NEGOTIATING EXPECTATIONS: HOW COMMUNITY HEALTH NURSES CONCEPTUALIZE HEALTH PROMOTION IN THE CONTEXT OF THEIR PRACTICE

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in

THE FACULTY OF GRADUATE STUDIES
(Department of Educational Studies)
(Agent Education)

We accept this thesis as conforming to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

August 1997

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ABSTRACT

The theory and rhetoric of health promotion are proclaimed in academic circles, the policies are decreed by those in control of health service organizations, but little attention has been given to how the people expected to apply these ideas to social action are managing change. The purpose of this research was to generate an inductive theory of how community health nurses (CHNs) describe their conceptualizations of health promotion within the context of their practice. The initial research question was: how have CHNs transformed policy and management expectations into action at the messy, indeterminate place of clients and community? What have been their supports in this process? What have been the barriers?

The grounded theory, *negotiating expectations*, provides an explanation of how CHNs cope with the multiple and diverse demands they experience in the context of their practice as they implement health promotion. *Negotiating expectations* is the fulcrum process in the theory and *facilitating possibilities* describes how they conceptualize health promotion as a currently preferred facet of their practice. This theory provides a guide for implementation of any innovation in community health nursing. It also contributes to a better understanding of the dialectic of policy, implementation and adaptation.
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Introduction

Overview

Over the past ten years the health promotion movement in Canada has introduced a philosophy with new concepts, language, voices, and expectations intended to influence community health practice. This movement, termed the *new public health* (Robertson and Minkler, 1994), has created space for experts and others with new ideals to challenge the beliefs, assumptions and practices of traditional community health approaches. The theory and rhetoric of health promotion are proclaimed in academic circles, the policies are decreed by those in control of health service organizations, but little attention has been given to how the people implementing the theories and policies are managing change. This study explored how six community health nurses conceptualized the tenets, the practice, and defining characteristics of health promotion.

Through an inductive process, the participants described their conceptualizations of health promotion within the context of their practice. The initial research question was: how has the experience of implementing health promotion influenced the meaning perspectives of community health nurses (CHNs) in their nursing practice? The researcher asked: how have CHNs transformed policy and management expectations into action at the messy, indeterminate place of clients and community? What have been their supports in this process? What have been the barriers?

Grounded theory methodology has resulted in an inductive theory which contributes to a better understanding of policy development and more informed implementation with enhanced formal and informal continuing professional development systems.
Researcher's Story

I have been a CHN for 27 years and have been intimately involved in the conceptual and political struggles associated with the development of health promotion. During my years in community health, implementation of new programs has typically been assumed to be occurring once manuals and procedures were written and staff had attended workshops. But even when innovations are simply refinements of current practice, effective implementation (Ottoson and Green, 1987) requires time and a well conceived and effectively delivered process. The changes demanded by the new public health are broad and deep. Sometimes, the conceptual struggles occurred internally in the meaning perspectives of practice carried by myself and colleagues in the absence of organized support for continuing professional development. The ability of community health agencies to provide continuing professional development in this domain have been limited due to scarce resources and different priorities. At other times, the struggles have been external, located in the political arenas of management and power. Commitment to the principles of health promotion is fragile and tenuous.

As a manager, I assist and encourage CHNs to develop critical thinking skills and to learn from and with each other, their clients and communities. I am aware it is easy to expect my interpretation of my experience with the paradigm shift is consistent with others. I endeavoured to guard against that predilection. Interpretivist learning theory (Mezirow, 1990) guides us to focus on the personal constructs of each person we communicate with and not to assume there are common meanings even when the same language is used. Hence my interest in engaging with CHNs in describing and theorizing about how they have conceptualized the changes that have occurred, frequently in domains where they had little input or influence but which have significantly altered their work.
CHAPTER 1
Purpose and Method

Context and problem

Community health nursing practice in British Columbia and Canada continues to be profoundly affected by the adoption of health promotion as a central philosophy (Clarke, Beddome, and Whyte, 1993; Hayward, Ciliska, Mitchell, Thomas, Underwood and Rafael, 1993; Labonte, 1989; Millar, 1994). Health promotion has been featured in Canadian health care policy since the LaLonde report of 1974 and was reinforced by Achieving Health For All (Epp, 1986). Health promotion is increasingly viewed as the primary function of community health professionals. Previously, these professionals functioned with disease prevention and control and the primary goals.

Health promotion works with people not on them; it starts and ends with the local community; it is directed to the underlying as well as to the immediate causes of health; it balances concern with the individual and the environment; it emphasizes the positive dimensions of health; and it concerns and should involve all sectors of society and the environment (Nutbeam, 1986, p. 3).

The emphasis of health promotion is on community development, empowerment, and participatory action research directed towards ameliorating determinants of poor health. The term, new public health, refers to a shift from a functionalist medical to a critical social action model of health. Population health, a newer term introduced over the past two years, is adding to the variety and confusion of terminology and philosophy.

The practice standards for community health professionals, in particular, CHNs, have altered with the changing focus of community health. CHNs comprise approximately 80% of
all professionals working in community health. As the predominant group of professionals in this field, their practice has been a focus of attention by those responsible for introducing and managing the changes. The espoused role in health promotion is directed towards population health with CHNs in partnership with communities. Previously, CHNs assumed the role of the expert- solving problems for individuals and families within the context of the community. The alterations in their practice are based on a shift in world view or paradigm which requires a new way of viewing knowledge, power and resources. Therefore, it is reasonable to anticipate that changes in philosophy and policy, combined with the associated and expected changes in practice, have profoundly affected CHNs.

Traditionally, community health nursing has not been well addressed in nursing education or research (Hayward et al., 1993; Salmon, Riportella-Muller and Selby, 1991; Tappen, Sanchez-Murrell, Hopkins, Donovan, Dolan, and Moore, 1990) and now the basic tenets of the practice are also being called into question, usually by people of other disciplines (Hayward et al., 1993). CHNs are being challenged to defend their place at the centre of an evolving community health service. For some experienced CHNs, the fit is self evident; the new directions in community health are congruent with the guiding philosophy, aims and approaches of their practice. For others, the new expectations are confusing and conflict with current practice and beliefs (Chambers, Underwood, Halbert, Woodward, Heale and Isaacs, 1994; Clarke et al., 1993; Hills and Lindsey, 1994; Vancouver Health Department, 1995).

It is a challenge for community health management to delineate roles and articulate responsibilities and clarify how CHNs should meet these expectations (King, 1994). This is a challenge because the change in roles and expectations is profound. It is not a matter of learning new technology- it requires transformative learning for all involved. Transformative
learning, as described by Mezirow (1990), is "the process of learning through critical self-reflection, which results in the reformulation of a frame of reference to allow for a more inclusive, discriminating, and integrative understanding of one's experience" (p. xvi).

A compounding factor is the response from the community based organizations employing the CHNs. Management in these agencies is expected to vigorously adopt the philosophy of the health promotion movement and create organizational parameters for its implementation. Frequently, the understandings or assumptions and beliefs of this movement are at the rhetorical stage. Often, field staff are expected to put the philosophy into action at the practice level with questionable support (Labonte, 1994; Robertson and Minkler, 1994). Much attention has been given to the rhetoric of community health outcomes, proposals have been written and funded, sometimes with a barely veiled sense of competition between management at different work sites. CHNs who appear to have taken on the language and the espoused action are praised and given accolades (Shamansky, 1989).

Just as the data collection phase for this research was to begin in September, 1996, a new provincial Ministry for Children and Families was created. The new Ministry was formed by integrating programs of five ministries including Health. This alteration had the potential to create another paradigm shift in direction and mandate for CHNs and their local and regional management. The focus on health promotion so fervently fought for might be subsumed by the predominant political need to enforce child protection. The work context for CHNs could become even more ambiguous and hazardous.

Concurrent with the political dynamics in the workplace, and not necessarily in opposition with them, is shared governance or “pushing decision making down”. On the surface, these workplace approaches appear to be consistent with the philosophy of
empowerment embedded in the new public health. There appears to have been little, if any, attention paid to how these changes have affected the people expected to carry them out. These include the community health field staff and, for this study, CHNs.

Dramatic shifts in expectations for CHN practice and in the organizational structure have raised many questions. What meaning does this paradigm shift have for CHNs; for professional development, in defining and articulating effective practice, in orientation and program management? How have CHNs critically reflected on their practice, on their personal and professional values and beliefs in light of altered expectations due to implementation of health promotion? How can managers as mentors and educators help develop answers to these questions? How will CHNs alter their beliefs and practices if management changes direction?

This study was based on the assumption that many CHNs adopted beliefs and attitudes espoused by health promotion advocates and transformed them into flexible, responsive and empowering actions. A secondary premise was that the new public health paradigm requires appropriate professional support programs for CHNs. The primary purpose of this study was to generate a detailed description and theoretical analysis of conceptualizations of health promotion held by CHNs in the context of their practice. Secondly, it is expected that the theory generated through this study will provide a framework for continuing professional development and organizational support for implementing health promotion. The long term goal of this research was to support the vision of "Health for All".

Significance

The skilled health promotion practitioner requires the ability to synthesize widely disparate information in a seemingly indeterminate situation to develop plans for action
(Labonte, 1994). Plans need to be reassessed and modified daily, based on new variables and alterations in the environment. The developers of theory in academia and policy in health service agencies depend on the actual “doers” for implementation. To date, insufficient attention has been paid to integrating theory, policy and practice in the meaning perspectives of the CHN. I believe a dialectic relationship between practice and theory is important. We will make significant contributions to healthy communities when there is authentic collaboration with mutual respect between these two domains.

Through the data collected and analysed for this study, I intend to add to knowledge needed to develop a responsive continuing professional development program for CHNs. The research findings provide a theory that will assist management to meaningfully engage with field staff to explore assumptions embedded in health promotion.

**Conceptual Framework**

This study was inevitably framed from conception to completion by my personal constructs and assumptions. *Framing* (D. Pratt, lecture notes, February 1995) is the act of assigning meaning to a phenomenon. It shapes how we anticipate something (our expectations), perceive it (selectively attend to some part of it), conceptualize it (symbolically encode it), interpret it (assign significance), and then decide on a course of action. The impetus for the study arises from my awareness of potential disparities in power, expectations and values between policymakers, management, implementors and their communities; hence, the problem is situated in critical social theory.

The process used for the study shifts from critical theory to a more moderate approach. The framing of this study is anchored in interpretivism. In this paradigm, knowledge is socially constructed, negotiable through dialogue and context and is transient and fluid. This
paradigm is located in the domain of social balance and regulation (Burrell and Morgan, 1989).

The selected methodology, grounded theory, is located in a subset of interpretivism called symbolic interactionism. Symbolic interactionism originated in the 1920's with the Chicago School of Sociology (Bowers, 1988). Since then, it has developed into a general orientation concerned with understanding social phenomena through micro-analysis of human affairs. Grounded theory as articulated by Strauss and Corbin (1994) is situated in a branch called phenomenological interactionism (Burrell and Morgan, 1989). In this view of society, individual selves interpret their situation as a basis for action. Group or collective action is seen as consisting of an alignment of individual actions brought about by the individuals' interpreting or taking into account each other's actions. It seeks explanation within the realm of individual consciousness and subjectivity, within the frame of reference of the participant as opposed to the observer of the action. In symbolic interactionism, the social world is understood to be an emergent social process created by the individuals concerned. Social reality, insofar as it is recognized to have any existence outside the consciousness of any single individual, is regarded as being little more than a network of assumptions and intersubjectively shared meanings. Inquiry located in this paradigm is oriented towards understanding the subjectively created social world (Strauss and Corbin, 1994) as expressed by participants.

Action resulting from the outcome of this study may take place in the arena of critical social theory. I believe that if CHNs are to authentically engage in reflective practice and attempt to follow the principles of health promotion, they will inevitably challenge decision making bodies and management. I am hopeful that the theory generated through this study will contribute to a transformation of social and organizational reality through coordinated
action of enlightened actors. There is a risk in pursuing this route, but, if the goal of "Health for All" is to be realized, social and organizational change has to occur. It will not always be comfortable for those holding power.

Organization of the Thesis

Chapter One describes the phenomenon to be explored, its context and significance. The purpose is articulated with its associated methodology. The position of the researcher is clarified along with the associated conceptual framework. Chapter Two is a review of related research and relevant adult learning theories and concepts. These are organized by a discussion of concepts related to community health nursing practice. The topics for exploration are community health nursing practice, the health promotion movement, empowerment, and the policy-implementation connection. Adult learning theories of constructivism, situated and transformative learning are outlined, including a description of how they contribute to understanding paradigm shifts. This review was conducted to inform the research process. Chapter Three describes grounded theory and the research design for this study including sampling, data gathering and analysis methods. Validity and reliability as well as ethical considerations are discussed. Limitations of the study are articulated in this chapter. Chapter Four contains the findings of the research including an overview of the participants and their work as well as salient basic social processes. Chapter Five describes the dynamics of the substantive theory, negotiating expectations, and discusses implications for organizational response, implementation strategies and continuing professional development. Chapter Five concludes with a summary and recommendations for further research.
CHAPTER 2
NEW PUBLIC HEALTH

Introduction

The literature review has been structured around the elements of the research question, how do CHNs conceptualize health promotion in the context of their practice? Key concepts are community health nursing, health promotion, conceptual thinking, the context for practice and the notion of a community of practice.

Historical Review

Before reviewing the literature pertinent to the changing role of the community health nurse, it is helpful to describe the context for these changes. From the genesis of public health, CHNs have worked with allied health professionals and have been influenced by social, technological and political environments.

In Europe and North America, four distinct phases of public health have been identified over the last 150 years. The first began in the industrialized cities of Northern Europe in response to the appalling toll of death and disease among the working classes and those living in poverty. The primary focus of this movement was on improving housing, sanitation, and regulation of safe water and food. This first movement was gradually augmented by initiatives in the second phase in the 1950's aimed at personal preventive medical services such as immunization and family planning. As the medical model grew in emphasis and technical expertise, it subsumed the more general socio-environmental emphasis of the first and second phase.

By the 1970's the therapeutic era (the third phase) was increasingly being challenged. Health care costs were rising simultaneously with increasing demand for services. There was
and continues to be an ever improving technology for medical intervention. Illich (1975) spoke out for those questioning the ethics of modern medicine. He argued that modern medicine was more of the problem than the solution. Not only had it taken away from people the control over their bodies and health but was responsible for iatrogenic (medically induced) disease.

In 1974, *A New Perspective on the Health of Canadians* was released by the federal Minister of Health, Marc LaLonde. This document introduced the health field concept, identifying the importance of the balance between the individual and the environment in determining health status (LaLonde, 1974). This report signalled an intention to move the controlling power in the health field from the medical profession and biomedicine to a wider field (King, 1994).

In 1977, *Health for All By the Year 2000* was adopted by the World Health Organization [WHO, 1977] and, in 1978, WHO advocated for the concept of primary health care. Equity in distribution and accessibility of all primary health care programs (Hayward et al., 1993; King, 1994; Registered Nurses Association of British Columbia [RNABC], 1990) are key concepts.

In 1986, another Canadian government document marked the fourth phase. *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986) identified health promotion as a multifaceted intervention designed to reduce inequities, increase prevention and enhance coping. Jake Epp, the federal Minister of Health, endorsed the notion that health is a personal and societal responsibility. Provincial and local public health agencies in British Columbia embraced the tenets of the new public health. Recent documents reflect the change in emphasis and expectation (Millar, 1994; Strategic Plan, Vancouver Health Department, 1994;
Health Plan, Vancouver/Richmond Health Board, 1997).

In 1996, the Canadian Public Health Association reconfirmed its commitment to health promotion and published the document, *Action Statement for Health Promotion in Canada*. The purpose of this was to reaffirm the importance of health promotion, to expand the field to an understanding of population health and to provide guidelines for community action.

Health Promotion-Concepts and Strategies

**Health**

Over the past ten years the definition of health has evolved on four dimensions: 1) absolute versus relative; 2) subjective versus objective; 3) individual versus societal responsibility and 4) unidimensional versus holistic (King, 1994; RNABC, 1990; Nutbeam, 1986). In the 1970's, health was viewed as an absolute state that could be objectively measured by medical experts but, nevertheless, was the responsibility of the individual to achieve (Labonte, 1989). Today, the more common definition held by those working in the health promotion field is the definition in the Epp report, “Health is seen as a resource for everyday life, not the objective of living.... The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity” (1986).

This emerging construct emphasizes autonomy or ability of people to function effectively in their environment in partnership with health professionals on Health Promotion, (WHO, 1986). A healthy person is able to realize aspirations, to satisfy needs and cope with their environment. In this conceptualization, a person with terminal cancer can still be considered healthy.
Health Promotion

Health promotion is an emerging field with many facets including variances in the definitions of the term. Some commonly used definitions are:

Health promotion is any combination of educational, organizational, economic and environmental supports for actions conducive to health (Green and Kreuter, 1990).

Health promotion is the process of enabling people to increase control over, and to improve, their health (WHO, 1986).

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies, and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies (WHO, 1986).

There is no consensus among public health agencies, disciplines and researchers about a consistently held definition. Meanings and beliefs are constructed and reconstructed over time, place and action.

Strategies

Using these definitions, the health professional actively engages with the community to identify its health issues. The professionals work with community members to develop and implement strategies to address these issues in ways that make sense to the community. Health promotion involves many activities, including education, maintenance and protection, community and environmental development, research and healthy public policy (Ashton and Seymour 1988; King, 1994; Labonte, 1989). The emphasis is on community development, community empowerment, and participatory action research directed towards the improvement of social and economic conditions. "This dynamic interplay across time between
social and techno-economic innovation is a key feature of human development. Maintaining high levels of coping, competence, and health and well-being is essential for moving this dynamic in a positive rather than a negative direction” (Keating and Mustard, 1996).

Population Health

The term, population health, began to emerge in public health literature in 1994. The differentiation of meanings of health promotion and population health vary across locations, professionals and worksites.

Many are asking how population health and health promotion are related. Health promotion is commonly defined as a process for enabling people to take control over and improve their health. Population health is an approach that addresses the entire range of factors that determine health and, by so doing, affects the health of the entire population. Many people think that population health is no different from public health and community health. Others believe that it is new paradigm, while others believe that the concepts and principles of population health and health promotion are essentially the same (Hamilton, N. and Bhatti, T., 1996, p.1).

Implications for Community Health Nurses

History

Community health nursing has existed in Canada as a recognized profession since the late 1800's (Anderson and McFarlane, 1988; Hayward et al., 1993; Stanhope and Lancaster, 1993). It has two coexisting programs, one concerned with care of the sick at home and the other with prevention and protection. The second program is the focus of this study, although the impacts of the paradigm shift are also being experienced by the home care nurses. The first CHN was Florence Nightingale, whose model of health reflects the central
philosophy of the LaLonde report. In her model health was seen as a function of the interaction between nursing, the person and the environment. Nursing contributes, directly or indirectly, to the person's ability to regain or maintain health through management of the person's environment (Anderson and McFarlane, 1988; Stanhope and Lancaster, 1992). In the 1920's community health nursing was comprehensive health and illness care that embodied social reform and political involvement (Anderson and McFarlane, 1988). The CHN of that era was described as "one of the very greatest agents in the advancement of health, both individual and public, in this country" (Welch, 1920). This position of public credibility and influence was replaced by advances in medicine and gradually the role of the CHN was reduced to fragmented programs aimed at specific health concerns such as communicable disease.

The constriction of the role marked the beginnings of the "prevention" mandate so well known to the currently practising CHN. In British Columbia, the program is called Prevention. The prevention and protection mandate is based in the biomedical paradigm that stresses the expertise of professionals whose work concentrates on the avoidance or early detection and treatment of disease. In contrast, health promotion focuses on enhancement and encouragement of growth and development in full and equal partnership between the professional, the clients and their community (Pender, 1987).

Implementation of Health Promotion

The typical CHN in British Columbia received undergraduate and graduate education based on the biomedical model with overlays of nursing theories and models that directed the nurse's primary concern to people's experiences of health or healing (Hills and Lindsay, 1994; Stanhope and Lancaster, 1992). "The unique role of nursing is the nurse's ability to understand
people's situations from their perspective and to participate with them through a caring, informed relationship to promote healthy responses to life experiences" (Hills and Lindsay, 1994). With this approach, the social, political, and economic environments affecting the clients are considered merely background factors. In the new paradigm, the professionals and community members are collaborative change agents with the environments as the target of action.

Many experienced CHNs have become confused and frustrated by the alleged paradigm shift because they claim to be already practising in the new domain. The predicament is that, while the preferred strategies are neither new nor different from many approaches already familiar to CHNs (Hayward et al., 1993), the underlying philosophy is. That is, the emerging popularity of health promotion to define new directions in health care is not explained by its offer of an exclusive category of intervention. At the heart of health promotion is the idea of empowering those whose health is at issue. While some may assert that public health has always valued empowerment, the old model positioned the professional as expert. The call for a new approach to public health may be seen as just one expression of a call for new and different voices to be heard.

CHNs must, therefore, acquire a new understanding of their practice. This new understanding includes a conceptualization of health care as involving many sectors of the community other than health services, addressing community as more than an aggregate of individuals, and maximizing effectiveness through innovative methods such as action research (Alberta Health 1993; Hayward et al., 1993; Hills and Lindsay, 1994; RNABC, 1990).

Current Articulation of Community Health Nursing Practice

The responses to the new public health fall into two streams. The first concerns the
need for meticulous documentation of the effectiveness of CHNs' interventions in health
promotion. The second is the call for further education and research into the effectiveness of
nurses practising in this paradigm. These streams seem to be at odds with each other in that
the first seeks to prove that the abilities exist while the second calls for more education and
research to increase effectiveness. This tension points to a need for further clarification and
investigation.

**Effectiveness of Community Health Nursing Interventions.**

Alberta Health, the Registered Nurses' Association of British Columbia, and the
Quality of Nursing Worklife Research Unit in Ontario have published working papers over the
last seven years. The papers explore the role of community health nursing in relation to the
new public health and provide examples of work in action (Alberta Health, 1993; Hayward et
al., 1993; RNABC, 1990). Articles published in the United States have similar focuses. Deal
writes, "it is imperative that CHNs define their services and provide evidence supporting the
effectiveness of interventions they offer" (1993, p.315). Deal describes more than twenty
examples of such effective interventions. These articles and papers are an effort to
demonstrate that CHNs are a professional group able to perform effectively in the new public
health. Similarly, Baldwin (1995) writes," Community and public health nurses have been and
will continue to be at the forefront in implementing community health promotion" (p.161). In
the same article, however, she acknowledges that there is a significant gap between rhetoric
and practice.

**Call for Education and Research**

The more dominant theme is the call for education and research. While some CHNs
are quietly and competently practising the new public health, many more wonder if they are.
One of the reasons for the questioning is a lack of role definition. Although the concept feels "right", the scientific basis and theoretical foundations for directing nursing practice have yet to be made explicit (Clark et al., 1993). This is consistent with the observation of Hamilton and Bush (Ashton and Seymour, 1988) that, after a century of community health nursing, "a lack of clarity and relative paucity of theory development persist in this field of nursing." Similar pronouncements are echoed in the literature over and over again (King, 1994; McKnight and Vandover, 1994; Salmon et al., 1991).

CHNs are also seeking education and clarification of their role. A 1992 Ontario Health survey revealed that the roles most needing further preparation and clarification were community developer, policy formulator, researcher/evaluator, and resource manager/planner/coordinator. The Ontario CHNs stated they believed they were performing these roles but were unsure of the definition of expertise in this domain (Chambers et al., 1994). Similarly, a survey conducted by the Registered Nurses' Association of British Columbia in 1988 and 1989 found that CHNs as an aggregate could articulate a vision for their future in the new paradigm, while as individuals, they had only partially developed understandings (Clarke et al., 1993).

More recently, in Vancouver, CHNs were asked to describe their needs for education about community development (Vancouver Health Department, unpublished, 1995). The responses revealed a continuum of comfort and knowledge and a need for ongoing support to explore concepts underpinning community development. A few illustrative quotes from the survey are:

Personal growth/skill development in building trusting, positive, healthy group process. I think this is the key.
How does one keep the commitment to this process over the long term?

How can we bring in/ work on multi sectoral approach within health reform (pull in the determinants of health rather than focus on health services)?

Current Responses to these Expressed Needs

Review of the literature and public documents revealed a paucity of material directly focussing on the continuing education needs of CHNs. Six articles were located that speak to the need but none detail any methodology for doing so. None of the books addressing the continuing education needs of nurses dealt addressed the new public health. A detailed exploration of in service training and workshops available to CHNs in British Columbia over the last two years confirmed that there were approximately twenty opportunities for further education. However, these concentrated on the cognitive domain, not on the exploration of personal beliefs and attitudes. They were not planned explicitly for CHNs. It, therefore, seemed apparent that there was ample space to explore with CHNs their personal belief structures and philosophies in relation to health promotion and how they have been supported to transform the philosophy into action.

Salient Adult Learning Theories

Interpretivist Paradigm

The adult learning theories situated in the interpretivist paradigm are relevant to this research question. Constructivism, socially situated learning and transformative learning all speak to questions about how adults continue to learn and grow in their understanding and interpretation of their work and life. Constructivism has its roots in anthropology, philosophy and sociology. “The basic concern of constructivism is how people make sense of the perplexing variety and constantly changing texture of their experience” (Candy, 1981). The
underlying assumptions of this perspective are found in the following statement:

We know reality only by acting on it. This means that knowledge is neither a copy or a mirror of reality, but the forms of and content of knowledge are constructed by the one who experiences it. The active interaction between the individual and the environment is mediated by the cognitive structures of the individual (Nysted and Magnusson, 1982, p. 34).

Community of Practice

Socially situated learning moves beyond constructivism to articulate the influences the social environment places on the individual’s meaning schemes. It “explores the situated character of human understanding and communication. It takes as its focus the relationship between learning and the social situations in which it occurs” (Hanks, 1994, p. 14). Lave and Wenger applied the principles of situated learning in exploring how practice grounds learning and how novice practitioners learn the artistry of their new profession. They termed their theory, legitimate peripheral participation. “The central concept denotes the particular engagement of a learner who participates in the actual practice of an expert, but only to a limited degree and with limited responsibility for the ultimate product as whole” (Hanks, 1994, p. 14). Lave and Wenger furthered their exploration of apprenticeship to include an analysis of how a community of practice develops:

Thus we have begun to analyse the changing forms of participation and identity of persons who engage in sustained participation in a community of practice: from entrance as a newcomer, through becoming an old-timer with respect to new newcomers, to a point where those newcomers themselves become old-timers. Rather than a teacher/learner dyad, this points to a richly diverse field of essential actors and,
with it, other forms of participation (Lave and Wenger, 1994, p.56).

Health promotion is in its infancy as a community of practice and, therefore, this research study adds to the knowledge of how the players learn and mould their parts. It contributes answers to the questions: How is expertise defined? How is knowledge endorsed, transferred and transformed? Transformative learning, as defined by Mezirow is:

the emancipatory process of becoming critically aware of how and why the structure of psycho-cultural assumptions has come to constrain the way we see our selves and our relationships, reconstituting this structure to permit a more inclusive and discriminating integration of experience and acting upon these new understandings (1981, p.78).

This study assumes that CHNs will have moved through this process to a lesser or greater degree as they attempt to fully practice health promotion.

Definitions

The following definitions arise from the literature review:

1. **Community Health Nurse** - A nurse working in a community focussing on the promotion of health and prevention of disease and injuries.

2. **Field Staff** - Community health professionals of different disciplines who work directly with clients and communities.

3. **Health** - Health is seen as a resource for everyday life, not the objective of living.... The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity (Epp, 1986).

4. **Health Promotion** - Health promotion is the process of enabling people to increase control over, and to improve, their health (World Health Organization [WHO], 1986).
5. **Meaning Perspective** - The structure of assumptions that constitutes a frame of reference for interpreting the meaning of an experience (Mezirow, 1990, p.xvi).

6. **Transformative Learning** - The process of learning through critical self-reflection, which results in the reformulation of a meaning perspective to allow a more inclusive, discriminating, and integrative understanding of one's experience. Learning includes acting on these insights (Mezirow, 1990, p.xvi).

7. **Implementation** - Implementation is an iterative process in which ideas, expressed as policy, are transformed into behaviour expressed as social action (Ottoson and Green, 1987).

**Summary**

The literature review summarized in this chapter provides an overview of the history of public health as it pertains to the practice of community health nursing and health promotion. There has been sparse investigation of how CHNs are coping with implementing a new scope and direction for their practice, thus validating the need for this study. It has also explored, in a preliminary mode, a few of the more salient theories in adult education that may provide insight into the research findings and the resultant theory. Chapter Three delineates the research process for this study.
CHAPTER 3

RESEARCH PROCESS

Methodological Considerations

Theoretical Perspective

The qualitative research paradigm was selected for this study because it is congruent with the interpretivist theoretical perspective of the question. Qualitative research discovers how individuals make meaning of their world and their experiences with it and others (Marshall and Rossman, 1989). This perspective (Depoy and Gitlin, 1993) maintains that individuals create their own subjective realities and that knower, knowledge and the social, political and economic context are interrelated and interdependent. There is a continuum of research methods contained under the classification of qualitative research reflecting differences in purpose, degree of researcher involvement, and imposed structure and control.

Grounded theory was selected for this study because it directs the researcher to seek to understand how participants make sense of their environment. "Grounded theorists base their research on the assumption that people sharing common circumstances share a specific social psychological problem that is not necessarily articulated" (Hutchinson, 1994, p.185). The problem examined in this study is how have CHNs transformed policy and management expectations into action. What have been their supports in this process? What have been the barriers? The task of the researcher was to discover and conceptualize through interview, observation and reflection, how the participants made sense of their world.

The Research Process

The research process in grounded theory does not follow a linear path in the sequencing of its stages. The steps of problem identification, literature review, data gathering
and analysis occur coincidentally in a circular, repetitive fashion rather than in a discrete series of predetermined steps (Bowers, 1988).

**Subject Selection**

The typical unit of analysis in grounded theory (Chenitz and Swanson, 1986) is a cohort of individuals who appear to share a set of experiences. The design is structured from an emic perspective, focussing on the insider's or informant's way of understanding and interpreting that experience. Subject selection can be purposeful and opportunistic. There is no need to be random. Theoretical sampling is a fundamental strategy employed by qualitative researchers to ensure theoretical sensitivity. It directs the researcher to systematically seek multiple perspectives of the conceptualizations and phenomena under study (Strauss and Corbin, 1994). Theoretical sampling (Chenitz and Swanson, 1986) is continued until data from new participants is consistent or representative of the developing categories and their links. Sampling can be considered complete when no new information is offered to indicate the need for new codes or for the expansion of existing ones.

**Procedures**

**Subject Selection**

I sought the support of three local health departments to conduct the research with some of their staff during work time. All of these departments have been implementing health promotion over the last five years. I had to gain permission from management and make presentations at staff meetings. I left notices (see Appendix A, p.74) at each unit with my phone number. I sought CHNs who had been employed full time in the local area for at least five years for the initial interviewees. I believed that this cohort would provide a fairly consistent base for the initial interviews and data analysis. The response to my call for
participants was enthusiastic. Ten women called me within a week. Five initial participants representing three health departments were accepted on a first come basis. A sixth was selected from the remainder through the process of theoretical sampling.

Respect for confidentiality was discussed with the potential participants and, after consent (see Appendix B, p.75), with them individually. It is almost impossible to maintain anonymity in any health department office but I was diligent in ensuring that I did not divulge identities. The political domain was another problematic area. Management had provided education and consultant support to increase understanding and competence in health promotion. They were interested in discovering if field staff shared their perception of the value of this and, if so, of its usefulness. The purpose of this study was not to evaluate the effectiveness of their implementation strategies. Therefore, I ensured that the management for each department understood and agreed with the focus of this study. I also ensured that potential participants were aware of that understanding.

After the first interviews were completed with four of the original five participants, I recognized that there was consistency in the participants’ stories. Therefore, I sought another subject who might offer a different perspective. A novice CHN, recently graduated from a degree program, was on my wait list of participants. She presented the possibility of offering new information that contrasted with the meaning perspectives of the other participants because her education program focussed on the principles and practice of health promotion. By this stage of the data analysis, one of the emerging variables was the level of confidence in understanding the concepts of health promotion. She agreed bringing the final number of participants to six.
Interview Process

I met with the volunteers individually to outline the purpose and process of the study, answer any questions and obtain written informed consent as per the UBC ethics requirements. I requested two interviews of approximately 60 minutes with an option for a third group meeting with all willing participants. The interviews took place in locations offering privacy that were mutually agreeable. All participants elected to have the interviews in offices in their health department. The initial interviews lasted for an average of 90 minutes with a few being over 2 hours. The interviews were semi structured and encompassed the following queries:

1) Please describe your understanding of health promotion.
2) Have there been changes in your understanding of health promotion over the past five years? Tell me about those changes.
3) Please describe how you incorporate health promotion in your practice. Please give some examples.
4) What meaning does health promotion have for you in your day to day work as a community health nurse?
5) Is your approach to health promotion different from five years ago? How is it different?
6) If so, what has assisted you in making these shifts?
7) Have you experienced any obstacles in making these shifts? Please describe.
8) How do you think the current approach to health promotion has influenced your role as a CHN?
9) If the Ministry for Children and Families’ mandate alters your role in health promotion, how do you expect to respond?

The interviews were audio taped and notes taken with the permission of each participant. Following the first interview, the tapes were transcribed and preliminary analysis
started. The second interviews all took place within two weeks of the first. The purpose of the second interview was to seek clarification and explore the emerging themes from the tentative analysis. As the process proceeded and the interviews accumulated, the questions shifted, adjusting to themes that rose to the surface. Bowers (1988) suggests a strategy of emphasizing the participant's position as an expert. One approach used in the second interview was asking: Pretend that you are orienting a new CHN to health promotion at your place of practice. How would you proceed to assist the new staff member? I also asked each participant to select a case or concern where they had incorporated principles of health promotion. These case examples likely represented only a small part of their practice but were illustrative of a turning point with clients or with the professional. I offered a choice of a starting point such as a problem situation, an unexpected outcome, or a new situation that the CHN wanted to explore further. Incidents cited involved some future planning situation, situations from the past or those currently occurring.

The third interview was conducted as a focus group with five of the participants. This session occurred three months after individual interviews had been concluded. The purpose of this session was to share the emerging theory with its codes, categories and interrelationships and encouraged the participants to critique it. I assumed the role of learner and engaged in an interactive dialogue with participants about the relevance, validity and trustworthiness of the analysis to date. The two hour session was audio taped and transcribed. The participants supported the fledgling theory, added more stories and reflections to it and commented that it added to their personal understanding of their practice. The diagram of the theory was redesigned with their input.
Internal Validity

"Internal validity of qualitative designs is the degree to which the interpretations and concepts have mutual meaning between the participants and the researcher" (Schumacher and McMillan, 1993, p.391). In qualitative research, data collection relies on a mutual trust and transparency between the researcher and the participant. The researcher aims to listen to the participants' meanings and attempts to avoid hearing with a personal interpretation (Marshall and Rossman, 1989). The intent is to represent the participants' experience and world as authentically as possible. Interpretivists (Depoy and Gitlin, 1993) aim for authenticity through a variety of means: triangulation, or using three different methods of gathering data from each participant; sharing analysis in progress with participants and with the researcher’s peers for further clarification and reflection; using the participants' language as much as possible; and checking all assumptions with participants and peers.

Data collected (Depoy and Gitlin, 1993) needs to be available for analysis and has to be transparent, interviews are taped and transcribed, observations recorded at the time, and most information is shared with participants. I kept a journal and recorded my personal thoughts throughout the process. I did not share these two sources of data with the participants.

There are techniques (Marshall and Rossman, 1989) that increase the internal validity of grounded theory research. I used the following as described in the following section: accuracy and rigour in analysis, member checks, peer debriefing (maintaining confidentiality), reflexivity, transparency of researcher bias, assumptions, beliefs, and an audit trail.

Data Analysis

In grounded theory (Strauss and Corbin, 1994) the processes of literature review, subject selection, data collection, and data analysis are not linear but fluid and reflexive. Bowers
(1988) suggests that the researcher looks for the structural invariants of particular types of experience, the patterns, and submit these patterns to a colleague for review. In order to reach this point, I began to analyse the information and tentatively categorize it from the beginning of data collection. Fagerhaugh (1986) refers to this process as "contextualization," or the placement of data into a larger perspective. Immediately after each interview, I listened to the tape twice through, transcribed it and separated it into small pieces of data, each about two or three lines. I kept a log of the interviews with notes of my subjective and objective observations of the participants. I documented the process of my tentative hypothesizing and inductive thinking, "memoing" (Corbin, 1986).

**Basic Operational Strategies**

I followed the operational techniques described by Bowers (1988), Chenitz and Swanson (1986), and Strauss and Corbin (1994). First, I identified tentative, broad categories (level II codes) and coded information to these. I followed Swanson's (1986) advice to novice researchers and used the "6 C's" family of theoretical codes devised by Glaser. These are causes, contexts, contingencies, consequences, co-variances and conditions. I labelled large pieces of paper with these titles. The next step was repeated review and micro examination (level I codes) of the narrative. I copied each piece of data onto postit notes and placed these on one of the labelled large pieces of paper to attempt to understand the bigger picture or how the parts fit together to make a whole. Each piece of paper was a place to organize collections of seemingly related data. I moved these from one category to another until a noticeable pattern emerged. I classified these categories into taxonomies (level III codes) or theoretical constructs. I organized the initial constructs of "personal practice desires" and "evolving context" by time and interdependence. A pattern emerged connecting the CHNs' personal
practice desires with their context. A memo, dated January 29, 1997, states:

There is the CHN working with the community to meet their health goals. But, always at the back of her mind, is her awareness of the management and their expectations. Can she agree to meet with this group next week? Can she manage to find some money for childcare and food? What about her job share partner who doesn’t share her belief in working with groups? How can she ask her to cover the baby clinic so she can meet with this group? What strategies do these CHNs use to deal with these mixed messages?

I noticed that as the context became more supportive of their vision, they experienced increased job satisfaction or increased congruence with their personal beliefs and those of their context. Other constructs that began to emerge were power and autonomy, dimensions of time and credibility. Throughout this process, I was looking for ways to distinguish between similarities and differences in the information, using the constant comparative method (Depoy and Gitlin, 1993). Before the process was too established, and thus self fulfilling, I pulled back from the data and considered alternative ways of classifying it. One method I used to accomplish this was to search for the negative case, the pieces that were incongruent. I searched the interviews for the frequency of comments relating practice and context. I was unable to locate any examples where they were not linked. At this point, I had completed the first interviews with the initial participants and I listened to each again, paying attention to tone and quality of speech, noting areas of emphasis or increased intensity. Then I interviewed the sixth participant, the most recently graduated CHN. New data from this participant and all others confirmed the tentative categories and fitted the predicted behaviour and organizational patterns being defined.
Throughout this process, I sought peer review with my colleagues in my workplace and other health units. I shared the tentative categories and links to discover if they were congruent with others’ experiences. I also kept my journal and continued with literature surveillance to avoid premature closure.

Next, I began to search for integrating patterns across the categories, sub-categories and taxonomies. Two core categories were identified and named, facilitating possibilities and negotiating expectations. Facilitating possibilities embodied the idealized constructs of health promotion. Negotiating expectations described a social and political process that appeared to determine the nature and quality of facilitating possibilities. They gradually emerged as the basic social processes (BSP). A BSP (Fagerhaugh, 1986) is a gerund (“ing”) suggesting process over time. They recur frequently in the data and link the other categories and contexts. Once I identified them, the other pieces fell into place and the storyline made sense. The external and internal (personal) contexts were identified as key factors in determining the processes used in negotiating expectations and the consequences for facilitating possibilities.

Three months after all interviews were completed, a fledgling theory emerged. The linking category was negotiating expectations. It addressed the problem of how CHNs conceptualized health promotion in the context of their practice, it explained the variations in behaviour over time and it used the fewest number of constructs possible. I was still not certain how to organize the theory in its entirety.

At this point, I invited the participants to meet with me for the third interview in a group. As mentioned earlier, five of the six participants participated in a two hour session. This session was taped and subsequently transcribed. I brought all the data organized on large pieces of paper covered with myriads of postit notes, the transcripts and several explanatory
diagrams. I shared my analysis process with them and described the storyline of the tentative theory. We dialogued, critiqued the parts and the synthesis and searched for deeper or alternate meanings. They concurred with my proposition that negotiating expectations was the central process for them in their experience. They added dimensions to it and to several other categories. They assisted me in improving the linkages and the co-variances between the parts. We also discussed a section of the theory that I was not sure of, the consequences of an unsatisfactory outcome of negotiating expectations. They concurred with the three alternative consequences that had been generated from the data and assisted in adding dimensions to them.

Integration

The resultant theory meets the criteria for quality as defined by Chenitz and Swanson (1986). The codes fit the data and field of community health nursing practice. The theory answers the research question, provides meaningful explanation and prediction of and for behaviour. It is represented in a schematic as well as in written form. The participants and other practising CHNs recognize the constructs and their interrelationships. As the context for health promotion and community health nursing practice alters over time and with the players, the theory can be applied to these and tested for its validity and usefulness.

Limitations

This study has limitations. Most are based in qualities inherent in the interpretivist paradigm. All knowledge created is based on the mutual meaning making of the researcher, the thesis committee, and the participants within the context of time and place. Ultimately, the researcher's viewpoint defines the essence of the product. All efforts to enhance validity and authenticity, as described earlier, have been made to counteract this limitation. The
participants did volunteer to participate. It can be reasoned that they may be either more invested in health promotion or, perhaps, more cynical, than their colleagues who did not volunteer. Also, my role as researcher is merged with my ongoing role as a manager with an acknowledged affiliation with the principles of health promotion. While this relationship provides me with an insider's knowledge and insight, it is also a limitation. Stacey (personal communication, 1994) created the term, delusions of alliance, the predilection of an insider researcher to unconsciously assume that a common knowledge and belief structure exists between the researcher and the participants. I realized during the interview process that I did have a preconceived notion of how CHNs would respond to a potential threat to their practice as health promoters. I had postulated that CHNs who had been well supported in their workplace through clear and consistent management direction would be very firm in their conviction if the mandate altered. That assumption was challenged as I heard from interview to interview that the CHNs would balance their personal visions with that of the workplace and they would not be overly assertive.

I strove to be vigilant in searching for multiple perspectives and to seek alternate viewpoints and interpretations of the data. This vigilance started with participant selection, moved through the interviews and analysis and continues to the dissemination of the results. I intend to invite the participants to participate in any presentations of the theory or the study. I will also send them drafts of any journal articles that arise from this work to ensure that I am continuing to represent their stories as they were recounted to me at the time of the interviews.

Summary

Chapter Three describes the methodology used for this study to allow other researchers
to replicate the process. It begins with a description of the theoretical perspectives of qualitative research and grounded theory as the selected method. It proceeds to provide a review of the process used to select subjects, gather data and analyse the data. The ethical considerations, limitations, and efforts made to enhance the internal validity and authenticity of the findings are included. Chapter Four contains the findings.
CHAPTER 4

FINDINGS

Background

The Participants

The six participants shared many common characteristics. All were women in their 40's or early 50's who had been nurses for more than twenty years. All but one was born in Canada. Four of them received their degree in nursing in the 1970's, one in the 1980's and one in the early 1990's. Four had been CHNs in British Columbia for most of their career, one fourteen years and one for less than five. Two participants had held other jobs unrelated to nursing during their adult life. At the time of the research, three were working in a generalist role and three in health promotion designated functions for most of their practice. All were enthusiastic about the purpose of the study and stated that they appreciated the opportunity it offered them to reflect on their practice. “It is interesting to have time to reflect and to talk because we are doers.”

As the participants spoke of the changes in their practice, commonalities emerged. The first was their attitude towards change. They were aware that their practice had altered over the past five years and this did not concern them. These women were comfortable with change. In fact, they sought it. “I didn’t need to be brought in kicking and screaming.” They “intuitively believed that health care exerted too much control over the clients” but held these feelings privately. “I had to keep my holistic thinking hidden but now I am able to openly work with it.”

Another commonality was a sense of excitement tinted with urgency. They spoke of the present with passion, “The time is now.” “This is it, this is what I want to do.” “My mind
is flashing with ideas but you try to keep them under control because you’ve got more than enough to do.” There seemed to be a sense of the temporality or fragility of this phase, “if we give this away, there are other professionals ready and waiting to tell us what our role is.” “It is like walking on egg shells, maybe that’s not what you are supposed to be doing in a year.”

The third shared characteristic was the fit between the current expectations and the participants themselves. The CHNs spoke of their personal values of honesty and integrity and their commitment to health promotion. “If we are truly committed, then we can do it.” “This job right now very much coincides with my values as a person and a nurse and I can see the value in this kind of work. So this is a good fit, a good temperamental fit.” “I know in my heart that this is the right thing to do.” Simultaneously, they were clear about boundaries, “you have your own value system but you have to be open to appreciate where other people are coming from.”

They shared a connection with clients and communities and a comfort with the ambiguity inherent in health promotion as they conceptualized it. Associated with this connection was their affinity for autonomy for themselves and their clients. “Once you are out in the community, it tells you what is needed, you see the gaps and you get involved, then you see all the partners.” “I don’t have the solutions, but that’s okay.”

The enveloping characteristic was the contextualization of their practice. These women spoke of the embeddedness of their personal practice in a much larger and often inaccessible context. Their workplace, their nursing and other colleagues and the management were viewed as both influencing them and being influenced by them. Their community partners and clients were within their touch and often were more responsive. Beyond their range of influence but definitely holding power to influence them were the academic and
political powers.

**Their Work**

The nature of the participants' practice was congruent with their colleagues in any urban health department in British Columbia. They worked with CHNs and other health professionals in a loose team format with a nursing supervisor and a nursing manager between them and the director. Their work consisted of a wide range of responsibilities from visiting new mothers and infants, to baby clinics, daycare centres, school health, community committees and responding as required to communicable disease outbreaks. All health department management had been actively encouraging a practice and philosophy shift to health promotion. One had chosen to fully implement health promotion as the preferred practice strategy, while the others had chosen to allow CHNs to make the shift in their own style.

Two major events occurred during the course of the research that had an impact on the CHNs and their work. First, a provincially directed process of health care reorganization had been taking place for two years with all three health departments shifting the governance, budget and power base to a regional authority. At the time of the research, the change was at mid point resulting in increased ambiguity and instability.

The second event began in the spring prior to the interviews and reoccurred at the time of the third interview. A decision had been made by the Provincial Medical Health Officer to immunize all children from eighteen months to eighteen years of age within a three month period in the spring of 1996. All CHNs were required to significantly alter their practice during this time to achieve this goal. The goal was met with success and the CHNs returned to their relatively autonomous practice. In January 1997, a measles outbreak occurred at a local
university and the CHNs were pulled away from their work and redirected to immunize 30,000 students in a three week period. The target was met and was a success from an epidemiological perspective. The CHNs, on the other hand, found it frustrating because direct service, especially immunization, had been viewed as less important than community development work. Yet, they had been redirected to it without consultation.

Components of the Theory

**Basic Social Psychological Processes**

The original focus of interest for this research was how CHNs conceptualized health promotion in the midst of their practice. Managing their context emerged as the critical factor for them. The data analysis process led to the creation of two interdependent, iterative social processes (gerunds), *negotiating expectations* and *facilitating possibilities*, situated within a dynamic, developmental and political theory. *Negotiating expectations* is the fulcrum process in the theory and *facilitating possibilities* describes how they conceptualize health promotion as a currently preferred facet of their practice (see Figure 1, p.40).

**Negotiating Expectations**

This is a complex and sophisticated process of situated negotiation and renegotiation of meaning in the context of shifting action, ambiguity and paradox (see Figure 2, p. 56). It demands a knowledge of personal values and meaning perspectives, a willingness to listen to alternate interpretations and to persevere with conviction. Communication skills are paramount in this process. "I thought everyone thought like me— but you don’t know until you start talking to people." "As we [multi-agency committee] started to work together it became apparent that there was a lot of difference in goals, strategies, assumptions and philosophy. There was lots of tension." CHNs are more likely to manage this process when they are
skilled in listening, learning, modelling, negotiating and articulating their expectations. In the course of their practice, CHNs negotiate expectations simultaneously with different sets of colleagues, partners or clients. Occasionally, some of the players are the same people in a different context.

CHNs employ three groups of strategies to negotiate expectations. The initial strategy is monitoring. CHNs vigilantly scan their context to maintain their awareness of the current range of expectations. Reading literature, attending conferences, questioning, and listening are the usual methods they use. "They are always changing the definitions, I read as much as I can." "I learn from team members, I listen to their perspectives." "I try to stay up to date, knowing what others are doing, what's in."

The next level is clarifying expectations. They do this through dialogue and sharing meanings. "We discovered differences in our philosophies and had to acknowledge them." "We raised different questions and clarified expectations."

The last level is bargaining. "I asked if we could try my approach first, then theirs if mine didn't work." "We said, 'well, wait a minute, that's not how it was supposed to be', we had to sort out the rules again." This is the critical place for determining the outcome of negotiating expectations. If the CHN determines that the other players involved have more power or influence in the particular issue or arena under negotiation, then the CHN will determine the best action to take to preserve her ability to continue functioning in the work environment with all these partners. "Sometimes it's not worth it, I don't want to clash with existing expectations."

Similarly, there are three dimensions of the contextual influences contributing to negotiating expectations: clarity, consistency and congruity of expectations. The more these
are equally present in the expectations for the CHNs, the more likely it is that CHNs will be able to negotiate expectations and facilitate possibilities.

**Facilitating Possibilities**

CHNs conceptualize health promotion as a process of *facilitating possibilities*. “I want to change my title to facilitator of health.” “I don’t see myself making a decision on the direction of a group other than, hopefully, bringing them together so they can decide on their own directions.” “The ultimate goal is for these groups to be healthier, however they would define it.” “The process we use is enabling, empowering to figure out what their issues are.
Then we help them find resources, help them get partners, help them problem solve, help them find solutions and help them get the skills they need.”

Table 1

**Three Categories of Professional Qualities Required for Facilitating Possibilities**

<table>
<thead>
<tr>
<th>Category</th>
<th>Qualities</th>
</tr>
</thead>
</table>
| Commitment             | Endurance  
                        | Courage  
                        | Time  
                        | To action                                                                 |
| Competence             | Belief in peoples’ innate ability to seek health  
                        | Understanding of human motivation  
                        | Respect for alternate perspectives  
                        | Ability to hold a vision  
                        | Receptive to new information  
                        | Ability to learn in a variety of ways  
                        | Problem solving skills  
                        | Belief in social equity                                                                 |
| Conceptual skills      | Building and maintaining relationships with community partners  
                        | Listening to understand  
                        | Comfort with ambiguity  
                        | Networking, connecting  
                        | Respectful questioning                                                                 |
| Communication skills   | Group facilitation  
                        | Proposal writing  
                        | Applied research  
                        | Fund raising                                                                 |
| Organizational skills  | Self directed / autonomous  
                        | Faith in self and others  
                        | Learning through action  
                        | Risk taking  
                        | Legitimate CHN practice                                                                 |
| Confidence             |                                                                           |
Commitment. Commitment is demonstrated in several ways. CHNs facilitating possibilities have high levels of personal commitment to the process and their partners.

“I am committed to work without self gain.” “I know what it is like out there for clients and communities. I want to move my frustration to action.” “You have to work through conflict. It is healthy and progressive, in the long run, you can reach consensus.” “I was pulled off the project but continued anyway because I knew how important it was to the group.”

Commitment is also displayed through their concept of time.

“It is a slow process, I laid the seed, supported the participants, assisted writing the proposal, helped handle the money and advocated for the group.” “This is long term thing.” “It took a year of planning and preparation before we got to the real stuff.”

The level of commitment has dimensions of depth and endurance co-varying with the balancing factors present in the internal and external context surrounding the CHN.

Competence. CHNs identify many competencies required to successfully facilitate possibilities. These competencies can be sorted into three sections: (1) conceptual skills, (2) communication skills, (3) organizational skills. The following list highlights the skills with associated descriptors used by the participants.

(1) Conceptual skills:

I “promote whatever makes people get on with their life.”

“Discover differences in philosophies, differences in opinions.”
“Learn by doing, use current practice as is, make the links to new knowledge.” “I like to learn through stories, seek alternate ways to communicate.” “Look beyond the immediate behaviour.” “Foster self care and community capacity.” “All humans strive to be healthy, they have to learn to take back the responsibility and sense of ability.” “Connect groups with less power to those with power.” “There are no walls in community health, there is no structure telling us what to do. Take the vision of health to the community, motivate people, find partners, offer to help, involve all sorts of people. It is just a matter of how creative we can be.”

(2) Communication skills:

“We use group development skills, monitoring peoples’ participation, and moving to increase participation.”

“Mobilizing communities for action”. “Linking other initiatives together.” “CHNs who have readiness to practice health promotion are keen, know the process, can share knowledge and are willing to hang in for the long haul.” “Reach out to clients, communities with respect, don’t want to alienate them.” “Help people develop the skills so they can advocate for themselves.” “Share the work, the vision. Ask who else is doing it? Who else can do it?” “Demonstrate mutuality with clients, groups, share stories, be human.” “Share our strengths, give
credit to each other, share ideas.”

(3) Organizational skills:

“You have to set reasonable time lines, lay stepping stones, keep the vision ahead of you.” “I took on other issues because they were there.” “We have more support for evaluation now, that’s important.” “I am chairing committees, doing minutes, delegating.” “I never just do my regular routine, always seek change.”

The concept of expert in this arena of practice is defined by the ability to be an excellent facilitator of process. One CHN stated, “as health promoters, we take responsibility with the community but not the control.” We are agents for change.” Another said, “we offer new information, new possibilities.” It is crucial to measure the quality of relationships, numbers of partners and how participants rated the relevance of the process. Other appropriate measures are increases in community control, community knowledge and decreased dependency on services.

Confidence. The third category involved in facilitating possibilities is confidence. CHNs require confidence in their ability to carry out this process especially because the results are long term and tenuous. Confidence is developed through action and reflection after action. Learning through doing and role modelling are viewed as the best ways to improve abilities in this process. CHNs rely on developing shared meaning with colleagues and partners to reinforce their confidence that they are on the right track. Risk taking is associated with confidence. One declared, “I’m willing to step on water that has never been walked on. I can ask for something that has never been asked for. I will go to places in the community that are
not usually visited by nurses.” Another facet of confidence is the conviction that this is appropriate work for CHNs. “Nursing is moving in the right direction. As long as we know what we want to do and what the community wants, then we can just go out there and do it with them.” “I have faith that this will lead to something better because I have done something similar before.”

Outcomes. When CHNs are fully engaged in facilitating possibilities, they use words such excitement, energy, passion, purpose. “This is the most rewarding work I have ever done.” They can see the difference it makes for clients, communities and partners. It is a more efficient and effective use of their time. They can work with groups of people with similar concerns and assist these people to develop their own support structure. “My assumption is that if people are connected, they are healthier and better resourced.” “They just took off, it was wonderful.”

Other outcomes are that CHNs make more demands on their own system and recognize that there is much more they could be doing. “We need support for research and evaluation.” “What about policy? We don’t do much in that area yet.” Sometimes, CHNs have to deal with unexpected outcomes. The community they have worked with has learned to advocate against the community health system. “You can create monsters!”

Basic Social Structures

CHNs practice in a context comprised of external and internal spheres of influence or social structures. Some are remote and CHNs may not be immediately aware of the impact these have on her work. Others surround her on a daily basis and exert their influence subtly but surely. Each of these structures hold constructions of practice as displayed in the following table.
Table 2

Social Constructions of Practice Held by Basic Social Structures

<table>
<thead>
<tr>
<th>Basic Social Structures</th>
<th>Credibility of CHNs</th>
<th>Best practice of community health</th>
<th>Definition of community health status</th>
<th>Evaluation norms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political/academic sphere</td>
<td>Are CHNs the right people to do health promotion?</td>
<td>Is health promotion considered best practice for CHNs?</td>
<td>Does a community participate in defining its goals for health?</td>
<td>Is qualitative research considered valid?</td>
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<td>Personal sphere</td>
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<td>Does a community participate in defining its goals for health?</td>
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Political/Academic Sphere

This sphere has an impact on all others but is the most remote from field staff. Alterations in philosophy and epistemology are generated in this sphere and often take a decade to reach the field. The CHNs referred to this influence as a support and confirmation for their present practice. “I’m very aware of Jake Epp’s and LaLonde’s models of health. I always found them exciting.” “The literature is supportive of this work.” Measuring the current status of political/academic support for health promotion is a monitoring function of field staff. This sphere has the potential to alienate field staff.
“That’s the trouble with these mind numbing phrases. Population health, what does that mean? These phrases come, I don’t know where they come from. They’re brought down and say we are going to do population health now and we know what that means up here but you people who are supposed to be doing it, maybe we should talk about what it means to you.”

Community Sphere

The nature of community health nursing demands an interdependent relationship between the CHN, clients and the community. The clients, residents and members of community agencies exert a strong influence on community health nursing practice. The extent to which community partners and residents understand and accept the tenets of health promotion is an important factor for CHNs. Sometimes the climate is supportive and other times it isn’t. “The community climate is right, corporate partners want to be involved.” “Medical model is still out there and people just expect service.” “The community groups had different expectations than we did, we had to work through that before we could proceed.”

Workplace Sphere

The extent of support for health promotion as exhibited through policy, action and culture is a key factor for field staff. Management and colleagues can be powerful allies or serious deterents.

Management at the level of practice is a crucial determinant. Consistency and clarity of expectations are pivotal for field staff to move through negotiating expectations to facilitating possibilities quickly. The scale moves from vaguely supportive to consistently demanding. All participants agreed that “management has the power to
change your direction.” Other observations were “we have encouragement for doing health promotion but still have to do regular work on top of everything. Others just do the regular work.” “We weren’t relieved from our work so much as we were told to start from scratch. Here’s your population, what are you going to do? Don’t start any program until you can justify it.” Participants believed effective managers are clear about decision making levels, are responsive to staff learning needs, and are mentors and “cheer leaders.” At one site, “all meetings were centred around the new direction.” They brought in literature and anyone who was speaking the party line.”

The nature of the management/worker relationship is another factor. The more available the management is for sharing meaning, the more likely the CHN is to be able to facilitate possibilities with confidence. “Management needs to be in a team with staff, be in a dialogue, come to consensus, let them run with their ideas, staff flourishes.”

The nature of the workplace learning culture is another factor. The more continuous learning is valued and encouraged, the more likely practice will flourish. Learning is an integral and inseparable aspect of a generative social world. One CHN stated, “you have to keep the policy framework in mind, this is the direction they want you to go, respect that, but create your own ideas to go with it. Hear, listen to it, they are not stopping you.”

Colleagues are key players in negotiating expectations. This sphere contains a range of support levels. When most or all are aligned with the language and philosophy of health promotion, there is a mutuality and respect. “Colleagues give each other lots of pats on the back.” “This is a positive environment to work in.” “We need the team to share work, share ideas, share skills.” “My work is backed by my management and my
colleagues. They tend to validate my work along the way.” When those who practice health promotion are in the minority, they are “seen as weird”, according to one CHN. Another said, “you have to be very careful, don’t talk too much about your projects.” You can’t ask them to help out with workload. I have to do my regular work and try to fit in the as best I can.” Another commented, “after a while you know who you can talk to and who you can’t.” One summarized her bargaining strategy this way, “I manage the tensions, negotiate the differences without upsetting the others.” A CHN who worked in a health promotion team was very aware that colleagues outside the team were not supportive, “We had to be very careful because we were conscious of the resentment. We tried to be low key.”

Personal Sphere

The participants displayed a strong personal commitment to and an understanding of the tenets of health promotion. They described colleagues who did not and who appeared to be less willing to “jump through all these hurdles for something they don’t understand.” Strength and willingness to persevere is a key factor in facilitating possibilities when other spheres were not as supportive. As one interviewee said, “do your job as well as you can for your community, negotiate for what is right.” When there are obstacles or controversy, these CHNs “react, then moderate and then continue the journey, the vision.” They mediate between the system and their personal beliefs. They ask themselves, “how am I going to get around this?” Autonomy is a foundation for these CHNs to practice health promotion. “I don’t have to see the manager.” “I set my own direction.” “If management can’t provide the resources, then I seek them in the community.” “We are self directed here.”
Comfort with ambiguity and faith that the process will result in positive outcomes is another facet. One CHN said, "I have to have faith that this will make a difference."

Another declared, "if I don't do this, then I will be totally frustrated. I have to do my work this way."

**Social Constructions of Practice**

Every community of professional practice has a set of generally accepted social constructions defining the nature and purpose of its efforts, its epistemology and ontology, and the requirements for membership. Health promotion is a new community of practice and the social constructions of it are variable and inconsistent. Four constructions are fundamental to shaping expectations of CHNs in the practice of health promotion.

**Credibility of CHNs**

Many professions claim to have membership in the health promotion community. Social workers, community planners, physicians, and recreation therapists are only a few. The credibility of CHNs as practitioners of health promotion varies over time and context. Sometimes, they are fully recognized as the most credible and at other times, alternate practitioners may be viewed as more appropriate than CHNs. The process of negotiating expectations is expedited when the spheres of influence support CHNs in this function.

"We bring a proactive model to the table and more community based, developmental skills to the team, but I don't know if that's our role." Mixed messages and lack of clarity in role definition results in increased time and energy interpreting and clarifying expectations.

**Best Practice of Community Health Nursing**

This refers to the extent to which health promotion is linked with best practice for community health nursing by any of the spheres of influence. Health promotion may be
viewed as the predominant role or as an adjunct activity when other priorities are not pressing. In one workplace, “the message kept coming through...this should be the main part of your work.” A CHN in another said, “I feel sad that certain people refuse these assignments.” Still another commented, “it is this grey area, you know you feel right there, the community wants you there, just keep telling yourself this is ok.”

Definition of Community Health Status

This refers to the extent to which the endorsed goals for the health of any given community are congruent with those of health promotion. If mortality and morbidity statistics are predominant and service levels most important, it is a challenge to involve key partners in community development activities. One CHN stated, “they [hospital partners] define health promotion as pamphlets and education events. They don’t see that this process is better.” If the community does not expect more than service, the CHNs have to alter those expectations through education before they can proceed to facilitating possibilities. “I try to work with people’s definition of health and assist them to broaden it. I don’t want to clash with existing expectations, but move along with them to a new way of figuring things out together.”

Evaluation Norms

This refers to the extent to which the measurements or criteria for success are congruent with those of health promotion. Measuring the quality of relationships is important in facilitating possibilities, but if the norm is reduction in hospital bed usage, then the process of negotiating expectations interferes with facilitating possibilities. One CHN expressed her frustration about the lack of clarity, “we need more evaluation supports, how do we know we are making a difference? They expect numbers and quick
changes. We can’t produce that.” Another commented on the lack of congruence, “I didn’t want to be a square peg in a round hole.”

Contingencies, Resources, Power, and Consequences

**Contingencies**

As the CHN moves through time, events will occur in and out of her control. These may create alterations in any of the spheres of influence or constructions of practice resulting in a change in expectations. The CHN must revisit the understandings she has with any of her partners, colleagues, clients or management to renegotiate expectations. Community members change, other agencies get the grant you were aiming for, your colleague moves. The measles campaign mentioned earlier is an example of a contingency.

**Resources**

CHNs require access to resources to effectively practice health promotion. They need to be able to have partners and consultants. They need to able to secure funds for a variety of community endeavours. They need to meet with colleagues and mentors to share new information and knowledge and they must be able to work autonomously. Time was another resource frequently mentioned by all participants. They needed time for health promotion activities, respect for the length of time required for effective work in health promotion. They identified the importance of timeliness, the need to wait for other partners or clients to be ready before they could work with them in *facilitating possibilities*.

**Power**

Power in many guises is an underlying theme throughout this theory. Power to act, power to change direction, power to influence groups. There is a continuum of comfort
with this concept. “You have to come to terms with the dark side. You do have the power
to do things without anyone knowing. You can make people do things that they may not
want to do.” “...you have the ability to choose what to take and what to ignore. That is a
big responsibility.” The power of professionals when working with community members
needs to be acknowledged by the CHNs and monitored. Power and autonomy are linked.
“I should be responsible for my own actions, be accountable for my actions.” The notion
of power balance is most apparent in the arena of negotiating expectations. CHNs will act
with overt power when they assess that most factors are supportive of their preferred
direction. I “...feel angry if power is taken away. We said, ‘wait a minute, that’s not what
we agreed.’ We went to management and rechecked our understandings.” However, when
they assess that the spheres of influence are not in alignment with their position, they
choose to use covert power. “They can change the direction but I can still be an
autonomous thinker.” “I could not go back to prescriptive work unless they can show me
tons of research and a fun way to do it.”

Consequences

When a CHN decides that she can not successfully work through the process of
negotiating expectations, she adjusts and moves to the coping strategies of moderation,
adaptation and submersion. The preferred option is to moderate. In moderation, the CHN
performs the work expected of her while continuing to quietly but firmly sell health
promotion as a preferred practice to her colleagues, the management and the community.
A less preferred option is adaption. The CHN relinquishes her engagement with health
promotion, adopts the language and culture of the workplace or community while
attempting to facilitate possibilities quietly whenever possible. One CHN openly shared
her adaptation strategy. "Even though mandates change, our philosophy won't change. Just use their lingo but that doesn't mean the same thing isn't happening." The third option, and least preferred, is submersion. In this process, the CHN transfers her personal values and energy to activities outside her place of employment. At work she meets the minimal acceptable standards of practice. Submersion also occurs when the other spheres of influence support health promotion but the CHN herself does not understand it or believe in its value. A CHN commented that these CHNs "just do their work and no more."

Summary

Chapter Four has described the research findings. It has provided an overview of the participants and their work. It introduced and defined the basic social processes of negotiating expectations, the fulcrum of the theory, and facilitating possibilities, how CHNs conceive health promotion. It introduced the basic social structures and the social constructions that influence CHN practice. It describes the dimensions of clarity, congruence and consistency that affect the ability to negotiate expectations. It describes the consequences of moving through negotiating expectations, engagement when successful, moderation, adaptation or submersion when not successful. Chapter Five describes the integration of these components.
CHAPTER 5
NEGOTIATING EXPECTATIONS

Answering the Questions

The purpose of this study was to seek answers to the following questions. How do CHNs conceptualize health promotion in the context of their practice? How has the experience of implementing health promotion influenced the meaning perspectives of community health nurses (CHNs) in their nursing practice? How have CHNs transformed policy and management expectations into action? What have been their supports in this process? What have been the barriers? How is expertise defined? How is knowledge developed, transferred and transformed?

The theory, negotiating expectations, (illustrated in figure 2, page 56) provides an explanation of how CHNs cope with multiple and diverse demands they experience in the context of their practice. The original focus of interest for this research was how CHNs conceptualized health promotion in the context of their practice. Managing their context emerged as the critical factor for them. The resultant theory provides a guide for implementation of any innovation in community health nursing including health promotion as the currently preferred direction for their practice. However, practice changes and it is conceivable that the preferred direction for public health may alter from health promotion to another as yet not apparent philosophy.

The core category, negotiating expectations, formed the basis for the generation of the theory. The other categories, properties, phases and dimensions all relate to each other via this core category.

Negotiating expectations occurs within a shifting context of four spheres of
Figure 2 Schematic portraying the dynamic relationship between negotiating expectations and facilitating possibilities.
influence, political/academic, community, workplace, and personal. A varying portion of attention is devoted to interpreting and managing the expectations of these spheres.

Social constructions of practice held by each of these spheres are credibility of CHNs, definition of best practice for community health nursing, definition of community health status, and evaluation norms. CHNs engage in an iterative, intuitive process of interpreting and managing these expectations. They can dissipate much time and mental energy in this process. That isn’t what they really want to be doing but it has to be dealt with so they can do their currently preferred work, *facilitating possibilities*.

*Facilitating possibilities* embodies values, principles and attitudes commonly held by most health professionals, academics and policymakers. In action, it requires the CHN to work with clients and communities as they broaden their understanding of health and its meaning to them. In this way, most things can be done in a health promoting way if the defining attributes of collaboration, participation, equity and empowerment are taken into account. Inevitably, it leads to an altered definition of expert and social action at the community and policy level.

These processes occur concurrently in a melange of players, communities and “truths” over time. CHNs have developed sophisticated and integrated methods for assessing and interpreting the status of the blend as they proceed with their work. At any point, a CHN may be experiencing and managing all these processes to a lesser or greater degree depending on the piece of work she is engaged in. “When you go into those kind of situations, the expectations are not clearly laid out, so you are on your own.” Michael Lipsky identified similar demands made of government workers.

Confronted with resource inadequacies and threats which increase the salience of
work-related results, street-level bureaucrats often find their difficulties exacerbated by uncertainties concerning the expectations of performance. Role expectations may be framed by peers, by bureaucratic reference groups, or by public expectations in general. One way street-level bureaucrats may resolve job-related problems without internal conflict is to drift to a position consistent with dominant role expectations. This resolution is denied bureaucrats working under conflicting role expectations (1970, p.394).

The strategies used in *negotiating expectations*, monitoring, clarifying and bargaining illustrate a proactive, assertive approach to managing conflicting expectations.

Power imbalance is inherent in this theory. As one participant said, the CHN has the personal power to "think autonomously and act surreptitiously", but the other spheres have the predominant power to determine her ability to successfully *facilitate possibilities*. The less time they have to spend in *negotiating expectations*, the more energy and time they have to devote to *facilitating possibilities*. As the congruence in expectations increases, the more time and resources they have available to devote to *facilitating possibilities* resulting in higher job satisfaction.

The process of *facilitating possibilities* incorporates three intertwined and complex sets of skills and attributes: a) commitment, b) confidence, and c) competence. These three have an iterative relationship with the spheres of influence and the social constructions of practice. For example, the level of commitment of the workplace to health promotion demonstrated through organizational policies has a direct effect on the CHNs' ability to *facilitate possibilities*. Another example is the level of confidence the CHNs have in their ability to work through the ambiguous and lengthy processes with
their communities.

When the process of *facilitating possibilities* is successful, individuals experience excitement, enthusiasm and energy. Expertise or competence is defined as the ability to assist and support clients and communities to find their own voice, to advocate for their desired outcomes and to support itself. In short, the role of the CHN is to empower those she works with. “If I do my role well, no one knows I have done it.”

If during the process of *negotiating expectations*, the CHN concludes that the influences of the external environments are weighted against health promotion, she adjusts her internal expectations as well. CHNs have three options for coping in this situation, moderation, adaptation and submersion.

**Discussion**

**Power, Politics and Critical Theory**

Vaill (1989) used the image of *permanent whitewater* to describe the environment of chaotic change we live and work in. “Things are not going to settle down. New values are not going to become established to replace old values. Technologies are not going to shake down. We are not going to descend on the learning curve to a mode where we are smoothly performing whatever the new activity is” (Vaill, 1989, p.28). *Negotiating expectations*, provides a potential framework for guiding CHNs through the maze of power, politics, and hegemony lurking in the domain of health promotion and social action.

**Power**

Power emerged as an underlying, pervasive theme. The CHNs were uncomfortable with their use of it and, yet, power to act and negotiate is a key factor in successfully
negotiating expectations and facilitating possibilities. One CHN commented that she doesn’t like to think about power because it is so negative. Other research has pointed to the ambivalent relationship community health nurses have with power. “A recent study of public health nurses’ perceptions of the power and the powerlessness they experienced in their work found serendipitiously that the participants often expressed discomfort with the idea of power (Rafael, 1996, p.3).” When encouraged, the CHNs in this study acknowledged they did use personal and professional power at times, but they were distinctly uncomfortable with this. Somehow it was linked in their mental models with oppression or abuse of their position.

Power is neither good nor evil. It is simply the capacity to influence other peoples’ behaviour. Power (French and Raven, 1959) is the ability to mobilize resources, to get and use whatever is needed for the goals a person or group is attempting to reach. Being naive or reluctant to use power has negative effects on negotiating expectations, especially in the unexpected contingency category. One of the CHNs recounted her experience with what she named “first blood.” She had been working with a community group for over a year to plan and organize services with full assurance that the endeavour was supported and valued by the powerbrokers. However, the status of the existing powerbrokers altered, new ones emerged and the committee was unilaterally disbanded. The CHN describes the personal learning that took place over the experience and how she is more alert in monitoring the state of the powerbrokers as she proceeds in her goal to facilitate possibilities. Unexpected contingencies will continue but this CHN has honed her monitoring and clarifying skills to be better situated to assist herself and her allies to deal with them.
Politics

Politics are also neither good nor evil. They exist wherever there are people with different goals, values and needs. Politics is power in action or the process of acquiring and using power. Politics consists of intentional, self-interested, and non-consensual activities of group members. Politics can be explicit, hidden, or disguised. The process of health care reform sweeping Canada is attempting to alter fundamental beliefs and assumptions held by the public and the health professionals. “The barriers to reform [health] are not only that it threatens the privileges and interests of currently dominant groups, but also it is not supported by current ways of thinking about the relationship between medical care and health” (Lomas and Contandriopoulos, 1994, p.74).

Negotiating expectations names and relates the many different interest groups and interests that frame any and all actions of CHNs including their own. The actions of moderation and submersion speak to hidden ways to continue to work in a personally preferred fashion while keeping management happy.

Critical Theory

Critical theorists begin with the premise that all people are essentially bounded by limitations of understanding and perception and live in a world of social contradictions and asymmetries of power and privilege. Various theorists have postulated processes for assisting people to develop a more wise and critical view of the world and its actors, including themselves.

Habermas (Ewart, 1991) describes three kinds of knowledge. The first is instrumental, achieving task-related competencies. For CHNs, these are the familiar and varied nursing tasks. The second concerns interpersonal understanding. This domain is
concerned with dialogic learning, with gaining insight and understanding through communication and interaction. This learning domain is embedded in negotiating expectations. The third is labelled emancipatory by Habermas and transformative by Mezirow. “Perspective transformation involves not only becoming critically aware of habits of perception, thought and action but of the cultural assumptions governing the rules, roles, conventions and social expectations which dictate the way we see, think, feel, and act” (Mezirow, 1981, p.67). In this kind of learning, problems are addressed through critical reflection of how problems are defined and solutions generated.

*Negotiating expectations* and *facilitating possibilities* are meaning making in a social and political context. There is no concrete or stable truth but there is an ongoing series of understandings created amongst the players. Underlying *facilitating possibilities* is an enhanced and altered view of the world and its possibilities. In the process of *negotiating expectations*, the CHN transforms her set of understandings about her role as expert and emerges with a broader set of expectations for herself and her work. The challenge is moving players to a more astute and almost cynical perspective. Argyris and Schon (1978) labelled this the principle of “substantial rationality,” defined as the capacity for intelligent action based on reflective understanding of the nature of the system and its context. *Negotiating expectations* guides us to widen the span of the context and the system. Practitioners need encouragement and help to observe and question the consequences of their own actions and of the system in which they work. This will mean challenging values, norms, and policies at all levels.

The measles outbreak of Spring 1997 created a stage for action of this type. One of the participants recounted with fervour her sense of betrayal by management. She had
been working for five years in a workplace culture totally directed to health promotion allied with staff autonomy. Suddenly, the rules changed and she and her colleagues were told they had to drop all community activities and revert to providing immunizations for at least three weeks. After an emotional reaction to this turn of events, which Mezirow (1981) would label a “disorienting dilemma,” the CHN expressed a more worldly-wise view of the power relations in her workplace.

Implications

Negotiating expectations, provides a framework for continuing professional development and organizational support for effective implementation of health promotion. It also provides guidance for management if the preferred focus of practice were to alter from health promotion to another direction.

Implementation

Academics, politicians, and senior bureaucrats rely on field staff to understand and implement their theories and policies into effective action to meet their anticipated outcomes. The most effective work force is energetic, enthusiastic and engaged in this process. Negotiating expectations describes the process of implementation from the practitioner’s perspective. It demonstrates that if the spheres of influence and domains of practice are not in alignment with the desired outcomes, the CHNs will have to expend more energy in interpreting and monitoring expectations than carrying out the work itself. If this situation persists, then eventually, CHNs resort to coping strategies that further reduce their effectiveness in the workplace.

Professional Development

Management can apply the theory to the workplace through effective
organizational support and professional development structures and supports. First of all, middle managers can discuss the theory and seek to understand it in their context. They can then share their knowledge with first line supervisory staff and incorporate its tenets into practice. They can analyse the current status of the constructions of practice and spheres of influence with regards to health promotion and plan steps to ameliorate less supportive categories.

Management can be more involved in the practice domains of the CHNs. The theory guides them to seek to understand the realities of the communities and clients. CHNs can be engaged in this process of assessment and action. A culture that supports continuous learning can be fostered through establishing work teams and helping them learn reflective practice. Decision making processes can be explicit and open to negotiation. Self managed work teams flourish in this environment and support autonomy for practitioners. Key ingredients for success are clarity and consistency of expectations, open communication with management and access to necessary resources. In the course of *facilitating possibilities*, CHNs seek self-fulfillment on the job, authority and accountability and autonomy. They require sufficient power to access information, secure funding and control their time.

Orientation and professional development can be enhanced through the application of this theory. Competent and confident CHNs can be supported to become mentors for newcomers. Their skills of adaptability, flexibility and transferability are best taught through an iterative process of co-participation in practice.

Some CHNs will have personal attributes congruent with the principles of health promotion and flourish in this environment. Others may be less willing to engage
themselves. The theory guides the supervisor to explore those personal values about the nature of work with the CHN. The goal is to enhance the likelihood that the CHN can learn to perform health promotion at least at the moderation level of the coping strategies.

Community of Practice

The theory is consistent with the notion of legitimate peripheral participation. Lave and Wenger (1994) describe the process of engaging new practitioners in a community of practice. A community of practice is a socio-cultural community with defined boundaries of membership, a unique language and articulated methods of knowledge production and replication. Community health nursing, as practised in the previous decades, is a community of practice, but health promotion is still developing as one. The process of negotiating expectations explains how CHNs work through a situation where they are novices in a community that is not yet well defined.

Mastery requires timing of actions related to changing circumstances and requires an ability to improvise. The CHNs describe a process of learning totally embedded within practice. Much of this learning takes place in their introspection about “performance events” (Lave and Wenger, 1994, p.53). Where possible, they seek compatible colleagues to assist in this process. Negotiating expectations explains how CHNs move from learning and listening, to action, to reflection, and dialogue in a continuous flow. Expertise and knowledge are not defined in this new arena. Norms for good practice and research are fluid and dependent upon the immediate context. Where possible, they seek compatible colleagues to assist in this process. Competencies are necessarily altered by this theory. The goal will be competencies in the arena of emancipatory learning, the art of negotiation and empowerment. The competencies outlined on pages 41 to 45 are also required.
Membership in this community of practice is not defined either. Does this belong to one profession or many? The participants in this study believed that health promotion was an entity of public health, but there are many other disciplines and organizations that would dispute that claim.

**Expert Practice**

The notion of expert practice alters with this theory. Through concept analysis (Jasper, 1994) expert practice is defined as a nurse who has developed the capacity for pattern recognition through high level knowledge and skill, and extensive experience in a specialist field, and who is defined as such by her peers. At this stage of development of health promotion, there are likely very few practitioners who can claim the title of expert. In this community of practice it is still unclear what is deemed as credible knowledge and who is considered the expert knower. CHNs would be well advised to take hold of this relatively virgin territory and begin to mark it through publishing, research and advocacy.

**Policy Changes**

*Negotiating expectations* is a politically balanced theory, linking notions of power balance, management and professional practice. It provides guidance in the situation where political forces or others outside the immediate workplace seek to alter the nature of the practice. A current example is the interface between the Ministry for Children and Families (MCF) and the Ministry of Health (MOH) in British Columbia. CHNs and the nature of their work is of great interest to each of these ministries. The rhetoric is similar but beneath the rhetoric are potentially conflicting expectations. When MCF uses the term health promotion in the context of CHN practice, the intent is to alter the behaviour of at risk families in order to reduce the need for child protection. MOH uses the term to
encourage the enhancement of the overall capacity of a given community or population group. Strategies and outcome measures are very different. Applying the theory provides direction for senior management and field staff in negotiating these differences. Clearly, if the differences are not mediated and resolved, CHNs will make their choices and likely move to adaptation or submersion. The goals of “Health for All” will not be met.

Recommendations for Further Research

The theory was developed with the input of six CHNs in three locales. In order to be tested and verified, it needs to be taken to the arena of practice and tested.

* Negotiating expectations* suggests that a better interface between academia and practice be established. Theory can inform practice but needs to do so within a context of respect and humility. Field staff have much to offer academics. They are making sense in the midst of a maelstrom of competing notions and interests. How they do this is still somewhat of a mystery. It would be fruitful to have anthropologists study the art and science of *negotiating possibilities* in the field over time.

Another area that would benefit from further study is the concept of power and how it is used, denied or under utilized by CHNs in their work with management, colleagues, clients and communities. Feminist researchers would be appropriate allies in this endeavour. During the data analysis process, I noted that the CHNs were interested in the nature and influence of power relationships between themselves and their communities. The word empowerment has been used in health promotion practice and literature for over five years, yet, there continues to be a lack of clarity of this term at all levels. Participatory action research with CHNs and communities around this theme would help build an informed community of practice.
Finally, further research in the discrete categories of the theory would be appropriate. Participatory action research between management and CHNs with academic involvement would provide more discrete information about how the CHNs actually engage in the process of *negotiating expectations*. What are the critical factors that determine when a CHN will resort to coping strategies? How can those be addressed to increase the potential for quality practice and job satisfaction?

**Conclusion**

This study sought to understand how CHNs experienced the implementation of health promotion in the context of their workplace. It has resulted in a theory that describes a rich and complex context with multiple actors. CHNs have incorporated the principles of health promotion in their practice with perseverance and humour. The most interesting facet for me in conducting this research was discovering the depth of discomfort and naivete of CHNs with the concept of their personal power. Even those who claimed high allegiance with the principles of health promotion acknowledged that if the mandates were to change, they would adjust their practice and mediate. None would “rock the boat.” This is a reminder that health promotion as a community of practice continues to be fragile. All agencies, disciplines and communities which espouse it must be vigilant.
REFERENCE LIST


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