or listen to music. There are mostly girls here, and then two boys arrive. The sessions at the clinic for young people are focused; the bodies are stationary, more orderly. They have designated places. The theme or topic is the thread of focus.

The school setting

I sit in the hall on a little bench waiting for the public health nurse; surrounded by pupils going to and from classes. I hear snatches of conversation: "careface", "pleeeeeease", "you spiteful...". I hear laughter. Five girls dance past in tune to music from a CD-player. I see the surrounding landscape from a little window, just sea and mountains. The pupils move singly, or in small cliques; no exodus of whole classes, suggesting that I have not arrived at break time. The nurse's office exudes comfort, ease and solemnity, a lighted candle signalises time, a guest, and an invite to stay. The atmosphere gives an impression of openness to the girl's stories of past, present and future events.

Figure 2: Scan of a sample of drawings from the site observations



The interviews

The interviews took place in the same or in adjacent rooms to where the consultations were carried out. The interviews were open and the notes from the observations gave the researcher the opportunity to clarify issues and ask questions pertaining to her understanding of the sessions. Fog (2004) reminds us of the necessity of being open and not having all the questions ready in advance, but at the same time having a clear purpose for the interview. Due to the magnitude of data a trusted secretary helped with transcribing some of the taped material. The data were analysed using qualitative content analysis.

Data analysis

The taped consultations and interviews were listened to, the transcribed texts studied and the field notes and drawings were examined. Attending to all available data helped recreate the scene (Table 3).

Table 3: Overview of analysis

- | |
|--|
| <ol style="list-style-type: none">1. The researcher listened several times to the recordings from the consultations and interviews.2. The detailed field notes and drawings were examined in order to ensure that “on the spot” themes, noted or drawn on site, were not omitted from the analysis.3. Sentences, words and phrases in the transcribed text, that could describe the respondents’ experiences of the sessions were highlighted as meaning units.4. These meaning units were further abbreviated into condensed meaning units.5. The condensed units were examined further to see if they were interrelated in any way and then abstracted into fewer categories.6. The categories merged into one main theme7. The drawings, notes and transcriptions were then reexamined to see if they supported the construction. |
|--|

Study limitations

The number of participants is small and the findings cannot be generalised. Other methods could also have been used to gain knowledge of the interaction. Videotaping the consultations could have enhanced the analysis; an approach the author considered but decided against due

to the amount of data it would generate and the disturbance it could have caused during the sessions. Baggens (2002) mentions the limitations of a static video camera that lacks the ability to follow movement around the room; this would have been a clear limitation during the sessions at local child health clinics. Filming the session would however have provided the second author with more information in order to carry out an independent analysis of visual aspects of the consultation. Transcripts from the audio taped sessions and interviews provided the second author with data for validation. Despite the small size of the sample, being present at the sessions gave access to visual aspects of the site visits. The study has further limitations. The young people were a mixed group who divulged complex problems, the parents were however a more homogenous group: there were no lone, or unemployed parents, or parents who divulged serious problems other than the ordinary everyday trials, tribulations and joys of parenting.

It can be argued that there is a risk of bias due to selection, that the supervisor picked out the “best” nurses who in turn picked out the most amiable clients. My being there can also have influenced how the nurses behaved, even though some of the nurses specifically mentioned that they quickly forgot my presence. The PHNs’ supervisor passed on information about the project and did not handpick the PHNs. The nurses agreed voluntarily to participate. Six young people and a mother were not selected by the PHN, but were asked to participate as they were at the clinic the days I visited. The remaining participants were personally selected by the nurses. This can have created elements of selection bias. Even though the service users were asked specifically, none of them were negative to the PHN service. Two of the parents and a PHN in the study were aware of other parents’ critical attitude to the PHNs’ service at the child health clinic. This can illustrate the limitations of this study in capturing negative perceptions of PHNs’ practice.

Method study IV: In-depth interviews and qualitative content analysis

Data collection

Eleven decision makers from seven municipalities in different regions of Norway were interviewed during 2006 and 2007. They were selected by purposeful sampling aiming to reflect variation in community size. The method used in this study is qualitative content analysis. Patton (2002) refers to content analysis as any qualitative data reduction and sense making effort that attempts to identify the data's core consistencies and meanings.

Data analysis

Analysing texts entails describing and interpreting themes (Kvale, 1996). Reflections on the text reveal certain core consistencies (patterns) and themes. A pattern is a descriptive finding whereas a theme takes a more categorical form (Patton, 2002).

The inductive content analysis started with a holistic reading of the text material and openness to its content. Words, phrases and paragraphs that conveyed the same meanings were highlighted and themes noted. The thematic statements were then grouped together into categories. The research questions guided this first stage. The first categorisation revealed 12 categories that generated the basis for subsequent categorisation: contribution, new areas of contribution, boundaries, collaboration, visibility, priorities, organisational factors, profession, status, changes, challenges and continuity. These 12 categories were further reduced into four content categories which provide the basis for reflection and interpretation in the paper: contribution, challenges, collaboration and visibility. The categorisations show the manifest content of the text. The latent content becomes apparent in how the respondents describe their experiences. Graneheim and Lundeman (2004) write that it is the implied feeling that emerges. The respondents show satisfaction and gratitude, but also concern when revealing their opinions of the service.

Study limitations

The scope of the study is small and its results cannot be generalised, but it does however provide a variety of reflections on how municipal decision makers view Norwegian public health nursing. Focus group methodology could have been used as an alternative approach that could have provided a wealth of interesting discussions and could have contributed to generating new hypotheses. Focus groups are time consuming and not always practically possible to conduct (Wibeck, 2000). Due to structural differences in the municipalities, certain issues might not have been relevant for discussion in a group interview. Practical issues (long distance travelling, time factors) would have made it difficult to find a time and place that suited all the interviewees. The study has also limitations in that it does not focus on gender issues.

Method study V: a cross sectional questionnaire study

Data collection

According to Bowling (2002) planning and piloting are important procedures at the outset of questionnaire research. A preliminary pilot study was carried out in May 2008 in order to test and develop the questionnaire and both the main project and pilot study are approved by the Norwegian Social Science Data Services (NSD). The choice of municipal collaboration amongst PHNs and their collaborators as the theme of focus was based on findings from the three qualitative studies (Studies I, II and IV). In order to test layout, understanding, and time needed to fill out the form; the questionnaire was tested out by one professional from each group of respondents and seven research colleagues before the pilot study was conducted. After these initial preparations the pilot study was carried out. A community with a population of between 15000 and 50000 was randomly selected as the pilot community. E-mail questionnaires (n=280) were sent to teachers at lower secondary schools, child protection workers, midwives, public health nurses and doctors. The pilot study revealed that the questionnaire was understood by the respondents, comments were noted; certain questions were removed, others rephrased. There was a low response rate from the teachers; this was

attributed to the likelihood that they did not have access to a PC. Due to the low response rate (11%), they were not included in the main study.

In December 2008 a national survey was carried out amongst the following collaborators in municipal health and social services: PHNs, municipal doctors, midwives and child protection workers. An internet survey software package “Questback” was used. The sample frame was defined as PHNs and doctors working in clinics and school health services, and child, protection workers and midwives from all municipalities in Norway. Pre-notification was sent to supervisors the week prior to start. The use of e-mail internet survey meant that increasing the sample size did not require increased resources in time or money. The electronic questionnaire was sent out to municipal leaders in all municipalities (n=430) and to County leaders of the professional interest groups. The pilot municipality was not included in the main study. The addressees were requested to forward the questionnaire to the respondents. A similar method of recruiting respondents was used by Andersson, Norvoll, & Ose (2006) in their study on public health nursing competence. The questionnaire was sent directly to those of respondents the authors had e-mail addresses (accessed either via internet, or address databases). Two reminders with links to the questionnaire were forwarded in January 2009.

The following criteria were chosen in order to ensure representativeness: all counties and different sized municipalities should be represented. The characteristics of the sample frame should be mirrored as much as possible in the sample collected. With the final reminder, non respondents who received the invitation but choose not participate, were asked to specify reasons for not taking part in the survey. They were asked to tick off whether it was due to: lack of time, interest, relevance, high work load, whether they questioned the seriousness of survey, simply choose not to, or other reasons. The response for drop out specifications was 93 persons. The Universal Resource Locator (URL) link to the survey remained open from 6th of Dec. 2008 until the 16th of February 2009. A total of 1596 respondents returned the questionnaire; Table 4 provides an overview of the sample with total population size given in man labour years. Based on data from Statistics Norway (2009) (given in man-labour years): there are 3176 child protection workers employed in municipal child care services, 278,43 midwives, 207 doctors, and 1945,26 PHNs employed in municipal family health clinics and school health services. According to Andersson et al. (2006) when examining portions it does

not matter whether we compare man-labour years or numbers.

Table 4: Overview of sample

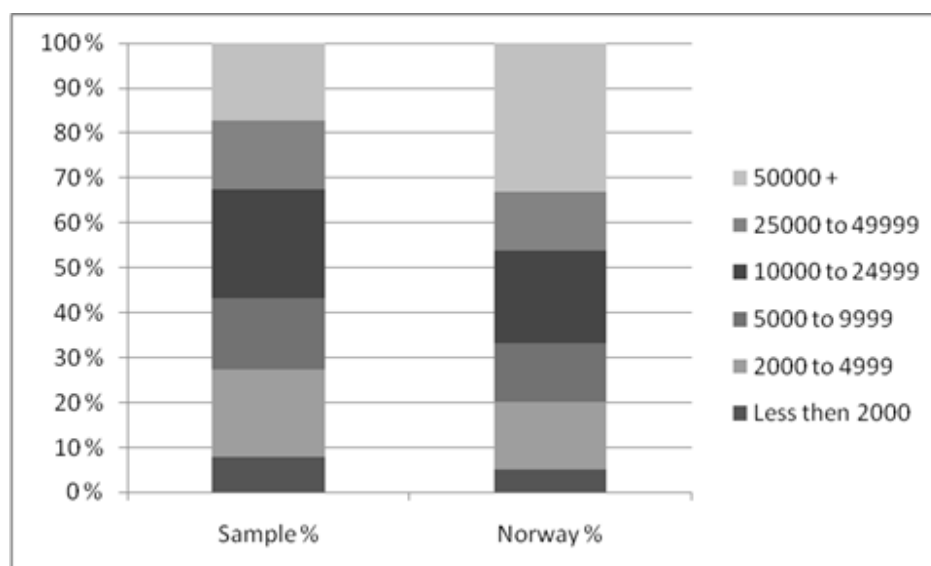
Professional groups	Respondents	Total population size in man-labour years	Percent of total population
Doctors	113*	207	54.8%
PHNs	849	1945.26	43.64%
Midwives	115	278.43	41.3%
Child protection workers	519	3176	16.3%
Total	1596	5664	28.18%
Specifications for drop out	93	5664	1.6%

*Doctors working at local health clinics and school health services.

Response rate and representativeness

The mean response rate was 48% for health professionals and 16% for child protection workers. Diagram 1 illustrates representation of professionals in the sample related to municipality size and representation of professionals in frame sample related to municipality size. The diagram illustrates that there is an overrepresentation of the smallest municipalities and a clear underrepresentation of larger municipalities in the sample. Communities with populations: 5000-9999, 10 000-24999 and 25000-49999 mirror to a greater extent the frame population.

Diagram 1: Representation of municipalities in sample compared with total population



Municipalities in Norway vary in population size, climate and geographical area. They range from remote rural arctic villages in the north to large towns and cities further south. All counties are represented as well as different size municipalities (Table 5). The average age of respondents is 45,33 years and average number of years of experience is 12,4. Gender in percent is as follows: male PHNs =1%; male doctors =58,4% male midwives =1% and male child protection workers 12,3%.

Table 5: Representation of different sized municipalities

	Representation of different sized municipalities						
Population	< 1999	2000 til 4999	5000 til 9999	10000 til 24999	25000 til 49999	> 50000	Total
Public health nurses (PHNs) (5 community size missing)	65	138	126	206	148	161	844
Midwives	12	31	26	18	9	19	115
Child protection workers (6 community size missing)	39	121	82	130	67	74	513
Doctors*	8	20	18	31	16	20	113
others	4	19	12	20	4	8	67
Total	128	329	264	405	244	282	1652

*working at clinics and school health services

The questionnaire

A computer software package “Questback” was used to design the lay-out of the questionnaire allowing automatic transfer of data into a database linked directly to SPSS for analysis purposes; this reduced the need for manual input and thus the risk of potential errors in data entry. The e-mail questionnaire allowed for the use of advanced skip techniques where respondents only received relevant questions and did not have to manually skip to applicable questions. The respondents received an e-mail with a URL to the questionnaire. The questionnaire consisted of 23 main questions; the majority had pre-coded response alternatives, five had 6-point Likert response scales: (1-6 and a “don’t know” category). Three short open ended questions and one open question titled “other comments” allowed the respondents to elaborate beyond the confines of the questionnaire. The authors hoped in this way to secure additional contributory factors not specified at the outset. Studies I, II, IV as

well as background literature on inter-professional collaboration guided choice of wording and themes. The questions that are analysed in this study are presented in the appendix to study four.

The purpose of study V is to examine collaboration issues relating to public health nursing in different sized Norwegian municipalities by answering the following questions: Do collaborators meet less often compared with five years ago and are there associations between community size, frequency of meeting points and time spent on collaboration by and with PHNs? Which elements do the respondents classify as important in order to achieve successful collaborative relationships? Which professionals are missed most in collaborative relationships? Six-point Likert response scales on statements and elements pertaining to collaboration, short open ended questions on time spent collaborating, absent collaborators, and pre-coded response category for meeting points, are used in the analysis in study V.

Data analysis

The statistical significances of differences between groups were tested using the chi-square test, *ANOVA* and *Kruskal-Wallis H*. These were cross tabulated in order to reveal individual characteristics for each professional group and for community size. The responses to the short open ended questions were coded and categorised. The statistical analyses were performed using SPSS package no. 17. Statistical difference was determined at the 95% level.

Study limitations

Samples are seldom perfect, when doing surveys the goal is to obtain a sample that properly mirrors the population it is chosen to represent (De Vaus, 2002). Response rates are declining for all types and manner of surveys. E-mail surveys give lower response rate than mail and telephone surveys (Fricker, 2008). The mean response rate of 48% for health professionals and 16% for child protection workers has limitations. Telephone and face to face surveys may give higher response rates but due to issues of social desirability the quality of the responses may be poorer, mail and internet samples may have a lower response rate but do, however,

give the best quality response (De Vaus, 2002). The questionnaire is short and the use of skips has helped simplify filling out the questionnaire. Issues of anonymity and confidentiality arise when e-mail addresses are used. The automated responses were transferred directly to the database; this ensured that the researcher could not identify the respondents.

The fact that the questionnaires were sent out to supervisors and leaders who were asked to forward the questionnaire gave the researchers limited control over the number of respondents who actually received the questionnaire. At the same time the supervisors acted as gate keepers ensuring that only relevant respondents received the link to the questionnaire. Analysis of non respondents provides reasons for non response the group of respondents as a whole but not from each individual professional group. The response scales were both positively and negatively formulated and questions with numerous alternative response categories were broken up in order to avoid stereotype automated responses.

Cross-sectional studies cannot be used to establish an association between cause and effect (Bowling & Ebrahim, 2005). This study has limitations and can only point to associations, and not imply causality between variables. The study only looks at collaboration over a five year time span. Studying collaboration over the same period as the first study (1984-2005) would have generated interesting data for comparison and discussion, but would have been more difficult to conduct.

Ethical considerations

According to Levinas science can capture moments and fixate ontological structures, whereas ethics already exists as a fundament (Levinas, 1991). Acknowledging the fundamental position of ethics as first philosophy has implications relating to both ontology and epistemology. Ontology is about “being” and the nature of existence; epistemology is about knowledge, its possibilities and limitations. To interpret Levinas is to dare to venture into the boundaries of language. Levinas writes about the essence of living that goes beyond “being” and about an ethical language that extends beyond words. Levinas’ philosophy implies that ethics and not knowledge is the primary source of meaning (Aasland, 2007). Accepting that ethics is the fundament for knowledge seeking activities entails accepting that there are limits to what science can claim to know and discover. Even though Levinasian philosophy is difficult to define in words; its implications in research are straightforward: the researcher must make a sincere attempt to do her best in the service of others and at the same time recognise the limitations of this knowledge seeking activity. Rules of scientific method such as trustworthiness, reliability and validity are basically ethical conditions (Aasland, 2007).

Resnik (1998, p. 36) writes that it is impossible to be employed as a scientist without “mastering a wide body of knowledge”. Ethics in qualitative research has been largely associated with following guidelines and gaining ethical approval from ethical or professional bodies before commencing the research (Birch & Miller, 2005). For the four qualitative studies I, II, III, IV there are situational ethical considerations that must be reflected upon. Reflections from the interviews and especially from the site visits and observations have opened up aspects of research ethics that go beyond the outer boundaries as defined by laws and regulations that provide the official ethical framework.

The welfare and integrity of the participants in the research project is always more important than the interest of science and society (Helse- og omsorgsdepartementet, 2007). Studies II and III were reviewed by the regional ethical committee for the North of Norway. Studies III, IV and V were reviewed by the Norwegian Social Science Data Services. No data register was created and the data was not electronically processed for studies I and II. Written consent forms were signed by all the participants. Keeping the interest of the participants at the fore entailed giving careful consideration to the importance of information, informed consent,

confidentiality and usefulness of the project. The Helsinki declaration (1996) and the Convention on Human Rights and Biomedicine (1997) provide a basis for research ethics; there are however other unwritten ethical laws. According to (Bell & Nutt, 2002) less attention has been paid to ethics in qualitative research than other areas of the research process. My experience as a researcher has shown me that the inner, ethereal challenges and boundaries in situational ethics are not fenced in by a solid framework but are volatile and less clear cut.

Metaphor: On situational ethics

Painting a model from a photograph can have its limitations but it has also advantages. The artist can work in her own time, at her own pace, in her own space. The experience will be different if the model sits for the artist and there is a designated time and space to do the work. Both artist and model are exposed to the situation. Being a spectator can create feelings of discomfort. The artists discomfort can help her understand the plight of the model. Both model and artist may share the same worries about how the finished product will be viewed. The artist may be tempted to adorn and adjust the painting to satisfy the model's expectations just as the model may choose certain poses in order to present herself in a certain light.

Birch, Miller, Mauthner and Jessop, (2002) emphasises that ethics in research entails so much more than rules and guidelines. Other principles and considerations encountered in the research process need to be discussed as they go beyond pragmatic rules, principles and guidelines. A critical questioning attitude is necessary in the search for knowledge (Stenbock-Hult, 2004). Having worked as a public health nurse for many years has influenced both my knowledge of the field and how I regard the profession. I have strived for transparency in my writing and through dialogues with my mentor achieved awareness of areas where my personal lived experiences could blind me from faithfully and accurately seeing and interpreting the collected data. Being a researcher in (what was once) my own field requires that I pay attention to my presuppositions and the challenges they impose. At the same time I can not be consciously aware of everything that influences my present stance. I strive therefore to ensure that my reflections are made as visible as possible.

It is important for a researcher with knowledge of the field not to “go native” and in this way become blind and not investigate important aspects of the research that a researcher unknown

to the field would. The challenges and problems attached to being a researcher in ones own field are often highlighted as confounding factors in research.

Bell and Nutt (2002, p. 71) write about whether or not the researcher should emphasise the role of practitioner during the research process; as research can involve making professional as well as “research” judgements within the research setting. Being a former public health nurse, the possible duality of my position required attentiveness to my role as researcher and at the same time an awareness of my knowledge of the field. This was especially evident in study III during the participant observations. A public health nurse is in many cases a participant observer (Tveiten, 2006). Neumann (2007) experienced feeling like a client when she interviewed PHN’s at their offices. I experienced feeling like a public health nurse when I interviewed the parents and young people in Study III. I was very aware of my role as researcher but paid attention to the voice of the public health nurse to see if it gave me access to thoughts or ideas that were demanded by the situation and that could secure ethical aspects or complement the research process. Bell and Nutt (2002) reflect on the necessity of acknowledging the tensions between the roles of practitioner and researcher. Ethics is about how to deal with ambivalence rather than attempting to eliminate it (Ribbens & Edwards, 1998). My insider experience necessitated my assessing the situation at hand, dealing with ambivalence and if necessary acting on my professional convictions be they as a professional researcher or a health professional. Neumann (2007) described a feeling of unrest in the waiting room due to what she felt was an overwhelming calmness. I interpreted the unrest I felt during the observations as being due to my position as researcher. An observer, intruder, and outsider invading a zone I no longer belonged to.

Overview of the findings

The five studies give insight into perceptions of public health nursing practice; how the nurses experience their work, what goes on in a consultation and how leaders, collaborators and service users perceive public health nursing practice. The original themes were changes in professional status and challenges in public health nursing work. The empirical data sharpened the analytical focus and the findings point specifically to challenges related to borders and boundaries, and visibility and voice in public health nursing. The findings from each of the five studies will be listed before the subsequent discussion.

Study I

Study 1: How and why has public health nursing changed regarding: tasks, status, leadership and collaboration over the last 20 years?

This study provides a backdrop for the remaining studies and gives insight into changes and challenges the profession has faced from 1984 and up to the present day. The study focused on tasks, collaboration, professional status and leadership. The nurses are more concerned about the effects changes in their role could have on public health rather than on their professional status, stating that they do not have time to engage in activities that promote their professional status. The respondents say that they have become less visible; but that losing tasks has made it easier for them to limit their scope and define their boundaries. The nurses feel that the Norwegian Nurses Association (NoNA) has forgotten about them both locally and nationally.

The PHNs maintain that doctors have less time and opportunity to collaborate with them. The nurses stated that these collaboration difficulties apply especially in large communities and that physical proximity in smaller communities makes collaboration easier. The nurses mentioned collaboration difficulties with child protection workers and that interprofessional tensions occur at local levels. Issues of leadership were also discussed; the fact that other professions could now lead the nurses was mentioned as a threat to the nurses' professional development. The nurses seem more concerned with providing a good service, being respectful towards their clients and being respected, rather than promoting their professional

status. Analysis of documents showed that focus in policy documents is now more on task-performance and less on the professional involved.

The following conclusions can be drawn; the nurses feel that they are a respected, trusted profession despite being less visible. They voice dissatisfaction over collaboration issues and with the NoNA's role in promoting their professional development. The nurses feel that loss of tasks helps them concentrate on their target population of families, children and young people. The nurses have been given new tasks (limited prescription rights) that can give increased status. The results show that PHNs are not only concerned with promoting their own special interests, being a respected profession and respecting their service users is more important to the nurses than having an authoritarian position. The study concludes that due to demographic changes, with an increasing older adult population, it is important for PHNs to become more visible, and to have a broad public health focus in order to promote child and adolescent health.

Study II

Study II: How do experienced PHNs reflect on their practice?

The study's intentions were to explore how PHN experience their work and highlight aspects of public health nursing not visible in annual reports and statistical presentations of public health nursing practice. The study illustrates the relational challenges the nurses face with their service users. In interpreting the nurses' stories the themes of *personal responsibility, boundaries, temporality, being alone; worry, fear and uncertainty, and a sense of satisfaction* emerge. As the themes are developed further it becomes apparent that despite their diversity they are all interrelated aspects of ethical responsibility. The nurses in the study have worked as hospital nurses but feel a greater sense of personal responsibility as PHNs. The nurses feel a personal responsibility for their clients, they have the power to help but at the same time feel helpless. They describe incidents where they felt they should have but did not make clear boundaries and define their limitations with both collaborators and service users. The nurses felt a duty and strong loyalty towards their clients and close involvement in many cases. Each nurse has to make decisions that are not only based on quality standards but on professional intuition and personal involvement.

Time was an issue for the nurses in the study, illustrated by their descriptions of heavy work loads and the nature of their job that necessitated that they always had to plan ahead. They spoke of time; past, present and future and that it was not easy to forget cases that had made deep impressions on them. Their loyalty was to their clients and, as one nurse said, even though she was pressed for time she always gave her clients at the youth clinic the time they needed. Working alone, the lack of rigid boundaries and the independent nature of the public health nurses' work in the community seem to contribute to their feelings of responsibility. Apart from descriptions of physical loneliness, they describe feeling alone with their worries even though they collaborated with others. All five respondents used expressions of care and worry to describe their relationship with their clients. They spoke of the worry of making the wrong decisions, overlooking potential suicide cases that they should have discovered and prevented. The study provides an introduction to Levinasian philosophy and brings forth the challenges of responsibility in public health nursing, by highlighting the nurse's "responses" to the demands in her work.

The study concludes that the PHNs feel a sense of satisfaction in their work, experience a strong sense of personal responsibility, and often feel alone with their fears and worries. Time is an issue that poses challenges as well as boundaries for relational responsibility. Even though these nurses are "faced" with and not "forced" into responsibility they still feel the force of the pull between closeness and distance in relationships. Levinas' philosophy shows us that the nurses wish for clearer boundaries seems impossible to reach. Their stories illustrate some dimensions of the demands of ethical responsibility in public health nursing that can have practical and theoretical implications for public health nursing practice.

Study III

How do PHNs and their service users experience PHN consultations?

Study III gives a glimpse into what goes on in a PHN consultation and gives insight into how a visit to the public health nurse is experienced by the PHN, parents and young people.

Field notes and transcribed recordings give insight into the PHN's approach. The nurses at the child health clinic started where they had left off at the last visit. Topics of the day were

broached by both nurse and parents and the sessions were concluded by opening up for the possibility of renewed contact or by referring to the next appointment. The drawings (page 40) illustrate relaxed bodies and a relaxed atmosphere at the child health clinic and school health service, not a strict ceremonial order. The sessions at the drop-in clinic for young people were focused; the bodies stationary, more orderly. They had designated places. The theme or topic brought up by the young person was the thread of focus. The sessions were short and to the point. It seemed the young person came, presented their problem and left. The session at the school was one of many meetings between nurse and pupil. There was no fixed agenda. The young person brought up what was worrying her and the nurse asked about issues that they had discussed during previous visits.

Interviews with all the nurses show that they are concerned with maintaining relationships, being supportive, listening to the needs of the service users and promoting empowerment at an interpersonal level. The nurses spoke of the importance of the school health services as a support for the clinic for young people. Due to the universal nature of the public health nurses services, the young people were familiar with the nurses' services.

The interviews with both young people and parents show that they were satisfied with the service provided, the nurse's personality, and her competence. They appreciated a pleasant, but also an honest, direct nurse. The parents were aware that PHNs were different. Two nurses and a mother knew of other parents who were not satisfied. The parents felt lucky that they had such a good relationship with their nurse. The young people did not have any negative comments on the service. All service users appreciated the continuity of services and wished for more extensive services.

The study throws light on situational and relational aspects of a public health nursing consultation and reveals that there is an implicit active dimension to *being*. The observations opened up for an understanding of continuity and space not just in the physical room but also in the space or expanse within which each consultation exists and transcends. Spaciousness is relevant in relationships and the nurse must use her clinical judgment, to give room so that the individuality of the person in her office can come forth. The compatibility of the nurse and service user played a part in the success of the interaction. The findings from the study contribute to further developing existing theoretical models on PHN approaches.

The study concludes that maintaining relationships is important to both nurses and service users and that ordinary families need support. The nurses have different approaches. The study shows that relationships are not only sustained by pleasantness but also by honesty and directness, provided the relationship is based on trust and sincerity. Continuity of services seem paramount to the service users' satisfaction and their trust in the service. Even though the parents, young people and nurses were satisfied after the sessions, they were not always able to put the reason for their appreciation into words. Words often fall short when attempts are made to capture the essence of caring, trust and other life phenomena. Not all sessions with PHNs are empowering. Voicing the PHN's agenda and her health promotive intentions as well as encouraging feedback from parents could further improve the PHNs' services.

Study IV

Study IV: How do municipal decision makers perceive public health nursing practice?

The objective of this study was to describe and analyse municipal decision makers' attitudes to public health nursing and to reflect upon and discuss the relevance of their views to the future of public health nursing in Norway. The study shows that decision makers lack knowledge of public health nursing services especially those at local child health clinics. All the interviewees had views on collaboration; some discussed the importance of the public health nursing leader's role in collaboration. Politicians felt that collaboration had improved; administrators had mixed views on the nurses as collaborators and felt that they should work more towards promoting collaboration. One administrator felt that the family centre model had helped promote collaboration amongst health and social professionals.

The decision makers feel that PHNs need to face certain challenges regarding visibility, boundaries, and collaboration; that PHNs need to become more visible as professionals in promoting what they do and in making services at local child health clinics more visible. Some decision makers were also concerned about the challenges the nurse faces in limiting involvement in certain cases and in defining her professional boundaries. Two administrators had the impression that PHNs were a closed profession that held on to its clients. One politician was conscious of how strong pressure groups (for instance the elderly) could

influence prioritisation and saw dialogue with professionals as important. Another politician was worried that strict control by administrators could inhibit dialogue with politicians.

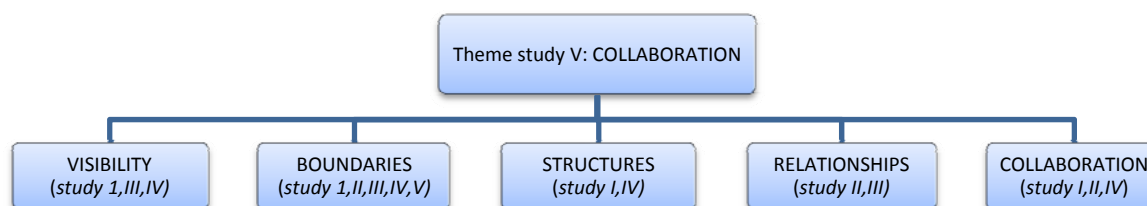
The study concludes that decision makers recognise the nurses' contribution to public health. The decision makers felt that public health nurses should become more visible, challenge their surroundings and show the context they are part of. Politicians were positive to the nurses as collaborators. The administrators had mixed views and some described unfortunate collaboration incidents with the nurses. Filtering of information in reporting challenges can minimize the likelihood of top level decision makers receiving a realistic picture of the nurses' services. Dialogue between nurses and decision makers is essential in order to ensure updated evaluation and continued development of public health nursing services.

Study V

Study V: How do PHNs and a sample of their collaborators view issues that can influence interprofessional collaboration?

The findings from the first four qualitative studies were used as sources of information for this fifth and final study with its focus on collaboration. Collaboration was an important theme for nurses and decision makers. Issues of visibility, boundaries, structures and relationships influence collaboration and were discussed in studies I, II, III and IV (figure 3). Based on the results from the qualitative studies, the purpose of study V was to examine collaboration issues relating to public health nursing in different sized Norwegian municipalities. The PHNs in study I felt that conflicts occurred at local levels and that physical proximity made it easier to collaborate in smaller communities. The PHNs felt that doctors had less time and opportunity to collaborate with them and mentioned difficulties in collaborating with child protection workers (CPW). The nurses in study II spoke of loneliness and lack of meeting points and the decision makers in study IV were concerned with collaboration issues. The decision makers showed concern about lack of visibility and clear boundaries, and some expressed irritation over lacking collaboration. Figure 3 illustrates the themes that contributed to the focus in the final study.

Figure 3: Concepts that can influence collaborative processes



The results from study V reveal that the majority of respondents (67.1%, n=1072) state that collaboration amongst professionals who work with children functions well; 82.1%, (n=1309) state that collaboration has improved and 30.3%, (n= 485) agree that conflicts are common. The majority (88.8%, n=1418) maintain that physical proximity is important for collaboration. A total of 81.3% (n= 588) of doctors, midwives and CPW state that they do not have fewer meeting points with PHNs compared with five years ago. The distribution was as follows: 83.2% midwives (n=95), 82.2% CPW (n=393), and 76% of doctors (n=100).

A higher percentage of PHNs in municipalities with populations >10 000 respond that they have fewer meeting points with child protection workers (CPW) and midwives compared with PHNs in municipalities <10 000. A higher percentage of doctors, CPW and midwives in municipalities >10 000 respond to the statement that they have fewer meeting points with PHNs compared with those in municipalities with populations < 10 000 (chi-square test) (Paper V).

Different patterns are apparent when the respondents are asked questions about what promotes collaboration. All respondents rank respect, trust and collaborative competence to be most important; and economy, formalised structures and leadership to be the least important. Analysis of variance (ANOVA) shows significant variance in mean responses related to municipality size. Municipalities with populations <10 000 have a higher mean response to the statement that collaboration functions well and has improved whereas municipalities >10 000 show a higher response to the following statements: that political directives are necessary, that territorial thinking and sector boundaries inhibit collaboration.

The study concludes that doctors, midwives, child protection workers and PHNs state that mental health professionals are missed most in collaborative relationships. Trust, respect and collaborative competency rank highest for all the respondents and are more important than formalised structures, leadership and economy. Greater frequency of meeting points in small communities in comparison with large municipalities is a finding that should be of interest when organising health and services. The study concludes that community size can influence frequency of meeting points and views on collaboration.

Summary of results from the five studies

How do PHNs, their service users, collaborators and decision makers perceive public health nursing practice?

Even though PHNs experience a lot of responsibility in their work they also express contentment and feel that they are respected by their service users (study I, II, III). Respect and trust are important values for the nurses (study I, III, V) and their collaborators (study V) and seem more important to PHNs than professional status (study I) or formalised structures, economy and leadership (study V). Young people and parents express the need for more extensive public health nursing services. Study II illustrates aspects of the complexity of public health nursing practice. The service users interviewed in study III were satisfied with the PHNs' services, but knew of others who were not. Even though it is not always easy for nurses, young people and parents to put into words what goes on in a consultation; maintaining relationships was important to them and they were aware that the sessions helped. The municipal decision makers in study IV were aware of PHNs' contribution to public health but saw the need for the nurses to make visible what they do, limit their involvement in certain cases and work toward promoting collaboration amongst professionals.

Triangulation of results from studies I and IV with study V have confirmed that municipality size and physical proximity can influence collaboration and support both PHNs' and decision-makers' views that collaboration issues require further attention. Study II illustrates the challenges PHNs face in their work. Awareness of results from study II enabled me to see beyond explicit expressions of satisfaction by service users in study III that not all consultations with parents are empowering. Study V shows that psychological services are

most missed by PHNs and their collaborators. Table 6 illustrates the thematic results from the five studies. These themes will provide the framework for the subsequent discussion section.

Table 6: Overview of the results

Borders and boundaries	Visibility and voice
Boundaries for satisfaction	PHNs are not visible for decision makers
Opposite borders and contradictory forces	PHNs are visible for their service users and collaborators
Professional borders and boundaries	The invisible nature of psychosocial problems
Borders and boundaries in interpersonal relationships	Tacit nature of consultations
Borders and boundaries in interprofessional collaboration	Invisibility is the nurses' method

Discussion

The findings are discussed within the theoretical framework of this thesis: the philosophy of Emmanuel Levinas, concepts of health, public health and theories of professions. The themes from the empirical data are grouped under the main themes of: borders and boundaries, visibility and voice in public health nursing practice, in relationships and in interprofessional collaboration.

Borders and boundaries are often looked upon as limiting. Like fences they hold together, protect and confine; they keep outsiders and those who do not belong, on the other side of the fence. Boundaries can give security, be they visible fixtures such as barbed wire fences or invisible intangible constructions such as implicit rules of behaviour in social systems. Lack of, or poorly defined borders and boundaries can be challenging and cause uncertainty. Visibility and voice are connected with openness and understanding. When we are visible we can be seen but we are also exposed. Voicing issues can draw attention to us; remaining silent can be a protective strategy; just as invisibility and inability to verbalise can cover up and blur.

Metaphor: on borders and boundaries visibility and voice

Paintings hang there, silent fixtures waiting to be seen. We may notice them as physical objects, part of the furnishings in a room or we may stop up and pay attention to what they express. The impression they make on us is not solely based on the framed in motif. The painting can transcend its own boundaries and help us voice and make visible other silent pictures within us and create new ideas for future work.

Borders and boundaries

Boundaries for satisfaction

The unanimous satisfaction expressed by the parents and young people in study III can give cause for concern that issues of bias have skewed the results. Norwegian studies reveal however that service users are satisfied with services at local child health clinics (Andersson, Norvoll, & Ose, 2006; Andersson & Steihaug, 2008; Bild, 1995, 1998; Seierstad & Strand, 2005; Sitter, 2008). International studies also reveal that service users are satisfied with public

health nursing services (Bowns et al., 2000; Uosukainen, 2001). School nurses can play an important role for pupils in susceptible situations (Borup, 2007; Tinnfält, 2008). Jentoft's (2005) study on health clinics for young people showed that the young people trusted both the service and the health professionals working there. Peckover's (2003) study showed however that when family violence occurred, families did not receive adequate support or enough information on supportive services from the nurses.

The service users expressed satisfaction with interactions with the PHN, her personality, her competence, as well as the availability and accessibility of the services she provided. These findings comply with other studies on what service users are satisfied with in meetings with doctors and physiotherapists (Johansson, Oleni, & Fridlund, 2002; Marcinowicz, Chlabicz, & Grebowski, 2009). Interpersonal relationships were important for the participants in study III. Interpersonal aspects of care are regarded as the principle component of satisfaction (Sitzia and Wood 1997). Satisfaction is a complex and difficult concept to evaluate (Marcinowicz et al., 2009).

A public health service can always be improved. The themes that generated expressions of satisfaction can throw light on potential reasons for dissatisfaction. Concentration on areas of expressed dissatisfaction can be more valuable than obtaining consistency in expressed satisfaction (Sitzia & Wood 1997). Dissatisfaction with interactions, unavailability of services, and PHN's lack of competence, can to a greater degree illustrate the complexity of maintaining relationships and point towards aspects of the service that require further study. Even though the service users were prompted to discuss dissatisfaction, the only issue that emerged was a critique at system level of the availability and accessibility of the service.

The service users can have felt gratitude to the PHNs and due to issues of social desirability believed that positive responses were expected. Study III has also shown that issues of social desirability and the belief that positive responses are expected can also limit the PHN's success in reaching service users who may need her help. There are certain issues of relational competence and issues of power that did not come forth in this study. The picture of angelic nurses and service users in study III defies the realities and complexities of public health nursing practice as portrayed in study II. Levinas' reminder that we are not angels but men and women of flesh and blood trying to live together in a responsible way (study II) caused

me to stop up and pay attention to the voice of the third (those not present to make their demands known). References by the participants to others who were dissatisfied with the services and my awareness that both PHNs and service users are composite groups tell me that there are other sides to the story. The nurses' intentions of being supportive, bringing things into the open, listening to the needs of the service users and promoting empowerment at an interpersonal level were not always successful. A mother who participated in study III spoke of a friend who was afraid to divulge to a PHN at the same clinic that she had stopped breastfeeding because she felt it was expected of her to continue. This resulted in her not receiving adequate support and help. Neumann (2007) interviewed both nurses and parents at local clinics and carried out observations in waiting rooms, with the intention of examining normality and deviation; what PHNs see and do not see in mother/child relationships. Neumann's study showed that even though the service is universal the PHNs may not always discover children who receive deficient parental care. Paying attention to the voice of the third in this study has drawn attention to another group. Service users, who in their desire to live up to what they feel are the PHN's expectations, do not divulge or seek help for their problems. The PHNs in study II worried about those they did not see, nor respond to, who may have needed their help. Neumann (2007) describes the PHNs' view on normality as being very broad. This denotes that there should be room and acceptance for mothers who do not breastfeed. This can indicate a need for voicing PHNs' health promoting intentions both to the nurses themselves and to their service users. The PHN can be dependent on a person's willingness to "give" indication of their needs in order to ensure that they "receive" adequate help. Chalmers (1992) describes that giving and receiving behaviours between clients and PHNs influences the care they receive. These behaviours are complex and have deep foundations. Study III illustrates the importance of trust and continuity as a foundation for open relationships.

Opposite borders and contradictory forces

Collective and individual responsibilities are keywords in public health. The nurses in study I seem more concerned about providing a good service, being respectful towards their clients and being respected, than promoting their professional role. This is a commendable stance. It can however have repercussions if involvement in relationships causes them to neglect their public health role in promoting knowledge of the greater societal context they are part of.

Studies I, II and III support existing research that PHNs focus to a great degree on relationships. Time was an issue for the nurses in study I and II. Heavy workloads, unavailability of resources and the need for more supportive management are some of the factors nurses feel need to be addressed in a primary health care context (Besner, 2006). Structural factors such as heavy case loads can limit the PHNs' possibilities to engage in societal issues. Just as rigid tight structures can threaten time allotted in face to face meetings. There is also a danger that a focus on collective public health models can play a part in undermining the strength of the relationship between PHN and service user in facilitating change (Elkan et al., 2000a). Medical tasks can also dominate the PHNs' work and be given priority over health promotive dialogues (Lindström, 2007).

These factors can pull public health nursing in different directions. This research has shown that it is necessary to acknowledge these contradictory forces and promote the connection between individual health promotive relationships and a broad public health focus in public health nursing practice. PHNs are visible in public health campaigns for young people (study IV). They face a challenge in promoting their relationship centred role in everyday meetings at local clinics and school health services. Reporting systems that make visible these aspects of their work and the context they are part of to decision makers seem lacking.

Professional borders and boundaries

Discussing professionalization processes is no easy task. Andrews and Wærness (2004) write that Norwegian PHNs are going through a process of de-professionalization. The nurses in the case study do not feel that they are going through this process. They regard themselves as professionals and feel that loss of tasks has enabled them to concentrate on their work with children, families and young people. It appears that the perceptions of Andrews and Wærness (2004) and the nurses differ. It can be argued that the practical world and the sociological world of terms collide; that professionalism is a sociological definition, a theoretical concept not a practical one and that the views of the nurses have little to do with sociological theories on professionalization processes. Even though the world of terms collides, the nurses' views on their professional status are important and indicate their professional values. Andrews and Wærness (2004) discuss de-professionalization due to changes in the nurses' jurisdiction and

their loss of monopoly on certain tasks, their focus is not on public health nursing as a legitimate professional health service.

Changes in professional jurisdiction influence professionalization processes (Abbot, 1988). Losing tasks can entail losing professional status; gaining new tasks (limited prescription rights) can give added status. Lindström (2007) questions whether prescribing medicines can be overestimated from a professional point of view. This is a legitimate question. Performing medical tasks can appear to give status by showing the nurse's connection to an esoteric knowledge base. It can also contribute to undermining the primacy of their health promotive nursing role in supporting and enabling the people she meets in her practice. Neumann (2007) writes that PHNs' potential authoritative position is undermined by the fact that they have been given new tasks, even though their knowledge base is basically the same. Medical tasks may not necessarily give the nurse more status, because doctors will always be the "expert" prescribers.

Respect is deemed important by the nurses interviewed in study I. They mention being respected and caring for their clients as hallmark criteria for their professional practice, not authoritarian status. Underpinning their professional moral values in this way can connect the descriptive sociological word of social organisation and the real world of practice. Macdonald (1995) refers to influences on and features of professional practice; such as the pursuit of a project that gives existential meaning and moral value. The fact that respect is an important value to the nurses in the study adds clout to this view on professional practice. It is in being trusted professionals the nurses feel that they receive their professional status.

The case study helps illustrate what motivates the PHNs. Nursing is a paradigm case of a caring profession (Abbott, 1988) where practice is its most important aspect. Abbot (1988) writes that case studies on professions can give valuable information on professionalization processes. Even though the case study is not an analysis of a professionalization process it does illustrate important aspects of motivation in public health nursing. It is from the minutiae of personal conduct that the stuff of professions is made of (Macdonald, 1995, p. 207). In their early days professionals emphasised respectability as their trademark, whereas there has been an increasing scepticism as to where professional loyalties really lie. Freidson (2007) writes that it is the ethical values of professions, not their institutional privileges, that are

threatened by increased market orientation. Maybe attitudes to professional practice are changing more than the essence of ethical values that professions are made of? The nurses in study I wish for clearer areas of responsibility and feel that losing tasks gives them the opportunity to focus on their core function with: children, young people and families.

The fact that other professions can now lead the PHNs' services was a worry for the nurses in study I. The case study also shows that PHNs are mentioned less in official documents and that public health nursing leaders have no longer a monopoly as leaders of local health clinics and school health services. Edgecombe (2001) writes that the role of public health nursing leaders is under threat as country after country reviews and restructures its health care systems. Decision makers in study IV saw the importance of the public health nursing leader in promoting a collaborative climate with other professions. Norway is at the threshold of a new health reform that emphasises coordination and primary health care (Ministry of Health and Care Services, 2009), making it especially important for public health nursing leaders to help define the PHNs' role and function in conjunction with the new reform.

Borders and boundaries in interpersonal relationships

The nurses in Study II elaborated on boundaries and openings for involvement in public health nursing relationships. Professional boundaries are like corner stones. They give professional identity and make visible a person's role, tasks and function. There were barriers to what was visible of the PHNs' interventions for service users and nurses in study III. All service users appreciated the nurse's competence and liked her as a person. They were conscious of the importance of the relationship as a starting point for meeting needs. A keen sense of professional boundaries can protect clients and others from invasive well meaning interventions from the public health nurse. Lack of these professional boundaries can lead to the individual professional feeling a limitless responsibility for the client resulting in worn out professionals and even violation and infringement of the Other's personal space.

Issues of closeness and distance can create other challenges for PHNs. There was a certain pattern to the visits at local child health clinics. After participating at five sessions, I felt that they took on a sheen of sameness. The nurses and parents in study III seemed in many ways very compatible. Can the nurse's focus on maintaining relationships cause a closeness and

acceptance of sameness in goals (with service users) that in turn can inhibit the nurse from interpreting and responding to possible differences and challenges? The question is a legitimate one, especially when pleasantness and sameness are deemed important by both nurse and parent. One parent spoke of assessing public health nursing profiles in order to pick out a suitable nurse. A cornerstone in Levinas' philosophy is the unique alterity of each individual. Levinas (1987) warns against the pitfall of reducing the Other to the same. A challenge for the PHN is that even though closeness can promote trust, as a responsible professional she must maintain a certain professional distance in order to critically view each situation. Boundaries are described by Schütz as being beyond which we cannot see (Schütz & Luckmann, 1973). The reflections of the nurses in study II and the service users in study III serve as a reminder that there is a need to acknowledge not only boundaries for involvement but also for limitations in what the PHN can actually see, gain access to and verbalise in meetings with parents, children and young people.

Maintaining relationships was important for nurses, young people and parents in study III. The study has shown that there is a need to bring forth a type of evidence in public health nursing practice; that which is evident in relationships and in each situation. Evidence is defined by Sackett (1997) as health care interventions that are shown to be effective by scientific research. Evidence encompasses more than what can be gleaned from scientific guidelines; it embraces life phenomena such as: the good, the infinite and the vulnerable, (Martinsen & Eriksson, 2009). The professional must be open and use her clinical judgement in order to discern what is at stake in each situation. Professional knowledge is important and can help the nurse discern what to do. Knowledge has however limitations in the study of persons (Levinas, 1993). What is evident in each situation is not always easily verbalised. The fact that relationships are important in building trust can seem an obvious, common sense conclusion. The conclusion has however theoretical underpinnings. Researcher Jane Robinson describes "the relationship-centred approach" as a model for nurses working with families; the approach is "dependent on less tangible factors such as acceptance, empathy and rapport"; Robinson cautions against relying only on quantifiable research in order to provide an evidence base for public health nursing (Elkan et al., 2000a, p. 1318).

The young people in study III trusted the service even though they did not always know the PHN on duty. Trust in persons results from past experiences of concrete persons; knowing the

tradition, culture and values of the group can generalise trust to all the members of that group (Offe, 1999). Knowing that “everybody goes there” can also enhance trust. According to Warren (1999, p. 348) “The core *trust* relation is interpersonal. Whatever it means to trust an institution is somehow scaled up from the domain of socially thick, face-to-face relations”.

The service users’ openness to intimate topics reveals trust in the individual nurse and their knowledge of and trust in her services (study III). Williams (2001) writes that market led health services can render close intimate relationships between patient and nurse difficult to achieve. Taking the limitations of the sample into consideration, this does not seem to be the case for many of the public health nursing consultations in this study. Confining the outer space or framework of continuity and the availability and accessibility of services can pose a threat to the intrinsic part of public health nursing practice that intimacy and trust are built upon.

Holism is a concept that should be strived for in public health. Meetings with public health nurses could be considered totalities, where the nurse strives to encompass physical, psychological, spiritual and social aspects within the boundaries of each session. Meetings between PHNs, young people and parents (study III) occur within a continuum of persons, practice and places, from past, through present and to future. The present demands responsibility, the past exposes vulnerability and the future uncertainty and alterity (Levinas, 1987). Each meeting transcends the sessions given boundaries of time, space, bodies and relationships. Levinas writes that the concept of infinity disturbs the possibility of totality and refers to Paul Valery who writes that infinity is so deep that we can never go far enough back (Levinas, Peperzak, Critchley, & Bernasconi, 1996, p. 60). Professionals can easily be lulled into thinking that showing an interest, being aware of contextual factors, looking back and planning ahead will safeguard a holistic view. These perspectives are necessary but as study III has shown there are boundaries to what the Other will divulge and to the PHNs’ knowledge of other persons; reinforcing the limitations of the concept of holism and totality.

Borders and boundaries in interprofessional collaboration

Collaboration was an important issue for the nurses (studies I, and II) and decision makers in study IV. The nurses in study II describe incidents where they felt they should have but did

not make clear boundaries and define their limitations with both collaborators and service users. Boundaries in public health nursing practice are diffuse (Schjøtz, 2003). Clarke (2004) describes a PHN's working environment as unstructured, uncontrolled and even chaotic. In an unstructured environment with diffuse boundaries it is up to each individual PHN to mark her professional boundaries. Not always being able to refer to a concrete divide can leave doors ajar that can cause uncertainty as to where and how professional boundaries should be defined (study II).

Decision makers in study IV felt that PHNs at times went beyond the boundaries of their competence and did not refer cases when they should. According to Freidson (2007, p. 202) "Boundaries create a mutually reinforcing social shelter" within which a formal body of knowledge and skill can develop, they establish a barrier to other professionals and the public at large, without social closures, professionals may not survive as distinct disciplines. Diffuse boundaries can make it difficult for the professionals to recognise their limitations and areas of responsibility and make it difficult to find points of connection in collaboration. Complex problems are not easily referred; lack of services (studies II, IV, and V) and lack of clear boundaries leave the PHN to sort out complex problems making prioritising in her job difficult and promoting a negative picture of a closed profession that holds on to its clients. The decision makers do not discuss the fact that organisational structures can hinder interprofessional collaboration. When the collaborators in study V were asked if sector boundaries inhibited collaboration, there was a significant difference between the respondents' average scores directly related to municipality size. Respondents from municipalities >10 000 had a significantly higher score. Differences in organisational structures and differentiation of services into units can be barriers to collaboration and differences in orientation do not necessarily enhance collaboration (Ellefsen, 2002, Hultberg, Glendinning, Allebeck, and Lönnroth 2005).

Lack of necessary services can hinder referrals. The PHNs in study II spoke of making the wrong decision and overlooking potential suicide cases. Study V showed that psychological services were those most missed in collaborative relationships by PHNs, child protection workers, midwives and doctors. Psychological problems are an important public health issue. Every third adolescent that is in touch with a PHN has psychological problems (Andersson et al., 2006). Lack of mental health services can necessitate continued contact between PHNs

and certain service users due to lack of services and not necessarily be an indication that the nurses are “holding on to their clients”.

Study V has shown that the majority of respondents agree that collaboration functions well, that interprofessional collaboration has improved and that conflicts amongst collaborators are not common. The nurses in study I felt that doctors had less time to collaborate with them but that physical proximity in small communities made collaboration easier. Even though this statement cannot be generalised, study V has shown that size of municipality can be associated with differences in views on collaboration, and frequency of meeting points with collaborators. Analysis of variance illustrates variance in opinions that indicates that there is an association between positive responses on collaborative activity and municipalities with populations <10000. Physical proximity can be an asset to collaboration, which is the intention in primary health care. Chalmers (1993), and Lindström (2007) have however pointed out; that proximity to doctors’ surgeries in primary care settings can result in medical tasks being given precedence over other needs.

Collaboration is to be the main perspective in the development of health services in the future (Ministry of Health and Care Services, 2009). Trust and respect are important to the health and social professionals in study V. Successful coordination depends on collaboration which is again dependent on perceptions, dispositions and expectations (Offe, 1999). This reinforces the importance of the face to face relationship as the starting point for successful collaboration and coordination. A percentage of respondents (30.3%) state that conflicts are common. Resources must be utilised to identify factors that build and sustain trust; as according to Huxham and Vangen (2005) trust does not always exist as a precondition for successful collaboration.

Visibility and voice

PHNs are not visible for decision makers

Lack of visibility was an important issue for the nurses in study I. The study concludes that due to demographic changes, with an increase in an older adult population, it is important that

PHNs become more visible and have a broad public health focus in order to promote child and adolescent health. Decision makers feel that PHNs should make visible the context they are part of. Decision makers need to be made aware of the limitations of reporting systems and that there is a gap between what actually happens and what can be verbalised and reported. The need for increased visibility in public health nursing is not new (Clarke, 2004; Clendon & Mc Bride, 2001). In existing literature visibility issues are mainly discussed from the perspective of the nurses. It is an interesting finding in this study that decision makers also desire more visible PHNs.

Clarke (2004) argues that policy makers who lack knowledge of the complexities of public health nursing will compartmentalise and simplify the nurses' role. Ensuring the visibility of a public health nursing service is important not only to enable service users' and collaborators' access the professionals but also to make policy makers aware of ongoing public health challenges.

PHNs are visible for service users and collaborators?

The nurses in study I felt that their services were easily overlooked. Ellefsen (1995) writes that public health nurses are the champions of small things. Public health nurses' core function seems to be dealing with the silent complexities of daily life. It can be difficult for the nurses to promote primary prophylactic measures that do not give immediate results. The decision makers in study IV show interest in the PHNs' work. At the same time nurses have pointed out that primary health care has received token acceptance but not financial backing (Smith, 2000).

The nurses' focus on individuals rather than populations can make them less visible to decision makers. The PHNs' population based strategies for young people are promoted in the media and noticed by the decision-makers even though these campaigns occur only at certain times of the year and comprise only a part of her work. According to Chambliss (1996) a nurse's work has little dramatic potential and is of low visibility. Life comprises mainly ordinary every days, indicating that not only the dramatic but also the mundane should receive attention. Campaigns on sex, contraceptives and young people's health have a more dramatic potential and are more noticeable than the everyday nature of their work at the clinic and

school health services. Unexamined features of daily life are often the least noticed and possibly most important features (Chambliss, 1996). Schütz (1962) writes about the concept of “taking for granted”; an experience that is taken for granted is one that does not appear to need further analysis or attention. When everything is as it used to be, we do not reflect much on its meaning; it is first when what we take for granted is under threat that we see its meaning in our everyday life.

A service user in study III, spoke of how the nurse had sharpened his awareness of his sons development. PHNs can make positive sides to parenting visible and promote and reinforce positive interaction (Glavin et al., 2007). Can aspects of social desirability repress dialogue about “negative” sides to parenting? Trust is fundamental and is known to thrive best in conditions of non-anonymity (Offe, 1999). A trustworthy person is one who exposes herself, entailing that the PHN should be open and make visible her intentions.

Inaccessibility and unavailability of services was the only cause for complaint by the service users in study III. From the time the Other sees me I am responsible (Levinas, 1969). This phrase tells us that the Other may come knocking on my door, not I on his. The Other is invisible to us; yet we must be visible in order to help him (Beals, 2007). The philosophical implications of these statements are deep, the practical ones understandable: the public health nurse must be accessible, predictable and visible.

The invisible nature of psychosocial problems

Municipal health and social professionals felt that mental health professionals are those most missed in collaborative relationships (study V). PHNs spoke of the challenges they faced with complex psychological problems (studies II, III). Psychological problems provided challenges in public health in Norway and other western countries (Helsedepartementet, 2003). Due to changes in the health panorama the public health workers of today often fight silent battles against these less visible and less tangible enemies than their forerunners, who fought visible battles to combat the blatant effects of infectious diseases. The PHNs worried about making the wrong decisions, especially in relation to mental health issues (study II). PHNs in Norway have signalled that they need to acquire competence in order to deal with problems related to psychological health (Andersson et al., 2006). Swedish school nurses judged schoolchildren's

mental health as deteriorating (Clausson, 2008). An increase in psychosocial problems indicates an increased need for mental health services as visible supportive services in primary health care.

Tacit nature of consultations

In the introduction I mentioned the necessity of exploring what PHNs actually do and how they contribute to public health before assigning new roles to the profession. PHNs do not engage in “hands on” nursing which is a distinctive feature of nursing practice. Neumann (2007) writes that nurses’ knowledge base is different to medicine but that their concern for the child’s physical health and their affiliation with public health work causes them to adopt a medical gaze. Neumann’s findings are based on interviews and observations from waiting rooms, not direct observations from consultations. Neumann describes PHNs at child health clinics as being calm, reserved, clinical, and having a distant medical gaze. The findings from the observations and the interviews in this research do not support a description of distance and ceremonial order. The relaxed bodily positions (drawings page 39) as well as the activity and noise (on tape) gave an impression of normality and continuity. Even though nurses perform medical functions they need not adopt a solely medical perspective while performing their work (Besner 2006).

Study III has shown that not all issues become visible in consultations. As a former leader of the PHN’s professional interest group said: “invisibility is the nurses’ method” (Study I). Can conceptual models have practical implications and help make visible and verbalise what PHNs do? Despite my views on the limitations of totalities; categories and models can have a function in rendering aspects of practice visible. Chalmers (1992) and Helseth (1999) models of public health nursing interventions provided a basis for reflecting on the PHNs’ approach at the clinics and school health services (study III). The observational study has contributed to further developing Helseth and Chalmers theoretical models on public health nursing approaches. The main categories in Chalmers (1992) model are *entry*, *health promotion*, and *termination*; further developed by Helseth (1999) into *entry*, *health promotion* and *evaluation*. In study III where relationships were ongoing and already established at the child health clinic and school health service a further adaptation of the existing models seemed to fit better with the PHNs’ approach. *Evaluation* of the former visit was the first stage before moving on to the

health promotive interventions and finally providing an appointment as an *opening* or *entry* to the next meeting. This model takes into consideration aspects of continuity inherent in the sessions. Chalmers (1992) model: *entry, health promotion, termination* held continued relevance as a theoretical model for the nurses' approach for "drop in" meetings at the clinics for young people.

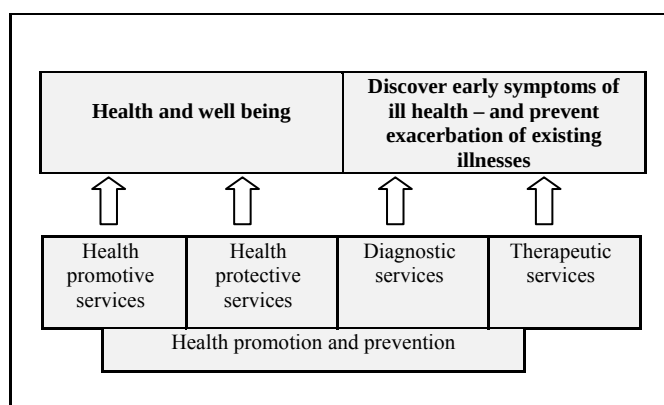
If figures only are used to indicate what the professional does then important aspects of the service can be overlooked. A quantitative paradigm can count *what* has been done, but falls short in elaborating on and giving depth to the complexities of establishing and maintaining relationships. Rawson in Leathard (1994) writes about *what* and *who* as being different paradigms in knowledge development. The *what* discourse focuses on tasks and the orientation of this approach leads to quantitative methodology. The *who* approach focuses on human factors, that real people occupy task positions, have personal approaches and make personal contributions when performing tasks. Not focusing on core municipal public health professionals or institutions in policy documents can illustrate the promotion of an instrumental discourse whilst contributing to silencing a professional one. Focus on instrumental aspects of public health nursing can ensure that measurable tasks are seen as indicators of what the profession does resulting in other aspects such as the intricacies of the health promoting and caring dimension being overlooked.

Important aspects of PHNs' contribution to public health can be ignored if focus is on measurable tasks and not on persons and performance. Freidson (2007) reminds us that if medicine is used as the prototype for professional knowledge it can lead to the conclusion that prototypical professional knowledge is scientific in character. No visible application of rules or esoteric knowledge to procedures can make actions taken by nurses seem "mundane", both to the nurses themselves and their service users. This can undermine both the ethical and knowledge foundations on which these practical actions are founded and promote a notion that takes the intricacies of nursing knowledge and practice for granted.

Elo and Calltorp's (2002, p. 206) Health promotive and preventive action model (HPA model) illustrates the wide range of public health services provided by PHNs. The HPA model is based on Swedish conditions. Two domains (rehabilitation services and terminal care) are not considered relevant for Norwegian conditions. An adapted HPA model (figure 4) with fewer

domains can be used to illustrate current Norwegian public health nursing practice related to the process of human health –ill health. Norwegian PHNs' services can be described as being health promotive, health protective, diagnostic and therapeutic. The purpose of using models is not to totalise in a rigid static way, but to give the PHNs a legitimate tool to help them voice and document the actions they perform. Reports in the form of contextual descriptions from their practice can also serve to merge patterns recognized in their relationship based role with a broader public health focus.

Figure 4: HPA model for Norwegian conditions



Invisibility is the nurses method

Decision makers feel that PHNs should not to hold on to clients but limit their involvement and refer cases. Neumann (2007) referring to a Norwegian white paper (1982:26), writes that local health clinics and local doctors had an important role in referring cases to local child protection authorities. Twenty years later national statistics from 1995 and 2002 show that it is the parents themselves that refer most cases. What the statistics do not show is what this changing pattern represents and how and if the role of the professional has changed. The intention of the nurses in Study III was to encourage and enable parents. This is a practice, in accordance with health promotion ideals and can result in more empowered parents who seek help themselves, a fact that is not necessarily easily captured in reporting systems.

The PHN's doubt as to the seriousness of problems (Neumann, 2007) can result in non-referrals. PHNs may also uncover illnesses and diseases but because they are not sanctioned to refer directly to specialist services; they may have to refer to doctors for the sole purpose of

further referral. The nurses' involvement and role as initiator in the referral process is not always visible. A finding that is supported by Neumann (2007) who discovered that what the nurse uncovers and how she acts are not necessarily registered. Study V has shown that mental health services are those most missed in collaboration. The lack of certain services can also contribute to the necessity of PHNs having continued contact with their clients.

PHNs do not necessarily hold on to cases or contribute less to referring cases. An empowering approach can enable service-users to contact the child protection services themselves. Service users who choose not to divulge problems, lack of services, current referral systems and insufficient routines for documenting practice can contribute to blurring the nurses' role in the referral process. There is much less knowledge of how nurses act than about client problems and how to solve them (Ellefsen, Kim, & Ja Han, 2007). Clarke (2004) encourages PHNs to make their embeddedness and situatedness visible arguing that policy makers who lack knowledge of the complexities of their practice will compartmentalise and simplify their role. It is as if the field of public health nursing evades exposing itself (Neumann, 2007). This statement from Neumann (2007) was not only due to the fact that she was not given access to public health nursing consultations during her research project. It was also due to, what she felt was, the difficulty in exposing the core of public health nursing work. Systems that monitor and report public health nursing practice seem lacking.

General methodological considerations

Levinasian philosophy provides the foundations for my views on knowledge and ethics. Levinas places ethics as first philosophy (Levinas, 1969) implying that knowledge is secondary to, and always follows ethics (Aasland, 2007). It is not all knowledge that is criticised by Levinas, only our knowledge of persons (Levinas, 1993). For Levinas the foundation of justice is the ethical relationship with one Other (Beals, 2007). His philosophy acknowledges the limitations of scientific methods but recognises the importance of knowledge seeking activities in the service of others.

It can be pertinent to consider how my affiliation to the profession has affected the design, the aims and research questions, the empirical and analytical strategies as well as the interpretations and discussion. The choice of open design is indicative of my standpoint as a researcher who has a belief in an open approach to scientific studies. The open approach to the design and asking both insiders and outsiders was an attempt at alleviating issues of bias. I mentioned the possibility of “insider bias” in the introduction. Distance to one’s own actions and activities are a requirement for both reflection on, and the construction of knowledge on “insider” actions and activities (Kvernbekk, 2005). There are no clear boundary markers, (like number of years outside the profession) for defining whether I truly have the necessary distance to perceive the profession as an outsider. My interest in the profession provides the necessary commitment to carry out this research study. My knowledge of public health nursing allowed me to take into consideration what was going on and thus in the least invasive way participate at the consultations. My affiliation to the profession can also have created trust and been a door opener that allowed access to carry out the observational study and subsequent interviews. The greatest challenges lay in the empirical and analytical strategies as potential sources of error are many here, not only for a researcher with a former affiliation to the profession, but for all researchers. This will be discussed further under the next section “Trustworthiness of perceptions”. A questioning attitude in the discussion and in defining each studies limitations attempts to alleviate and elucidate possible issues of bias.

Genus perspective has not been delved into in this thesis. It can, however, have influenced the results that the majority of the participants in this research project are women. Levinas’ reference to women as Other was problematised by Irigaray (1985) as reducing the feminine

to sameness. Nerheim (1991) and Gilligan (1982) write that there is, however, such a thing as a woman's perspective on the world. Studies have shown that women have different attitudes to responsibility than men. According to Gilligan (2002) men are concerned about respecting others rights and expectations in moral questions; whereas women are more concerned about the contextual; about care and about responsibility. This can have influenced how the nurses in studies II view aspects of responsibility and on the importance of relational factors for nurses and services users in studies III and the respondents in study V. The tacit dimension of *doing* and *being* in the consultations in study III could have been discussed further from a gender perspective of nature, nurture and culture.

The research questions have determined the methods in this doctoral thesis. Both quantitative and qualitative approaches are used based on the assumption that there is a need for various types of knowledge in order to give a more extensive picture of the role and function of PHNs. Qualitative method is the principal method. The main epistemological position of the project is understanding public health nursing in a public health context.

The qualitative studies provide the theme of focus for the questionnaire study. Triangulation of methods is described as the use of multiple methods for data collection and interpretation (Malterud, 2003). Triangulation of results has helped me navigate and interpret the sea of data. Comparing and contrasting findings from the different studies has given a nuanced picture of the service. The different methods and perceptions of different respondent groups contribute to providing a multifaceted view and thus illuminating the field of public health nursing. The complexity and diversity of reality indicate that a combination of methods can add new perspectives to the phenomena being investigated, reflect the multiplicity of life and act as correctives to each other as no single approach can capture the whole complex reality of life (Foss & Ellefsen, 2002).

Foss and Ellefsen (2002) recommend that triangulation be viewed as an epistemological position in its own right and not as a mix of competing epistemological positions; and that research can benefit from an approach that entertains multiple theories, interpretations and explanations. The sample in the cross-sectional study is large; this does not however eliminate issues of validity and reliability. The researcher does not have access to each respondent in order to check the validity of each answer. The questionnaire provides a framework for examining perceptions of reality. Putting reality into existing frames of reference can limit

access to fundamental complexities of public health nursing practice. Combining frameworks can open up for ideas but I acknowledge the methodological limitations and complexities of capturing and portraying reality. The organisation that the PHN is part of could have been discussed to a greater degree. Environments not only affect service users, but also PHNs. If one wants to explain behaviour it is just as important to look at the system as it is to look at the individuals working there (Strong & Dingwall, 2001).

Metaphor: Disturbances along the way

The hopeful artist brimful of anticipation sits in a field of golden rape. Humming insects create no disturbance, merely reinforce the impressive scene. It takes a while to adjust the easel, create a palette and working space for the task ahead. The motif emerges on the canvas. Windy weather shakes the canvas and makes it difficult for the artist to sit still. The winds drop, calmness creates the possibility of renewed concentration. The buzzing insects fly closer now, sticking to the wet paint. The artist tries to remove these black spots, and in doing so damages more than he repairs. The invasion of these small bodies, creatures of nature serve as reminders that the real world creates disturbances that cannot be obliterated; yet must be dealt with.

Trustworthiness of perceptions

As the title suggests this thesis is based on perceptions. Perception incorporates seeing, hearing, understanding, insight and response. Science and philosophy have grappled with questions relating to how to gain access to a phenomenon as it is; a phenomenon as it presents itself to us, our ability to interpret what we see and our ability to express it. Perceptions of the world by different people will vary depending on their place in the landscape, the journey they have taken to get to that place, what, and how far they can see from where they stand and their ability to articulate it. Perceptions can also be influenced by the context and purpose of the interlocution; who the teller is (or strives to be interpreted as), who the listener is and the purpose of the dialogue. All these factors can create variations and different pictures of the reality being studied. As there is no factual truth (Levinas 1987), stories told will all have an element of truth. Do I see only what I want to see? Do the participants share only specific stories? I have strived for an open approach during the interviews and observations and

strived for a critical attitude in my interpretations in order to describe, clarify and elucidate these perceptions of public health nursing practice.

The persons who took part in the five studies shared their thoughts on aspects of public health nursing. My presuppositions influence the mode of study and the subsequent interpretations, just as the respondents' presuppositions influence their perceptions and interpretations of what they perceive. I worked as a public health nurse for a greater part of the period of change. This can have affected study I in the sense that it made it easier for me to merge my views with the nurses.

In study II the nurses share stories of their lived experience as PHNs and the ethical demands they face in their work. It can be argued that my lived experience of public health nursing can have contaminated the data. This is partly true. The phenomena of personal responsibility, boundaries, temporality, being alone; worry, fear and uncertainty and a sense of satisfaction that emerged from the study are life phenomena inherent in all ethical relationships. My life experience both inside and outside the profession as well as my scholarly schooling enables me to recognise and acknowledge the nurses' stories and render it possible for me to write about them. It is not as angels, but by virtue of our humanness that we are in a position to know and understand fellow humans (Levinas, 1993). Neumann's (2007) descriptions of the child health clinic do not coincide with my findings in study III. This can have to do with different cultural settings in different regions of Norway, or with our perceptions of the same as different. The forthcoming ethnographic study on observations will strive to describe and reflect on these issues.

The results in study III paint a positive picture of public health nursing as both parents and young people expressed unanimous satisfaction with the nurses' services. I am aware that this can be interpreted as bias and cast a dark cloud over the credibility of such positive findings. Issues of bias have been discussed in the methods section for study III. There is another issue that must be mentioned. As a researcher I must remain loyal to the empirical findings and cannot suppress positive perceptions in favour of creating and promoting the impression of a critical analytical researcher. It would be bias to ignore positive perceptions and undermine the voices of the participants.

In study IV, the decision makers were satisfied with the public health nursing service but saw the necessity of clearer boundaries for the nurses' competence and their involvement in certain cases. The participants in this study had varied experiences of the services. Can their perceptions be regarded as trustworthy? As there is no factual truth, perceptions can trump facts when it comes to how they recall their experiences with PHNs.

Bengtsson (2001) writes that we are both aware and unaware of what influences our perception of the world. Schutz and Luckmann (1989) explain how immediate situations transcend the present and are interpreted on a background of self experiences. Can the respondents' perceptions be regarded as trustworthy presentations of public health nursing? Participants in a research project will always have presuppositions; there can be no presupposition-less understanding. All the participants have experiences of public health nursing either as PHNs, collaborators, leaders or service users. The respondents lived experience influences their insight and their hindsight.

Lincoln and Guba (1985) refer to four specific criteria for trustworthiness in qualitative research: credibility, dependability, confirmability, and transferability. Credibility entails getting to know and understand the research context and in the researchers ability to show that she studied what she set out to. My familiarity with the profession and consciousness of adhering to ethical guidelines helped further issues of credibility. Dependability is achieved through detailed descriptions (transparency). I was very much aware that my past experience as a public health nurse could influence the interpretations. Astute questions from my mentor and subsequent discussions increased awareness of and loyalty to my position as researcher. Excerpts from the empirical data are presented in each study in order to give the reader direct access to the respondents' statements and in that way to make visible the author's point of departure. Description of the steps taken by the researcher is detailed for all studies. Confirmability entails accounting for methods and thoroughly discussing these. The detailed methods section, as well as using different sources of data and cross analysing these can increase credibility and confirmability. Transferability is about whether the findings are relevant in other settings. Generalisability holds little meaning for qualitative researchers (Creswell, 1998). In the qualitative studies the number of participants is small and the findings cannot be generalised in a statistical sense, but the results can be relevant in the study of PHNs both inside and outside Norway.

Each method has its strengths, but also its obvious limitations. These will be discussed further in the following paragraphs.

Towards understanding - a reflection on trustworthiness

The goal in research is not to convince but to promoting an understanding of findings and bring forth shortcomings (Wolcott, 1994). When reading up on issues relating to trustworthiness I found that I am not alone in using metaphors to help clarify methodological issues. Richardson (1994) resorts to a metaphorical description in order to explicate on issues of validity in research (Creswell, 2007, p. 199). Richardson's description of the multi-dimensions of a crystal illustrates the complexity of the prism of truth. Skjervheim (2003) differentiates between being convinced *achieving an understanding* and being persuaded *let oneself be talked round* (Martinsen, 2006). Both Wolcott and Skjervheim promote the importance of understanding. The aim of this thesis is not to persuade, but more, in a convincing way, to promote an understanding of my research into perceptions of the field of public health nursing. Wolcott (1994, 2002) is precise; only understanding matters. You want the reader to see what you see; in analysis you want the reader to know what you know and in interpretation you want them to understand what you think that you yourself have understood (Wolcott, 2002).

The trustworthiness of perceptions has been discussed as well as aspects of my preconceptions. The limitations for each individual study have been discussed in the methods section in order to allow the reader to judge if the results and subsequent discussion are grounded in the empirical data. The methodological section has strived for openness. Are the findings in this thesis credible? What will make them so? Richardson's crystal metaphor (Cresswell, 2007) is a reminder of the many facets of reality, just as Levinas' philosophy reminds us of our limited ability to interpret them. Life is inconsistent; it consists of confusion, contradiction, repetition, ironies and indecisions (Wolcott, 1994, p. 142). Wolcott's statement and Levinas' philosophy serve as reminders that there are always limitations to interpreting a complex reality.

The first four studies numbered I-IV reflect upon and interpret speech acts, and bodily actions within their context. Study V interprets numerical data that can give statistical descriptions and show associations between variables. Reliability and validity are important terms in assessing statistical studies. In essence the researcher must carry out the study in such a way that what is relevant to measure has been measured, and that the study has been carried out in a reliable way so that the results achieved are dependable.

It is however important to consider: if different methodological approaches give contradictory outcomes, which results should be considered valid? The finding of two realities in itself is an important outcome and indicates different, but not necessarily competing realities which can none the less give rise to new hypotheses and questions that could have otherwise been overlooked. The findings from the different studies, using different perspectives, have helped promote a deeper understanding of public health nursing practice.

Concerns with professionalization, interrelationships, competencies and other aspects of occupations share a history of limitations due to the conglomerate of concepts and the plethora of possible interpretations of these (Rawson, 1994). Despite the complexity of the topics covered in this thesis, certain aspects should, however, be noted for further focus and research.

Concluding remarks; practical and theoretical relevance of the thesis

The findings should be of interest to PHNs, nationally and internationally, their special interest group, their educators, as well as decision makers both locally and nationally. The findings point to practical and theoretical implications and indicate the necessity of further research in accordance with current and future public health needs. Studying perceptions of PHN practice has opened up for new understandings that can improve the theoretical and practical underpinnings of the public health nursing service and contribute to knowledge development in the field.

Practical implications

Can the nurses' lack of visibility have undesired outcomes and will a profession that is not visible have problems being heard when it tries to promote issues concerning child and family health? There is an increasing demand to promote evidence based public health nursing practice and to document steps taken and goals attained. The public health nurse's affiliation to medicine and her execution of measureable tasks can be seen as her prime contribution to public health. PHNs' health promotive caring role can easily be overlooked due to the tacit and ordinary everyday nature of many of the sessions. Even the nurses' role in more complex sessions at the clinic for young people and school nurses' office may not be voiced due to their tacit nature.

Dialogue is necessary, current reporting systems not only fall short in making visible the PHNs' role and daily function but also their public health purpose. It is necessary to make visible the public health connection between the PHNs' relationship based role and her community role. Reporting systems that allow for adequate descriptions of the PHNs' daily practice are necessary. Connecting macro and micro levels of practice through adequate reporting systems can bridge this gap. PHNs must report patterns in health and social challenges they meet at health clinics and school health services. These reports can help create a profile of the population and throw light on important public health issues.

Aspects of the public health nurses' relationship centred role require further study. The data from the observations study provides the basis for a forthcoming study on the subtleties of

public health nursing practice. It is apparent that local child health clinics are important for parents; the young people also acknowledge the importance of the school health services and clinic for the young people. Study III has shown the interconnectedness and dependency of these three services. Further studies should focus on the continuity and interdependence of public health nursing services.

Studies I, II and III have helped give an understanding of aspects of moral responsibility in public health nursing and the importance of ethical values for PHNs. These studies help to emphasise the primacy of the relationship to the one Other as a foundation for all other relationships.

If mode of description can influence how the service is understood, then nurses need to be aware of the importance of describing their work in terms that can elucidate their health promotive function, to decision makers and also to service users who feel that they are unable to live up to the PHNs' expectations. Study III showed that trust enabled the parents and young people to open up. Further studies are indicated on mechanisms that promote distrust and cause those in need of help to close up. The PHNs in study II worried about those they did not see, nor respond to, who may have needed their help. Further studies using snowballing techniques that gain access to parents who did not receive adequate help could complement this study.

Do attitudes to professionals need to be reassessed? PHNs are not only concerned with promoting their own special interests, being a respected profession and respecting their service users is important to them. Further research on professionalism and professionalization processes in public health nursing is indicated. Understanding how responsibility is experienced by public health workers is important if it affects the work they do. Decision makers need to be made aware of the responsibilities these nurses face. Further studies on boundaries for responsibility in public health nursing could throw light on the nurses' need for supervision and support within a complex public health practice. Genus perspective would also provide a relevant focus for further study.

Even though certain decision makers question the need for a universal service, they need to be made aware of research that shows that ordinary families need support. If decision makers

take local family health clinics for granted then the future development of these clinics could be threatened. It is important that public health nurses listen attentively, encourage feedback and respond to perceptions of their practice from others outside the profession; in order to improve the service they offer to their clients.

Collaboration was an important focus for nurses and decision makers. Compared with other factors influencing collaboration the questionnaire study showed that PHNs and their collaborators do not place leadership high on a list of important items in obtaining good collaborative relationships. Decision makers see the public health nursing leaders' important role in coordinating services at local health clinics and school health services. The role of public health nursing leaders in leading the profession and coordinating public health services requires further research.

Mental health professionals are those most missed in collaborative relationships. In order to give depth to this finding further qualitative studies on different professional cultures and organisational structures as well as availability and stability of mental health collaborators are indicated, in order to give the respondent groups the opportunity to elaborate on the concepts that were broached in the questionnaire study. Study V with its focus on collaboration has shown that there is an association between community size, time spent collaborating and frequency of meeting points. There are differences between how the different professional groups view certain issues relating to collaboration. Trust, respect and collaborative competence are important to the nurses and their collaborators. Case studies that focus on the development of public health nursing in local communities can provide valuable information on understanding present challenges in different sized Norwegian communities.

Theoretical relevance

The Levinasian philosophical foundation that this thesis is built on provides a novel theoretical framework from which to study aspects of moral responsibility in Norwegian public health nursing. Study II has contributed to creating an understanding of the theoretical and moral underpinnings of public health nursing practice by describing reflections on their responsibility in Levinasian terms. Levinas' philosophy sharpens the concept of *alterity* and not *sameness* as a point of departure for health promotive public health nursing activities. Bearing this in mind Levinasian ethics and the concept of trust/distrust in interpersonal

relationships would be an interesting concept for further study. The research has also contributed to an understanding of the concept of holism. The thesis has shown the relevance of philosophical enquiry to public health work and provides an incitement to pursue further studies on how Levinas' philosophy can contribute to developing a theory of health promotion.

The limitations of the concept of totality as well as issues of boundaries and visibility, brought forward in this study, have theoretical relevance for further studies. Reflections mined from the data on the public health nurses' approach, using existing theoretical models, has contributed to further development of two existing models for visualising the PHNs' services and her approach in established meetings at local child health clinics and school health services. The connection between the PHNs' relationship based role, reporting systems, and her community based role has relevance for further studies on public health nursing and public health. These findings have theoretical implications as they help illustrate where on the continuum of health - ill health PHNs provide health care services.

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