

Meanings of knowledge and identity in public health nursing in a time of transition: interpretations of public health nurses' narratives

Berit Misund Dahl RN, PHN, MSc (PhD Student)^{1,2} and Anne Clancy RN, PHN, DrPH (Associate Professor)³

¹University of Bergen, Bergen, Norway, ²Faculty of Health Sciences, Aalesund University College, Ålesund, Norway and ³Department of Health and Social Work, School of Nursing, Harstad University College, Harstad, Norway

Scand J Caring Sci; 2016; 29; 679–687

Meanings of knowledge and identity in public health nursing in a time of transition: interpretations of public health nurses' narratives

Background: A changing healthcare system affects the professional identity of nursing groups. Public health nursing has experienced challenges in balancing the paternalistic expert ideology and the empowerment participation ideology. A strong professional identity can legitimate nursing, and possibly influence the quality of nursing work. Narrations from practice can illuminate the nurses' theoretical and practical knowledge and help illustrate their collective professional identity.

Aim: To illuminate the meaning of public health nursing knowledge and professional identity in a continuously changing public health nursing practice.

Method: A qualitative interview study with a purposeful sample of 23 Norwegian public health nurses was carried out. Data were analysed using phenomenological hermeneutics, a descriptive method inspired by Ricoeur's philosophy of interpretation.

Findings: Three themes emerged (i) Being a generalist: emphasising the need for generalised knowledge and using clinical judgement, (ii) Being one who empowers:

focusing on resources and coping strategies, (iii) Being occupied with individual problem solving: focusing on individuals with special needs, using standardised techniques and protocols, and lacking specialised knowledge.

Conclusion: Interpretation of the nurses' stories illuminated their need for generalised evidence-based knowledge, but also the importance of using sound clinical judgement in a diverse complex practice, where service users need encouragement, support and expert advice. Time pressures can limit the nurses' involvement. Many had an individual problem-focus more than a primary prevention focus, in contrast to governmental regulations stating that Norwegian public health nurses should focus on health promotion and primary prevention. Public health nurses have a broad generalised knowledge of their special target group giving them a 'specialist generalist' role. Clarification of this role, in relation to jurisdictional borders, can create a strong identity at a time when healthcare policy promotes economic values, professional neutrality and increased collaboration.

Keywords: knowledge, Norway, phenomenological hermeneutics, professional identity, public health nursing.

Submitted 5 September 2014, Accepted 25 October 2014

Introduction

Health care is undergoing major health service reforms owing to a changing socio-economic and demographic situation (1) and a shift towards a greater public health focus (2). Public health nursing is under pressure with regard to the quality of care due to technological

developments and demands for an evidence-based service (3). Due to changes in health priorities, the professional identity of nursing groups has been challenged (4). It is argued that nursing identity was stronger in the past and that it is more complex and diverse in the present (5, 6). Scholes (7) calls for a reframing of nurses' professional identity. In establishing a professional identity in nursing, possessing theoretical knowledge (8–10), having 'transferable skills' and 'being a generic specialist' (11) can be essential. Hence, it is of importance to integrate both theoretical and practical knowledge to develop the advancement of nursing practice (12). There is a lack of studies on professional identity in public health nursing. In today's complex health care with

Correspondence to:

Berit Misund Dahl, Faculty of Health Sciences, Aalesund University College, N0-6025 Ålesund, Norway.

E-mail: bd@hials.no

The copyright line for this article was changed on April 5, 2016 after original online publication.

© 2015 The Authors.

Scandinavian Journal of Caring Sciences published by John Wiley & Sons Ltd on behalf of Nordic College of Caring Science.

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

increased interprofessional collaboration, clarifying the public health nurses' (PHNs) knowledge can contribute to developing the identity of the profession. A clarification of professional identity is also a clarification of professional responsibility towards the population and is related to the quality of work (13).

Background

Public health nurses (PHNs) were among the first community health professionals to reduce inequalities in health in the population they served (14). Norwegian PHNs are Registered Nurses with 1 year of postgraduate studies in public health nursing. In contrast to many other countries where PHNs provide services for the whole population (15), PHNs in Norway provide services to a more specialised target group. They work in municipalities; provide home visits to families with newborn babies and on occasion to children and young people with special needs. They carry out consultations at child health clinics and school health services, focusing on health promotion and primary prevention, including immunisation of the children. Almost a 100% of Norwegian families avail of the services. PHNs' also work with environmental health and communicable diseases and can prescribe contraceptives to young people aged between 16 and 19 years.

Knowledge base

Public health nursing knowledge is related to core competencies in nursing, health promotion and primary prevention. The theoretical and practical forms of knowledge in nursing can be described using Aristotle's (16) intellectual virtues of episteme, techne and phronesis. Episteme refers to theoretical, evidence-based knowledge that can be standardised; techne refers to practical skills; and phronesis refers to practical wisdom, which can be the use of clinical judgement based on a situational understanding and relevant theoretical and practical knowledge. PHNs knowledge-basis includes medical, psychological and social knowledge and has a basis in holistic nursing care in face-to-face work (17).

There has been a shift in PHNs approach to health since the first International Conference on Health Promotion in Ottawa 1986. Health promotion strategies involve individual and population participation and resource orientation (18). At the same time, PHNs are expected to master disease prevention based on a paternalistic approach with a pathogenic risk focus, where the focus is on solving individual problems with general recommendations based on the right cure (19). To carry out disease prevention, PHNs work on three levels of intervention as follows: primary prevention, focusing on whole populations in order to prevent problems or diseases from

occurring; secondary prevention, to limit the duration and extent of a problem or disease; and tertiary prevention which focus on preventing or minimising sequelae (20).

Public health nursing research (21, 22) has illustrated the challenges involved in combining biomedical knowledge and a paternalistic ideology with social scientific knowledge and empowerment ideologies.

Professional identity

Understanding professional identity is not straightforward (4). Identity can be understood as some characteristics of an individual or a group that distinguishes the individual/group from others, and where an individual/group can be recognised through life in spite of different contexts and influences based on biological, psychological and sociological processes (23). In this paper, professional identity is understood by reflecting on how PHNs characterise themselves based on their narrations of how they work and how they experience their practice. Narrations imply a preunderstanding (prefiguration) of the situation, a narrative phase (configuration), and the reflection afterwards (refiguration), where something general about the individual can be constituted (24, 25).

When professionals narrate and critically reflect on situations in education, and in communities of practice (26), the stories can illuminate their theoretical and practical knowledge. The narratives of professionals can be influenced by institutional and professional directives (27, 28), and when the narratives intertwine with some common stories or characteristics of the profession, a collective professional identity can be developed.

Aim

The aim of this study was to illuminate the meanings of public health nursing knowledge and professional identity in a continuously changing practice.

Method

Design

This study has a phenomenological hermeneutic approach, inspired by Ricoeur (29) and adapted as a research method within health care by Lindseth and Norberg (30). The focus of the method is to reveal in-depth knowledge, and it was found appropriate to elucidate the nature of knowledge and lived experiences of PHNs.

Sample. The informants were a purposeful sample of 23 female Norwegian PHNs. Inclusion criteria were PHNs

working at health clinics for children and/or young people and/or in school health services within two defined counties in Norway. The characteristics of this sample are outlined in Table 1.

Data collection. Access to the research field was established through oral and written inquiries to public health nursing supervisors. These supervisors informed the PHNs, who then established direct contact with the researcher.

The first author carried out all the interviews and transcribed the data. This can minimise some sources of error. Both researchers discussed the transcriptions critically in relation to the research questions, to reveal the most probable interpretation. An awareness of our pre-understanding as nurses and as nurse researchers contributed to a continued need to revise, question and broaden the critical reflection; and, following Patton (31), an exploration for rival themes and other ways of organising the data. The interviews lasted from 60 to 80 min.

The informants were not asked directly about their knowledge and professional identity; instead, information regarding their work and their experiences with their work was attained through questions such as: Can you describe a situation where you experienced having relevant knowledge, or where you felt you lacked knowledge in a particular situation? What is your most important task when meeting a service user? The interviewees were allowed to speak with as little interruption as possible.

Data analysis

The phenomenological hermeneutic analysis involves three steps: a naïve reading; a structural analysis; and a comprehensive understanding of the interview text (30). The first step was reading the text as a whole, so as to

grasp its essential meaning. The text was read several times, which led to a naïve understanding of the meaning of PHNs' knowledge and professional identity. The second step was a thematic structural analysis where the focus was on identifying meaning units in the interview text, which are sections of text that convey one meaning. The meaning units were condensed into everyday language. The condensed meaning units were critically reflected on, compared to each other, and then abstracted and organised into subthemes. Subthemes with similar meaning were identified and sorted into themes, which validated or invalidated the understanding gained from the naïve understanding. The analysis process was repeated until the naïve understanding was validated by the structural analysis (30). The comprehensive understanding involved a reflective reading of the text as a whole and a dialectic movement between the naïve understanding and the themes in the structural analysis. It is necessary to follow the text from what it says to what it talks about (29). Doing so led to a comprehensive understanding of the text, which was developed further using relevant literature, and where the authors' preunderstanding was also taken into account (30).

Findings

Naïve understanding

The PHNs expressed the need for having both general knowledge about the normal development of the child and specialised knowledge and extensive clinical judgement. PHNs focused on empowering service users to make healthy lifestyle choices. When PHNs detected problems, some referred the service users immediately to specialised services. Other PHNs were more occupied with solving problems on an individual basis and found it challenging to find time to work more with primary prevention.

Themes and subthemes

The structural analysis divided the text into themes, resulting in three themes and seven subthemes (Table 2).

Theme: being a generalist

The theme 'Being a generalist' was formulated from two subthemes 'knowing a little about a lot'; and using clinical judgement.

'Knowing a little about a lot' meant that PHNs at times could feel that they needed to brush up on their knowledge. One PHN (3, HS) spoke about being asked to talk to pupils after a pupil's mother had died of cancer. She said

Table 1 Sample characteristics ($N = 23$)

PHNs working at child health clinic (H)	6
PHNs working in school health service (S)	7
Both health clinic and school health service (HS)	10
Length of service	0.5–25 years, with a mean of 11.2 years
0.5–5 years length of service	7 (PHN 1–7)
10–15 years length of service	9 (PHN 8–16)
16–25 years length of service	7 (PHN 17–23)
Number of municipalities/districts	12
Size of municipalities	4500–625 000 inhabitants
Distribution of informants	1–4 in each municipality/district

Table 2 Themes and subthemes formulated from the structural analysis

Subtheme	Theme
'Knowing a little about a lot'	Being a generalist
Using clinical judgment	
Revealing resources of service users	Being one who empowers
Using coping strategies	
Focusing on individuals with special needs	Being occupied with individual problem solving
Following guidelines and protocols	
Lacking specialised knowledge	

that she called the Norwegian Cancer Society and obtained the information she needed. 'Knowing a little about a lot' could also mean knowledge about what to do and when to refer. One PHN (3, HS) spoke about a girl who had suddenly lost a lot of weight. Feeling that this situation was more than she could deal with, the PHN referred her to psychiatric services for children and young people. PHNs also discussed challenging situations with each other. They experienced they always had to be up to date on relevant topics, and could sometimes feel ill at ease when they were not able to answer questions from parents.

Using clinical judgement meant having knowledge about what was required in a situation. One PHN (8, HS) described a mother with severe mastitis who was in so much pain that she could barely lift her baby. The nurse commented, 'It is about the importance of bonding with the baby, and that is actually more important than breastfeeding'. In this situation, the PHN recommended the mother to bottle-feed her baby; however, the PHN pointed out that she seldom advised mothers to stop breastfeeding. The PHN knew about the importance of breastfeeding but she also knew what was at stake and was aware of important medical, psychological and social factors. Some PHNs described how they could detect problems in a family at a glance. One PHN (7, S) spoke about newcomers, a mother with four children (all close in age) and how she realised quickly that both the children and the mother needed referral to a range of services. Other times the PHNs saw mothers who struggled for their family but without a need for specialist services. The PHNs often discussed this problem, and wondered whether their worries were due to lack of experience. Discussions of face-to-face work permeated the majority of the PHNs' narratives. It could mean letting parents take the time needed to explain their situation, to share their thoughts so that they could explain properly what was frustrating and difficult for them. One PHN (2, H) said:

But now and then they need specific advice. Then I try to engage in a dialogue [with them] and then ask them to confirm that they have received adequate help.

It was important for this PHN to try to meet the expectations of the parents, to answer their questions and know that they were satisfied; however, this was time-consuming and sometimes made it difficult to stick to their allotted time schedule.

Theme: being one who empowers

The theme 'being one who empowers' was formulated from two subthemes revealing resources of service users; and using coping strategies.

Revealing resources of service users meant that most of the PHNs strived for good dialogues with service users, in order to reveal their resources. One nurse (23, S) said that when she had an adolescent with a particular problem in her office, she always closed the meeting by asking how the pupil was getting on at school. Normally, she got a positive answer, and if so, she told the pupil that she was there if they ever needed her. However, sometimes the answer was 'I am not feeling well', 'I can't concentrate at school' or 'I can't manage to do my homework' or 'I am not able to submit my assignments'. Then she had to essentially restart the session with the pupil so that she could determine what was wrong and at the same time reveal their resources. The PHN said that she had many experiences related to mental health – and had also taken further education in mental health promotion – on how to engage in a good dialogue and use cognitive therapy. She said that she used communication techniques and was influenced by Antonovsky's (19) sense of coherence (SOC) about motivation to cope (meaningfulness); understanding a challenge (comprehensibility); and believing in available resources to cope (manageability). Another PHN (13, S) described a class of 9-year-old children where some pupils expressed feelings of sadness, sorrow and anxiety. The PHN mentioned that one pupil had made the following remark: 'I am afraid. No one likes me. I am uncertain whether Mamma and Pappa love me'. Strong statements, such as this, from pupils made the PHN feel frustrated and powerless. For confidentiality reasons, the PHN discussed these problems in individual conversations, never in groups. The PHN was very conscious of health promotion strategies instead and focused on what the pupils could do to achieve good health.

Using coping strategies could be about 'finding the positive things' as a way to get young people and parents back on track. One PHN (7, S) said that when she told young people and parents that they were really outstanding individuals, she immediately noticed the positive effect this had on them. Another PHN (13, S) spoke about meetings, she had with a girl who had been bullied on Facebook and on her mobile phone for being obese. The PHN went for walks with the girl, 'then we talked much better', she said. The PHN had a dialogue

with the girl and her parents, and collaborated with the school and the psychological services.

Theme: being occupied with individual problem solving

The theme 'Being occupied with individual problem solving' was formulated from three subthemes focusing on individuals with special needs; following guidelines and protocols; and lacking specialised knowledge.

Focusing on individuals with special needs meant that time which had been initially reserved for health promotion activities for all the pupils was often spent on particular individuals who needed attention. One nurse (7, S) said:

Because of lack of time, I have to cut out office hours for all the pupils and instead attend meetings about pupils with special needs.

Many PHNs experienced that individual pupils with special needs were prioritised over general health promotion and primary prevention work. One nurse (23, S) stressed that she could see the results of individual prevention:

Yet I think that I see many results.... Some just need to talk to sort things out, and afterwards, they can move on, relieved. And some people may need several conversations.

As in most of the PHNs' responses, this PHN felt that she had an important job in understanding and meeting the needs of the individual service user. Another PHN narrated about a meeting with a family with a 3-year-old child where the problem was lack of boundaries. The PHN (5, H) said:

Then I want to follow them up myself, and not just refer them [to specialised services]. But that means that I spend a lot of time on the consultations, which causes other delays, so it is not an easy balance. It is a dilemma.

Some nurses felt that they should be working more with the healthy population, but that they were kept busy helping young people, who because of capacity problems could not be referred to more specialised services.

Following guidelines and protocols meant using standardised knowledge in the form of general procedures and protocols. PHNs sometimes depended on guidelines and communication techniques developed by other professionals to manage certain situations. This entailed that they used standardised expert knowledge. One nurse (5, H) described a situation where she followed guidelines when parents needed advice regarding their child's sleep patterns:

I advised them. Felt they were ready for that. And gave them concrete instructions. These parents were

exhausted. It was their first child; they agreed to meet again in one week. By that time, the child slept the whole night. "We only did as you said", the parents told me.

However, following guidelines was not always straightforward. Many PHNs articulated that they had to carry out their statutory tasks and that parents might have other expectations which the PHN could not meet because of time pressure.

Lacking specialised knowledge meant that some PHNs could experience they lacked the right knowledge in a situation. The population they serve is often updated on their particular cases and PHNs experienced that they were not always able to answer questions from parents. One PHN (9, HS) described her experiences as a newly qualified PHN as follows:

Oh, I felt that I must give an answer at once, and you do not quite realise it is possible just to say "I don't know" and that you need time to find out about it and get back to them. Generally, people accept this, and they mostly feel that they are being taken seriously.

The PHNs also had to possess basic medical knowledge. One PHN (23, S) spoke of having a differential diagnosis in the back of her mind when adolescents presented with gynaecological problems. The PHN had to be able to ask relevant questions but was aware that she should not make diagnoses. Medical knowledge was needed for instance when giving advice about contraceptive pills so as to inform young people about thrombosis and other medical issues.

Comprehensive understanding

Meanings of the phenomenon of knowledge and identity in public health nursing have been interpreted from the PHNs stories. The PHN is characterised as being one who empowers and one who works towards solving the problems of children, young people and families. The health promotion empowering role can be interpreted as being based on social scientific knowledge and a relational caring perspective. The PHNs combined health promotion activities with problem-solving work and on giving advice based on medical knowledge and standardised techniques. The professional knowledge of PHNs was thus based on both relevant theoretical episteme knowledge and practical techne and phronesis knowledge. Freidson (13), however, maintained professional knowledge can be specialised and standardised. This theoretical understanding of knowledge has been challenged by Martinsen (32), who pointed out the significance of knowledge other than positivistic and evidence based, and maintained phronesis, or practical

wisdom and relational competence must be valued over scientific knowledge in nursing, as practical wisdom is crucial for best practice (16, p. 166), and hence the quality of nursing. The study shows the interdependence of theoretical and practical knowledge in public health nursing. The empowering role of PHNs involves a shift in power from the professional as an expert advisor to an approach that involves dialogue with the service user. The stories illuminated that the PHNs' expert advice is still needed in certain situations and that when PHNs use their clinical judgement wisely, good professional decisions are made. However, it was not always easy for the PHNs to combine empowering and expert problem solving and standardised strategies due to time pressures.

An increased demand exists for instrumental skills in nursing (33), and the use of standards and protocols has become more common in public health nursing. Because health care is based on scientific evidence (34), there is a greater focus on standardised tasks and expectations rather than on clinical judgement in situations. The use of evidence-based standardised protocols and techniques has been questioned. In their review of the clinical pathways in nursing and midwifery, Hunter and Segrott (35) found a weak evidence base, which could be problematic when nurses rely on checklists to support decision-making. According to Benner (36, p. 37), nursing knowledge cannot be put into abstract principles or even explicit guidelines. Guidelines and protocols increase evidence-based care but restrict professional innovation and reduce the focus on communication (37). The findings reveal that guidelines and protocols can give good results, but they can also weaken the clinical judgement of PHNs if they hinder the nurses from being flexible and meeting individual needs. The use of standardised protocols and measurable tools can create an impression of professional practice. Excessive use of protocols and tools can, however, lead to an instrumentalisation of public health nursing and weaken professional identity in the long run. The results of the study indicate that PHNs will benefit from having a strong professional identity related to acceptance of an approach that is based on the application of sound clinical judgement to generalised evidence-based knowledge in complex practice situations.

Public health nurses' disease prevention work was mostly at a secondary and tertiary prevention level. Their primary prevention work was limited to standardised programs in child health clinics and schools. Problem-solving work at an individual level can be time-consuming, and the PHNs experienced that it distracted them from population based primary prevention work.

The findings indicate that a great number of PHNs' followed up individuals and families over time. These

activities are more closely related to the ethos of nursing than traditional public health population work. Norwegian governmental strategies state that PHNs should work with health promotion and primary prevention (38).

The problem focus in PHNs work could also cause challenges due to PHNs' lack of specialised knowledge in individual problem-solving work. Previous research has discussed whether PHNs are generalists or specialists (14). Meanings of the phenomena of knowledge and identity in this study indicate that PHNs can be characterised as generalists, having a broad range of knowledge and skills of normal development, 'knowing a little about a lot'. Because PHNs meet almost all families with children, they possess a generalised knowledge of normal development, which makes it easier to discover deviations (39, 40). In the role of providing supportive universal, low threshold services PHNs can reach groups of people who will otherwise not receive health services. In this sense public health nursing can be considered a specialist service, and PHNs can be identified as 'specialised generalists'. The concept 'specialist' here relates to the understanding that no other professionals can do what they can do (11).

From the findings, it can be argued that the 'specialised generalist' role was a role PHNs will need to develop further, as PHNs did not always feel capable to meet the demands of knowledge in their practice. In order for professionals to empower others, the professionals must first empower themselves (41, 42). PHNs can need to focus on their main mandate of health promotion and primary prevention and refer service users with severe problems to specialised services, to avoid blurred jurisdictional borders of the profession. The jurisdiction gives them control over a particular knowledge field, which can define a profession (43). In a health and social care focusing on public health interprofessional collaboration and neutrality of professions, PHNs may have weakened their position as public health workers and can need to clarify their public health role as contributors against inequality in health. Uncertainty about their role can weaken the identity of public health nursing.

A way to confirm and develop the identity of the profession is that professionals meet in what Wenger (26) names communities of practice, where PHNs can narrate and critically reflect on activities and become aware of their role in relation to professional and institutional directives and practice demands. The PHNs' narrations were a refiguration of their understanding of practice. It is the narratives that people tell about situations that contribute to constituting their identity (24, 25). Thus, the interpretation of narratives has helped illuminate meanings of public health nursing knowledge and identity.

Methodological considerations

Lincoln and Guba (44) use the terms credibility, dependability, confirmability and transferability as criteria for the trustworthiness of qualitative studies. The credibility or truth of the data is based on the dependability or stability of the data. The data are derived from 12 different settings; it showed variation in the experiences of the participants, this can promote the credibility of the data. The confirmability or objectivity of the data relates to the interpretation processes, which were described by illuminating accurately what was done. Some of the interpretations are supported by other literature, which can strengthen confirmability. Together with trustworthiness, qualitative studies also require authenticity and a critical approach with honourable intentions (45). The findings can be transferred to similar contexts and viewed as arguments in an ongoing discourse (29).

There are limitations to the study related to research participants and methodology. The PHNs in the present study had different working contexts and experience, but in spite of differences, these were some common characteristics illuminated from the narrations. The sample is a limited number of Norwegian PHNs, can only to some extent be compared to PHNs in other countries, and represents only one group of nurses. However, the theme of professional identity in nursing is universal in nature and is of international interest. There is a predominance of women in public health nursing; the gender aspect is not explored.

There are methodological limitations to focusing solely on individual PHNs' narrations. Carrying out field observations and interviewing service users and investigating their experiences from practice situations could have given additional insight.

Conclusion

The PHNs are occupied with individual problem-solving activities, and they experience that they lack specialist knowledge. This emphasis on secondary and tertiary prevention is in contrast to governmental regulations, which state that PHNs should focus on health promotion and primary prevention, and refer those with severe problems to specialised services. Their knowledge and identity is also characterised by challenges in combining clinical judgement and empowering strategies with standardised protocols. Their specialisation, as nurses, in health promotion and disease prevention can support their public health nursing role as 'specialised generalists' in public health. Time pressures and the uncritical use of evidence-based techniques and protocols developed by other professions can weaken their clinical judgement and blur their professional identity. With the increased focus on

professional neutrality and interprofessional collaboration, it can be of importance that PHNs are empowered as in their role in health promotion and primary prevention against inequalities in health. Critical reflection on their experiences in communities of practice can strengthen the collective identity and legitimacy of the profession.

Future research should focus further on clinical judgement and on the gender aspect related to professional identity in public health nursing.

Implications for public health nursing practice

- Public health nurses' narrations illuminate that service users appreciate the advice of an expert nurse, but they also appreciate dialogue and meeting a nurse who empowers.
- When using clinical judgement, sound action choices can be made, but the PHNs can be challenged by time pressures and the use of standardised techniques and protocols.
- Public health nurses are clear about their supportive role but need a stronger health promotion and primary prevention focus.
- Illuminating the complexity and diversity of the PHNs' role for their target population, can build a strong 'specialised generalist' public health nursing identity.

Acknowledgements

The authors would like to thank the participants of the study for sharing their experiences with us.

Author contributions

Berit Misund Dahl designed the study and collected the data. The analysis and interpretation was carried out by Berit Misund Dahl and supervised by Anne Clancy. The drafting of manuscript was made by both authors.

Ethical approval

The study was approved by the Norwegian Social Science Data Services (NSD). Research ethical guidelines were followed. The participants signed consent forms and were informed that they could withdraw at any time that the confidentiality of their personal information would be maintained and that their anonymity would be preserved.

Funding

We thank Aalesund University College, Norway for their support. No conflict of interest has been declared by the authors.

References

- 1 Horton K, Tschudin V, Forget A. The value of nursing: a literature review. *Nurs Ethics* 2007; 14: 716–40.
- 2 Winters L, Gordon U, Atherton J, Scott-Samuel A. Developing public health nursing: barriers perceived by community nurses. *Public Health* 2007; 121: 623–33, University Press, Cambridge.
- 3 Markham T, Carney M. Public Health Nurses and the delivery of quality nursing care in the community. *J Clin Nurs* 2008; 17: 1342–50.
- 4 Crawford P, Brown B, Majomi P. Professional identity in community mental health nursing: a thematic analysis. *Int J Nurs Stud* 2008; 45: 1055–63.
- 5 Tye CC, Ross FM. Blurring boundaries: professional perspectives of the emergency nurse practitioner role in a major accident and emergency department. *J Adv Nurs* 2000; 31: 1089–96.
- 6 Harmer V. Are nurses blurring their identity by extending or delegating roles? *Br J Nurs* 2010; 19: 295.
- 7 Scholes J. Coping with the professional identity crisis: is building resilience the answer? *Int J Nurs Stud* 2008; 45: 975–8.
- 8 Gregg MF, Magilvy JK. Professional identity of Japanese nurses: bonding into nursing. *Nurs Health Sci* 2001; 3: 47–55.
- 9 Tabari Khomeiran R, Yekta ZP, Kiger AM, Ahmadi F. Professional competence: factors described by nurses as influencing their development. *Int Nurs Review* 2006; 53: 66–72.
- 10 Deppoliti D. Exploring how new registered nurses construct professional identity in hospital settings. *J Contin Educ Nurs* 2008; 39: 255–62.
- 11 Hurley J. A qualitative study of mental health nurse identities: many roles, one profession. *Int J Ment Health Nurs* 2009; 18: 383–90.
- 12 Christensen M. Advancing nursing practice: redefining the theoretical and practical integration of knowledge. *J Clin Nurs* 2011; 20: 873–81.
- 13 Freidson E. *Professionalism: The Third Logic*. 2001, Polity Press, Cambridge.
- 14 Edgecombe G. *Public Health Nursing: Past and Future. A Review of the Literature*. 2001, World Health Organization (WHO) Regional Office for Europe, Copenhagen.
- 15 Philibin CA, Griffiths C, Byrne G, Horan P, Brady A-M, Begley C. The role of the public health nurse in a changing society. *J Adv Nurs* 2010; 66: 743–52.
- 16 Aristotle. *The Nicomachean Ethics*. 2004, Penguin Books, London.
- 17 Keller LO, Strohschein S, Schaffer MA. Cornerstones of public health nursing. *Public Health Nurs* 2011; 28: 249–60.
- 18 WHO. *Ottawa Charter for Health Promotion*. 1986, World Health Organization, Geneva.
- 19 Antonovsky A. *Unravelling the Mystery of Health: How People Manage Stress and Stay Well*. 1987, Jossey-Bass, San Francisco.
- 20 Caplan G. *Principles of Preventive Psychiatry*. 1964, Basic Book, New York.
- 21 Andrews T. Radical changes or traditional approaches in a different guise? An analysis of the Norwegian mother-child service. *Int J Health Services* 2003; 33: 219–34.
- 22 Dahl BM, Andrews T, Clancy A. Contradictory discourses of health promotion and disease prevention in the educational curriculum of Norwegian public health nursing: a critical discourse analysis. *Scand J Public Health* 2014; 42: 32–37.
- 23 Erikson EH. The problem of ego identity. *J Am Psychoanal Assoc* 1956; 4: 56–121.
- 24 Ricoeur P. *Time and Narrative*. 1984, University of Chicago Press, Chicago.
- 25 Ricoeur P. *Oneself as Another*. 1992, University of Chicago Press, Chicago.
- 26 Wenger E. *Communities of Practice: Learning, Meaning, and Identity*. 1998, University Press, Cambridge.
- 27 Hotho S. Professional identity – product of structure, product of choice. *J Organisational Change Management* 2008; 21: 721–42.
- 28 Wackerhausen S. Collaboration, professional identity and reflection across boundaries. *J Interprofessional Care* 2009; 23: 455–73.
- 29 Ricoeur P. *Interpretation Theory: Discourse and the Surplus of Meaning*. 1976, Texas Christian University Press, Fort Worth, TX.
- 30 Lindseth A, Norberg A. A phenomenological hermeneutical method for researching lived experience. *Scand J Caring Sci* 2004; 18: 145–53.
- 31 Patton MQ. *Qualitative Research & Evaluation Methods*. 2002, Sage, Thousand Oaks, California.
- 32 Martinsen K. *Care and Vulnerability*. 2006, Akribes, Oslo.
- 33 Scott SD. ‘New professionalism’ – shifting relationships between nursing education and nursing practice. *Nurse Educ Today* 2008; 28: 240–5.
- 34 Swider S, Levin P, Ailey S, Breakwell S, Cowell J, McNaughton D, O’Rourke M. Matching a graduate curriculum in public/community health nursing to practice competencies: the Rush University experience. *Public Health Nurs* 2006; 23: 190–5.
- 35 Hunter B, Segrott J. Re-mapping client journeys and professional identities: a review of the literature on clinical pathways. *Int J Nurs Stud* 2008; 45: 608–25.
- 36 Benner P. *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. 1984, Addison-Wesley, Menlo Park, CA.
- 37 Halldorsdottir S, Karlsdottir SI. The primacy of the good midwife in midwifery services: an evolving theory of professionalism in midwifery. *Scand J Caring Sci* 2011; 25: 806–17.
- 38 Meld. St.16. *Report to the Storting (white paper). National Health and Care Services Plan (2011–2015)*. 2010–2011, Norwegian Ministry of Health and Care Services, Oslo.
- 39 Clancy A. *Perceptions of public health nursing practice: on borders and boundaries, visibility and voice*. 2010:7 Doctoral thesis, NHV, Göteborg.
- 40 Clancy A. The ceremonial order of public health nursing consultations: an ethnographic study. *J Clin Nurs* 2012; 21: 2555–66.
- 41 Laverack G. *Public Health: Power, Empowerment and Professional Practice*, 2nd edn. 2009, Palgrave Macmillan, New York.
- 42 Cawley T, McNamara PM. Public health nurse perceptions of empowerment and advocacy in

- child health surveillance in West Ireland. *Public Health Nurs* 2011; 28: 150–8.
- 43 Abbott A. *The System of Professions: An Essay on the Division of Expert Labor*. 1988, University of Chicago Press, Chicago.
- 44 Lincoln YS, Guba EG. *Naturalistic Inquiry*. 1985, Sage, Beverly Hills, CA.
- 45 Whittemore R, Chase SK, Mandle CL. Validity on qualitative research. *Qual Health Res* 2001; 11: 522–37.